STAFFING MODEL FAQ'S

Amr Abouleish, MD, MBA

University of Texas Medical Branch
Galveston, Texas
aaboulei@utmb.edu

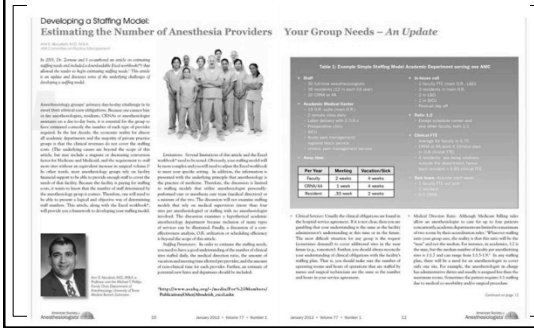
DISCLOSURE

- ECG Consultants
- Technical Expert in Staffing Models

STAFFING MODEL CHALLENGES

- Hospital Requirements
- Staffing Ratio issues
- Clinicians on the Model but aren't in a room at 7 am
- Perioperative "Immediate Area"
- NOT Going to go over how to make the staffing model. For that …

MAKING A STAFFING MODEL ASA MONITOR JANUARY 2013



Developing a Staffing Model: Estimating the Number of Anesthesia Providers Your Group Needs – *An Update*

STAFFING MODEL: TELLING NOAH ABOUT THE FLOOD

- Budget reality[1-2]

  Institutional Support = Costs – Revenue

  - Revenue – mainly clinical revenue
  - Costs – mainly staff
- Clinical revenue is impacted by payer mix, surgical duration (units per hour of care), operating room utilization, hours worked, and Dean's tax
- Major determinants of Staffing Costs are compensation and number of providers.

INSTITUTIONAL PERSPECTIVE: "SINCE WE ARE PAYING, …"

- "How do we know we are getting our money's worth?"
- Institutional Support negotiations end up focusing on
  - Incentives to "work more and better"
  - Focus on number of providers
- Hire Consultant
  - The "Dean's Logic"
  - Often try to apply "per FTE" measurements to determine if staffing numbers
  - … Benchmarking using "per FTE" does not work for Anesthesiology Groups

STAFFING MODEL: HOSPITAL REQUIREMENTS

- Since sites determine the staffing needs, knowing the sites that are to be covered and for what hours is essential!
- Should be in the hospital service agreement
- Often the hospital administrator's perception is not reality… especially the further from day-to-day operations
- Discuss, Define, and Agree
- Make sure OR nursing staff matches
  - Example Don't be staffed for 2 ORs all night if nursing staff only has one team in house.

STAFFING MODEL: STAFFING RATIO AND DEMAND MATCHING

- Should be simple to justify staff who are assigned to a site first thing in the morning, …
- … but still challenges surrounding staffing ratio & demand matching
- Residents and Staffing Ratio
  - Resident Program Accreditation (RRC) is max ratio 1:2
- 1:1 Coverage needs to be in your model
  - Type of Surgery and/or Co-Morbidities limit ratio in medical direction model
    - In full service Hospital: Rule of thumb 1 OR covered 1:1 per 10 ORs
  - Administrative Anesthesiologist should have lower staffing ratio.
- Remote sites and NEW buildings invariably cause inefficient ratio

STAFFING MODEL: STAFF NOT ASSIGNED TO OR AT 7 AM

- In contrast, you have to justify every clinician that is on the model but not starting case at 7 am.
- Lunch Break CRNAs
  - Often arrive at 11 am.
  - Use to pickup rooms in afternoon and evening.
  - Depends on staffing ratio and the OR Schedule and Caseload/OR
- PACU, Preop Assessment, Block Service
  - May need Anesthesiologist(s) not performing surgical anesthesia
- Call Anesthesiologist(s)
- At home Call Team may need some "post call" allotment
- Obstetrics

STAFFING MODEL PERIOPERATIVE IMMEDIATE AREA

- Not simply remote sites, but now new OR suites are not geographically part of the old suites
  - Different floors
  - Different buildings
- Effects Daily Staffing, but …
- Effects Late Room and Call Staffing more!

- HAVE YOU DEFINED IMMEDIATE AREA FOR YOUR GROUP?

IMMEDIATE AREA: OIG

http://oig.hhs.gov/newsroom/podcasts/2013/anesthesia-trans.asp


REPORT FRAUD

Office of Inspector General
U.S. Department of Health & Human Services

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Transcript for audio podcast: Anesthesia Service Payments

From the Office of Inspector General of Department of Health and Human Services

http://oig.hhs.gov

[Lori Ahlstrand] This is Lori Ahlstrand, Regional Inspector General for Audit Services in San Francisco, speaking with Kristin Scully, an auditor from the San Diego field office. Let's talk about your involvement with the anesthesia services investigation, which led to a $1.2 million dollar settlement. Can you tell us more about your role in this investigation?

[Kristin Scully] Thanks, Lori. Well, we assisted OIG's Office of Investigations and Office of Counsel to the Inspector General, the Department of Justice, and the FBI with a case involving whistleblower allegations at the University of California, Irvine, Medical Center. Anesthesiologists at the hospital allegedly falsified claims by signing anesthesia records before procedures were performed. In some cases, anesthesiologists were not physically present or immediately available to supervise resident physicians who were performing procedures. DOJ asked us to help them by reviewing Medicare and Medicaid claims along with the anesthesia records.

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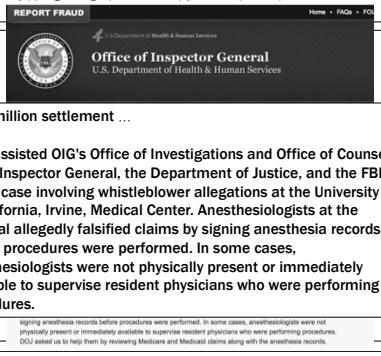
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Office of Inspector General
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…when we arrived at the hospital, they asked us to put on full-body scrubs since the operating room was a sterile area, and there was a chance of unscheduled emergency surgeries at any time. The hospital staff then guided us through the floor and showed us each operating room, and we took careful notes. This is not something that auditors normally do. But since the audit required us to determine whether the anesthesiologist was "immediately available," the tour helped us visualize the distance that an anesthesiologist would have to travel from room to room or building to building and the time that it would take.

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After reviewing selected numbers of Medicare and Medicaid claims, we found that anesthesiologists oversaw multiple procedures, in different buildings or on different floors, where they were not immediately available.

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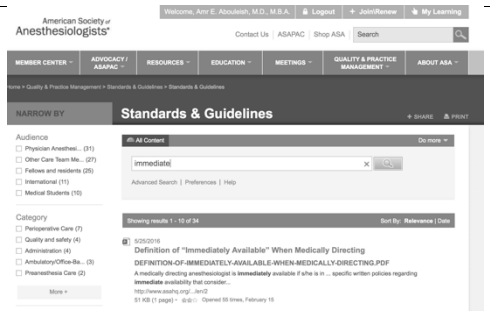
IMMEDIATE AREA: ASA STATEMENT

www.asahq.org



IMMEDIATE AREA: ASA STATEMENT

www.asahq.org

American Society of Anesthesiologists

DEFINITION OF "IMMEDIATELY AVAILABLE" WHEN MEDICALLY DIRECTING

Committee of Origin: Economics

(Approved by the ASA House of Delegates October 17, 2012, and last amended on October 15, 2014)

Definition:
An anesthesiologist who is personally performing an anesthetic is exclusively and completely dedicated to that case. A medically directing anesthesiologist is immediately available if s/he is in physical proximity that allows the anesthesiologist to re-establish direct contact with the patient to meet medical needs and any urgent or emergent clinical problems. These responsibilities may also be met through coordination among anesthesiologists of the same group or department.

Guidelines for Developing Policy Regarding Immediate Availability:
Differences in the design and size of various facilities make it impossible to define a universally applicable specific time or distance for physical proximity. The physical layout of the operating room and other anesthetizing locations are important in determining how medically directing

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DEFINITION OF "IMMEDIATELY AVAILABLE" WHEN MEDICALLY DIRECTING

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GUIDELINES:
Individual anesthesia groups and/or departments should establish objective and specific **written** policies regarding immediate availability that consider objective elements such as distance, a map or time that recognizes the specific local environment, and factors that should be taken into account so that a medically directing anesthesiologist is available to immediately conduct hands-on intervention for each patient. The demands of particular surgical and other diagnostic or therapeutic procedures and the clinical needs of patients may further restrict what constitutes immediate availability under specific circumstances.

IMMEDIATE AREA: NEED TO DEFINE FOR YOUR GROUP

- IN YOUR BILLING COMPLIANCE PLAN
- Definition of Perioperative Area(s)
  - Maximum distance an anesthesiologist can be covering two sites and be immediately available
  - Vertical Hallways acceptable
    - 2 flights is what we use
    - Is possible for more?
    - But not if on crutches or in wheelchair
  - Despite definition, there are times that an anesthesiologist cannot be immediately available for a case in adjacent room. Definition is for the maximum
- Biggest impact is evening as cases come down. If in two sites not in same perioperative area, then may be left with 1:1 care and more staff at the hospital.
- Call – important discussions with hospital as new buildings are built

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