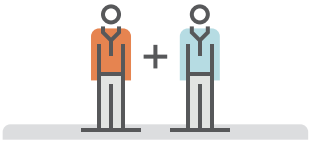

CONSULTATIVE/COLLABORATIVE MODEL

WITH PHYSICIANS AND CRNAS TO OPTIMIZE THE BUSINESS VALUE OF ANESTHESIA SERVICES

The Consultative/Collaborative (CC) model is designed to promote professional cooperation as well as create the most value for patients.[1] It does not prioritize licensure like the anesthesia care team (ACT) model, but instead it focuses on maintaining quality, maximizing efficiencies, and increasing patient/surgeon access. In the CC model, all anesthesia providers are clinically autonomous and encouraged to use their full skill set and licensure in caring for patients. Recognizing provider value and autonomy is critical for effective interprofessional collaboration and to develop an anesthesia care model that maximizes effectiveness.

The CC begins by determining the number of anesthetizing locations which are staffed with CRNAs. Then, based on local factors, the number of physician anesthesiologist team members desired to support patient throughput is determined. This creates an anesthesia care model that is completely flexible and based on patient need. In the CC model providers are free to adjust the workflow to match demand, without fear of violating regulations and arbitrary billing requirements. This flexibility also allows providers to spend more time focused on patient care than arbitrary billing activities.

By focusing on value instead of politics, anesthesia practice models involving collaboration among CRNAs and physicians allow maximum efficiency for patients and facilities while remaining responsive to facility norms and traditions. This renewed focus on value is why many facilities are abandoning models that restrict provider autonomy or dictate staffing ratios, both of which only increase healthcare spending with no evidence of benefit to the patient or health systems.

Legally CRNAs and physician anesthesiologists both have statutory authority to practice independently. Nevertheless, local communities and individual practice settings may choose to structure their anesthesia delivery models around legacy policies particular to the facility. Although surgeons and staff may be accustomed to certain staffing arrangements in the operating room environment and their preferences should be acknowledged and considered, these decisions may need to be reevaluated when determining the anesthesia care model most effective for the facility. Such decisions should be driven by appropriate clinically based evidence and organizational needs, not professional politics.

REFERENCES

1. Hoyem RL, Quraishi JA, Jordan L, Wiltse Nicely KL. Advocacy, Research, and Anesthesia Practice Models: Key Studies of Safety and Cost-Effectiveness. Policy Polit Nurs Pract. 2019;20(4):193-204.