TEAMHealth ANESTHESIA

WHITE PAPER

TRANSITIONING YOUR HOSPITAL'S ANESTHESIA SERVICE TO A CARE TEAM MODEL

MAURY PARRISH, CMPE, MBA
VICE PRESIDENT
CLINICAL SERVICES
TEAMHEALTH

CINDY LILLEY, RN, BSN, MHA
DIRECTOR OF SURGICAL SERVICES
LEGACY GOOD SAMARITAN
MEDICAL CENTER

Making a wholesale delivery model change in the anesthesia department can create challenges for the hospital executive team. Often the decision to make a change is reached after repeated efforts to address operational, coverage-related or customer satisfaction issues. But to take action what's often required is new leadership and expertise either in the form of new group management or, in many cases, the replacement of the existing group with a provider organization that can effect change rapidly. To be successful, the executive team must understand the advantages of an anesthesia delivery model change and have realistic expectations about how that change can be accomplished and what to expect from its providers. This white paper will focus on the transition of an anesthesia department from an all-physician model to a medically directed anesthesia care team (ACT) model.

Introduction

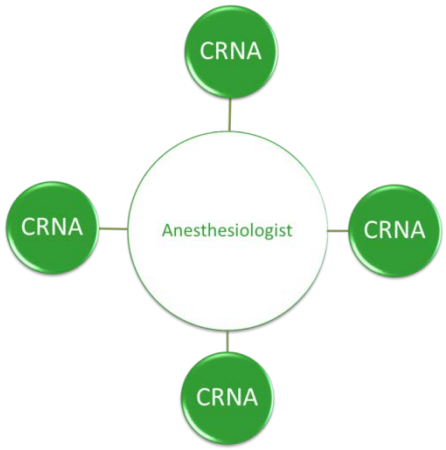
Change in the healthcare industry is forcing hospital executives to sharpen their focus simultaneously on providing high-quality care, boosting patient and physician satisfaction and enhancing their bottom lines. With these imperatives, many hospital leaders are turning their attention to their operating rooms (ORs),

which are responsible for as much as 70 percent of a facility's revenue and 40 to 50 percent of its profits, and discovering that converting their anesthesia service from an all-physician delivery model to an anesthesia care team (ACT) model can help them reach all three goals. This white paper will explore the benefits of medically directed ACTs and discuss the process through which hospitals can transition from an all-physician delivery model to an ACT service model.

The Care Team Advantage

In a traditional, all-physician anesthesia service delivery model, hospitals commonly staff one anesthesiologist for every active OR in the facility. So, if there are nine ORs, there are likely nine anesthesiologists on duty during normal OR hours. An anesthesiologist is assigned to a specific OR and is responsible for the patients that come through their OR, from pre-operative evaluation and testing, preparation for surgery, surgery and recovery. Given this structure, physicians handle one case at a time, from start to finish, before moving on to the next patient.

A medically directed ACT combines one anesthesiologist with up to four certified registered nurse anesthetists (CRNAs) as a team. Together, the team can manage a complex array of cases with the physician's attention involved at critical junctures of each patient's anesthesia experience. The physician is available to the CRNA throughout the entire case, during which the CRNA handles much of the pre-op preparation, remains at the patient's bedside throughout the surgery, and is with the patient when they are transferred to the post-anesthesia care unit (PACU). Meanwhile, the anesthesiologist is involved with each patient at important points in their care, including the patient's pre-op interview, working with the CRNA to develop the anesthesia care plan, attendance during intubation, emergence from anesthesia and at regular monitoring points throughout the case.



Why a Care Team Model?

Improved efficiency

Flexibility

Increased revenue and profits

Improved teamwork and communication

Higher surgeon and patient satisfaction scores

Standardization of care

Service line specialization

Alignment with hospital mission and goals

Advantages of a Care Team Model

The advantages of the care team model are several, including:

- **Improved efficiency.** A care team model allows the providers to simultaneously prep one patient while others are in surgery and recovery, instead of having one physician managing a single case at a time from start to finish. Together, the care team providers keep each patient moving efficiently through the continuum of care, thereby eliminating or dramatically reducing anesthesia-related case delays or cancellations. Specifically, the ACT model increases surgical efficiency and throughput by allowing faster room turnover and, when possible, "flipping" rooms. It also lowers nursing overtime costs by decreasing the need to push cases later into the evening.
- **Flexibility.** There are times when the hospital needs anesthesia skills outside

of the OR, such as for providing airway support during a code or sedation services for the endoscopic lab, CT service, catheterization lab, co-located ambulatory surgical center or other department. In an all-physician model, the hospital depends on having an available physician to attend to these needs, which can often delay the start of other cases.

In an ACT model, the anesthesia team has the flexibility to assign a CRNA to those sites, or in an emergent situation an anesthesiologist can find another partner to manage his cases while he deals with the emergent/urgent need.

- **Increased revenue and profits.** By streamlining the perioperative functions to eliminate backlogs and reduce turnover times, the ACT allows a hospital to complete its usual number of daily surgeries in less time. As a result, the hospital will be able to accommodate at least one to two additional cases in their daily surgical block. Each incremental additional case that can be added through efficiency, without incurring additional labor cost, adds $2,500 to $4,500 in margin to a hospital's bottom line in direct OR or ancillary revenue profits.[i] During a year's time, those additional cases can add up to significant revenue for the hospital.

- **Improved teamwork and communication.** Research has shown that teamwork and communication not only boosts efficiency, but it also improves employee satisfaction,[ii] reduces nurse turnover,[iii] and contributes to patient safety and reduced mortality rates.[iv] Yet, according to a study by the American Association of Critical Care Nurses,[v] three-quarters of healthcare workers are concerned about a teamwork issue, more than two-thirds say the problem has lasted more than a year and only 16 percent have addressed the issue with their peers.

  In an ACT, teamwork and communication are built into the model. The structure allows anesthesiologists to be available to answer questions, help with scheduling changes or troubleshoot. The anesthesiologist and CRNA develop each patient's anesthesia care plan collaboratively so there is no confusion and they can accommodate variations in anesthetic approach based on surgeon preferences. Plus, daily and weekly team huddles facilitate discussion about upcoming cases in order to help reduce cancellations and keep the schedule running smoothly.

- **Higher surgeon and patient satisfaction scores.** An ACT model can increase job satisfaction for the entire perioperative team and patient satisfaction with the hospital experience. The perioperative team benefits from the reductions in turnover times, delays and overtime that allow them to perform additional cases and/or return to their office practices sooner in the day.

  Likewise, patients benefit from the on-time procedures, reductions in case cancellations, and the continuous care and communication of a dedicated CRNA. These improvements can help both groups drive additional surgical business to the hospital. Higher patient satisfaction scores on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys can lead to better reimbursement levels under Centers for Medicare and Medicaid's (CMS's) Value Based Purchasing program.

- **Standardization of care.** Every physician is different, and in an all-physician anesthesia delivery model, processes and practices may vary from provider to provider. The ACT model promotes collaboration and sharing of best practices among providers and creates a standardization of processes and protocols that are designed to ensure efficiency across the continuum of care and consistent outcomes.

- **Service line specialization.** An ACT model more easily lends itself to specialization around a critical service line focus for a hospital (e.g., orthopedic, bariatric). Unlike an all-physician model, an ACT model allows the hospital to limit the number of physicians and CRNAs on a particular service line to a select few, letting those teams develop specific skill

sets. This specialization can lead to better outcomes without compromising provider availability.

- **Alignment with hospital mission and goals.** The structure of an ACT allows providers to more easily implement processes and practices that address core hospital goals, such as improvements on specific core measures. Typically, the anesthesia service leader is in regular contact with hospital leadership, and he or she then directs delivery processes across all care teams in order to reach desired outcomes. Metrics can and should be tracked on a team and provider level in order to measure progress on individual goals.

Making the Decision to Change

After identifying the need to convert anesthesia service delivery to a care team model, the hospital should convene a group of key stakeholders in order to achieve necessary buy-in and discuss how to move forward.

The stakeholder group should include surgical team leadership, C-Suite executives, and in some cases the hospital's board of directors. Together, the group should weigh the benefits of transitioning to an ACT model and whether a new anesthesia management team/provider group will be required. The stakeholder group should outline the qualities the hospital is seeking in its anesthesia partner, research potential companies and vet the candidates until they reach a decision.

The stakeholder group must clearly define the expected deliverables, articulate the hospital's goals for the next 12 to 24 months that impact the anesthesia service and assess the problem areas that need to be addressed by the new partner. They should also ensure that the hospital's bylaws allow for CRNAs to be credentialed to practice in the anesthesia department.

The Transition Process

Converting to a new anesthesia management company and a new delivery model takes time and preparation. However, if the hospital picks the right partner and the process is managed properly, the transition should result in minimal headaches for hospital leaders and staff and immediately begin to provide benefit to the hospital.

Depending on the hospital, the conversion timeline can be as short as a few weeks or as long as several months (generally 60 to 90 days). In general, the process includes the following steps:

1. **Timeline for conversion.** If the hospital has an exclusive contract with the current provider group, the executive team needs to know what the provisions are for "without-cause termination." This can vary, but generally requires a 90- to 120-day notice period to the existing anesthesia providers. The new group should be able to seamlessly take over the practice at the end of that notice period.
2. **Preparation for conversion.** Once the decision has been made by the hospital C-suite team and key medical staff leaders, the parties must conduct due diligence, meet with the new anesthesia group management team to outline expectations, develop a contract for services with the new partner and execute that contract. These actions are critical in order to ensure the hospital and medical staff leadership teams are aligned on the need to change and willing to meet with interested stakeholders to explain that need—a key component of the transition's future success. In addition, the meeting with the new anesthesia partner will create the foundation for all future meetings with the group based on the outlined expectations and contract terms.
3. **Inform the existing group.** Once the hospital selects its new anesthesia

partner, it should inform the existing anesthesia group of its decision to make a change and the rationale behind the decision. If an exclusive contract exists, that contract will need to be formally terminated in accordance with its terms. Often, this conversation is followed closely by an introduction of the new management company and its team. If the hospital has a preference for retaining certain former group members, they should inform the new group's management team promptly.

4. **Recruit department leadership.** Essential to creating any successful provider group is finding the right leader—someone with vision, who understands what the hospital wants and needs, has the operational prowess and authority to get the job done and possesses the interpersonal skills to create a positive group culture. With a robust management group behind him or her, this group's medical director should be able to "off load" most administrative tasks in order to focus on clinical and service delivery needs for the practice.

   Together, the anesthesia management company and hospital should conduct a search to determine the appropriate group medical director, who will serve as the spokesperson for the practice during the startup period.

5. **Recruit providers.** In some cases, some of the existing anesthesia providers may elect to remain with the hospital through the transition, but the new anesthesia management company will be tasked with forming the new group, creating the employment agreements, developing the infrastructure and recruiting providers, as needed.

6. **Form the business entity.** Although the new provider team may include familiar faces for the hospital, the group will need to form an entirely new business identity. With all the CRNAs and physicians as part of the same group, the management company can better align economic incentives with the performance goals of the hospital so everyone is working toward the same quality, operational, and efficiency targets.

7. **Negotiate payer contracts.** As an entirely new entity, the provider group will need to establish contracts with all appropriate commercial and governmental payers. The anesthesia management company should facilitate this process.

8. **Conduct an orientation session.** Before the transition date, it's vital for the hospital and its new anesthesia partner to conduct an orientation session for the anesthesia providers, surgeons and the nursing leadership involved in the transition. This session, typically held within a week of the "go-live" date, will provide attendees with information on new processes, protocols and expectations. The orientation, which will need to be repeated for each new hire, is intended to inform staff about the care team model and set the expectation for the group's dedication to high quality, efficient care and alignment with the goals of the hospital's leadership team.

9. **Follow through.** As with the implementation of any new process or system, there may be a few complications or challenges in the initial days. Administrators, providers and staff should continually communicate any issues, as well as best practices, in order to fine-tune the model to fit the hospital's needs. This communication should occur during frequent, regularly scheduled meetings during the first year of the new contract, during which time all parties can ensure that benchmarked goals are being met.

After identifying the need to convert anesthesia service delivery to a care team model, the hospital should convene a group of key stakeholders in order to achieve necessary buy-in and discuss how to move forward.

The stakeholder group should include surgical team leadership, C-Suite executives, and in some cases the hospital's board of directors. Together, the group should weigh the benefits of transitioning to an ACT model and whether a new anesthesia management team/provider group will be required. The stakeholder group should outline the qualities the hospital is seeking in its anesthesia partner, research potential companies and vet the candidates until they reach a decision.

The stakeholder group must clearly define the expected deliverables, articulate the hospital's goals for the next 12 to 24 months that impact the anesthesia service and assess the problem areas that need to be addressed by the new partner. They should also ensure that the hospital's bylaws allow CRNAs to be credentialed to practice in the anesthesia department.

Conclusion

In today's environment, hospital leaders need strategies that allow care delivery that is both highly efficient and of the highest quality. An ACT model improves upon the traditional physician-only model of anesthesia delivery by improving efficiency, increasing patient and surgeon satisfaction, and reducing costs associated with a hospital's ORs. Converting to a care team model requires time and collaboration among hospital leaders and staff, but with an understanding of what to expect in the process and the right anesthesia partner, the transition should go smoothly and set the tone for future success of all parties.

[i] TeamHealth data on file.

[ii] Leonard, M., et al. "The Human Factor: The Critical Importance of Effective Teamwork and Communication in Providing Safe Care," Qual Saf Health Care 2004;13(Suppl 1):i85–i90.

[iii] Ibid.

[iv] Neily, Julia, et al, "Association Between Medical Team Training and Surgical Mortality," JAMA, October 20, 2010—Vol 304, No. 15

[v] Maxfield, David, et al. "Silence Kills: The Seven Crucial Conversations for Healthcare." Vital Smarts/The American Association of Critical Care Nurses.

BROUGHT TO YOU BY

TEAMHealth®