FELLOWSHIP PROJECT

Implementation of a Contractual Relationship for Anesthesia Services in an Acute Care Facility

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ORGANIZATIONAL INFORMATION
The hospital referred to in this article is a not-for-profit community hospital located in the upper midwest. The 410-bed hospital is a tertiary care facility that employs more than 3,500 health professionals who care for more than 183,000 patients annually. The medical staff has more than 260 members.

Over the last several years the hospital has added new programs and enhanced various existing services. Cardiac and cancer care, diagnostic imaging, same-day surgery services, helicopter and fixed-wing service, and dialysis are among the new or enhanced services offered by the hospital.

The hospital was incorporated in 1979 as a result of a merger of the community's two hospitals. The hospital is governed by a 15-person self-perpetuating board of trustees whose membership includes various community members, the chief executive officer (CEO), chief and vice chief of medical staff, and four medical staff representatives.

Located in a city of 60,000 people, the hospital's service area includes the entire western portion of the state and adjoining portions of four neighboring states. The hospital is in the unique position of being a sole community provider of healthcare services. Furthermore, the nearest hospitals of like size and complexity are approximately 400 miles from the hospital.

The hospital continues to develop an integrated delivery system through management and affiliation agreements with medical facilities. The hospital owns, operates, or manages 18 other facilities in a three-state region. These agreements enhance the hospital's ability to provide appropriate, quality healthcare in the region.

BRIEF SUMMARY OF THE PROBLEM
For many years the hospital's surgery department experienced a variety of problems in the area of anesthesia services. No formalized contracts or relationships with the groups providing this service to the hospital had been established. There was a pronounced level of dissatisfaction on the part of many surgeons regarding the availability of anesthesia providers. When I assumed the position of surgical services director it was clear that formalized agreements were critical, and a consistent level of anesthesia services needed to be ensured.
DESCRIPTION OF THE PROBLEM

The consistent availability of quality anesthesia services is key to efficiently and effectively providing surgical services in an acute care facility. Quality anesthesia services are a major factor in promoting surgeon, staff, and patient satisfaction. Lack of consistent services generates irregular case scheduling, ineffective use of surgery manpower, slow response time to unscheduled cases, and surgeon and patient dissatisfaction (Johnson & Johnson Healthcare Systems Consulting Services 1999).

Several models exist for providing anesthesia services at an acute care facility. A surgery area runs most efficiently by using only one model. Examples of models include the following (Charles Pearson Associates 2000):

1. The “all anesthesiologist model” allows the anesthesiologist (MDA) to provide all the clinical services.
2. The “anesthesia care team model” allows the certified registered nurse anesthetist (CRNA) to provide the majority of anesthesia services at the hospital. This model has several variations, including models with the MDA providing either medical direction or supervision.
3. The “CRNA model” allows the CRNA to provide 100 percent of the anesthesia required by the hospital. No medical direction or supervision is needed.

I came to better understand these different models through a review of the literature, outside consultant assistance, and positive communications and relations with the different anesthesia providers. I identified many philosophical differences between the MDA and CRNAs regarding the most effective and efficient models to use.

Two models were in place at the facility in 2000. A “modified anesthesia care team” approach was most commonly used and included a combination of MDA and CRNAs providing anesthesia services. The MDA medically directed the CRNAs according to a supervisory ratio of one MDA to two to four CRNAs. These ratios were determined primarily by the Centers for Medicare and Medicaid Services’ definition of “medically directing/supervising a case.” The ratio was based on meeting a set of seven conditions of reimbursement and then modified based on the institution’s surgical caseload and availability of MDAs and CRNAs. In 2000 an MDA group employed the CRNAs and provided the majority of services to the hospital. Under this modified model the MDA group allowed CRNAs to provide anesthesia to the majority of surgical patients; however, the MDAs would not allow the CRNAs to do open-heart cases, insert epidural catheters, place lines, or provide pain management.

The second model in place was the “all anesthesiologist model.” An independent MDA provided direct anesthesia care but would not supervise or direct the CRNAs.
These varying approaches to practicing anesthesia made it difficult or impossible to provide a consistent surgery scheduling system. The type of cases and who was scheduled to work each day determined the number of rooms that could be used. Work schedules were not routinely adhered to by any of the anesthesia providers, and planning for the flow of cases was difficult.

Early in 2001 reimbursement from most payers began to decrease. There was also competition from local surgi-centers, which could select the better paying cases. A number of CRNAs left the MDA group for job opportunities in the local same-day surgery center. Recruitment of new CRNAs was difficult and expensive. The nation was experiencing a shortage of providers, and colleges could not keep up with the demand (Schubert et al. 2001).

Significant turmoil and conflict began to be seen in the anesthesia provider group. The MDAs began to cut back on staffing and cover fewer operatory suites during each 24-hour period. The MDAs would not change the service model used even though state law allowed CRNAs to do procedures such as open-heart cases, line insertion, and regional blocks.

This caused significant surgeon and patient dissatisfaction. The surgeons were vocal about the lack of service and requested that administration step in to address this issue. The MDA group responded to administration with a letter that informed the hospital that the MDAs would no longer employ the CRNAs. They requested the hospital to assume responsibility for the CRNAs. The MDA group gave the hospital a four-month window to deal with this issue. With no contractual arrangements in place, the MDA group had no commitments to the organization, and their request had to be addressed.

**Administrative Decisions**

With only four months in which to deal with this issue, the chief operating officer (COO) and I put an immediate prioritized plan into place. The immediate issues that needed to be addressed included the following:

- Maintenance of positive communications and collaboration with all the MDAs and CRNAs
- Assurance of continued 24-hour-a-day surgical care
- Maintenance of open and clear communications with the surgeons on the progress of the negotiations
- Analysis of employment options for the CRNAs
- Analysis of anesthesia coding, billing, and reimbursement
- Review of state laws and Medicare rules
- Agreement on an anesthesia contract with the MDAs

Maintaining positive communication with all parties involved was key in quickly implementing a process to ensure continued anesthesia services. Key
leaders from all groups were identified. The business manager and a respected anesthesiologist within the MDA group were willing to meet routinely. A well-established and respected leader within the CRNA group was also identified. The independent MDA was also invited to participate in the discussions. Ground rules were established for the meetings. I led and recorded the meetings with the guidance of the COO of the organization.

The major issue initially addressed was the immediate need for increased 24-hour anesthesia coverage for the facility. Decisions were made to have the hospital employ locum tenens MDAs and CRNAs. This immediate decision allowed assistance for the overwhelming workload that the anesthesia providers felt they were facing. This assistance allowed key leaders to attend the meetings and have critically needed rest. Locum assistance was quickly found through the help of the organization’s physician recruiter, who had the resources and knowledge to find quality individuals.

Routinely, I updated the surgeons on the progress of the negotiations. This was done through communications at their surgery section meetings as well as one-on-one discussions with the leadership within the surgeon group. Although the surgeons appreciated the updates, they continued to voice concern about the lack of consistency in service and the amount of time it was taking to get the agreements finalized.

The finance department and CRNA leader assisted me in looking at coding, billing, and reimbursement. Coding for anesthesia is complex; few individuals have an understanding of this highly specialized area. The business manager for the MDA group was of great assistance in detailing the many areas of coding. Once this area was understood, a financial analysis of employing the CRNAs was drafted.

A firm organizational commitment for employing the CRNAs was obtained by January 2001. This occurred following numerous financial analyses and discussions with the CEO and board of trustees.

With the assistance of the personnel department, a market study was completed and employment options were drafted for the CRNAs to review. Several meetings and negotiations with the CRNAs occurred in finalizing an acceptable package of employment. The CRNA leader was key in making these negotiations run smoothly.

Legal services and the finance department assisted me in reviewing state laws and Medicare guidelines. Additional outside consultant services were sought to clarify specific questions and concerns. The leadership from both the CRNA and MDA groups was also helpful in clarifying questions that arose.

In April 2001 contracts with the MDA group were drafted and negotiations were initiated. Several months of negotiations and discussions took place. The role of the CRNAs and their scope of practice were major concerns. The role of the independent MDA was also part of these difficult discussions.

Each group wanted to practice a different model of anesthesia. It was difficult to come to consensus because the financial implications were different for each
group. The MDA group wanted to ensure that the care team model was practiced, and they wanted it to include medical direction by the MDA. This approach maximized reimbursement for the MDAs. The organization also supported a care team model but wanted the CRNAs to be supervised by the MDA group. This approach would allow increased case volumes and greater job satisfaction for the CRNAs. The independent MDA wanted to continue his practice under the all anesthesiologist model. He did not want to supervise or medically direct CRNAs. His practice clearly affected the volume of cases done by both the CRNAs and the MDA group.

RESULTS
In mid-February 2001 the CRNAs sent a letter of intent to the COO expressing their strong intention to become employees of the hospital at the conclusion of their employment with the MDA group. By March 2001 finalized agreements were in place to employ the CRNAs. Their employment began in mid-March. All CRNAs previously employed by the MDA group signed on. Immediate recruitment of additional CRNAs was initiated. The locum coverage was expensive, and further stability would be seen with a fully staffed CRNA group.

Anesthesia coding and billing was put into place on hiring the CRNAs. This was a difficult process, as few individuals in the organization had any experience with this. By September 2001 a confirmed approach to coding and billing was used and the financial benefits could be seen.

The negotiations on a confirmed contract with the MDA group and independent MDA were far more difficult. The models of practice, CRNA scope of practice, and role of the independent MDA continued to be the biggest hurdles.

Months of discussions and exchange of draft contracts occurred without any positive move toward a confirmed agreement. There was great concern that no agreement would ever be reached. During these months of negotiations two MDAs left the MDA group and moved to different communities. Two additional MDAs were also considering departure from the community. The strength and stability of the MDA group was in question. The surgeons voiced their dissatisfaction routinely to the MDA group. The surgeons wanted more service and confirmed commitment to the hospital by the MDA group.

The independent MDA had developed a positive relationship with the surgeons and continued to have a huge caseload of patients through physician request. He began to voice interest in recruiting a second MDA to his practice. However, the only model of service he would practice was an all anesthesiologist model. This was deeply concerning to the hospital, as it had just employed the CRNAs.

With the unstable MDA situation, the hospital began to prepare for the worst. Through the direction of the COO I contacted a company that could provide MDA services on short notice. Keeping continued 24-hour anesthesia service available at the hospital was critical. This rural area had no other MDA services that could be used.
We continued to keep communications open with the MDA group. The MDA group began to see that other anesthesia services could be brought in to replace them. The hospital did not want to work with an outside group. This approach would be financially draining to the organization. However, the situation was at a critical point and outside resources had to be considered.

The hospital’s commitment and desire to work with the MDA group needed to be emphasized. At this point we requested the hospital’s CEO and board leadership to be more directly involved with the negotiations. Pressure to come to agreements was clearly heard from the board. The board expressed its desire to work with the local MDA group and independent MDA, but without formal agreements the board was clear that another group of practicing MDAs would be brought in.

The board and CEO met with us several times to try to move negotiations along. It became clear that a single model of practice was not going to be seen in the negotiations. The independent MDA had gained a tremendous amount of support from the surgeons, who communicated clearly to the board that he should be allowed to continue to practice independently.

Negotiations continued with the MDA group as to the type of oversight the CRNAs would have. The final resolution allowed the CRNAs to do more procedures within their scope of practice under a medically directed model. This allowed maximized billing for the MDAs and additional volumes for the CRNAs.

By November 2001 final agreements were reached with the MDA group, and a formalized contract between the group and hospital was signed. The agreements did allow the MDA group to practice using the medically directed model. The independent MDA was allowed to continue his practice within the organization but could not bring in any additional partners.

Although the hospital did not move into a single model of anesthesia practice, it gained commitment to service and a desire to work toward common goals. These goals would eventually drive efficiency in the surgery area. This work was a beginning point for future negotiations and changes. It was mutually agreed that the contract would be in effect for only one year. Negotiations for the following year were scheduled to begin a minimum of four months ahead of the contract date.

The agreements also mandated that all anesthesia provider work schedules be available to the surgery department and scheduling office. Each practicing group was committed to fulfilling its obligations on the posted schedules. This allowed a planned and consistent scheduling process.

From November 2000 to November 2001 24-hour anesthesia services were maintained in the institution. Each anesthesia provider group addressed coverage needs through the use of locum tenens and voluntary overtime. The finalized agreements ensured that all groups involved would maintain coverage and work toward common goals. Within six months no locum tenens were needed.

With the contract in place, we felt a need to celebrate. All individuals involved in the negotiations, including the CEO and president of the board of trustees, met for a special dinner. This celebration put positive closure to a difficult negotiation.
It also fostered an environment that would allow for continued positive discussions and changes in the future.

The critical elements to the success of this project included the following:

• Positive and continual communications with all parties involved
• Understanding of a rapidly changing anesthesia provider market
• Trust building
• Skilled and active involvement of numerous experts employed by the organization
• Celebration and closure of the project

The 2003–2004 negotiations on the anesthesia contract have now been completed. This contract, which covers three years, includes changes that will further enhance the efficiency in surgery. Clearly, many future changes are needed. Future resolution of the different viewpoints regarding anesthesia services will be attained through continued trust and communications.

Sources
Primary sources of information used in the preparation of this Fellow Project were the author’s first-hand observations and experiences. Meeting minutes and notes were also used.

References