10 Keys to Successful Anesthesia Employment Models

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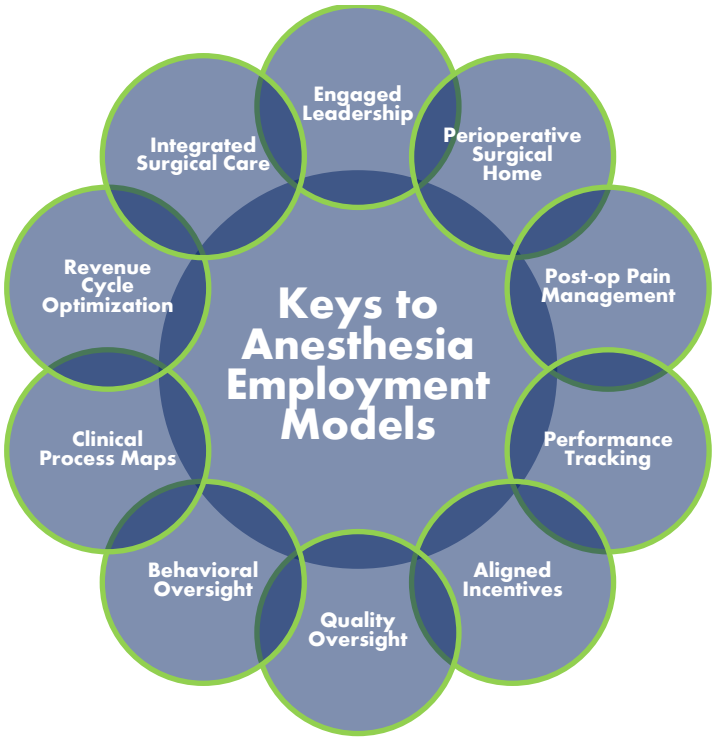
COVID-19 has impacted all aspects of healthcare, including a dramatic increase in hospitals choosing to transition to employment of their anesthesia providers over the course of 2020. In this article we will explore the forces behind this trend and discuss 10 key items to address when considering employment of anesthesia providers in 2021 and beyond.

Traditionally, anesthesia groups have been independent, often with an exclusive contract with a hospital or health system. Since the late 1990's, the frequency and magnitude of hospitals requiring financial support to secure anesthesia services has continued to climb, with over 80% now paying such stipends. As the stipend amounts continued to escalate into the millions and sometimes tens of millions of dollars, many hospitals have come to view significant financial support as de-facto employment. Prior to the COVID-19 crisis however, employment of hospital-based physicians (HBPs), including anesthesia providers, lagged behind that of surgeons, proceduralists and primary care providers.

Pandemic related elective surgical shutdowns and slowdowns buffeted the underpinnings of previously stable anesthesia group finances, often necessitating dramatic reductions in services and/or requests for increased stipend support. These changes along with the uncertainty of future surgical capacity and the potential for bundled or outcome-based payments, has led an increasing number of healthcare leaders to believe that employment of HBPs offers the clearest path to control spend and maximize coordination of care. In the vital area of surgical care, anesthesia providers play a pivotal role in developing a high quality, efficient OR delivery system and their integration into an aligned surgical delivery team will be crucial to success as healthcare continues to evolve.

As new anesthesia employment models are created or existing arrangements restructured, facilities will be best served by creating a framework to align providers as true partners. Successful models will facilitate integration, while incentivizing efficiency and quality of care. Having advised and supported several anesthesia employment arrangements in the last few years, we developed the top 10 areas hospitals and anesthesia providers should focus on when considering their own transition.

THE 10 KEYS TO SUCCESSFUL ANESTHESIA EMPLOYMENT MODELS:



ENGAGED LEADERSHIP – Identifying the best leaders and creating a supportive group culture are fundamental building blocks for success. Successful anesthesia leaders must provide ongoing communication to surgeons as well as operating room and hospital leadership. They should seek to continuously improve the quality, safety and efficiency of surgical care and be actively involved in tracking performance and outcomes. The expectation is that anesthesia directors actively participate in all perioperative committees and play a key role in OR process improvement initiatives.

PERIOPERATIVE SURGICAL HOME (PSH) – Prevailing reimbursement mechanisms lead many anesthesia groups to focus resources on intraoperative care (while the patient is in the operating room). To optimize the anesthesia value proposition in an integrated delivery system, expectations for services should expand to encompass the concept of PSH, addressing the entire perioperative continuum (from patient preoperative preparation to postoperative discharge and recovery). Successful models place the anesthesia provider group as a leader in conjunction with surgeons and hospital resources to maximize a consistent and data-driven approach to the entire perioperative experience. Protocols for evidence-based practice and postoperative pain management are increasingly well-established and your anesthesia group should be appropriately positioned to incorporate them into the PSH methodology.

POST-OPERATIVE PAIN MANAGEMENT – The use of catheters, long-acting regional blocks and adjustment of intraoperative medication can significantly reduce postoperative pain. Anesthesia groups appropriately utilizing such techniques can improve patient satisfaction scores and reduce postoperative complications and length of stay. While these techniques are vital to many PSH approaches noted above, each on their own, even in the absence of a formal PSH program, represents value-added anesthesia care, and will be differentiators allowing facilities to be more competitive under outcome-based payment arrangements.

PERFORMANCE TRACKING – Metrics related to the quality and efficiency of anesthesia services should be measured and linked to a portion of provider compensation. The obvious items include MIPS measures such as sterile technique during central line placement and maintenance of normothermia. Many additional items may be monitored, as applicable, to each clinical and operational environment. Examples include surgeon satisfaction scores, day of surgery cancellations, completion of preoperative evaluations prior to the day of surgery, and response time while on call. The most important metrics are often displayed monthly, as a departmental scorecard or KPI dashboard tracked by facility and group leaders.

ALIGNED INCENTIVES – While there is widespread recognition that productivity and performance incentives should be incorporated into physician employment agreements, the calculations for anesthesia groups are somewhat unique. Providers typically receive base compensation, but we increasingly see components of compensation placed at-risk based upon a number of anesthesia specific measures including relative productivity, support of OR efficiency, performance and quality.

QUALITY OVERSIGHT – As reimbursement becomes increasingly linked to quality and outcomes, anesthesia departments must be able to track and document quality metrics for individual providers as well as the entire department. Targeted metrics are best tracked using an anesthesia specific tool.

BEHAVIORAL OVERSIGHT – Inappropriate behavior on the part of anesthesia providers may have a negative impact on anesthesia group culture, OR staff morale and surgeon satisfaction. Nonetheless, many groups are reluctant to actively monitor and unwilling to address inappropriate behavior. Development of predefined mechanisms of tracking and evaluating behavioral issues, evaluating them through peer review, and identifying consequences of such actions should be in place for all hospital-based physician groups.

CLINICAL PROCESS MAPS – Provider variation in response to common clinical issues is a frequent source of dissatisfaction among surgeons and operating room staff. Variations may include lab value abnormalities, preoperative preparation of patients with cardiac disease, NPO status, requirements for consultation reports, etc. As with any service-oriented business, consistency leads to customer satisfaction. An employment platform gives OR and anesthesia group leaders an ideal opportunity to develop written policies defining how they will address common clinical issues.

REVENUE CYCLE OPTIMIZATION – Optimizing revenue cycle performance for anesthesia professional services requires expertise in time-based billing, documentation and compliance, and anesthesia specific payer contract negotiations. Hospitals are typically best served by outsourcing revenue cycle functions to well-established, anesthesia-specific firms to avoid the significant loss of revenue which is often suffered by attempting to bill through internal resources.

INTEGRATED SURGICAL CARE – One clear theme in healthcare optimization efforts is that closer integration will be required throughout the continuum of care. In the operating room, that will involve closer clinical and process related coordination among anesthesia providers, surgeons, OR nurses and other supporting services. Your employed anesthesia provider should be in the forefront, creating a tightly aligned delivery model for all surgical cases and throughout the entire perioperative experience.

SUMMARY

Facility leaders should recognize that applying a "cookie-cutter" approach designed for primary care and referring specialists to employment of anesthesia providers is not a blueprint for success. The 10 keys discussed above offer a framework to create an optimally aligned model, incorporating the unique attributes of anesthesia practice, as well as the boundaries and limitations within which anesthesia can have a positive impact on your surgical services. Working with anesthesia subject matter experts to support the transition, optimize revenue cycle performance and co-manage employed models will ensure that your newly employed practice will be a strong force that will position your facility for surgical volume gains in today's market while creating an important foundation to optimize the delivery of surgical care.