The surgeons want more OR rooms running later in the day and even on weekends. With reimbursement pressures, they say they need to spend more time in their offices seeing patients. But who’s going to provide the anesthesia coverage for these extended hours? Anesthesia providers say it isn’t financially feasible. They’re already unhappy about downtime during the day. They are asking the administration for a stipend, or a higher stipend. What’s going on?

Demographic and economic issues are pulling surgeons and anesthesia providers in different directions. Though there has been slow but steady growth in the number of anesthesiology residents in recent years, experts say anesthesia providers are still in short supply relative to the number of anesthetizing locations. Though numbers of anesthesia providers are up, other trends are also at work:

• They are being asked to cover more sites—cath labs, imaging suites, pain clinics, and labor and delivery areas, but reimbursement has lagged for those services.
• Growth of ambulatory surgery centers (ASCs) has exploded, and they also need anesthesia coverage.
• Lifestyle issues such as vacation and predictable work hours are more important now.

Too little supply and more demand mean anesthesia providers have leverage in today’s market. An anesthesiologist entering practice today commands an average starting salary of $300,000 plus benefits and 8 to 9 weeks of annual leave. Certified registered nurse anesthetists (CRNAs) and anesthesia assistants (PA-As) start at $164,000 on average with 6 weeks of leave.

An anesthesiologist’s pay package is a big expense for an anesthesia practice to absorb, notes William Mazzei, MD.

“Most anesthesia groups don’t want to take the risk of hiring a new person, even if they can get them, and dilute the income for everyone else,” he says. If the hospital wants more services, anesthesia groups think the hospital should put up the money to support the risk of hiring a new person.

Inpatient practice less desirable

Logistical issues make the hospital setting less attractive financially for anesthesia groups, adds Dr Mazzei, an anesthesiologist who is medical director of perioperative services at the University of California, San Diego, and consults on anesthesia issues.

“There’s been a large increase in demand for anesthesia outside the operating room, but those areas are scheduled inefficiently from an anesthesia standpoint. So anesthesia groups are hesitant to assign anesthesiologists to those,” he says.

Meanwhile, ASCs are attractive. “Not only is the payer mix better, but the cases are short,” he points out. That’s an advantage because the anesthesia billing rate is higher at beginning of cases than for subsequent time increments.

“An anesthesiologist who does 6 short ENT cases in an ASC and is out by noon can make more money than a person who comes to a hospital an hour earlier and finishes at 4:30 pm doing a CABG,” he says.

As a result, the desirability of an inpatient practice has gone down at a time when demand for those services is up. Hospitals also tend to have a high number of
Medicare and Medicaid patients, who have lower reimbursement rates than patients with commercial insurance.

“Even if an anesthesia group bills perfectly and gets their bills out quickly, you can’t generate market-level salaries with a pure inpatient practice,” Dr Mazzei observes. “Most groups that are primarily hospital based need a stipend to be able to guarantee a salary that will get new anesthesiologists to come.”

A new analysis shows anesthesia groups are being asked to cover more sites without an equivalent increase in cases and billings. Median total units and total time units billed per anesthetizing location for anesthesia groups fell by 13% and 21% respectively from 2004 to 2006, note Amr Abouleish, MD, MBA, and Todd B. Evenson, MBA in the December 2007 ASA Newsletter. The median number of anesthetizing sites rose by 15%, and median encounters fell by 10%. Economically, they say, groups are forced to negotiate compensation from facilities.

**How common are stipends?**

The number and amount of hospital stipends rose dramatically from 2000 to 2005, according to a survey by the American Society of Anesthesiologists. In all, 57% of hospitals paid a stipend in 2005, up from 50% in 2000.

In a new article, Franklin Dexter, MD, PhD, showed that 2 types of agreements are rational, meaning that other types increase profit for the hospital or anesthesia group at the expense of the other. For a bibliography and FAQs, visit www.frankindexter.net/bibliography_Group Management.htm.

**Tense standoffs**

Hospital administrators don’t always understand the market conditions, and that can lead to tense standoffs with anesthesia groups. Administrators, particularly those over 50 who remember when anesthesia providers were plentiful, may think the stipend demands are unreasonable. Younger administrators “tend to be more accommodating,” Dr Mazzei says.

Plus, he says, the hospital and anesthesia group may have different understandings of what a stipend means. Hospitals may think it means the anesthesia providers are like employees they can direct, whereas anesthesia groups see the stipend as what is necessary just to get them in the door.

Jerry Ippolito, MBA, MHSA, FACMPE, president of a Naples, Florida-based consulting firm, OR Efficiencies, says market conditions for anesthesia coverage are creating an imbalance that makes it difficult for hospitals to provide surgeons with enough OR time, recruit more surgeons, maintain market share, and increase revenue.

The shortage also creates more pressure for OR throughput so that cases will be tightly scheduled with little downtime. He says this can only happen if there is collaboration among all the professions—surgeons, anesthesia providers, and nurses. Ippolito advocates a culture in which all parties treat one another as customers (sidebar, p 9). Too often, he adds, expectations for the hospital and anesthesia providers aren’t clearly defined, even when there is an exclusive contract, and communication can break down and become adversarial.

**Defining expectations**

“I frequently hear from hospitals that ‘the OR would run better if anesthesia
stepped up to the plate,” Ippolito says. But if expectations aren’t defined, and anesthesiologists aren’t collaborating with OR leaders on issues like schedule planning, “then anesthesiology can only be reactive.”

He advises that anesthesia providers and perioperative leaders develop expectations that at least include defining:

- what number of ORs will be staffed by hour of day and day of week
- how call coverage will be managed (in-house versus out-of-house, anesthesiologist or CRNA, etc)
- what services are required by obstetrics, and what is considered timely delivery of those services
- what is needed to develop and deliver effective and efficient preadmission screening services
- what the expectations are for anesthesia providers being familiar with cases and patients prior to the day of surgery
- what services are provided to peripheral sites such as endoscopy, radiology, response to codes, etc
- what the role of anesthesia is in schedule planning and administration
- how anesthesia services will be compensated if there is insufficient revenue from anesthesia professional fees.

Anesthesia care teams

One approach to increasing anesthesia coverage is a care team model in which each anesthesiologist directs 2 to 4 CRNAs or PA-As. The number of anesthetists is increasing, which could make this model a trend, Dr Mazzei notes.

The care team model must be managed carefully, cautions Ippolito, because there are strict billing and direction requirements.

“Frequently, the hospital administration does not fully understand how complex anesthesia billing and compliance are and how easy it is to be in violation of fraud and abuse statutes,” he says.

Some anesthesia groups have suffered big financial penalties for inappropriate billing under the care team model. In many of these cases, anesthesia groups did not intend to do things inappropriately or didn’t have appropriate checks in place, he notes. As a result, most anesthesia groups are conservative in interpreting the regulations.

In general, rules require that an anesthesiologist perform the preoperative evaluation and prescribe the anesthesia plan. The anesthesiologist must ensure procedures are performed by a qualified provider. The anesthesiologist must be “readily available” during the case, a term that is vaguely defined, and must personally participate in the most demanding parts of the procedure, including induction and emergence.

Using the care team model is a tradeoff, Ippolito points out. More ORs or anesthesia sites may be covered at less expense, which can help reduce the need for a stipend or the amount. But the use of the care team model might slow down the ORs because an anesthesiologist must be present during each case for induction and emergence. That can affect surgeon satisfaction, with the potential for lost cases and lost revenue that can more than outweigh cost savings in anesthesia staffing, he points out.

Logistics of the care team model are more complicated in organizations that have more than one OR suite, such as a main OR and an ambulatory surgery unit.

“In one big OR suite, if you had 2 cases running late, one anesthesiologist could cover those with 2 CRNAs. But if you have one case running late in each of 2 OR suites, you need 2 anesthesiologists,” notes Amr Abouleish, MD, MBA, professor of anesthesia at the University of Texas Medical Branch, Galveston.

Anesthesia leadership

To serve everyone’s interests, Ippolito and Dr Mazzei both advocate a collaborative approach to OR governance, with joint leadership by surgeons, anesthesia providers, and nurses.
“That’s the most effective model in my experience and one that allows most problems to be solved amicably and quickly,” Dr Mazzei says.

They also recommend that anesthesia providers have a formal role in managing the daily schedule.

Dr Mazzei advises having a medical director of the OR who is an anesthesiologist. The medical director works with the OR nurse manager daily to run the schedule and address physician issues.

For most community hospitals and medical centers, Ippolito recommends developing a charge anesthesiologist function. One anesthesiologist is designated as the lead and is responsible for developing the role, working with other OR leaders to set up protocols, and training the other charge anesthesiologists.

“In an ideal world, the position should be limited to one person for consistency,” he says. “But seldom is one person willing to perform this task every day.” As a compromise, he recommends having 3 to 5 charge anesthesiologists, each with good organizational, interpersonal, and communication skills.

“Consistency is paramount,” he says. “This requires development of a function description as well as agreement on how policies and procedures are enforced.” The administration, OR managers, surgeons, and anesthesia providers must reach a compromise on the role’s definition, direction, expectations, and responsibilities.

The charge anesthesiologist acts as the anesthesia “go-to person” for the day, he explains, working proactively with nursing to manage the schedule, optimize throughput, organize add-ons and changes to the schedule, help resolve disputes, and make anesthesia assignments for the next day. For the position to be effective, the charge anesthesiologist should have minimal direct care responsibilities. But unless the position is supported with a stipend, in most hospitals, the charge anesthesiologist needs to have billable cases, Ippolito notes. He acknowledges that the logistics are more challenging when the charge anesthesiologist provides direct care rather than directing anesthesiasts.

“In these situations, it is even more important to have effective communication and schedule planning prior to the day of surgery to minimize the need for the anesthesiologist’s direct participation in running the schedule.”

Ippolito tells anesthesia groups that if they are reluctant to participate in developing clear expectations and don’t participate in schedule planning and administration, “they are putting someone else in charge of their business—they will constantly be in a reactive mode. They will not be able to provide customer service, and they will be regarded as not stepping up to the plate, regardless of how hard they try to or want to.”

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Jerry Ippolito is president of OR Efficiencies LLC. www.OREfficiencies.com.
Customer service in the OR

Patients are the OR’s primary customer. OR personnel also often think of surgeons as their customers because the surgeons refer the patients. Anesthesia providers are also customers, and their customers include patients, surgeons, and the nursing staff. Each group has different expectations and needs for the others. Compromise is required, and expectations need to be reasonable and clear, says Jerry Ippolito, president of OR Efficiencies, LLC, a consulting firm.

Here are some of his suggestions for customer expectations.

Anesthesia providers as customers

As customers, anesthesia providers should be able to rely on:

- clear and agreed-upon expectations about the sites they staff
- competitive compensation and lifestyle for services given to meet expectations (potentially requiring a hospital stipend)
- an OR committee (or governance body) that has developed effective scheduling policies and procedures—and consistently enforces them
- surgeons’ offices that effectively communicate with OR scheduling
- surgeons who communicate effectively with anesthesia providers about difficult cases or complex patients
- nurses who effectively implement preadmission screening protocols that have been developed jointly with anesthesia providers
- charts complete on the day of surgery
- patients appropriately prepared for surgery in either the day-surgery unit or the inpatient unit
- ability to transport the patient to the OR in a timely manner for on-time case starts
- surgeons reporting on time to the OR for case starts
- experienced OR staff and appropriate case setups to reduce case times
- experienced charge nurses who work with anesthesia providers to run the day’s schedule
- experienced postanesthesia care staff who can function with relative independence.

Customer service by anesthesia providers

In providing customer service, anesthesia providers should be expected to:

- be current in state-of-the-art anesthesia care with an emphasis on ambulatory anesthesia
- maintain reasonable flexibility with regard to agreed-upon expectations; maintain an attitude of meeting or exceeding expectations
- assure consistent and reliable staffing for all anesthesia sites agreed to (it should be rare—one or twice a year—that an OR is shut down due to a lack of staff)
- collaborate with nursing to develop state-of-the-art preadmission guidelines; agree as a group to established guidelines
- screen all ASA III and above patients and assess all inpatients prior to the day of surgery
- develop processes to administer anesthesia consults for the preadmission unit
- call patients on the evening prior to surgery
- be as familiar as possible with patients’ conditions prior to the day of surgery
- review patient charts at least the day prior to surgery
- proactively work with nursing to plan and manage the schedule
- begin reviewing the schedule with nursing several days prior to surgery
- facilitate getting patients into the OR for on-time case starts
- help to expedite turnaround time between cases
- maintain an effective medical direction model where CRNA or anesthesia assistant direction is based on case complexity, patient acuity, and anesthetist skill level
- be available promptly to support anesthetists during cases
- be available promptly to anesthetists’ cases to expedite induction and emergence
- develop a staffing model and service agreement in which anesthesia staffing requirements for sites peripheral to the OR do not disrupt OR staffing
- develop a QI and education model for all anesthesiologists, anesthetists, and hospital staff (RNs and respiratory therapists) where appropriate
- assign leaders to foster skills and business development in key services such as cardiovascular; obstetrics; ambulatory care; pain management; and potentially neuro, trauma, and pediatric care
- play a key role in developing and sustaining the anesthesia practice’s own business by focusing on what is required to develop a marketable and financially viable surgical program with increasing case volume
- focus on delivering the highest level of patient care with respect for the patient’s time.
References


