SOCIETY FOR AMBULATORY ANESTHESIA

Outpatient • Office Based • Non-Operating Room

SAMBA 2023 ASC MEDICAL DIRECTORS & LEADERS SUMMIT

LAS VEGAS, NEVADA

FRIDAY, JANUARY 13 - SATURDAY, JANUARY 14, 2023

SYLLABUS

Jointly Provided by the American Society of Anesthesiologists (ASA) and the Society for Ambulatory Anesthesia (SAMBA).

American Society of Anesthesiologists

SOCIETY FOR AMBULATORY ANESTHESIA

Outpatient • Office Based • Non-Operating Room

Phone: (414) 488-3915 • Email: info@sambahq.org • www.SAMBAhq.org

PROGRAM INFORMATION

Target Audience
This meeting is designed for anesthesiologists, anesthesia providers, practitioners, nurses and administrators who work and specialize in ambulatory, office-based or non-operating room anesthesia.

About This Meeting
The purpose of this meeting is to educate and share information that is tailored to physicians, AHPs, Medical Directors, and Administrative staff who practice in Ambulatory Surgery Centers. Opportunities for questions and answers will be provided at the conclusion of each panel.

The SAMBA ASC Medical Directors and Leaders Summit is being held concurrently with ASCA's 2023 Winter Seminar. For more information on the ASCA 2023 Winter Seminar, visit https://www.ascassociation.org/winterseminar.

Registration
Registration for the 2023 ASC Medical Directors & Leaders Summit includes access to all sessions and the program syllabus. Note that all fees are quoted in U.S. currency. Registration for the meeting is available to members and non-members via SAMBA's website at www.sambahq.org.

Disclaimer
The information provided at this accredited activity is for continuing education purposes only and is not meant to substitute for the independent medical judgment of a healthcare provider relative to diagnostic and treatment options of a specific patient's medical condition.

Accreditation and Designation Statements
This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the American Society of Anesthesiologists. The American Society of Anesthesiologists is accredited by the ACCME to provide continuing medical education for physicians.

The American Society of Anesthesiologists designates this live activity for a maximum of 7.5 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Maintenance of Certification in Anesthesiology® program and MOCA® are registered certification marks of The American Board of Anesthesiology®. MOCA 2.0® is a trademark of the American Board of Anesthesiology®.

Commercial Support Acknowledgement
The CME activity is not supported by any educational grants from ineligible companies.

CLAIMING CREDIT
1. Complete the evaluation.
2. Click on the certificate, enter the credit you are claiming.
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If you experience difficulties logging in, don't hesitate to contact jpmeetings@asahq.org, and we will be happy to assist you.

The deadline for claiming credit for this live activity is December 31, 2023, 11:59 pm CT.

Special Needs
The Society for Ambulatory Anesthesia (SAMBA) fully complies with the legal requirements of the Americans with Disabilities Act and the rules and regulations thereof. If any attendee in this educational activity is in need of accommodations, please contact the SAMBA Executive Office at info@sambahq.org or 414-488-3915.

Cancellation Policy
Cancellations received through December 15, 2022, will receive a full refund. Cancellation of a meeting registration must be submitted in writing. Refunds will be determined by date written cancellation is received at the SAMBA office in Milwaukee, WI.

OVERALL LEARNING OBJECTIVES

At the end of this activity, participants should be able to:

- Discuss current business topics such as leadership and financial understanding relevant to an ASC.
- Identify relevant administrative topics currently faced by medical directors in ASCs.
- Describe the current management issues facing ASC practices.
- Discuss compliance and legal risk faced by ASC medical directors.

PROGRAM SCHEDULE

THURSDAY, JANUARY 12

5:00pm – 6:30pm
Welcome Reception Hosted by Ambulatory Surgery Center Association (ASCA)

FRIDAY, JANUARY 13

7:00am – 8:00am
Breakfast

8:00am – 8:05am
Welcome
Steven Butz, MD, SAMBA-F &
Dawn J. Schell, MD

8:05am – 9:15am
General Leadership
Moderator: Simon Lee, MD

- **Change Management**
  Michael Guertin, MD, MBA, CPE, FASA
- **Conflict Resolution**
  Kathy W. Beydler, RN, MBA, CNOR, CASC
- **Culture/Engagement**
  Steven Butz, MD, SAMBA-F
- **Q&A**

9:15am – 9:45am
Break

9:45am – 11:00am
Quality
Moderator: Simon Lee, MD

- **Outcomes and Performance Measures**
  Jarrett Heard, MD
- **Credentialing and Effective Peer Review**
  Steven Butz. MD, SAMBA-F
- **Q&A**

11:00am – 1:00pm
Lunch on Own

11:30am – 12:30pm
Optional Lunch Symposium Hosted by Pacira (NON-CME)

1:00pm – 2:15pm
Management
Moderator: Arnaldo Valedon, MD, FASA, SAMBA-F, MBA Candidate 2023

- **Real World Issues and Solutions for Medical Directors**
  Arnaldo Valedon, MD, FASA, SAMBA-F, MBA Candidate 2023
- **Q&A**

2:15pm – 2:45pm
Break

2:45pm – 4:00pm
Financial
Moderator: Arnaldo Valedon, MD, FASA, SAMBA-F, MBA Candidate 2023

- **Blending Medicine & Finance / Ethics**
  William Prentice, JD
- **Maximizing ASC Billing**
  John J. Goehle, MBA, CASC, CPA
- **Value-Based Care**
  Kara Marshall Newbury, JD

SATURDAY, JANUARY 14

7:00am – 8:00am
Breakfast

8:00am – 9:15am
Legal
Moderator: Simon Lee, MD

- **Future of Independent Anesthesia Practice**
  Judith Jurin Semo, JD
- **Q&A**

9:15am – 9:45am
Break

9:45am to 11:00am
Legal (Continued) and Expanding Services

- **Legal: Anti-Kickback Law / Stark Law**
  Judith Jurin Semo, JD
- **Employment Law / Termination / HR**
  Judith Jurin Semo, JD
- **Q&A**

PROGRAM PLANNING COMMITTEE

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DISCLOSURE POLICY

The American Society of Anesthesiologists remains strongly committed to providing the best available evidence-based clinical information to participants of this educational activity and requires an open disclosure of any potential conflict of interest identified by our faculty members. It is not the intent of the American Society of Anesthesiologists to eliminate all situations of potential conflict of interest, but rather to enable those who are working with the American Society of Anesthesiologists to recognize situations that may be subject to question by others. All disclosed conflicts of interest are reviewed by the educational activity course director/chair to ensure that such situations are properly evaluated and, if necessary, resolved. The American Society of Anesthesiologists educational standards pertaining to conflict of interest are intended to maintain the professional autonomy of the clinical experts inherent in promoting a balanced presentation of science. Through our review process, all American Society of Anesthesiologists accredited activities are ensured of independent, objective, scientifically balanced presentations of information. Disclosure of any or no relationships will be made available for all educational activities.

Disclosures
The following staff and planning committee members have reported the following financial relationships with ineligible companies:

Name	Role	Interest	Ineligible Company
Basem Abdelmalak, MD	Planner	Consultant and Speaker	Acacia Pharma
		Consultant and Speaker	Medtronic USA, Inc.
Arnaldo Valedon, MD	Planner	Other - Literature Reviewer	ARC Medical

All relevant financial relationships for the planners of this activity have been mitigated. This activity's content is not related to products or services of an ACCME-defined ineligible entity; therefore, there is no potential for conflicts of interest for faculty.

All other planners, faculty, and staff have disclosed no relevant financial relationships with ineligible companies

MARK YOUR CALENDAR AND BE SURE TO JOIN US AT THIS FUTURE SAMBA MEETING!

HANDOUTS

Welcome

Steven Butz, MD, SAMBA-F & Dawn J. Schell, MD

01/13/2023
8:00am – 8:05am Pacific

HANDOUTS

General Leadership

Moderator: Simon Lee, MD

01/13/2023
8:05am – 9:15am Pacific

HANDOUTS

General Leadership: Change Management

Michael Guertin, MD, MBA, CPE, FASA

01/13/2023
8:05am – 9:15am Pacific

1

Disclosure

- I have a consulting agreement with Merck, but this has no influence on my presentation today.

2

3

What will we talk about?

- The importance of communication and involving front-line people in Changes
- Change management in Healthcare can be more difficult than other industries
- Process models & tools to successfully create Change

4

> **The only sustainable competitive advantage today is the ability to change, adapt, and evolve - and to do it better than the competition.**
>
> Mariotti J. 10 steps to positive change. *Ind Week* 1998;247:82

Reference 6

5

2 Types of Change

Adaptive change – minor, incremental adjustments that improve clinical processes & workflows	**Transformational change** – substantial alterations that impact how people, processes and tools operate
• Does not impact the business model of the facility • Affects small number of people & involves few changes • Based on the current state to improve existing ways of doing the work	• May lead to overhaul of critical functions & business structure of the organization • Long-term changes that impact culture & mission • Based on a future state & involves new way of doing things

References 4, 8

6

Why Change?

Benefits of good change management

Staff engagement	Better service delivery	Improved productivity & efficiency	Reduced anxiety, confusion and stress

Engaging staff at every level empowers a workforce of problem solvers achieving a shared goal

Improves culture & chances of successful change

Reference 3

7

Some Key Drivers of Changes in Healthcare:

- **Advances in technology**
  - Advances in artificial intelligence (AI)
  - Telemedicine used at home & in hospitals
  - Changes to wide-reaching regulations, like the Affordable Care Act (ACA)
  - Increased mobile device use
  - Modernization of payment options
- **New regulatory compliance requirements**
- **The need to continually improve efficiency and quality of care**
- **World events (ex= coronavirus pandemic)**
  - Sudden increase in telehealth use
  - Reduction in elective procedures

Reference 7

8

During any change, employees may feel emotions that can undermine attempts at promoting change

Complacency	Anger	False Pride	Pessimism	Arrogance
Cynicism	Panic	Exhaustion	Insecurity	Anxiety

Reference 12

9

People Naturally Resist Change

"The only people who like change are babies with wet diapers."	• Dr. Raphael Pollock
Kotter / McKinsey & Co.: 70% of change programs fail to achieve their goals	• Largely due to employee resistance & lack of management support

One of the reasons why people resist change is the fear of not being able to do something new

References 1, 8, 15

10

Push vs. Pull Approach

Push Approach – Compliance-based change
- Top down communication
- More resistance → Longer time to completion & more effort needed

Pull Approach – Commitment-based change
- More work up-front in planning & creating change
- Asking people to use their collective brilliance to solve issues
- Less resistance → stabilization earlier

For change to be effective in a system, it has to occur at the level of the technical and the social system
- People support what they help create

Reference 10

11

Effective Change Management Focuses on the Individual (Prosci®)

Organizations don't change, people change
- Change in a system → people in the system have their daily patterns disturbed
- Unless these people have input, they will resist the change

"Change Management:

…Is the application of a structured process & set of tools for leading the people side of change to achieve a desired outcome."

…Is also about treating people right & helping the people who make up an organization navigate change in a positive manner"

References 8, 10

12

Effective change management (Prosci®):

- MAKES ACHIEVING PROJECT GOALS 6X MORE LIKELY
- 5X MORE LIKELY TO STAY ON SCHEDULE
- 2X MORE LIKELY TO STAY ON BUDGET
- ACHIEVES ORGANIZATIONAL GOALS WITH THE LEAST POSSIBLE RESISTANCE

References 4, 8

13

While the foundations of change management are the same across all industries, changes in healthcare are particularly complex because of how many different people can be impacted

* The most successful change models in healthcare focus on the human element of guiding people through the change *

To be successful, the change model must be centered on how people react to change & strategies on getting them past resistance to change

Change management in healthcare has to consider all the stakeholders involved, which can be everyone from billing to frontline medical staff to patients

Reference 7

14

Healthcare: change is a challenge

Clinicians & staff view their work as a vocation as much as a profession

- They are historically suspicious of senior administrators & resistant to strategic agendas

Change management techniques apply:

- Internally to staff processes
- Externally to patients & families

Healthcare workers often view change as a threat to the outcome of their patients

References 3, 15

15

Change Failure in Healthcare

When employees feel strong ownership in existing methodologies they resist change

* Must get stakeholder buy-in to succeed *

Complex infrastructures can block effective communication across a large, dispersed group

Reference 3

16

Characteristics of successful changes in Healthcare organizations

Interview study: 11 physicians, 12 RNs & 7 assistant nurses (Sweden)

3 characteristics of successful changes:

- 1. **Having the opportunity to influence the change**
  - Changes initiated by the professionals themselves considered the easiest & rarely resisted
- 2. **Being prepared for the change**
  - Changes clearly communicated to allow for preparation increased chances for success
  - Changes implemented unexpectedly and/or without prior communication not supported
- 3. **Valuing the change**
  - Important for them to understand the need for and benefits of organizational changes
  - Valued perceived changes with a patient focus, with clear benefits to patients

Reference 5

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Some Change Management "Methods"

Kotter's 8-Step Change Management Model	ADKAR by Prosci®	5-Step Model (Mirrors DMAIC)	McKinsey 7-S Change Model
	Awareness, Desire, Knowledge, Ability, Reinforcement	Define, Develop, Implement, Stick, Analyze	Strategy, Structure, Staff, Skills, Style, Systems, Shared Values

References 4, 9

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Kotter's 8 Steps for Leading Change

1. Create a Sense of Urgency	• Identify the "WHY" & communicate it	SET THE STAGE
2. Build a Guiding Coalition	• Engage Core Stakeholders	
3. Create a Strategic Vision	• Develop a roadmap for the change	DECIDE WHAT TO DO
4. Enlist a Volunteer Army	• Communicate the plan & Organize staff to put it into action	MAKE IT HAPPEN

References 3, 11, 13, 14

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Kotter's 8 steps (cont.)

5. Enable Action by Removing Barriers	• Remove obstacles & adapt as they occur	MAKE IT HAPPEN
6. Generate Short-Term Wins	• Initiate changes & track progress	
7. Sustain Acceleration	• Assess effectiveness & Align interrelated structures with the new vision	MAKE IT STICK
8. "Anchor" the Change	• Ensure that change is supported long-term & becomes part of the culture	

References 3, 11, 13, 14

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Change to Improve Patient Satisfaction: An Improvement Project for a new Medical Director

1. CREATE A SENSE OF URGENCY

Press-Ganey Patient Satisfaction at 78th %ile
- Reviewed 6 months of P-G survey comments & created Pareto Chart of opportunities
- IV placement improvement (48th %ile) & improved communication were at top of chart

2. BUILD A GUIDING COALITION

Discussed results & plan with Director, NM, Executive team

3. CREATE A STRATEGIC VISION

Designed protocol & processes for IV placement & Family Presence in Preop
- IV: Buffered lido / 18-22 ga / no more than 2 attempts before ask for help
- Family presence in Preop as a "requirement" for every patient

4. ENLIST A VOLUNTEER ARMY

Discussed findings & need to improve with nursing staff = nurse buy-in
- Answered staff questions / addressed concerns / LISTENED

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Change to Improve Patient Satisfaction (cont.)

5. ENABLE ACTION BY REMOVING BARRIERS

Met with Pharmacy leadership regarding buffered lidocaine
- One staff left r/t IV protocol

Discussed with staff re: patient visitor logistics
- Staff decided solution to site design shortcomings
- Met with Facilities re: building codes & solutions

6. GENERATE SHORT-TERM WINS

Positive patient feedback reflected in compliments & surveys

7. SUSTAIN ACCELERATION

Continued improvement: U/S IV

8. "ANCHOR THE CHANGE"

Review P-G monthly → IV to 98th %ile, overall to 99th %ile
- Continued education, monitoring of new & existing sites

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Questions

WAS THIS CHANGE ADAPTIVE OR TANSFORMATIONAL?

WAS IT EFFECTIVE?

WAS IT MEANINGFUL?

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5 Step Plan for Change

Operational (DMAIC-type) Change Model

Reference 4

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Prosci® ADKAR Model

Change at the Level of the Individual

Awareness	Desire	Knowledge	Ability	Reinforcement
• Organization understands that a change is needed	• Create employee-belief that change is for well-being of themselves & organization	• Employees understand why & how of change and understand their role	• Employees must have knowledge & skills to do what is expected of them	• Reinforce desired behavior through rewards or other incentives

Reference 9

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Creating Change Indirectly

Influencing others to perform specific behaviors that produce the results we're after

- A plant manager can influence workplace safety metrics by getting employees to keep the workplace neat and tidy

These behaviors are tools that you might use to get a job done, like:

- A jack to lift cars
- A wheelbarrow to move heavy objects across a yard
- A hammer to put nails in wall-board

We call these "Levers" or High Leverage Behaviors (HLBs)

Reference 16

26

Examples of Levers

CHANGE PROBLEM	LEVERS
MRSA Infection Rates	• Strict hand-washing regimen • Eschew garments that can be vectors for infection
Surgical Outcomes	• Complete the Surgical Safety Checklist

Reference 16

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3 Features of Good Levers

Malleable	High Leverage	Concrete
The behavior can be influenced - Placing hand sanitizers at every point of entry & exit from patient care	Working the lever produces the result that we're after • Using the Surgical Safety Checklist = less likely to have a bad surgical outcome	Unambiguous, easy to recognize • Either you wash your hands or you don't.

HLBs are not the downstream outcome that you're trying to address

Reference 16

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What did we talk about?

People make Change happen!

Change management in Healthcare can be more challenging

Kotter and others have provided frameworks & tools for effective Change management

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Thank You

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Objectives

After this presentation, participants will:

- Understand the importance of communication and involving front-line people in Change Management
- Understand why Change Management in Healthcare can be more difficult than other industries
- Know several process models & tools to successfully create Change

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1. Effective management of healthcare change | Emerald Insight
2. complete dissertation.pdf (vumc.nl)
3. Change Management in Healthcare – The Biggest Challenges and How to Overcome Them – Capacity 4 Health
4. Exploring the Importance of Change Management in Healthcare | OnPage
5. Characteristics of successful changes in health care organizations: an interview study with physicians, registered nurses and assistant nurses | BMC Health Services Research | Full Text (biomedcentral.com)

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6. Managing Change in Healthcare - PMC (nih.gov)
7. Applying Best Change Management in Healthcare | All You Need to Know – Airiodion (AGS)
8. What is change management in healthcare? And why should you pay attention to it? - Spok Inc.
9. The 3 Best Change Management Models in Healthcare Practices | Giva (givainc.com)
10. Change Management Strategies in Healthcare Industry | OTM (on-the-mark.com)

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References

11. Change Management in Healthcare Literature Review
12. Change Management in Health Care : The Health Care Manager (lww.com)
13. www.kotterinc.com/methodology/8-steps/
14. Our Iceberg is Melting by John Kotter
15. How to Get Health Care Employees Onboard with Change (hbr.org)
16. Dr. Ben Tepper lecture to the Faculty Leadership Institute of The Ohio State University College of Medicine

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HANDOUTS

General Leadership: Conflict Resolution

Kathy W. Beydler, RN, MBA, CNOR, CASC

01/13/2023
8:05am – 9:15am Pacific

WHITMAN PARTNERS
Director of Surgical Services
Search | Consulting | Community

Conflict Resolution
SAMBA 2023 ASC Medical Directors & Leaders Summit
Kathy W. Beydler, RN, MBA, CNOR, CASC

1

Conflict Resolution

Four Key Strategies

1. Take Personal Responsibility
2. Hold Each Other Accountable
3. Encourage Collaboration
4. Build Relationships

2

Conflict Resolution

Four Key Strategies

1. Take Personal Responsibility
- Admit When You've Made a Mistake
- Don't Try to Blame Others
- Admit What You Can and Cannot Control

3

Conflict Resolution

Four Key Strategies

2. Hold Each Other Accountable
- Address Concerns in Private
- Address Mistakes without Assigning Blame

4

Conflict Resolution

Four Key Strategies

3. Encourage Collaboration
- Everyone Brings Their Own Expertise
- Publicly Recognize Excellence of Teamwork
- Encourage Each Other
  "We Don't Do Negative"

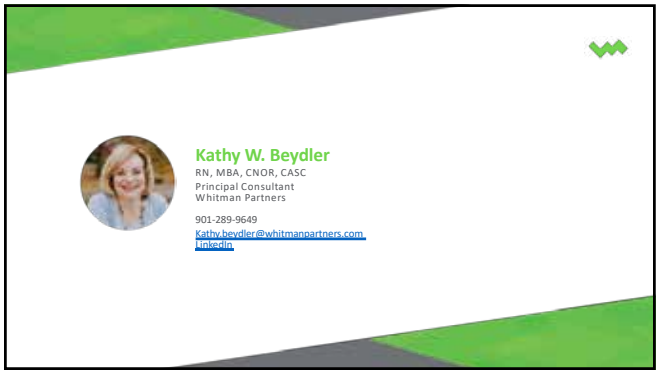
5

Conflict Resolution

Four Key Strategies

4. Build Relationships
- Negative Voices are Always Louder
- Look Beyond the Negative Voice to the Person
- Better Relationships = Better Patient Care

6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7

HANDOUTS

General Leadership: Culture/Engagement

Steven Butz, MD, SAMBA-F

01/13/2023
8:05am – 9:15am Pacific

Culture and Engagement

Steven Butz, MD
Associate Chief Medical Officer
Children's Wisconsin Surgicenter

1

Objectives

- Understand how a culture can affect team results
- Understand the concept of Engagement
- Describe a "Just Culture"

2

Conflicts of Interest

- None

3

Culture

- A team's culture affects:
  - Communication
  - Conflict Resolution
  - Performance

Uniformity of Culture is important:
- Centered
- Weakly differentiated
- Strongly differentiated

Vicente González-Romá and Ana Hernández. Journal of Applied Psychology. 2014, Vol. 99, No. 6, 1042–1058

4

Team Culture—what is strong team cx?

- Common goal
- Agreed leadership
- Common rules
- Understand roles
- Clear communication
- Shared identity*

5

Effective Teams

- Don't have fixed personalities
- Don't have fixed stereotypes
- Don't have the same people
- Don't have power differentials
- Don't have pre-existing conflicts

6

Team Culture: How to Improve

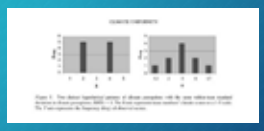
- Surgical "Time Out"
  - Sets Goal
  - Introduces players
  - Clarifies power structure
  - Should empower all to speak up
- "Sign Out"/Debrief
  - Impromptu feedback
- Training on conflict resolution
- Competencies may not transfer to another team…..

Jans, et al. Medical Education 2012: 46: 838–849

7

Team Uniformity

- Highly engaged or highly disengaged teams are uniform
- Middle team scores can be bell-shaped or bi-modal
  - Weak
  - Strong



González-Romá and Hernández. Journal of Applied Psychology 2014. Vol 99. No 6. 1043-58.

8

Team Uniformity

- Compared to teams with uniform culture, teams with Weak Dissimilarity
  - Had poorer quality of communication
  - Had higher conflict scores
- Communication scores most highly correlated with performance measures

González-Romá and Hernández. Journal of Applied Psychology 2014. Vol 99. No 6. 1043-58.

9

Team Uniformity

- Of teams studied, about a third had dissimilar culture distribution
- 27% were weak and 7% strong
- Managers of weakly dissimilar teams judged them less effective
- Importance of "hiring for culture"

González-Romá and Hernández. Journal of Applied Psychology 2014. Vol 99. No 6. 1043-58.

10

Engagement

- Reflects the culture of an entity
- More engage = more satisfied
- More satisfied = better performing
  - Better work/higher quality
  - Less attrition
  - Higher patient satisfaction

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Engagement

- Physicians are NOT your usual worker
  - No managers to guide them
  - Identify more with specialty than employer or medical staff
  - Most are ambivalent
- All have different needs and can't be one-size-fits-all

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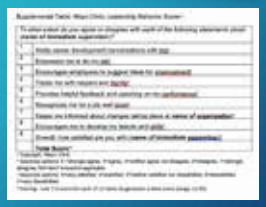
Engagement

- KNOW the provider
- Appreciates the provider
- Gives feed back
- Challenges/gives growth
- Gives tools to do the job
- RESPECT
- Transparency



Adapted from: Shanafelt TD, Gorringe G, Menaker R, et al. Impact of organizational leadership on physician burnout and satisfaction. *Mayo Clin Proc.* 2015;90(4):432-440

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What is Just Culture?

"Although different definitions exist, a just culture is generally regarded as a patient safety culture in which people can report accidents, incidents, mistakes, errors, and other mishaps without a risk of punishment. Only in the case of gross negligence or willful misconduct will punitive measures be taken. "

--Sjoerd van Marum, BSc, Daan Verhoeven, BSc, and Diederik de Rooy, LLM, MD, PhD

Journal of Patient Safety Volume18,Number7,October2022

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Elements of Just Culture

- Trust positively impacts job satisfaction and organizational effectiveness
- Staff need to:
  - Tell about errors truthfully
  - Not seen as "tattling"
  - Know that follow-through will improve patient safety
  - Know that personal reputation will be increased by reporting

Firth-Cozens. Qual Saf Health Care 2004;13:56–61

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Elements of Just Culture

- Management must:
  - Be open and fair about handling incidents
  - Investigate sensitively and transparently
  - Not harm reporter
  - Treat subject fairly
  - Demonstrate follow up
- Trust staff to be accurate and fair

Firth-Cozens. Qual Saf Health Care 2004;13:56–61

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Barriers to Just Culture

- Distant relationship between "reporter" and supervisor
- Large organizational reporting structure vs departmental (knowledge of system)
- Experience
  - Lack of confidence in skills
  - Fear of shame/blame

Van Marum, et al. Journal of Patient Safety Volume18,Number7,October2022

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Conclusion

- Culture affects team performance and engagement
- Uniformly similar teams perform better
- Culture needs to be groomed at all levels
- Hiring for culture is a must
- Maintaining Just Culture depends on all levels and can ultimately improve quality

18

HANDOUTS

Quality

Moderator: Simon Lee, MD

01/13/2023
9:45am – 11:00am Pacific

HANDOUTS

Quality: Outcomes and Performance Measures

Jarrett Heard, MD

01/13/2023
9:45am – 11:00am Pacific

Performance Measures

Jarrett A. Heard, MD, MBA
Medical Director Ambulatory Perioperative Services
Director Executive Leadership and Business in Anesthesiology Fellowship
The Ohio State University Wexner Medical Center

1

Disclosures

- I have no disclosures to report

2

Objectives

- Identify Common Measures in Ambulatory Anesthesia
  - Relate tools/organizations, KPIs to performance
- Review CMS Measures in Ambulatory Anesthesia for reimbursement
  - Share CMS Updates
- Define Future Measures for your organization

3

Performance Measures

- Well defined
- Easily Observed
- Analyzed
- Why?
  - Patient safety and satisfaction
  - Operations: efficiency/revenue
  - Quality, incentives/future performance

4

Performance Measures – Ambulatory

- Metrics Overload!!!!!
- PONV
- Decreased Pain Scores/OME
- NMB use and reversal
- Patient Follow-up/Satisfaction
- OR Utilization/Turnover
- Case Cancellations
- Operating Revenue Cash Flow

5

Where Can I Find Them?

- ASA (CPOM) – American Society of Anesthesiologists
- SAMBA – Society for Ambulatory Anesthesia
- ASCA – Ambulatory Surgery Center Association
- MPOG – Multicenter Perioperative Outcomes Group
- AQI – Anesthesia Quality Institute
- ASCQR – Ambulatory Surgical Center Quality Reporting (CMS)
- NACOR – National Anesthesia Clinical Outcomes Registry (AQI - CMS)
- MACRA/MIPS – Merit Based Incentive Payment Systems (CMS)

6

Key Performance Indicators - KPIs

- Objectively Measurable
- Easily Measurable
  - Try to use existing systems to measure rather than creating new ones
  - EMR/web-based tools
- Align with goals/needs of your practice
- Influenceable by employee/department

7

KPIs – ASA Statement

1.Is the problem/opportunity well defined and measurable?

2.How will the data be defined and measured to provide meaningful information?

3.How will the KPI be used or communicated to help meet the organizational objectives?

https://www.asahq.org/quality-and-practice-management/managing-your-practice/timely-topics-in-payment-and-practice-management/key-performance-indicators-how-do-you-measure-up

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Key Performance Indicators - ASA

- Days in Accounts Receivable
- Revenue Realization Rate
- Clean Claims Ratio
- Denial Rate
- Bad Debt Percentage

https://www.asahq.org/quality-and-practice-management/managing-your-practice/timely-topics-in-payment-and-practice-management/key-performance-indicators-how-do-you-measure-up

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MACRA – CMS.gov

- Medicare Access and CHIP Reauthorization Act – 2015
  - Quality Payment Program (QPP)
    - Affects physicians reimbursed by Medicare
  - Rewards Value over Volume
- MIPS vs. APMs
- Cooperative Agreement Awardees - 7
  - Receive financial and technical support
  - Develop, Improve, Update or Expand Measures in Quality Payment Program

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs

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MIPS – CMS.gov

- Several Previous Programs converted into "1"
  - Physician Quality Reporting System
  - Physician Value-Based Payment Modifier - Performance Based
  - Medicare Incentive Program
  - NPI and TIN - participation
- 4 Performance Categories
  - Quality – 30% (6 collection types) CAHPS
  - Cost- 30%
  - Improvement Activities – 15% (up to 4 activities, weighted differently)
  - Promoting Interoperability (PI) – 25%
- Check for exemptions/special status

https://qpp.cms.gov

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MIPS – CMS.gov

- 0-100 point scale
- 75 points = a neutral adjustment (performance threshold)
- > 75 points = positive payment adjustment
- < 75 points = negative payment adjustment
- Max payment adjustment will be 9 percent (up or down)
- Performance threshold based on the mean or median scores
- > 89 points = exceptional performance - eligible for additional positive payment adjustments.
- ASC-based clinicians that furnish 75% or more of their covered services in ASC are exempt from the PI category
  - PI – EHR technology

https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program

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APMs – Advanced Alternative Payment Models

- 50% of payments from an APM or 35% patient volume from APM Surgeons
- Limited number of APM participation opportunities
- CMS has not proposed an ASC-based APM
- ASCA urged CMS to implement a request for proposals process that is flexible enough to address the needs of the wide range of surgical specialties that practice in the ASC environment

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs

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ASCA/ASCQR

- Clinical and Operational Benchmarking Survey
  - Benchmarking Basics for ASCs
- National Quality Strategy
  - Better healthcare for individuals/populations and lower costs

https://www.ascassociation.org/asca/resourcecenter/benchmarking/ascabenchmarking

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Number	Measures Submitted via a Web-based Tool	Reporting Period	Submission Period
ASC-9	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	January 1, 2022 – December 31, 2022	January 1, 2023 – May 15, 2023
ASC-11*	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Voluntary)*	January 1, 2022 – December 31, 2022	January 1, 2023 – May 15, 2023
ASC-13	Normothermia	January 1, 2022 – December 31, 2022	January 1, 2023 – May 15, 2023
ASC-14	Unplanned Anterior Vitrectomy	January 1, 2022 – December 31, 2022	January 1, 2023 – May 15, 2023
ASC-20	COVID-19 Vaccination Coverage Among Health Care Personnel	Q1 2022: Jan 1, 2022 – Mar 31, 2022	Q1: August 15, 2022
		Q2 2022: Apr 1, 2022 – Jun 30, 2022	Q2: November 15, 2022
		Q3 2022: Jul 1, 2022 – Sep 30, 2022	Q3: February 15, 2023
		Q4 2022: Oct 1, 2022 – Dec 31, 2022	Q4: May 15, 2023

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ASC-Quality-Reporting

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ASC-20 COVID-19 Vaccination Coverage Among Health Care Personnel (HCP)***

* ASC-11 is a voluntary measure; any data submitted will be publicly reported.

** Does not require any additional data submission apart from standard Medicare Fee-for-Service claims.

*** Reported quarterly through the National Healthcare Safety Network (NHSN).

For more information about measure data submission and deadlines, refer to the Data Submission page.

For more details about the program requirements, see the Reference Checklist.

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ASC-Quality-Reporting

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ASC Payment Update - ASCA

- Update ASC payment system using hospital market basket update
- Increase payment rates by 2.7% based on ASCQR requirements
- Based on hospital market basket percentage increase of 3.1% reduced by a productivity adjustment of 0.4 percentage point

https://www.ascassociation.org/asca/aboutus/latestnews/newsarchive/newsarchive2022/july2022/202207medicare2023proposedpaymentrule

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	ASC	HOPD
Inflation update factor	3.1%	3.1%
Productivity reduction mandated by the ACA	0.4 percentage points	0.4 percentage points
Effective update	2.7%	2.7%
Conversion factor	$51.315	$86.785

https://www.ascassociation.org/asca/aboutus/latestnews/newsarchive/newsarchive2022/july2022/202207medicare2023proposedpaymentrule

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ASCA Updates

- Total payments to ASCs for CY 2023 ≈ 5.4 billion
- Changes to List of ASC Covered Surgical Procedures: For CY 2023, we propose to add one procedure, a lymph node biopsy or excision

https://www.ascassociation.org/asca/aboutus/latestnews/pressarchive/pressarchive2022/july2022/20220707medicare2023proposedpaymentrule

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Goodhart's Law

"When a measure becomes a target, it ceases to be a good measure"

20

Performance Measures and You

- Define Success in your Surgery Center:
- Patient Satisfaction
- Patient Safety/Quality
- Operational Performance
- Operating Revenue
- OR Utilization
- Case Volume
- Transfer/Admission Rate

21

Where can you go from here....

- Identify problems/areas of improvement
- Find those that are easy to measure
- Define metrics
- Develop systems to drive performance
- ASCs reimbursed ≈ 60% of HOPDs for similar procedures - CMS

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Transfer Rate/Admissions

- Define
  - Same Day? >24 hrs? Within 30 days?
- Measure
  - Self-report? EMR? Call center?
- Secondary/Proxy measures?
  - PACU LOS; pain diary
  - PONV/PDNV
  - Post-op Instructions and Follow-up

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Patient Satisfaction

- Survey scores
  - Granular data vs. raw score
  - Patient comments
    - IV Placement at OSUWMC
- Patient Selection and Optimization
  - Cancellations, Case Delays
  - Patient Education and Communication
  - Telehealth – Video Education
  - NPO Guidelines

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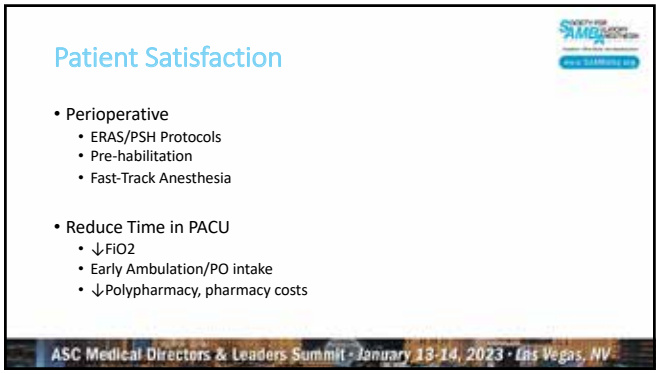

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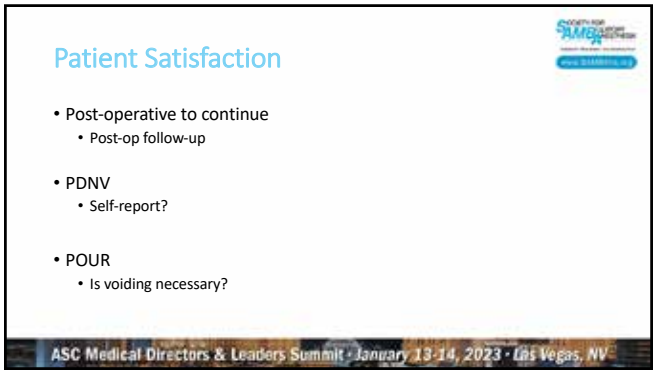

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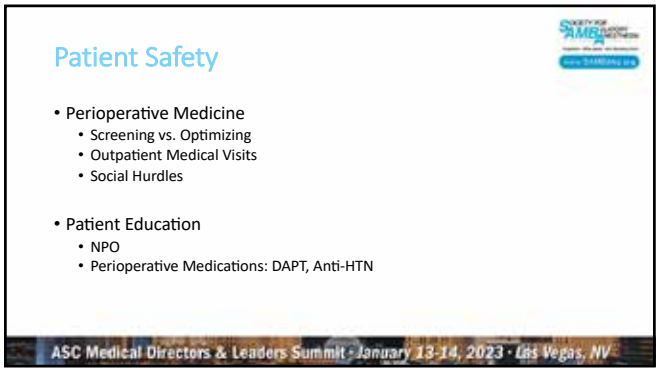

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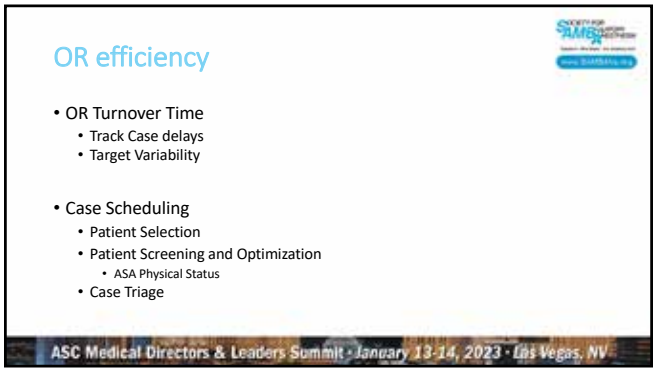

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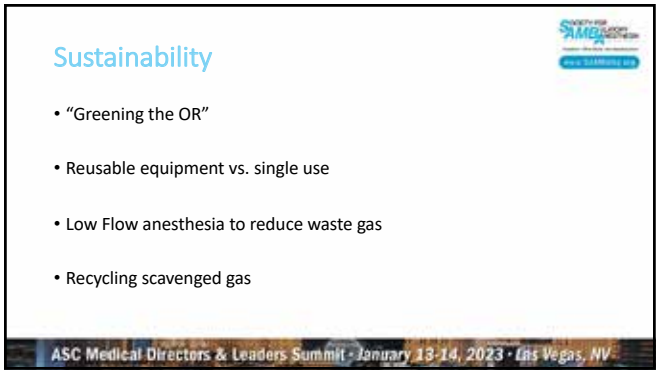

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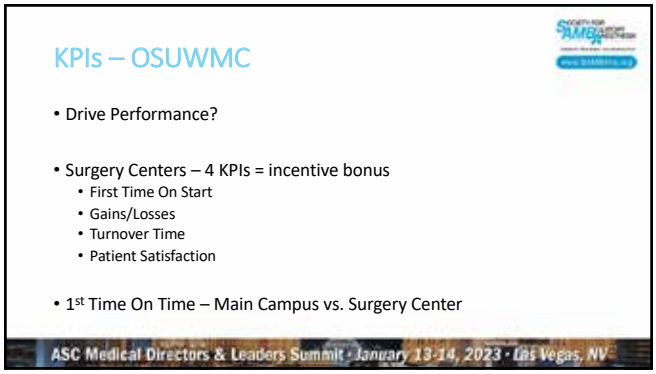

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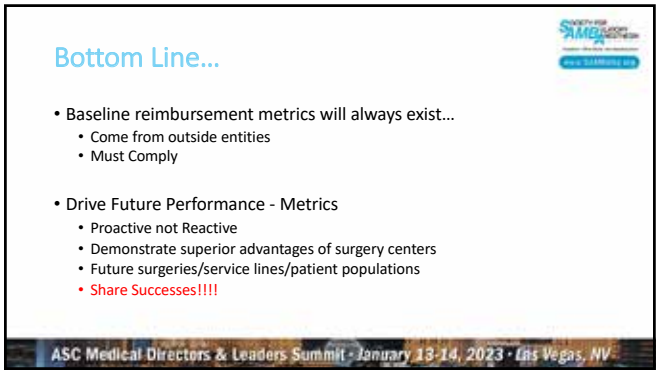
Bottom Line…
• Baseline reimbursement metrics will always exist…
• Come from outside entities
• Must Comply
• Drive Future Performance - Metrics
• Proactive not Reactive
• Demonstrate superior advantages of surgery centers
• Future surgeries/service lines/patient populations
• Share Successes!!!!
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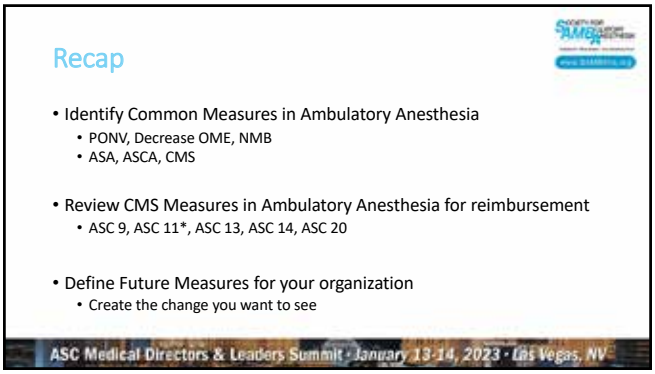
Recap
• Identify Common Measures in Ambulatory Anesthesia
• PONV, Decrease OME, NMB
• ASA, ASCA, CMS
• Review CMS Measures in Ambulatory Anesthesia for reimbursement
• ASC 9, ASC 11*, ASC 13, ASC 14, ASC 20
• Define Future Measures for your organization
• Create the change you want to see
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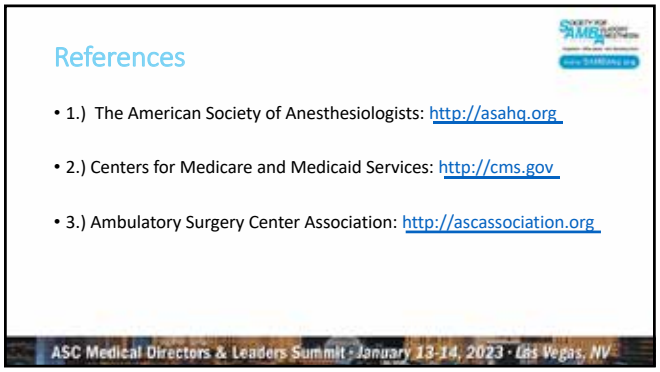
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• 1.) The American Society of Anesthesiologists: http://asahq.org
• 2.) Centers for Medicare and Medicaid Services: http://cms.gov
• 3.) Ambulatory Surgery Center Association: http://ascassociation.org
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Published in final edited form as:
J Clin Anesth. 2020 October ; 65: 109814. doi:10.1016/j.jclinane.2020.109814.

Patient Satisfaction Survey Scores are not an Appropriate Metric to Differentiate Performance Among Anesthesiologists

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Gen Li, M.Stat., M.Chem. contributed to the study design and to the acquisition, analysis and interpretation of data for this study, drafted and revised the manuscript for important intellectual contents.
Brendan Grant contributed to the acquisition, analysis and interpretation of data for this study.
Paul St. Jacques, M.D. contributed to the acquisition of data, revised the manuscript for important intellectual contents.
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Matthew S. Shotwell, Ph.D. contributed to the analysis, and interpretation of data for this study, revised the manuscript for important intellectual contents.
Jonathan P. Wanderer, M.D., M.Phil., FASA contributed to the conception and design of this study and to the acquisition of data for this study, revised the manuscript for important intellectual contents.
All authors have reviewed and approved the final version of the manuscript.

Prior Presentations: IARS 2018 annual meeting, Chicago, IL

Conflict of Interest: None

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Abstract

Study Objective: With the focus of patient-centered care in healthcare organizations, patient satisfaction plays an increasingly important role in healthcare quality measurement. We sought to determine whether an automated patient satisfaction survey could be effectively used to identify outlying anesthesiologists.

Design: Retrospective Observational Study

Setting: Vanderbilt University Medical Center (VUMC)

Measurements: Patient satisfaction data were obtained between October 24, 2016 and November 1, 2017. A multivariable ordered probit regression was conducted to evaluate the relationship between the mean scores of responses to Likert-scale questions on SurveyVitals' Anesthesia Patient Satisfaction Questionnaire 2. Fixed effects included demographics, clinical variables, providers and surgeons. Hypothesis tests to compare each individual anesthesiologist with the median-performing anesthesiologist were conducted.

Main Results: We analyzed 10,528 surveys, with a 49.5% overall response rate. Younger patient (odds ratio (OR) 1.011 [per year of age]; 95% confidence interval (CI) 1.008 to 1.014; $p < .001$), regional anesthesia (versus general anesthesia) (OR 1.695; 95% CI 1.186 to 2.422; $p = 0.004$) and daytime surgery (versus nighttime surgery) (OR 1.795; 95% CI 1.091 to 2.959; $p = 0.035$) were associated with higher satisfaction scores. Compared with the median-ranked anesthesiologist, we found the adjusted odds ratio for an increase in satisfaction score ranged from 0.346 (95% CI 0.158 to 0.762) to 1.649 (95% CI 0.687 to 3.956) for the lowest and highest scoring providers, respectively. Only 10.10% of anesthesiologists at our institution had an odds ratio for satisfaction with a 95% CI not inclusive of 1.

Conclusions: Patient satisfaction is impacted by multiple factors. There was very little information in patient satisfaction scores to discriminate the providers, after adjusting for confounding. While patient satisfaction scores may facilitate identification of extreme outliers among anesthesiologists, there is no evidence that this metric is useful for the routine evaluation of individual provider performance.

Keywords

Anesthesiologist; Patient Satisfaction; Survey Score; Performance Improvement

1. Introduction

The 2001 Institute of Medicine report, "Crossing the Quality Chasm", advocated for broad, sweeping changes in how healthcare is delivered in the United States, with a focus on implementing improved assessment of quality [1]. One of the six specific aims for improvement identified was patient-centered care -- "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient

values guide all clinical decisions." However, evaluating the quality of anesthesia is particularly challenging. Proposed quality metrics such as avoidance of intraoperative hypotension [2–3], post-operative pain scores [4], and timely administration of perioperative antibiotics [5] have all been shown to have significant limitations and perform poorly as quality indicators.

While anesthesiology has prided itself as a leader and innovator in the field patient safety, it has been criticized for being inadequately patient-centered by multiple leaders in the field [6,7]. In response to this concern, there has been a push for increased transparency on the part of providers and care groups about whether they are providing care that is perceived by patients to be of value. This perception of value, however, may correlate poorly with actual quality of care delivered [8].

One approach to improve patient-centered value has been through the measurement of patient satisfaction ratings. Satisfaction metrics have been proposed to evaluate individual providers. Although these ratings are widely-used and available, they have not been rigorously validated, particularly in the field of anesthesiology. Furthermore, it is unclear if these ratings can be used to compare providers or, perhaps more relevant to the patient centered quality imperative, to effectively identify underperforming providers within a cohort. We therefore sought to determine whether patient satisfaction data can be used to assess individual anesthesiologist performance at a large, academic medical center, after adjusting for confounding factors. We hypothesized that patient satisfaction scores are insufficient to rank-order individual provider performance.

2. Methods

The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines were used in the preparation of this manuscript [9].

2.1. Human Subjects Protection

This study received approval from the Vanderbilt University Medical Center (VUMC) Institutional Review Board (#180688) with a waiver of informed consent.

2.2. Data Collection

Patient, provider, and procedural data were obtained from the VUMC Perioperative Data Warehouse, which are derived from data from the Anesthesia Information Management System (AIMS; VPIMS, internally-developed at VUMC, Nashville, TN). These data were merged with patient satisfaction data obtained by a third-party vendor (SurveyVitals, Dallas, TX). SurveyVitals is now used by 1 in 4 U.S. physician anesthesiologists across 2,691 facilities (https://www.SurveyVitals.com/start/anesthesia). The tool uses an automated approach to contacting patients after their procedure and administering the Anesthesia Patient Satisfaction Questionnaire 2.0 (APSQ2). The internal consistency of the overall methodology of APSQ2 has been calculated internally by SurveyVitals (Cronbach's alpha 0.820, Appendix A.1) [10].

The APSQ2 is specifically designed to evaluate anesthesia care teams where an attending anesthesiologist is working with a Certified Registered Nurse Anesthetist (CRNA), and these two roles are individually assessed in the design of the questionnaire. Given this structure, we only included the surveys sent to patients whose anesthesia care was delivered by an anesthesia care team composed of one attending anesthesiologist and one CRNA in our primary analysis. A sensitivity analysis was performed as a secondary analysis to evaluate the effect of other care team models on satisfaction scores.

At our institution, contact is made within seven days after discharge or the conclusion of the procedure via email, telephone text message or an interactive voice response (IVR) phone call system. A patient can be contacted via several modalities as the contact campaign follows an established order: (1. SMS/Text message, two attempts; 2. Email, two attempts; 3. IVR call, three attempts). However, once the patient takes the survey, the campaign is stopped, and no more contact attempts are made. Patients who received anesthesiology services on an inpatient or outpatient basis, and for whom a valid email or telephone number is present in the hospital admission records are eligible to receive an APSQ2 survey, except for those with in-hospital mortality, or who had been surveyed within the past 60 days, or who had multiple anesthetics within their hospital stay, or whose anesthesia care team had multiple staff members per role (i.e. more than one attending).

As part of the APSQ2 (Q1, Table A), patients are shown a headshot picture of each member of their anesthesia care team, along with their name and role. These headshots were taken with each member of our department in clinical attire (i.e., hat, mask and scrubs), to improve recognition by patients. The APSQ2 only proceeds if the patient indicates that they remember each provider enough to answer questions about the care provided. Additionally, the patient is asked if they would like to be contacted to discuss their evaluation.

The APSQ2 consists of Likert scale questions, yes-no questions, and open-ended questions. Using an established methodology [10,11], responses from the seven Likert scale questions (Q3–Q8 and Q10) from the APSQ2 that focused on the patient satisfaction with their attending anesthesiologist were analyzed as the primary outcome. The remainder of the questions on the SurveyVitals questionnaire (Q12–15) pertain to other members of the anesthesia care team and were excluded. Three open-ended, unstructured questions (Q9, Q11 and Q18), and yes or no question focused on self-reported anesthesia outcomes, including pain, nausea/vomiting, and unpleasant memories, were similarly excluded.

All seven questions selected for analysis were posed as a typical Likert scale, with a 5-point ordinal scale used by patients to express their agreement or disagreement with a statement. “Strongly Agree” was assigned a value of 5 and “Strongly Disagree” a value of 1. The arithmetic mean scores of the responses to seven Likert-scale questions were also calculated as the overall satisfaction score in this study.

All anesthetics performed between October 24th, 2016 to November 1st, 2017 at VUMC, a large, tertiary academic medical center, were eligible for inclusion in the analysis. These dates were chosen based on the implementation of a new survey instrument (10/24/2016) and our go-live with a new electronic health record, which temporarily interrupted our

SurveyVitals data collection (11/1/2017). Based on a recent reliability study of APSQ2 conducted by SurveyVitals, we excluded attending anesthesiologists with fewer than 96 patient satisfaction ratings from analysis, which is estimated by SurveyVitals to provide a 95% confidence level for the accuracy of results (Appendix A.2).

2.3. Statistical Analysis

Descriptive statistics were calculated across patient encounters using the median and interquartile range for continuous variables and with percentages for categorical variables and stratified by overall satisfaction score. The raw response rates of the seven Likert scale questions centered on patient satisfaction were reported.

Two strategies were implemented to construct the primary outcome in this study. First, a specific multivariable ordered probit regression model was conducted using the natural overall satisfaction score on with ordered values between 1 and 5. In the second strategy, as a sensitivity analysis, the overall satisfaction score was dichotomized to a binary outcome, with overall satisfaction score of 4–5 were interpreted as "Satisfied" and 1–3 were interpreted as "Not Satisfied" for regular multivariable logistic regression [11].

2.3.1. Ordered Probit Regression—Data were analyzed using a multivariable ordered probit fixed-effects regression model with the ordered overall satisfaction scores of attending anesthesiologists as the outcome variable. CRNA performance was not assessed in this regression model given insufficient power. Covariates included attending anesthesiologists, CRNAs, patient age, patient gender, American Society of Anesthesiologists Physical Status Classification (ASA), anesthesia type, surgical service, surgery start time (as a categorical variable) [11], operating room location within the hospital, and surgeon [12,13]. After redundancy analysis, operating room location was removed from the model, given significant collinearity ($R^2 = 1.00$). The overall significance of the adjusted association between each covariate and the outcome was assessed using a Wald multiple degree of freedom Chi-squared test.

The odds ratios (ORs) with 95% CIs were reported for all significant factors to demonstrate the relative odds of the occurrence of the outcome of interest, given exposure to the other covariates for the ordered probit regression model. To be specific, for instance, let the ordinal patient satisfaction outcome be denoted by Y and one of its levels by y (e.g., 1, 2, 3, 4, or 5). Consider the probability that $Y \geq y$ for a patient seen by anesthesiologist A. The odds that $Y \geq y$ is the probability divided by one minus the probability. The odds ratio for provider A versus the median scoring provider is the ratio of the corresponding odds (provider A odds in the numerator). The ordered probit model assumptions require that the odds ratio is the same no matter which cutoff y is chosen. Thus, the OR should be interpreted as the fold-change in the odds of a higher patient satisfaction associated with a change in the corresponding covariate (e.g., provider, patient age), after controlling all the other covariates. For instance, a patient whose surgery was supervised by an anesthesiologist with corresponding odds ratio 1.25 would have 25% greater odds of higher satisfaction compared with the median scoring anesthesiologist. We also conducted a one-sided 0.05-

level Wald test for multiple comparisons for all pairs of anesthesiologists. No familywise hypothesis is considered, thus, no adjustment for multiple comparisons was made.

2.3.2. Logistic Regression— As a secondary analysis, a multivariable logistic regression was performed for the binary outcome to evaluate the covariates which would independently impact the patient satisfaction with their provider to receive a "Satisfied" response. The odds ratios (ORs) with 95% CIs were reported for all significant factors to demonstrate the relative odds of the occurrence of the outcome of interest, given exposure to the other covariates for the logistic regression model.

2.3.3. Sensitivity Analyses— A sensitivity analysis was conducted to discern the effect, if any, of different compositions of anesthesia care team on the responses from patient satisfaction surveys.

Additionally, we performed a multivariable ordered probit regression with two additional covariates. Surgery delay was included to examine how waiting affected patient satisfaction [14]. Moreover, the dosage of midazolam administered in the preoperative holding area was also included in the regression model to detect its association with patient satisfaction scores [15].

All statistical programming was conducted in SAS 9.4 (SAS Institute Inc., Cary, NC, USA).

3. Results

During the one-year study period, 58,468 eligible patients received an APSQ2 survey and 28,832 surveys were returned (49.5%). Specifically, according to the aforementioned sequence, the response rate of SMS/Text message channel was 30.0%. Then among the patients who did not reply to SMS/Text message, 23.3% responded the email. Furthermore, 31.8% patients who did not previously respond to either the text message or email, answered IVR call. Of the returned surveys, the response rates varied from 71.6% to 78.7% for each individual Likert scale question (Table B). Of 17,002 surveys from patients whose anesthesia care was delivered by an anesthesia care team composed of one attending anesthesiologist and one CRNA, a total of 10,528 (61.9%) patient satisfaction surveys met inclusion criteria and were analyzed for the 55 attending anesthesiologists with at least 96 scores in the study period as the primary analysis (Table C). In the sensitivity analysis with all care team compositions, 15,889 surveys were analyzed for 79 attending anesthesiologists.

3.1. Ordered Probit Regression

From the results of ordered probit regression model, we found that a younger patient age increased the likelihood of a provider receiving higher (more favorable) score (OR 1.011 [per year of age]; 95% CI 1.008 to 1.014; $p < .001$). Patients undergoing general anesthetics were more likely to assign their provider a lower score, compared with the those undergoing regional anesthesia (OR 1.695; 95% CI 1.186 to 2.422; $p = 0.004$). Moreover, patients who underwent nighttime surgery, with a case start time between 6 PM and 6 AM, were less likely to give their provider a higher score versus those with a start time between 6 AM and 12 PM (OR 0.557; 95% CI 0.338 to 0.917; $p = 0.035$) (Table D). The anesthesiologist odds

ratios panel (Fig. A) shows the sorted odds ratios for each individual anesthesiologist versus the reference provider, defined as the provider with the median adjusted odds. Compared with the median scoring anesthesiologist, the adjusted odds ratio for a higher satisfaction score ranged from 0.346 (95% CI 0.158 to 0.762) to 1.649 (95% CI 0.687 to 3.956), with all but only one (98.1%) of 95% CIs inclusive of the null value 1. To further assess the sensitivity of the patient satisfaction survey, all pairs of anesthesiologists were compared by conducting Wald's pairwise comparisons. For each provider, Fig. B shows the percentage of other anesthesiologists that received significantly higher or lower scores, and those for which there was insufficient information in the patient satisfaction scores to distinguish provider performance. The odds for the lowest scoring anesthesiologist was significantly lower than 90.7% of the other providers. In contrast, the odds for the highest scoring anesthesiologist was significantly higher than 44.4% of other providers. Nevertheless, only 10.1% of all pairwise comparisons had a 95% confidence interval for the odds ratio for satisfaction not inclusive of 1.

3.2. Logistic Regression

Similar results were observed from logistic regression model, an increasing patient age decreased the likelihood of a provider receiving a "Satisfied" feedback (OR 0.992 [per year of age]; 95% CI 0.986 to 0.998; p = 0.013), patients who underwent nighttime surgery between 6 PM and 6 AM were less likely to rank their provider "Satisfied" versus those with a 6 AM to 12 PM surgeries (OR 0.309; 95% CI 0.136 to 0.702; p = 0.018) (Table D). The adjusted odds ratio for a provider to receive a "Satisfied" ranged from 0.192 (95% CI 0.031 to 1.191) to 3.820 (95% CI 0.201 to 72.639), comparing with the median performing anesthesiologist (Supplementary A.1). The pairwise comparison panel displays the ranked ordered of comparisons between each individual anesthesiologist, in which only 4.8% of all pairwise comparisons were statistically significant (Supplementary A.2).

3.3. Sensitivity Analysis

Compared with the median performing anesthesiologist, the odds ratio for a provider to receive a higher satisfaction score ranged from 0.475 (95% CI 0.269 to 0.838) to 2.163 (95% CI 1.079 to 4.335), after including all different anesthesia care teams in the cohort. 14.3% of all pairwise comparisons had a 95% confidence interval for the odds ratio for satisfaction not inclusive of 1 (Supplementary B).

The effect estimates and the odds ratio comparisons did not substantially change after adjusting for additional confounding factors "surgery delay" and "midazolam dosage" (Supplementary C).

4. Discussion

There is substantial interest in incorporating patient-centered quality metrics, such as patient satisfaction, into the overall assessment of anesthesiology quality. The updated version of the American Society of Anesthesiologists (ASA) White Paper on patient satisfaction posits that the patient satisfaction measurement carries value even if the process is not statistically valid or clearly linked with patient outcomes [16]. Our goal in implementing a patient

satisfaction questionnaire was two-fold: to gather overall satisfaction data about the department's performance and to gather specific feedback from the open-ended questions. Both objectives facilitate the improvement of value delivered to patients by an anesthesia department. The presence of an ordinal scale in some questions invites the question of whether individual anesthesiologists can be ranked with respect patient satisfaction, though that was not our intent when implementing the system.

We present data demonstrating that patient satisfaction ratings may be used to rank attending anesthesiologists with confounder adjustment, but only to the extent of permitting outlier detection. In our study, elderly patients, general anesthetics and nighttime surgeries have been associated with lower survey scores confirming prior studies. After adjusting for confounders, the majority of providers could not be differentiated. While widely used, these scores seem to be unlikely to be helpful in evaluating individual performance for most providers.

In comparison to other patient satisfaction scores commonly employed in the perioperative environment, such as the Centers for Medicare and Medicaid Services-mandated Hospital Consumer Assessment of Healthcare Providers and Systems and Press-Ganey surveys, SurveyVitals is the most-widely used to assess anesthesia-specific data, with approximately 1 in 4 anesthesiologists currently using the metric to help guide their quality improvement efforts (Appendix A.1). This adoption has occurred in a broad mix of teaching and non-teaching hospitals. Yet despite its widespread adoption, it is not clear how the data obtained from these surveys should be used by institutions.

There are instances of patient satisfaction ratings falling short of expectations in other fields. Online ratings of neurosurgeons, for example, have been found to strongly correlate to where they trained and practice medicine [17]. And while patient satisfaction ratings may correlate with *US News and World Report* ratings in some fields, it is unclear if they correlate well with other metrics of the quality of care delivered, such as readmission rates [18]. Yet despite these issues, patient satisfaction may be used to guide physician compensation, even at the expense of decreasing physician job satisfaction [19].

Our work provides evidence that current implementations may be useful but appear to require further study on validity. Anesthesiology is practiced in a complex environment, in which patients may be meeting multiple physicians, nurse anesthetists, nurses, and care partners. In this context, trying to tie overall satisfaction to any one member of the team is inherently challenging, as a patient may attribute his or her satisfaction to a complex interplay of factors, as opposed to any one member of the care team.

There are limitations to this study. While data were obtained from questions asking broad questions about various aspects of the anesthetic care delivered, it is not clear that these are the best questions to assess provider quality. Other patient satisfaction questions could conceivably perform better and serve as a better metric of provider quality. The SurveyVitals questions were chosen because they are widely-used in a mix of practice settings and the internal consistency of the APSQ2 has been assessed by SurveyVitals [10] but, as with many other quality metrics, it is possible that they were inadequately validated and have not been

peer reviewed. Additional research is needed to better understand if other questions may better facilitate ranking and evaluating providers.

Even a tool as widely-used as a Likert scale may be challenging for patients [20]. In our analysis of responses, there were multiple instances of patients flipping the Likert scale, particularly in their first response - giving a provider a 1 but offering very positive written feedback. There is a large and robust field of literature around developing high-quality and reproducible survey instruments [21,22]. As designed, existing patient satisfaction surveys may be inadequately implementing these recommendations to facilitate meaningful ranking of anesthesiologists.

While surveys were sent to all patients who underwent anesthesia care during the study period, there was likely response bias - patients at extremes of satisfaction were more likely to respond to the survey. This bias was present for all surveys and for all providers, however, and it is unlikely to have significantly impacted our results. Similarly, our exclusion of providers with < 96 completed surveys to improve power may have biased findings, as providers with less time in the operating room (such as providers with significant academic or non-anesthesia roles) were largely excluded from analysis.

The study was performed at VUMC, a large, academic medical center. The APSQ2 was designed to assess anesthesia care teams comprised of an attending anesthesiologist and CRNA. However, in our department, the surveys were sent to all eligible patients, regardless of the anesthesia care team composition. We focused on cases where an attending anesthesiologist worked with a nurse anesthetist in our primary analysis, as this team composition has been previously studied by SurveyVitals. We also performed a sensitivity analysis to address concerns about how different anesthesia care models may impact patient satisfaction. Further study is needed to determine how a patient satisfaction score reflects CRNA performance. Furthermore, patients may have interacted with multiple anesthesia providers and may not have been clear on which provider was the attending physician. SurveyVitals attempts to ensure whether patients are evaluating the correct person by including providing a picture of the attending physician along with the web survey, but it is possible that some biases or confusion about roles & identities may have persisted. Additionally, the providers' photos were not available to patients during an IVR call. While this limitation should have impacted all attending anesthesiologists equally, it is impossible to fully address concerns about attribution in this methodology. Finally, an alternative explanation for our results could be that anesthesiologists at our institution are working at an essentially equivalent level and there are no actually differences in performance among the group to detect. In this scenario, the survey instrument may be correctly registering that lack of difference and working as designed.

While patient satisfaction ratings permit some ranking of attending anesthesiologists, the value of these rankings is of unclear significance, given the limited ability to discriminate between most providers after adjusting for confounding factors. However, ranking individuals is not the purpose for using the instrument. Instead, the department is focused on ensuring that it is on par with high-performing anesthesia groups with respect to patient satisfaction, and on providing individual clinicians de-identified, patient level specific

feedback about positive interactions and opportunities to improve. Meanwhile, the aggregate data may be used to assess the overall satisfaction of patients with the care delivered by the department, and it could also be used to compare our department to other hospitals.

Additionally, members of the department (including the department chair, WSS) have found individual patient comments in SurveyVitals to be useful in identifying themes in the feedback and for developing personal interaction approaches to address such concerns. Members of the faculty have found free-text comments from patients particularly valuable and are able to review them on an ongoing basis. For example, a patient gave WSS a low score on the question related to discussing options for anesthetic care. The patient's comment paraphrases to: "I just don't recall that any options were discussed, but I was pleased with the overall care." When no options for anesthetic technique are practicably available, WSS had heretofore omitted discussion of options. In response to this comment, WSS has included in his preoperative conversation an explicit discussion of why there are no options for the primary anesthetic technique, and also makes a point of inviting patient participation in other planning, such as analgesic and antiemetic strategies.

Anecdotally, patient comments often help to clarify extreme Likert scores and identify patients in need of follow-up or those who have experienced adverse events. In the study period, 399 patients requested additional follow-up from our department (Appendix B). As these data are not structured, they were not totally analyzed in this study. However, a thematic analysis of free-text comments related to dissatisfaction with care is an important area for further research. A better understanding of themes in the comments that span some or all providers could help the department optimize patient care in the future by implementing systematic changes. Furthermore, we did not study the change in scores over time. Future studies will determine if the process of obtaining and reviewing feedback leads to improved patient satisfaction scores over time. Future studies should better evaluate how to merge patient satisfaction data with other important quality metrics, to better facilitate identifying outlying providers who need help with patient interaction, or, more likely, to identify care environments where the department needs to develop strategies to help providers mitigate challenges imposed by the environment. For example, many preoperative preparation areas are open rooms with bed spaces separated by curtains. This arrangement makes respecting privacy (a specific question in the survey) challenging, but can be mitigated by explicitly stating that the anesthesiologist is open to finding a private space to discuss sensitive issues, or even by asking permission to move closer to the patient so that discussions can occur quietly.

In summary, the SurveyVitals tool distinguishes poorly between most anesthesiologists with respect to patient satisfaction with anesthetic care, though it does allow identification of a few consistently high- and low-scoring clinicians with respect to the median performing clinician. Groups of anesthesiologists might systematically learn and adopt techniques from anesthesiologists who receive very high scores, and they might search for ways to help colleagues who receive very low satisfaction scores improve. Importantly, the SurveyVitals tool provides no information on why low or high scores are given, though the text comments might be useful. Consequently, the tool is better suited to identify opportunities to improve than to rank order individual anesthesiologists.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments

Disclosures:

Funding: Dr. Freundlich receives ongoing support from the NIH-National Center for Advancing Translational Sciences (NCATS) #1KL2TR002245.

APPENDIX

Appendix A.1.

The Current Scope of SurveyVitals in Anesthesia-Specific Patient Experience Solution.

1. 119 Organizations
2. 2,316 Locations/Facilities
3. 12,236 Providers
4. 969,237 Anesthesia Surveys Year-to-date [a]
5. 112,250 Anesthesia Surveys Avg/Month (last 4 months) [b]
6. 1,300,000 Anesthesia Surveys expected in 2019

[a] From 1/1/2019–9/15/2019

[b] From May/2019-Sep/2029

[*] Data source: SurveyVitals, received on September 16, 2019.

Appendix A.2.

The Internal Consistency Study of APSQ2 from SurveyVitals of 2019-Q3 for Divisions and Providers.

	Confidence Level (%)	Completed Surveys
Divisions (Facilities or Sites)	70	100
	80	145
	90	222
	95	294
	99	435
Anesthesiologists, CRNAs, AAs	70	59
	80	79
	90	87
	95	96
	99	107

[*] Data source: SurveyVitals, received on November 7, 2019.

Appendix B.

Examples of the Follow-ups of Contact Requests from Free-Text Comments.

1. Accidentally requested to be contacted. No issues or concerns.

2. Accidentally requested to be contacted. Spouse did have a question concerning change in lower extremity function. Spouse encouraged to contact patient's oncologist and let them know.
3. Everything ok now. Pt instructed to notify anesthesia team of previous experience if having another procedure. Pt instructed to follow up with primary care MD.
4. Everything was fine but complains about throat discomfort. Explained sore throat can occur with general anesthesia. Encouraged to follow up with physician.
5. Accidentally requested to be contacted. However, did request to have same in room provider for next procedure. Request submitted to AIC and Lead CRNAs.
6. Very appreciative of the care received. Pt didn't know what expect from anesthesia and was a little scared, but doing much better. No issues now.
7. Spoke with spouse, patient unavailable at this time. Encourage patient follow up with surgeon regarding concerns he had expressed in the survey. Wife indicated patient has a follow up appointment with surgeon next week.
8. Pt took suboxone prior to procedure so didn't feel fentanyl worked, also felt needle for block. Pt instructed to let providers know during next procedures.
9. Pt was a little upset about the postoperative hallucinations. Other than that, he was pleased with care

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Highlights:

- A large sample of patient satisfaction survey data were analyzed.
- Nighttime surgery was associated with a lower satisfaction score.
- Decreasing age of patient was associated with a higher satisfaction score.
- Regional anesthesia was associated with a higher satisfaction score.
- While extreme outliers were identified, most providers could not be distinguished.

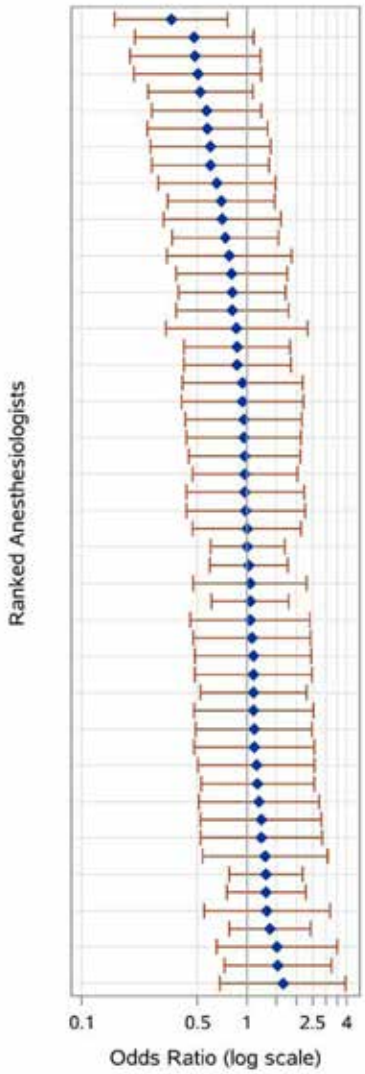


Fig. A.

Visualization of the distribution of comparisons to the median-ranked individual anesthesiologist, that derived from the multivariable ordered probit regression model (10,528 surveys, 55 attending anesthesiologists). The ORs panel shows the OR (95% CI) of receiving a higher satisfaction score compared to the median-ranked anesthesiologist.

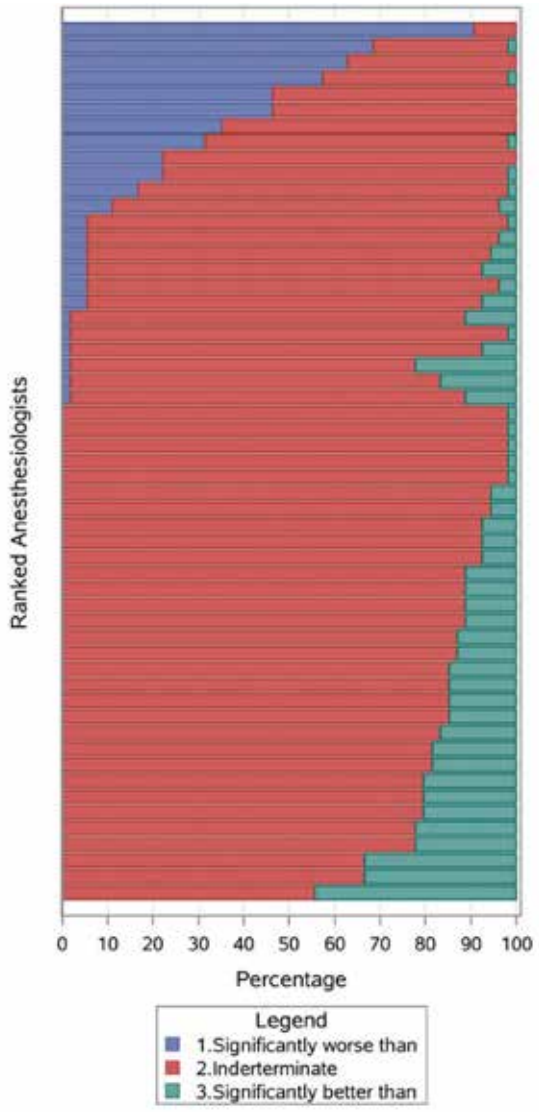


Fig. B.

Visualization of the pairwise comparison distribution that derived from the multivariable ordered probit regression model (10,528 surveys, 55 attending anesthesiologists). The percentage panel reveals the proportion of other individual anesthesiologists for whom each individual was statistically significantly worse than (blue), indeterminate (red) and better than (green).

Table A.

Patient Satisfaction Survey Questionnaires Sample

Questionnaires	Questionnaires Text	Included in Analysis
Q1	Please select the provider(s) for whom you remember enough to answer questions about the care provided.	No
Q2	Were you able to spend time with your anesthesia provider before surgery?	No
Q3	Your anesthesia provider did his or her best to respect your privacy.	Yes
Q4	Your options for anesthesia were explained before your surgery.	Yes
Q5	Your questions about anesthesia, the process, risks, and possible after effects were answered.	Yes
Q6	You were well prepared to make informed decisions.	Yes
Q7	Your anesthesiologist helped ease any anxiety you were feeling.	Yes
Q8	Your anesthesiologist ensured your comfort during the surgical experience.	Yes
Q9	Please share any thoughts or concerns from your visit to the operating suite.	No
Q10	Using a number from 5 to 1, where 5 is the best anesthesiologist possible and 1 is the worst, please rate your anesthesiologist.	Yes
Q11	Please share any additional comments about your anesthesiologist.	No
Q12–15	*Nurse Anesthetist Questions*	No
Q16	Was your anesthesia provider available to answer questions after surgery?	No
Q17	Did you experience nausea or vomiting after surgery?	No
Q18	Please add any comments you would like to make about your experience immediately after surgery.	No

Table B.

The Distribution of Patient Responses to the APSQ2 Survey.

	Strongly Disagree, Disagree, or Neutral	Strongly Agree or Agree	Total Cases	Response Rate
Q3	1,151 (5.4%)	20,347 (94.6%)	21,498	75.0%
Q4	1,690 (7.5%)	20,888 (92.5%)	22,578	78.7%
Q5	973 (4.3%)	21,421 (95.7%)	22,394	78.0%
Q6	712 (3.2%)	21,819 (96.8%)	22,531	78.5%
Q7	996 (4.8%)	19,647 (95.2%)	20,643	71.9%
Q8	692 (3.1%)	21,678 (96.9%)	22,370	78.0%
Q10	582 (2.8%)	19,949 (97.2%)	20,531	71.6%

*APSQ2: Anesthesia Patient Satisfaction Questionnaire 2.0.

Table C.

Demographic Information of Patients Stratified by Overall Patient Satisfaction Score

	Overall Patient Satisfaction Score				
	Score 1 (Strongly Disagree)	**Score 2 (Disagree)**	**Score 3 (Neutral)**	**Score 4 (Agree)**	**Score 5 (Strongly Agree)**
Cases (N)	10	49	494	3,669	6,306
Age in Years, mean (SD)	33.7 (23.6)	48.1 (20.7)	50.7 (22.2)	48.2 (23.6)	42.4 (24.6)
BMI in kg/m^2, mean (SD)	25.8 (10.2)	27.8 (7.0)	27.9 (7.8)	27.9 (9.4)	27.1 (9.9)
Gender (%)					
Female	60.0%	59.2%	54.9%	56.7%	55.4%
Race (%)					
Caucasian	80.0%	85.7%	82.6%	81.7%	81.6%
Black	10.0%	10.2%	8.7%	10.0%	9.1%
Asian	0.0%	0.0%	1.2%	1.2%	1.1%
American Indian	0.0%	0.0%	0.4%	0.1%	0.1%
Unknown	10.0%	4.1%	7.1%	7.0%	8.1%
ASA (%)					
I	0.0%	2.0%	5.0%	7.1%	9.5%
II	70.0%	44.9%	43.1%	45.5%	49.6%
III	30.0%	49.0%	48.0%	43.8%	37.7%
IV&V	0.0%	4.1%	3.9%	3.6%	3.2%
Patient Status (%)					
Same Day Surgery	80.0%	89.8%	85.4%	82.2%	82.2%
Observation Patient	10.0%	8.2%	5.7%	7.0%	7.2%
Inpatient	0.0%	2.0%	2.8%	3.1%	3.2%
Others	10.0%	0.0%	6.1%	7.7%	7.4%
Anesthesia Type (%)					
General	100.0%	81.6%	84.6%	82.9%	82.3%
MAC	0.0%	18.4%	14.8%	15.7%	15.6%
Regional	0.0%	0.0%	0.6%	1.4%	2.1%

	Overall Patient Satisfaction Score				
	Score 1 (Strongly Disagree)	**Score 2 (Disagree)**	**Score 3 (Neutral)**	**Score 4 (Agree)**	**Score 5 (Strongly Agree)**
Surgery Start Time (%)					
6 AM to 12 PM	70.0%	61.2%	66.2%	67.0%	68.2%
12 PM to 6 PM	30.0%	38.8%	32.4%	32.4%	31.3%
6 PM to 6 AM	0.0%	0.0%	1.4%	0.6%	0.5%

Table D.

Multivariable Fixed Effects Modeling Analysis of the Response of APSQ2.

	Covariates	Wald Test χ^2	p-value
Ordered Probit Regression	Anesthesiologist	163.36	<.001 *
	Patient Age	61.89	<.001 *
	Patient Gender	0.86	0.650
	CRNA	171.46	0.146
	Surgery Start Time	6.72	0.035 *
	ASA Class	0.01	0.809
	Anesthesia Type	11.18	0.004 *
	Surgery Service	39.56	0.490
	Surgeon	309.50	1.000
Logistic Regression	Anesthesiologist	127.35	<.001 *
	Patient Age	6.21	0.013 *
	Patient Gender	2.49	0.289
	CRNA	155.98	0.418
	Surgery Start Time	7.99	0.018 *
	ASA Class	2.68	0.101
	Anesthesia Type	2.47	0.291
	Surgery Service	30.77	0.853
	Surgeon	442.31	0.198

* Level of significance p = 0.05.

CRNA: Certified registered nurse anesthetists; ASA: American Society of Anesthesiologists Physical Status Classification.

HANDOUTS

Quality: Credentialing and Effective Peer Review

Steven Butz, MD, SAMBA-F

01/13/2023
9:45am – 11:00am Pacific

Credentialing and Effective Peer Review

Steven Butz, MD
Medical College of Wisconsin
Associate Chief Medical Officer
Children's Wisconsin Surgicenter

1

Objectives

1. Be able to compare credentialing and peer review with human resource functions
2. Be able to describe a thorough credentialing process
3. Be able to use peer review to assess quality of care given by a credentialed provider

2

Conflicts of Interest

- Surveyor for Accreditation Association for Ambulatory Health Care

3

From the headlines

10 News Staff, WTSP *1:05 p.m. EDT March 9, 2015*

4

From the News

1. How did this happen?
2. Didn't someone look at her license?
3. What about her previous jobs?
4. Did she get any training?
5. What if she posed as a physician??

5

Credentialing

- This is what an organization does to verify that someone who is hired is who they say
- Usually physicians, dentists, podiatrists
- But also physician assistants, nurse practitioners, CRNAs, private scrubs, laser operators, lithotripsy operators, etc.
- Also verifies training and certifications

6

Credentialing

- Familiar process of providing:
  - School
  - Residency
  - State license and DEA
  - Office locations
  - Contact information
  - Malpractice information
  - Disclaimers
    - Litigations
    - Limitations from other institutions
    - Statement that you are not impaired

7

Credentialing

- Most is verified by primary or secondary sources
  - AMA website for training
  - States for individual license*
  - OIG for CMS infractions*
  - Department of Justice*
  - National Practitioner Data Base*
- On-line makes it easy
- Services can perform this for you

* Needs updating

8

Credentialing

- Always need to get a letters of reference from *peers*
- New standards dictate that a picture is included in the application
- Lastly, a committee or person needs to:
  - Evaluate application
  - Make a recommendation
  - Move it on to the ultimate governing body

9

Credentialing

- Governing body needs to have evidence of discussion
- Need to send a letter of notification (according to time frame set forth in bylaws) that includes what was approved or not
- Allow for appeals for negative decisions

10

Credentialing

- Who does this apply to?

EVERYBODY YOU DON'T PAY THAT WORKS AT THE FACILITY!!

11

Credentialing

Special circumstances:

- Solo practitioners
- Contractual services
- Employed physicians
- Temporary providers

12

Credentialing

- Is this a 1-time event?

NO!!

- CMS says cycle length cannot exceed 3 years
- Most hospitals do 2 years, smaller groups do 3
- Still need to monitor for expirations, lawsuits, etc.

13

More from the Headlines...


A USA TODAY investigation shows that thousands of doctors who have been banned by hospitals or other medical facilities aren't punished by the state medical boards that license doctors.

P. Eisler and B Hansen, USA Today Aug 20, 2013

14

Privileging

- Now that you have decided who can be present at your facility and on your medical or allied staff, you need to decide what they can do
- Like a job description, but may be a core privilege or list of items
- Either must be approved by the governing body to even be offered in the first place
- Individuals are then specifically evaluated to be granted the privilege

15

Privileging

- **Core privileges** are a general statement of what someone completing training should be able to do:
  - Procedures
  - History and physical
  - Give local anesthesia
  - Read images
- Then there are special privileges or ones needing additional training
- **Traditional privileges** are more of a laundry list
  - Should list each procedure
  - List can include "special" procedures as they may be limited from those without training
  - Should have a point on form to indicate what is requested and what is approved by committee/board

16

Privileging

- Occurs as part of credential and re-credential process
- May be additional if new privileges are sought outside of typical cycle
- Carries with it the stamp of approval from the board
- Things not approved need to be described and given opportunity to appeal

17

Tomorrow....

You are working with your least favorite nurse, Dan. He never reads the preference cards and is always having to run for necessary equipment. He texts on his phone while in the OR and misses requests by the surgeon so *you* usually have to adjust the bovie, just to keep things moving. He arrives at 7:15 for his 7:30 start and always has an excuse. Since you teach the ACLS class for your center, you also know he is the last person you would want coding you if something happened!

If only *something* can be done.....

18

Human Resources

- It is called an annual employee review:
  - Evaluates employees according to their job descriptions and facility's mission statement
  - Seeks peer and superior's evaluations
  - Lists accomplishments
  - Summarizes incident reports and disciplinary actions
- Ultimately determines wages
- Should feed into an improvement cycle, as well

19

Then the next day…..

You have a 7:30 ACL repair. You did the block in pre-op and the room has been ready since 7 am. It is now almost 8 am and the surgeon, as per usual, is not there. You roll your eyes as you refill your coffee mug. Thinking that the day will be unpleasant as you have to deal with the surgeon yelling at the staff and breaking the arthroscopes, again. He also was noted to have his third infection in the last 3 months on a patient the last time he was at your center.

If only *something* could be done……

20

Peer Review

Definition: evaluation of scientific, academic, or professional work by others working in the **same field**.

- Evaluation--you actually have to look at what they are doing
- Professional work--separates from personality, but can include quality reports, results, *outcomes* and communication
- Same field or same specialty is great, but same level of training is what is expected

21

Peer Review

Peer Review	Human Resources
• Duties in bylaws and mission and 6 elements of care	• Compare to job description and mission
• Peer evaluations	• Peer evaluations
• Meeting goals set forth	• Accomplishments
• Quality metrics	• Incident reports/discipline
• May be triggered by an event or "focused"	

22

Peer Review

- Each center needs to decide the who, what, when of peer review
- Who gets it?

  Anyone you credential
- What do you look at?

  Depends on the job performed
- How often is it done?

  Center dependent, but quarterly is a good guide

23

Peer Review

Suggestions for What:

- Chart review
- OUTCOMES
- Incident review
- Quality measures (ABX, temp on arrival to PACU)
- Satisfaction
- Case observation
- 360° review

24

Peer Review

Then what?

- Annual or quarterly summary to provider
- Usually goes to MEC for discussion as needed
- Define opportunities for improvement
- Results must go into the Re-Credentialing process
- Use as a competitive way to improve all care provided

25

Peer Review Tips

- Keep it relevant
- Keep it do-able
- Make sure it is thorough enough to give a meaningful assessment
- Scan your facility for individuals you may not have considered
- Consider a peer review committee that is made up of individuals you need to review

26

Conclusions

- Credentialing is a process developed to protect your business and your patients
- Peer review can be a useful tool to drive quality and outcomes
- Both are continuous processes that need constant attention and reporting to governing bodies

27

HANDOUTS

Management

Moderator: Arnaldo Valedon, MD, FASA, SAMBA-F, MBA Candidate 2023

01/13/2023
1:00pm – 2:15pm Pacific

HANDOUTS

Management: Real World Issues and Solutions for Medical Directors

Arnaldo Valedon, MD, FASA, SAMBA-F, MBA Candidate 2023

01/13/2023
1:00pm – 2:15pm Pacific

Arnaldo Valedon, MD, MBA, SAMBA-F, FASA
Medical Director Outpatient Perioperative Services, WellSpan Health, PA, USA
President-Elect International Association for Ambulatory Surgery
Past President, Society for Ambulatory Anesthesia, USA

Real World Issues and Solutions for Medical Directors

1

DISCLOSURES

Conflicts/Commercial Support/Sponsorships:
Arc Medical-Literature Review

NO INFLUENCE
ON PRESENTATION CONTENT

2

Real World Issues and Solutions for Medical Directors

- Objectives:
  - Discuss clinical and administrative friction points currently faced by medical directors in ambulatory surgery facilities
  - Discuss some potential solutions to the issues stated by the attendees

Disclaimer: This presentation is for educational purposes only. Opinions or points of view expressed in this presentation represent the view of the presenter and/or attendees, and does not necessarily represent the official position or policies of the Society for Ambulatory Anesthesia. Nothing in this presentation constitutes legal advice. The individuals appearing in this presentation, if any, are depicted for illustrative purposes only.

3

Real World Issues and Solutions for Medical Directors

- Stipend Agreements for ASCs…
  - What do you know about them? When partnering with ASCs, are stipends based on volume? case complexity? Or a flat amount?
- Any new ideas/tips on making an Anesthesia group more financially viable?

4

Real World Issues and Solutions for Medical Directors

Quality Measures

- Death
- Cardiac arrest
- Perioperative myocardial infarction
- Anaphylaxis
- Malignant hyperthermia
- Transfusion reaction
- Stroke, cerebral vascular accident, or coma following anesthesia
- Visual loss
- Operation on incorrect site
- Operation on incorrect patient
- Medication error
- Unplanned ICU admission
- Intraoperative awareness
- Unrecognized difficult airway
- Reintubation
- Dental trauma
- Perioperative aspiration
- Vascular access complication, including vascular injury or pneumothorax
- Pneumothorax following attempted vascular access or regional anesthesia
- Infection following epidural or spinal anesthesia
- Epidural hematoma following spinal or epidural anesthesia
- High spinal
- Postdural puncture headache
- Major systemic local anesthetic toxicity
- Peripheral neurologic deficit following regional anesthesia
- Infection following peripheral nerve block

5

Real World Issues and Solutions for Medical Directors

- "Effective marketing for more business"-
  - An ASC marketing plan is an integrated system.
    - Define your target audience your
    - Define your competition
    - Define the services to promote, cases to attract
    - Define image you want to portray, etc.
  - https://www.jointcommission.org/resources/news-and-multimedia/blogs/ambulatory-buzz/2021/06/creative-ways-to-market-your-surgery-center/

6

Real World Issues and Solutions for Medical Directors

- Strategic Categories
  - Internal marketing
  - Branding
  - External advertising: newspapers, broadcast media, internet advertising, direct mail, circulars, posters, billboards
  - Internet marketing
  - Professional Internal Strategies
- Avoid:
  - Spaghetti marketing
  - Wait-and-see
  - Treat marketing as an expense
  - Marketing by Committee

7

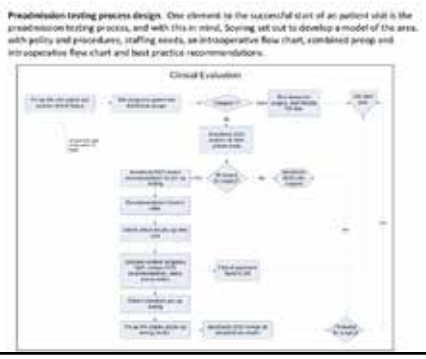
Real World Issues and Solutions for Medical Directors

- "Robust administrative support for PAT staff"
  - What is the exact need?
  - Online preadmission technology
  - Established PAT protocols

8

ASC Service Design & Planning

Soyring Consulting Case Study



9

Real World Issues and Solutions for Medical Directors

- How do you protect your business from surgery centers poaching your team?

10

Real World Issues and Solutions for Medical Directors

- One of the challenges at our surgery center is reminding nurses/techs to check the surgeon's preference cards to make sure they have what they need on the day of surgery. I have two people who do the ordering and are responsible for that, invariably one may be on vacation, and the other person forgets to check OR they think the other person has done so. We even have weekly meetings on Mondays to go over every case, and still it falls through. It may be more for discussion purposes, and tackling it from a systems standpoint.
  - **Perhaps if anyone has a better system of 1) checking preference cards and doing inventory and 2) reminding staff to contact the surgeons office regarding cases that may require special instruments or supplies.**

11

Real World Issues and Solutions for Medical Directors

- "My number 1 challenge as a medical director is finding out *who trumps who* regarding regulatory bodies"

12

Real World Issues and Solutions for Medical Directors

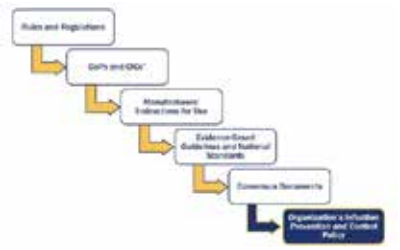
Regulations vs Standards vs Local Policies vs Advisories
Who Is In Charge??

Regulatory Bodies	Accrediting Bodies	Clinical Bodies
• Department of Health and Human Services • Center for Medicare and Medicaid Services (CMS) • Children's Health Insurance Program (CHIP) • Center for Disease Control • State Departments of Health • US Department of Labor • Occupational Safety and Health (OSHA)	• Joint Commission (JC)[1] • Accreditation Association for Ambulatory Healthcare (AAAHC)[2] • QUAD A (Previously know as AAASF, American Association for Ambulatory Surgery Facilities)[3] • Accreditation Canada (AC)[4] • Det Norske Veritas (DNV)[5]	• Local Governing Boards • Clinical Departments • Manufacturers • Specialty Boards • Professional Societies

13

Real World Issues and Solutions for Medical Directors

JOINT COMMISION:
INFECTION CONTROL HIERARCHICAL APPROACH



14

Real World Issues and Solutions for Medical Directors

- "How can I follow how my ASC is performing against other CMS-certified facilities?"

15

Real World Issues and Solutions for Medical Directors

- Public reporting of Facility-Specific Quality Reporting Data:
  - CMS Publicly reports ASC Data here: https://data.cms.gov/provider-data/
  - Facility Comparison Dashboard: https://www.qualityreportingcenter.com/en/facility-compare-dashboard/

https://www.qualityreportingcenter.com/globalassets/2021/11/asc/facilitycomparetooluserguide_final.pdf

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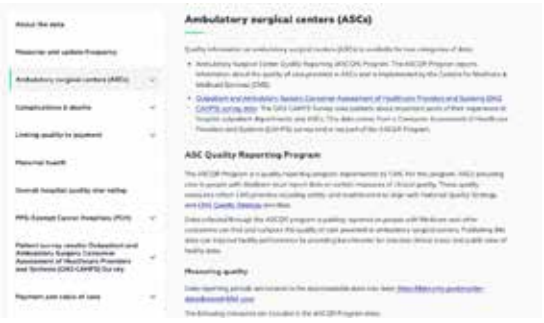
Real World Issues and Solutions for Medical Directors



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Real World Issues and Solutions for Medical Directors

18

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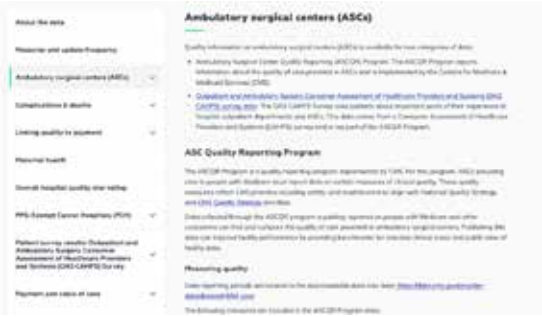
Real World Issues and Solutions for Medical Directors



21

Real World Issues and Solutions for Medical Directors

22

Real World Issues and Solutions for Medical Directors

- "We are starting to Total Joints in our ASC in a couple of months. Any good anesthesia recipes?"

23

Anesthesia for Ambulatory Total Joints
Example of Multimodal Approach

PREOPERATIVE

- Immediately prior on upon arrival to Pre-op:
  - Gabapentin 600 po
  - Oxycontin 10mg po
  - Celebrex 400mg po
  - Zofran 4mg IV
  - Dexamethasone 10mg IV
  - Antibiotic prophylaxis (e.g., Cephalosporin vs. Vancomycin vs. Clindamycin)
- For Hemi or Total Knee Arthroplasties: Adductor Canal Block plus IPACK Block
- For Hip Arthroplasty: Fascia Iliaca Block

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Strategies for Severe Pain Control After Hip and Knee Arthroplasty

- **Intraoperative**
  - General Anesthesia
  - Tranexamic acid 10 mg/kg IV x1 after induction
  - Ketamine 10-20 mg IV
  - Liposomal bupivacaine periarticular infiltration by surgeon (20cc diuted with 40cc NS); Bupivacaine with Epi for superficial closure
  - Toradol 30 mg IV within 30 min prior to wound closure
  - IV Tylenol 1000 mg IV within 30 minutes prior to wound closure
  - Second dose of Tranexamic acid 10 mg/kg

25

Strategies for Severe Pain Control After Hip and Knee Arthroplasty

- **Post-Operative: Aim for Opioid-Sparing Analgesia**

Alternative:

- Fentanyl 25-50 mcg q 5-10 min for moderate pain
- Dilaudid 0.5 mg q 10min for severe pain
- PO Analgesics
  - Mild/Moderate Pain
    - Acetaminophen 325 or 650 mg po q 4 hrs
    - Oxycodone 5-10 mg po q 4 hrs
    - Tylenol #3 (acetaminophen/codeine 15-60 mg po q4-6hrs PRN)
    - Percocet (acetaminophen/oxycodone 325mg/2.5-5 mg po q 6hrs PRN)
    - Norco (acetaminophen/hydrocodone: 325 mg/5-10mg po q 4-6 hrs PRN
    - Lortab (acetaminophen/hydrocodone solution: 300 mg/2.5-10 mg po q 4-6 hrs PRN)
    - Vicodin (acetaminophen/hydrocodone: 300mg/5mg po q 4-6 hrs PRN)

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Strategies for Severe Pain Control After Hip and Knee Arthroplasty

- Post-Discharge Analgesia
  - Acetaminophen and NSAIDs or COX-2 specific inhibitor around the clock
  - Oxycodone as a rescue
  - Avoid combinations of acetaminophen and weak steroids (codeine, hydrocodone, oxycodone)?; Only marginally superior to NSAIDs alone

McQuay, H. et al; BMJ. 1997 May 24; 314(7093): 1531–1535

27

Real World Issues and Solutions for Medical Directors

- "I have conflicting views from our anesthesia providers on whether or not patients with neuromuscular diseases should be done in ASC's? Any evidence-based guidelines as to who NOT to do?"

28

Neuromuscular Disorders in Ambulatory Surgery

- Cardiac Complications of NMDs[4]
  - Variable cardiac involvement
  - Duchenne muscular dystrophy: most severely affected; cardiac disease/myopathy leading cause of death. Similar with several subtypes of limb-girdle muscular dystrophy
  - Becker muscular dystrophy also associated with cardiomyopathy-later onset and slower course
  - Myotonic dystrophies and Emery-Dreifuss muscular dystrophy: primarily associated with conduction defects and may require pacemaker implantation
  - Friedreich ataxia and Pompe disease can be associated with hypertrophic cardiomyopathy

29

Neuromuscular Disorders in Ambulatory Surgery

- Sleep Dysfunction and NMDs[5]
  - Sleep dysfunction related mostly to sleep-related breathing disorders or sleep-disordered breathing (SDB); very common in neuromuscular diseases
  - The most common neuromuscular disorders causing SDB and sleep dysfunction consist of:
    - motor neuron disease (amyotrophic lateral sclerosis)
    - poliomyelitis and postpolio syndrome
    - myasthenia gravis including myasthenic syndrome
    - acute inflammatory demyelinating polyradiculoneuropathy (Landry–Guillain–Barré–Strohl syndrome)
    - phrenic neuropathy
    - muscular dystrophies including myotonic dystrophies
    - congenital myopathies

30

Neuromuscular Disorders in Ambulatory Surgery

- Gastrointestinal Dysfunction and NMDs
  - May alter intestinal wall muscle or myenteric plexus or both
    - Motor
    - Intestinal Pseudo-obstruction
    - Hollow visceral neuropathy/myopathy
  - Symptoms: chronic unexplained abdominal pain, abdominal distention and bloating, early satiety, nausea, vomiting, and alternating diarrhea and constipation

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Neuromuscular Disorders in Ambulatory Surgery

QUESTIONS STRONGLY ENCOURAGED!
avaledon@verizon.net

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HANDOUTS

Financial

Moderator: Arnaldo Valedon, MD, FASA, SAMBA-F, MBA Candidate 2023

01/13/2023
2:45pm – 4:00pm Pacific

HANDOUTS

Financial: Blending Medicine & Finance/Ethics

William Prentice, JD

01/13/2023
2:45pm – 4:00pm Pacific

HANDOUTS

Financial: Maximizing ASC Billing

John J. Goehle, MBA, CASC, CPA

01/13/2023
2:45pm – 4:00pm Pacific

HANDOUTS

Financial: Value-Based Care

Kara Marshall Newbury, JD

01/13/2023
2:45pm – 4:00pm Pacific

HANDOUTS

Legal

Moderator: Simon Lee, MD

01/14/2023
8:00am – 9:15am Pacific

HANDOUTS

Legal: Future of Independent Anesthesia Practice

Judith Jurin Semo, JD

01/14/2023
8:00am – 9:15am Pacific

The Future of Independent Anesthesia Practice

SAMBA 2023 ASC Medical Directors & Leaders Summit

January 14, 2023

Judith Jurin Semo, J.D.
(202) 329-8500 | jsemo@jsemo.com

1

Disclosures

- Am an attorney in private practice
- I have the following financial relationships to disclose:
  - Owner of Judith Jurin Semo, PLLC
    - Private law practice
  - Diversified portfolio that includes investment in health care companies (no active role)
  - Will not be discussing off-label uses of drugs/devices

2

Learning Objectives

- Understand the changes in the health care industry that adversely affect the independent anesthesia practice model
- Demonstrate the pressures on independent anesthesia practice
- Identify strategies to assist anesthesia practices to compete in the current evolving health care environment

** A note: Not legal advice

3

Presentation Summary

4

Health Care Industry Issues Affecting the Independent Anesthesia Practice Model

5

#1: Anesthesiology Services Are Not Self-Supporting

6

Anesthesiology Services Are Not Self-Supporting

- Undervaluation of anesthesiology services by government payor programs
  - Medicare
  - Medicaid
  - Tricare

7

Anesthesiology Services Are Not Self-Supporting

- GAO – 2020 Report
  - https://www.gao.gov/products/gao-21-41
- References three studies of private insurance payments ("PIS"):
  - Yale: PIS were 3.67 times Medicare payments (2015)
  - Health Care Cost Institute: PIS were 2 to 7 times Medicare payments for six services commonly provided by anesthesiologists (2017)
  - ASA: PIS were 3.46 times Medicare payments (2019 survey of members)

8

Anesthesiology Services Are Not Self-Supporting

- Updates the 2007 GAO Report (https://www.gao.gov/assets/gao-07-463.pdf)
  - Average Medicare payments were lower than average PIS in 41 Medicare payment localities in 2004
    - From 51% to 77% lower than PIS
  - For all 41 payment localities, Medicare payments were lower than PIS by average of 67%
    - Average Medicare payment: $216
    - Average PIS: $658

9

#2: Hospitals/ASCs Are Facing Financial Pressures

10

Hospitals/ASCs Are Facing Financial Pressure

- Multiple pressures on hospitals & ASCs
  - Sharply increasing staffing costs
  - Uncertain interruptions in elective surgery (Covid surges)
  - Supply chain woes
  - Uncertainty regarding federal payments
    - Changing policies (*e.g.*, "inpatient only" list)
  - Penalties – *e.g.*, for
    - Noncompliance with rules

11

#3: Payors Using Strong-Arm Tactics to Pressure Anesthesiology Practices to Accept Lower Rates . . . or Go OON

12

Payors Forcing Anesthesiologists OON

- ASA survey February 2020:
  - 42% respondents had contracts terminated in the prior 6 months
  - 43% experienced dramatic payments cuts from insurers
    - Both mid-contract and at renewal
    - In some cases, by 60%
- Nov. 2021 – NC BCBS uses No Surprises Act IFR as basis to push for reductions in rates
  - Letters to 54 practices
  - Threatening contract termination unless practices agree to payment reductions of 10% to 30%

13

#4: Increasing Trend Away From Private Practice & Toward Hospital/Health System Employment/ Practice Acquisitions

14

Trends in Physician Employment

- PAI (Physicians Advocacy Institute)-Avalere Health Report
  - Trends in Physician Employment & Acq'ns of Medical Practices in 2019-2020
    - Only 30% of physicians in US practice independently (as of beginning of 2021)
    - 70% of US physicians employed by hospital systems or other corporate entities (PE & health insurers)
    - See http://www.physicianadvocacyinstitute.org/PAI-Research/Physician-Employment-and-Practice-Acquisitions-Trends-2019-20

15

Trends in Physician Employment

- AMA:
  - Private practice dropped to <50% of physicians in 2020
  - 2020 data are largely consistent with trends since 2012 – but
    - Magnitude of changes since 2018 suggest acceleration of:
      - Shift toward larger practices
      - Away from physician-owned practices
      - See https://www.ama-assn.org/system/files/2021-05/2020-prp-physician-practice-arrangements.pdf

16

Trends in Hospital/ASC Employment of Anesthesiologists

- Continuing reports of hospital/health system employment of previously independent anesthesiology practices
  - Groups of all sizes – from larger groups (over 100 anesthesiologists) to smaller practices (15-25 anesthesiologists)
  - Seemingly in response to or otherwise resulting from hospital/ASC contract & stipend negotiations
- Just heard of three more on Thursday (Jan. 12, 2023) alone

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Trends in Hospital/ASC Employment of Anesthesiologists

- HCA Physician Services Group transitioned several hospitals in Florida to an employed group – *e.g.,*
  - Memorial Hospital, Jacksonville, FL: https://careers.hcahealthcare.com/jobs/7810274-anesthesia-medical-director-opportunity-in-jacksonville-fl

18

Knee-Jerk Reaction to Stipend Negotiations
(In Some Cases)

- Increasingly seeing hospitals insist on an employment model
  - Following request for compensation or
  - Unsuccessful negotiation for compensation
- Fewer stipends for ASC work, but they are increasing
- Also seeing hospitals/ASCs/health systems move to employment for strategic reasons

19

#5: Personnel Shortages and Rapidly Increasing Compensation Rates for Anesthesia Personnel

20

Personnel Shortages/Increasing Comp

- Combination of factors leading to shortages
  - Covid-related burnout & early retirements
  - Aging of anesthesiologists
    - In 2019, baby boomers represented 37.6% of active ASA members
    - Estimated: 1/3 of practicing physicians will be >65 in next 10 years
      - https://www.pyapc.com/wp-content/uploads/2021/02/PYA-Compensation-Study-Spotlight-on-Anesthesiology.pdf
  - Ability to earn more compensation by changing jobs
  - In some cases, response to hospital contract negotiations

21

Personnel Shortages/Increasing Comp

- In one consultant's words, CRNA compensation is changing by the week
- Merritt Hawkins: In 2022: "advertised starting salaries for CRNA positions through Merritt Hawkins range from $185,000 to more than $300,000 per year"
  - https://www.merritthawkins.com/news-and-insights/blog/healthcare-news-and-trends/2022-CRNA-Week/
- FMV assessments in recent negotiations support comp packages for CRNAs for 40-hours/week/no-call positions in the $250-$280K/year
  - Not including signing bonuses

22

#6: Competition for Anesthesia Services Continues/Facility RFPs Continue

23

Competition in Anesthesia

- New anesthesia practices continue to emerge
  - Privately owned
  - PE ownership
  - Both physician and CRNA ownership
- Anesthesia groups continue to solicit hospitals & ASCs

24

Competition in Anesthesia

- Hospitals & ASCs continue to issue RFPs
  - Even with longtime relationships
- Means that potential for change is ever-present
- Interestingly, in recent times, reports of some large groups declining to bid on RFPs
  - Unsure of reasons, but lack of staffing capability seems to be a prevailing concern

25

#7: Some Hospitals/ASCs Willing To Allow Practice Models Involving No Anesthesiologists or Few Anesthesiologists

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Some Hospitals/ASCs Moving to All/More CRNAs

- Reports in 2021 of a hospital in WI shifting to an all-CRNA model from anesthesiologist model
  - https://www.beckersasc.com/anesthesia/wisconsin-hospital-replaces-anesthesiology-staff-with-crnas.html
  - https://www.dailyunion.com/news/jefferson_county_area/changes-to-anesthesia-administration-at-wrmc-elicit-outrage-comment/article_8eeee5a4-10b7-5f9a-a2c9-492e2903ddd5.html
- Anecdotal reports of moves to "zone" model
  - Some zones involve one anesthesiologist overseeing two separate hospitals 30 minutes apart
  - Not just a single anesthesiologist overseeing 4-8 concurrent rooms

27

Report of One Hospital Moving to Test Having Family Practice Anesthetists

- Recent (January 6, 2023) report of a hospital in Canada looking to test using "family practice anesthetists"
  - Family doctors with additional training and certification in anesthesia
  - To provide local and general anesthetics "for cases that do not require a subspecialist. That means they would work on non-complex cases in general surgery, obstetrics and ophthalmology."
  - See https://www.cbc.ca/news/canada/nova-scotia/health-care-doctors-family-practice-anesthesiologists-1.6704376

28

#8: Consolidation Among Hospitals/Health Systems/ASCs Creates New Pressures

29

Consolidation Among Hospitals/Health Systems/ASCs Creates New Pressures

- As hospitals, health systems, & ASCs consolidate, more pressure to
  - Have a single group
  - Have master agreements covering multiple facilities
    - Fewer anesthesia practices in the system
  - Can lead to loss of practice opportunities for some anesthesia practices

30

#9: CMS Waiver of CRNA Supervision & State Opt-Outs

31

CMS Waiver/State Opt-Outs

- CMS Emergency Declaration Blanket Waivers for Health Care Providers
  - Beginning in March 2020, CMS waived requirements for physician supervision of CRNAs
    - Applies to hospitals, CAHs, & ASCs
  - To terminate as of end of the public health emergency ("PHE")
  - HHS extended the PHE again on January 11, 2023
    - See https://aspr.hhs.gov/legal/PHE/Pages/covid19-11Jan23.aspx
    - https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf

32

CMS Waiver/State Opt-Outs

- As of May 2022, 22 states & Guam opted out of federal physician supervision requirement

AZ	NH	OR	KY
OK	NM	MT	AR (May 22)
IA	KS	SD	MI (May 22)
NE	ND	WI	UT* (Feb. 22)
ID	WA	CA	Guam
MN	AK	CO*	

* For CAHs & specified rural hospitals

https://www.aana.com/advocacy/state-government-affairs/federal-supervision-rule-opt-out-information

33

#10: Continuing Burden of Regulatory Compliance & Lawsuits

34

Regulatory Compliance

- New laws – new regulations & policy
  - During initial COVID wave:
    - Understanding scope/limitations of federal aid programs
    - CMS waivers
  - No Surprises Act – effective Jan. 2022
  - State employment laws
  - Changing policy
    - *E.g.*, Biden focus on noncompetes & no-poaching clauses

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Regulatory Compliance

- Other regulations/requirements
  - HIPAA
  - Billing requirements
  - Telephone Consumer Protection Act
  - DOJ/FTC 2016 guidance on no-poaching clauses
    - Criminal enforcement of no-poaching provisions if parties are competitors
    - Caution on no-poaching provisions in hospital agreements if the health system employs anesthesiologists/CRNAs/CAAs

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Other Types of Antitrust Claims in HC

August 26, 2021, WA State Atty Gen issued a press release:

"**BELLINGHAM —** Attorney General Bob Ferguson today announced that . . . Bellingham Anesthesia Associates (BAA) must end its illegal dominance of the local health care market and pay $110,000 in costs and fees. BAA used unlawful non-compete clauses and exclusive contracts with area medical providers to take about 90 percent of the market share for physician-administered anesthesia services in Whatcom and Skagit counties. This legally enforceable agreement requires BAA to cease illegally requiring physicians to sign three-year non-compete contracts."

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Antitrust Consent Decree Against BAA

- "BAA used exclusive contracts with hospitals and clinics over the course of at least the last two decades to make itself the de facto anesthesia provider in Whatcom and Skagit counties. BAA also forced all of its doctors to sign overly broad non-compete agreements. Many physicians are also shareholders in BAA; their non-competes barred them from practicing anesthesia in medical procedures in the area for three years. Doctors who do not own shares of the business had 18-month non-competes."
  - https://www.atg.wa.gov/print/14099

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Recent Enforcement: "No-Poaching" Agreements

- August 2021: Class action lawsuit filed against Munson Healthcare and Traverse Anesthesia Associates (WD Mich)
  - Alleged antitrust violation based on no-poaching agreement
  - Allegation: No-poaching agreement between the parties intended to drive down competition in the job market and suppress pay for anesthesiologists & CRNAs
  - Hospital moved to dismiss; lawsuit still pending

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FTC Proposes to Ban Noncompetes in Employment

- Jan. 5, 2023: FTC proposed to ban noncompetes in employment
  - Published as a Notice of Proposed Rulemaking ("NPRM"), which will be published in the *Federal Register*
  - 60-day comment period
  - Potential for significant change before adoption

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#11: Questionable Arrangements to Capture Anesthesia Revenue Persist

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Questionable Arrangements Persist

- Still seeing arrangements in which referring physicians retain anesthesia fees, despite recent enforcement
  - Apr. 2022: DOJ $7.2M settlement with physicians & 18 anesthesia entities owned by a management company
    - https://www.justice.gov/usao-ndga/pr/paul-d-weir-john-r-morgan-md-care-plus-management-llc-and-anesthesia-entities-pay-72
    - "A physician's selection of an anesthesia provider for the patients he or she treats should be motivated by the quality of the anesthesia provider rather than by the income the physician can generate for him or herself" (U.S. Attorney Kurt R. Erskine)

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Questionable Arrangements Persist

- Nov. 2021: DOJ $28M settlement with three anesthesia providers & ASCs
  - https://www.justice.gov/usao-ndga/pr/anesthesia-providers-and-outpatient-surgery-centers-pay-more-28-million-resolve
- July 2020: Tenet $72.3M settlement of whistleblower suit
  - https://www.fiercehealthcare.com/hospitals/tenet-hospital-agrees-to-72-3m-settlement-doj-over-kickback-suit
  - https://blog.weisspc.com/tenet-to-pay-66-plus-million-to-settle-fca-suit-involving-company-model-of-anesthesia-services/

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Pressures on Independent Anesthesia Practice

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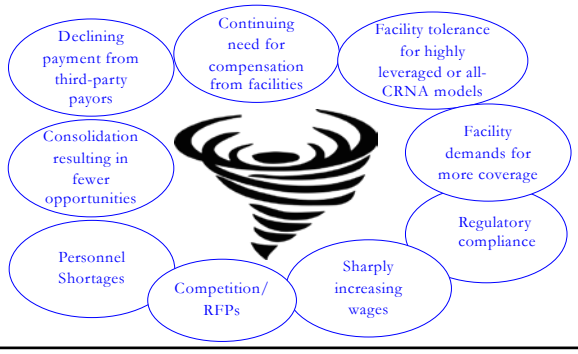

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Pressure on Independent Anesthesia Practice

- Increasingly hard to make a go of independent practice
- Increasingly important to pursue all practice opportunities
  - Must diversify
    - Continued Hospital insistence on noncompetes can limit a group's ability to pursue those opportunities

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Strategies to Compete in the Current Evolving Health Care Environment

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Strategies to Compete: Excellence

- Independent groups must continue to be the best at what they do
  - Provide excellent care
  - Provide excellent service
  - Document their excellence
    - Clinical quality metrics
    - Efficiency metrics
    - Surgeon-proceduralist/patient/facility staff satisfaction

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Strategies to Compete: Take Care of Group Problems

- Independent groups must take care of internal Group problems
  - Deal with tough Group issues:
    - Physicians/anesthetists who have clinical deficiencies
    - Clinical personnel who have interpersonal issues
      - Based on 360 review, survey results, other data
  - Either:
    - Work with them to improve, or
    - Make tough decisions
- Do not wait for the Facility to request removal

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Strategies to Compete: Be a Problem-Solver

- Independent groups must be problem solvers for their facilities
  - Work with facilities to address
    - Operational issues and
    - New challenges
- Best if the Group demonstrates initiative to suggest solutions before the facility identifies the need

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Strategies to Compete: Pursue Opportunities

- Must pursue new opportunities to provide anesthesia services
  - Are facilities issuing any RFPs?
  - Are there other opportunities to pursue?
    - Office-based anesthesia?
    - Providing staffing to other groups?
      - If your group has any excess capacity, can be a way to minimize losses

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Strategies to Compete: Plan Ahead

- More important than ever to plan ahead
  - Recruit early – especially given nationwide shortage of anesthesia personnel
  - Consider resources your group needs
    - Assistance with surgeon/patient/other satisfaction surveys
    - Assistance with valuing anesthesia services
      - For purposes of negotiating facility agreements

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Strategies to Compete: Develop Leaders

- Consider leadership training for your personnel
  - Multiple resources
- If individuals in the group are not stepping up to assist, take action
  - Do you need to recruit talent?
- Consider succession issues
  - Who are the current leaders?
  - Who is available to fill any gaps?
  - Who in the group is best-suited to fill any void?

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Strategies to Compete: The Right People

- Bring the right people to the table
  - Not everyone in the Group is suited to be the public "face" of the group

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Demonstrate Your Value Every Day

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Be Prepared for Change

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Pursue All Opportunities

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Create Your Own Opportunities

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HANDOUTS

Legal and Expanding Services: Legal: Anti-Kickback Law/Stark Law

Judith Jurin Semo, JD

01/14/2023
9:45am – 11:00am Pacific

Anti-Kickback Statute (Safe Harbor Law)/Stark Law

SAMBA 2023 ASC Medical Directors & Leaders Summit

January 14, 2023

Judith Jurin Semo, J.D.
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Disclosures

- Am an attorney in private practice
- I have the following financial relationships to disclose:
  - Owner of Judith Jurin Semo, PLLC
    - Private law practice
  - Diversified portfolio that includes investment in health care companies (no active role)
  - Will not be discussing off-label uses of drugs/devices

2

Objectives

- Review health care regulatory environment
- Review key concepts of Anti-Kickback Statute and Stark Law & how they apply to ASC practice & Medical Director responsibilities
- Suggest strategies to promote compliance

** A note: Not legal advice

3

Health Care is Highly Regulated

4

Legal Aspects of Health Care

- Legal rules govern much of medical practice
  - Who can practice
  - What services they can provide
  - Facilities in which services can be performed
  - Relationships w/patients
  - Relationships w/colleagues-competitors

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Overview

Health Care is Highly Regulated!

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Regulatory Issues

- "Fraud & Abuse"
  - Self-referral: Stark
  - Anti-Kickback Statute ("AKS")
  - Civil Monetary Penalties Statute
    - Payments to reduce/limit medically necessary services to Medicare/Medicaid patients
  - False Claims Act ("FCA")
- Antitrust
- Medicare Conditions of Participation (Hospitals) ("CoPs")
- HIPAA compliance
- Billing compliance
- National Practitioner Data Bank
- Tax exemption issues

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Acronyms

- AKS – Anti-Kickback Statute
- CMP – Civil monetary penalty
- CR – Commercial reasonableness
- DHS – Designated health care services
- FCA – False Claims Act
- FMV – Fair market value
- GMV – General market value

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Comparing the Anti-Kickback Statute & the Stark Law

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Anti-Kickback vs. Stark

	Anti-Kickback	Stark
Intent	Intent req'd for violation	Strict liability No intent req'd
Safe harbor/ exception	Safe harbors optional	Must fit w/in exception
Sanctions	Criminal sancs. Civil penalties	Nonpayment Civil penalties – knowing viols.

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Stark vs. Anti-Kickback

	Kickback	Stark
Conduct prohibited	Offering or soliciting something of value in exchange for referrals*	Referrals by physicians for certain services (DHS) to certain entities**

* Referrals of items or services payable under federal health care programs

** Entities with which they have a financial relationship

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Common Elements of AKS & Stark

- Both laws are intended to prevent corruption in decisions regarding selection and provision of medical services to patients in federal health care programs

Anti-Kickback	Stark
• No *quid pro quo* • Not offer/receive "remuneration" in exchange for referrals	• Preclude referrals for certain services (DHS) to entities w/which the physician has a financial interest • By ownership or compensation

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Commercial Reasonableness

- Important for AKS safe harbor (personal services) & Stark exception (FMV)

Does the arrangement make business sense in the absence of referrals?

- Medical Director arrangement should easily satisfy commercial reasonableness test

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Anti-Kickback Statute

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Federal Anti-Kickback Statute

- Prohibits *knowingly and willfully:*
  - Offering,
  - Paying,
  - Soliciting, or
  - Receiving
- Any *remuneration*
- To induce referrals of
  - Services reimbursable by federal health care programs

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Anti-Kickback Statute

"In some industries, it is acceptable to reward those who refer business to you. However, in the Federal health care programs, paying for referrals is a crime." (HHS OIG)

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Federal Anti-Kickback Statute

- Courts: Anti-Kickback Statute is violated
  - If even *one purpose* of remuneration was
    - To obtain money for the referral of services or
    - To induce further referrals
  - Even if other justifiable bases for making some level of payment

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High Stakes: Increases in Penalties

- Bipartisan Budget Act of 2018
  - Significantly increased civil & criminal penalties for federal health care program violations
    - Doubled statutory civil fines (for AKS, from $50K to $100K)
    - Quadrupled some criminal fines (including violations of Anti-Kickback Statute – from $25K to $100K)
    - Increases maximum jail time – doubled from 5 years to 10 years

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"Safe Harbors"

- Payment/business practice not subject to enforcement action
  - Purpose: provide *specificity* given broad scope of kickback prohibitions
- Optional: not illegal if do not fit into a safe harbor:
  - Legal if *no intent* to induce referrals
  - But no assurance of protection

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"Safe Harbors"

- 35 safe harbors – must meet all req'ts to be protected
- Multiple
- Of greatest interest to anesthesiologists
  - Personal services & management contracts
  - Employees
  - Investments in group practices
  - Investment in ASCs

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Personal Services Safe Harbor

- In writing & signed
- Covers/specifies all services to be furnished
- Term at least 1 year
- Methodology to set compensation is set in advance, consistent w/FMV, & does not reflect volume/value of referrals
- Services do not violate State/Fed law
- Aggregate services are reasonably necessary for commercially reasonable business purpose

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ASC Safe Harbor

- Regulatory concern: Is return on ASC investment *a disguised payment for referrals*?
  - *E.g.*, joint investment by physicians in specialties that typically cross-refer
  - So each is positioned to earn a profit from such referrals
- ASC safe harbor covers four types of ASCs
  - Surgeon-owned
  - Single-specialty
  - Multi-specialty
  - Hospital-physician

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ASC Safe Harbor

- Several common requirements – *e.g.*
  - Medicare-certified
  - No loans (by ASC or investors) to invest
  - Investment interests offered on terms *unrelated to volume/value of referrals*
  - Ancillary services "directly & integrally" related to primary procedures
  - No discrimination v. federal program patients
  - Disclosure of ownership to patients

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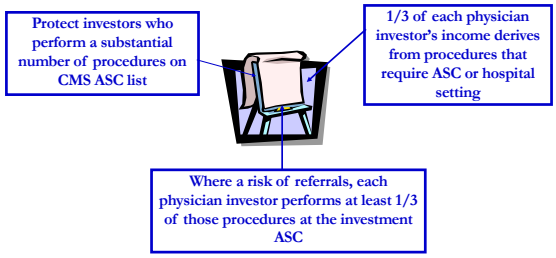
Common Elements



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ASC Safe Harbor Rationale

- Ensure that physician's investment represents an *extension of the physician's office*
  - 1/3-1/3 test: assure no significant incentive beyond professional fees to refer to the ASC or its investors
  - Issue for anesthesiologists: anesthesia services are not "procedures" for purposes of the safe harbor

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Anesthesiologists' Investments in ASCs

- OIG: Anesthesiologists' investments *not* protected if they can:
  - *Provide services to*,
  - Refer patients to, or
  - Generate business for
  - ASC or any of its investors
- Providing anesthesia for patients in ASC or serving as medical director is a "service"
  - So fall *out* of ASC safe harbor
  - But investment in an ASC is not illegal
    - Because no intent to induce referrals

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Anesthesiologists' Investments in ASCs

- Satisfy the spirit of ASC safe harbor
  - Anesthesiologists typically do not refer (if not providing pain management services)
    - Not using ASC investment to profit from referrals to other physicians who use the ASC
  - ASC represents an extension of their standard practice

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Significant Changes to AKS/Stark Rules

- Effective Jan. 19, 2021: Amended AKS and Stark rules to reduce regulatory barriers to care coordination and to promote payment for value and delivery of coordinated care
- Without getting into the weeds . . .
  - On the AKS:
    - OIG modified conditions an arrangement must meet to satisfy the "personal services and management contracts" safe harbor
      - One of the most relevant safe harbors for considering anesthesia arrangements – both legitimate and suspect

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Significant Changes to AKS Safe Harbors

- Increased protection and flexibility for the "personal services and management contracts" safe harbor:
  - Removed req't for part-time arrangements to specify the schedule, length, and exact charge for intervals of time worked
    - Greater flexibility for periodic services arrangements where parties unable to predict exact frequency of their need for services
  - On aggregate compensation, substituted requirement that the methodology for determining comp be set in advance
    - Rather than requiring that aggregate comp be set in advance
      - Allows productivity and unit-based methodologies, so long as
        - Consistent with fair market value and
        - Set in advance

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Significant Changes to AKS Rules

- Other changes to "personal services & management contracts" safe harbor:
  - Permitted outcomes-based payments – *e.g.*, payments for
    - Improving patient health, or
    - Reducing payor costs (while improving quality of care)
- Many other changes relating to innovative arrangements and value-based care
  - New safe harbors to protect value-based arrangements

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Changes to Key Definitions

- New rule includes revised definitions of key definitions
  - Fair market value ("FMV") and commercial reasonableness ("CR")
  - FMV: "[t]he value in an arms-length transaction, consistent with the general market value ("GMV") of the transaction"
    - GMV means "with respect to compensation for services, the compensation that would be paid at the time the parties enter into the service arrangement as the result of bona fide bargaining between well-informed parties that are not otherwise in a position to generate business for each other."
  - CR means "that the particular arrangement furthers a legitimate business purpose of the parties to the arrangement and is sensible, considering the characteristics of the parties, including their size, type, scope, and specialty. An arrangement may be commercially reasonable even if it does not result in profit for one or more of the parties."

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Key Themes in Revised Definitions

- "Volume or value standard" is a separate and distinct concept from FMV and CR
- Using wRVUs (in physician comp plans) not suspect for considering volume or value
- Arrangements may be commercially reasonable, even if they are not profitable
  - Especially important in anesthesiology contracts and arrangements
- Salary surveys alone do not constitute FMV
- Comp set at or below 75th percentile is not always FMV
- Value of a physician's services should be the same regardless of identity of the purchaser (*e.g.*, a private physician group or a hospital)
- Even when arrangements have a legitimate business purpose, they may not be CR
  - *E.g.*, second medical director for the same service line

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Anti-Kickback Law Penalties

- Both parties culpable
  - Party soliciting the kickback &
  - Party providing the kickback
- Felony
  - Maximum fine of $100,000 (quadrupled in 2018)
  - Imprisonment up to 10 years, or both (doubled in 2018)
  - Conviction ➔ automatic exclusion from federal health care programs
  - CMPs: $100,000*/violation + damages up to 3 x total remuneration (doubled in 2018)

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Anti-Kickback Law Intent

- Health care reform law (ACA):
  - Clarifies intent standard for conviction
    - Need not have actual knowledge that the alleged activity violates the Anti-Kickback Statute
    - Need not have specific intent to violate the Anti-Kickback Statute
- Easier to be convicted

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The Game Changer

- Affordable Care Act (2010):
  - Claims arising out of violations of the Anti-Kickback Statute are **false claims** for purposes of the False Claims Act (FCA)
- FCA penalties:
  - $12,537 (minimum) - $25,076 (maximum)/claim +
  - Three times the claim amount +
  - Legal fees

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The Game Changer: FCA Liability

- *E.g.*, single claim for $400 can result in penalties of
  - $13,737 (min)/$26,276 (max)
    - Penalties (per claim)+ 3x claim amount
- FCA penalties are in addition to penalties for AKS violations
- Practical pointers:
  - Liability for violations is staggering
  - Will force a settlement

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Stark Law

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Stark

- Contracts between physicians & hospitals involving any payment for the physicians' services will likely implicate the Stark Law
  - Somewhat different considerations with ASCs (due to definitions of DHS)
- Strict liability under Stark
  - Civil statute
  - Not intent-based

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Stark

- Hospitals & health systems are very concerned about Stark law compliance
- Examples of enforcement/whistleblower suits
  - Huge exposure
    - Tuomey Healthcare - $237M judgment
      - 10.16.15: Resolved w/DOJ for $72.4M
      - 9.27.16: Former Tuomey CEO settled w/DOJ - $1M
    - Halifax Hospital
      - 3.11.14: $85M settlement w/DOJ

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Stark

- Stark Law: A physician may not make referrals for certain "designated health services" ("DHS") payable by Medicare or Medicaid where physician (or immediate family member) has a financial relationship w/entity to which patient is referred
  - Unless all elements of an exception are met
- If physician is paid by the hospital or ASC for Medical Director role, creates a financial relationship under Stark

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Designated Health Services

- Clinical lab services
- Physical therapy, occupational therapy, & outpatient speech-language pathology services
- Radiology & certain other imaging services
- Radiation therapy services & supplies
- DME & supplies
- Parenteral & enteral nutrients, equipment, & supplies
- Prosthetics, orthotics, & prosthetic devices & supplies
- Home health services
- Outpatient prescription drugs
- Inpatient & outpatient hospital services

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Designated Health Services

- DHS do not include
  - Physicians' professional services
  - Anesthesiology services
  - ASC services
- No "referral" if physician personally performs a service
  - Many inpatient & outpatient services for which anesthesiologists refer are not personally performed by the anesthesiologist
- In ASC, less potential for referrals for DHS, but health systems are skittish about Stark compliance – will carry over to ASC setting

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Stark "Exceptions"

- Exceptions that may be available in context of Medical Director services
  - Ones that relate to compensation arrangements
    - Rather than financial interest via ownership
  - **Personal service arrangement exception**
  - **Fair market value exception**

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Common Elements: Personal Service & FMV Exceptions

- Agreement in writing & specifies services covered
- Covers all services to be furnished
- Aggregate services are reasonable & nec'y for legitimate business purposes of the arrangement
- Compensation is "set in advance" &
  - Does not exceed fair market value
  - Does not take volume/value of referrals or other business generated into account (except for physician incentive plan)
- Services do not involve counseling/promotion of an arrangement that violates Federal or State law

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Time: Personal Service & FMV Exceptions

Personal Service Arrangements	FMV Compensation
• Must be at least a year • If an arrangement is terminated (w/ or w/o cause), parties may not enter into the same or substantially the same arrangement during the first year of the original arrangement	• May be for any period of time & contain a termination clause • Parties may not enter into more than one arrangement for the same items or services during the course of a year

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Stark Personal Service & FMV Exceptions

- Key elements for Medical Director arrangement:
  - Compensation must be
    - Set in advance
      - Can be a formula
    - Not exceed fair market value
    - Not take into account volume or value of physician's referrals

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Structuring Compensation for Medical Director

- Base compensation
  - Independent appraisal of FMV of
    - Administrative services
      - Paid hourly or fixed fee
  - Documentation of time spent
- Incentive compensation
  - Objective quality indicators
  - Not based on subjective indicators
  - Not primarily based on cost reduction/revenue increases
  - Independent appraisal of proposed bonus/incentive

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Stark Rule Changes

- Also effective Jan. 19, 2021: Stark Rule changes, which include:
  - New exception for limited monetary comp (capped at $5K/year; adjusted for inflation) without a signed writing or comp set in advance
  - Changes to group practice definition – especially relating to physician profit-sharing (effective date of 1.1.22 for these changes, to allow group practices time to revise comp plans)
    - Key definition for many Stark exceptions
    - New rule addresses distribution of profits related to participation in a value-based enterprise ("VBE")
  - CMS noted intent to interpret Stark Law "prohibitions narrowly and the exceptions broadly"
    - Permits more flexibility for comp arrangements between a physician referrer and a provider of designated health services

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Examples of Anti-Kickback & FCA Enforcement

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Active Enforcement of AKS/FCA

- Enforcement continues!
- **There's money in enforcement!**
  - DOJ makes money from enforcement: "Justice Department's False Claims Act Settlements and Judgments Exceed $5.6 Billion in Fiscal Year 2021"
    - "Second Largest Amount Recorded, Largest Since 2014"
    - Of the > $5.6B, >$5B relates to health care
      - Additional recoveries for state Medicaid programs
    - https://www.justice.gov/opa/pr/justice-department-s-false-claims-act-settlements-and-judgments-exceed-56-billion-fiscal-year
  - Whistleblowers make money from enforcement!
    - Between 15-30% of the recovery
    - Whistleblowers filed 598 *qui tam* suits in 2021 alone

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$28M Settlement of AKS/FCA Claims

- More than $28M settlement: Three anesthesia practices, several Georgia ASCs, as well as their physician-owners & an administrator (Nov. 2021)
  - Allegations that the anesthesia groups made payments for drugs, supplies, equipment and labor, and provided free staffing to a number of Georgia ASCs to induce the ASCs to select the anesthesia groups to be their exclusive anesthesia providers
  - https://www.justice.gov/usao-ndga/pr/anesthesia-providers-and-outpatient-surgery-centers-pay-more-28-million-resolve
  - Whistleblower case brought by an anesthesiologist in a competing group, the competing group, & the group's administrator
    - That group had lost ASC work to the settling groups
    - The whistleblowers received > $4.7M from the recovery

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$72.3M Settlement of AKS/FCA Claims

- $72.3 million settlement: OK Center for Orthopaedic and Multi-Specialty Surgery ("OCOM"), affiliates, Southwest Orthopaedic Specialists ("SOS") & two SOS physicians (July 2020)
  - Multiple allegations of improper remuneration, free or below-market office space, employees, and supplies
  - Also alleged: preferential investment opportunities in connection with provision of anesthesia services at OCOM
  - Company-model-type structure: SOS and its surgeon owners created an anesthesia group to profit from provision of anesthesia at the ASC
    - https://www.justice.gov/opa/pr/oklahoma-city-hospital-management-company-and-physician-group-pay-723-million-settle-federal
  - Whistleblower case brought by SOS administrator/business mgr (while still employed) – served in that role for 15 years

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Settlement of AKS Claim - Anesthesia

- Dec. 2018: Interventional pain management physician, Jonathan Daitch, MD, agreed to civil settlement of $1.718M to resolve claims he violated FCA by receiving illegal kickbacks associated with provision of anesthesia services and submission of medically unnecessary urine tests
  - Dr. Daitch and his partner, Dr. Frey, owned Anesthesia Partners of SWFL, LLC
  - Provided anesthesia services exclusively for procedures performed by the two pain physicians
  - Anesthesia Partners contracted w/CRNAs to provide anesthesia – billed for them
    - Paid CRNAs a contracted rate
    - DOJ contention: Daitch's ownership interest in Anes. Partners & remuneration he received via his ownership interest induced him to refer his patients to Anes. Partners
  - https://www.justice.gov/usao-mdfl/pr/fort-myers-doctor-agrees-pay-more-17-million-resolve-allegations-fraud (settlement w/Daitch)
  - June 2018: Settlement w/Frey: https://www.justice.gov/usao-mdfl/pr/fort-myers-pain-management-physician-pleads-guilty-healthcare-offenses-and-agrees-28

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$3.2M Settlement of AKS/FCA Claims

- Mar. 2018: DOJ settlement with orthopaedic and anesthesia providers - $3.2M – allegations:
  - Southern Crescent Anesthesiology ("SCA"), Sentry Anesthesia Management ("Sentry"), & individual provided a free medical director to an ASC to induce it to perform more procedures in the ASC than in the office
  - Other allegations related to false claims for prescription drugs purchased outside US and not approved by FDA
  - Whistleblower action by former practice administrator
  - https://www.justice.gov/usao-ndga/pr/orthopaedic-and-anesthesia-providers-pay-32-million-settle-false-claim-act-allegations

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$1M+ Settlement of AKS Claims

- Aug. 2016: DOJ settlement with Sweet Dreams Nurse Anesthesia ("Sweet Dreams") ($1,034,415 to US and $12,078.79 to State of GA)
  - Multiple alleged violations, including:
    - Sweet Dreams provided free anesthesia drugs to ASCs in exchange for ASCs granting Sweet Dreams an exclusive contract to provide anesthesia services at those ASCs
    - Sweet Dreams affiliate funded construction of an ASC in exchange for selection of Sweet Dreams as the exclusive anesthesia provides at that ASC and other affiliated podiatry-based ASCs
    - Whistleblower suit by CRNA who worked for Sweet Dreams
    - https://www.justice.gov/usao-mdga/pr/sweet-dreams-nurse-anesthesia-group-pays-more-1-million-resolve-kickback-allegations

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Other Settlements

- April 2021: $4.1M settlement with Anesthesia Services Associates, PLLC d/b/a Comprehensive Pain Specialists – operated > 40 pain clinics in 12 states
  - Multiple allegations, including alleged false claims for medically unnecessary and/or non-reimbursable testing and acupuncture
  - Other alleged FCA violations relating to
    - Urine drug testing
    - Services not provided and testing not ordered
    - https://www.justice.gov/usao-mdtn/pr/comprehensive-pain-specialists-and-former-owners-agree-pay-41-million-settle-fraud

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Stark and Holdover Agreements

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Holdover Agreements

- Effective Jan. 1, 2016: Stark Law exception allows **indefinite** holdover of expired agreement
  - Parties must continue under the same terms
  - Previously, holdover arrangements were limited to six months
- Useful to know if you are involved in negotiating facility agreements

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Conclusion

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Conclusion

- The AKS & Stark Laws are similar, but entirely different
- Both are intended to prevent corruption in medical decision-making in federal health care programs
- Lots of details as to the safe harbors (for AKS) & exceptions (Stark)
  - And the rules change from time to time
- Important to get the basics – leave the details to counsel
- Medical Director roles can easily comply with both laws

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HANDOUTS

Legal and Expanding Services: Employment Law/Termination/HR

Judith Jurin Semo, JD

01/14/2023
9:45am – 11:00am Pacific

Employment Law – Termination – HR

SAMBA 2023 ASC Medical Directors & Leaders Summit

January 14, 2023

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Disclosures

- Am an attorney in private practice
- I have the following financial relationships to disclose:
  - Owner of Judith Jurin Semo, PLLC
    - Private law practice
  - Diversified portfolio that includes investment in health care companies (no active role)
  - Will not be discussing off-label uses of drugs/devices

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Objectives

- Identify the regulatory background underlying employment law that makes human resources ("HR") processes so important
- Review risk areas for ASC Medical Directors in addressing employment issues, including termination of personnel
- Identify the HR processes, documents, and policies needed to set expectations and assist a Medical Director to navigate employment and HR issues

** A note: Not legal advice

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Context

- ASC Medical Directors come from different backgrounds
  - Some are part of a private practice anesthesia group
  - Some may work for large national companies
  - Some may be employed by a health system that owns an ASC
  - Others may be part of an academic practice that staffs an ASC
  - Some may be direct employees of the ASC
- ASC Medical Directors also have different responsibilities
- Their interests in the HR topic may differ slightly, as there may be more or fewer repercussions for them as individuals

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Wide Scope of HR Laws

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HR Is Highly Regulated

- Human resources is a highly regulated area
  - Many different federal laws apply
  - Interpretations change
    - Change in administrations (federal level)
    - Court decisions
  - New laws
    - Federal
    - State
  - Employees' awareness of their rights

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Wide Scope of "HR" Laws

- Anti-discrimination laws/anti-harassment laws (multiple laws)
- Equal pay for equal work (Equal Pay Act)
- Worker classification
  - Employee/independent contractor
- Workplace safety laws (OSHA-type laws)
- Federal labor relations laws (National Labor Relations Act)
  - Social media policies
  - *Note*: NLRA applies both to unionized & nonunionized settings
- Fair Labor Standards Act ("FLSA")

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Wide Scope of "HR" Laws

- Federal laws (& many state laws) protect against discrimination in employment on multiple grounds:
  - Race
  - Color
  - Religion
  - National origin
  - Sex
    - Including sexual orientation, gender identity, & pregnancy
  - Older age (starting at 40)
  - Disability
  - Genetic information (including family medical history)

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Scope of Antidiscrimination Protection

Federal law forbids discrimination when it comes to any aspect of employment, including:

- Recruiting
- Hiring & firing
- Compensation (pay & retirement plans)
- Job assignments
- Promotions
- Layoff
- Training
- Fringe benefits
- Disability leave
- Any other term or condition of employment

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Federal Laws Barring Discrimination in Employment

- **Title VII of the Civil Rights Act of 1964** ("Title VII")
  - Prohibits discrimination in employment based on race, color, religion, sex, or national origin
  - Prohibits employers from treating employees differently, or less favorably, based on those factors
    - Prohibits employment decisions based on stereotypes (unfair or untrue beliefs) about abilities and traits associated with any of the illegal bases for discrimination

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Federal Laws Barring Discrimination in Employment

- **Equal Pay Act of 1963** ("EPA")
  - Requires employers to give male & female employees equal pay for equal work
    - Employers must pay men & women equally for doing substantially the same work at the same workplace
    - Often difficult: What is equal work?
- **Age Discrimination in Employment Act of 1967** ("ADEA")
  - Protects workers 40 & older from discrimination because of age

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Federal Laws Barring Discrimination in Employment

- **American with Disabilities Act of 1990** ("ADA")
  - Illegal to discriminate against a qualified person w/a disability
  - Employers must reasonably accommodate the known physical or mental limitations of an otherwise qualified individual w/a disability who is an applicant or employee
    - Unless doing so would impose an undue hardship on operation of employer's business
  - Importantly, prohibits discrimination based not only on a current or past disability, but also a perceived impairment

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Other Federal Laws

- **Genetic Information Nondiscrimination Act of 2008** ("GINA")
  - Prohibits employment discrimination based on genetic info of an applicant, employee, or former employee
- **Civil Rights Act of 1991**
  - Provides monetary damages in cases of intentional employment discrimination

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Workplace Harassment

- Harassment is a form of employment discrimination that violates Title VII, ADEA, & ADA
- Harassment is unwelcome conduct that is based on any of the prohibited grounds for discrimination
  - Race, color, religion, sex, national origin, older age, disability or genetic information
- Harassment becomes unlawful where:
  - Enduring the offensive conduct becomes a condition of continued employment, or
  - The conduct is severe or pervasive enough to create a work environment that a reasonable person would consider intimidating, hostile, or abusive

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Workplace Harassment

- Discriminatory harassment based on multiple grounds can create a hostile work environment
  - Race, age, sex, religion, national origin, disability, genetics
- Retaliation for complaining about discrimination based on protected characteristics also can create a hostile work environment
- If a supervisor's harassment results in a hostile work environment, the employer must prove the following to avoid liability:
  - It reasonably tried to prevent & promptly correct the harassing behavior &
  - The employee unreasonably failed to take advantage of any preventive or corrective opportunities provided by the employer

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Harassment/Hostile Work Environment

- Unwelcome conduct can be by supervisors or others
  - Co-workers
  - Customers
  - Contractors
  - Patients
  - Patients' families
  - Anyone w/whom victim interacts on the job
- The victim does not have to be the person harassed, but can be anyone affected by the offensive conduct
- Unlawful harassment may occur without economic injury to the victim, or discharge

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Liability Based on Agreeing to Patient Requests

- Acceding to patient requests can constitute discrimination if the patient's demand is based on a ground on which the employer may not discriminate
- Example: A nurse who was reassigned based on patient's racial preference filed suit for discrimination on the basis of race
  - Court agreed (2019 decision denying motion to dismiss): *Williams v. Beaumont Health System* (ED Mich. 2019)
  - 2010 case: Certified nursing assistant at LTC facility prevailed in a similar case: *Chaney v. Plainfield Healthcare Center* (7th Cir. 2010)

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Sex-Based Discrimination

- Sex discrimination: treating someone unfavorably based on that person's sex – includes:
  - Conduct that is sexual in nature – *e.g.*,
    - Sexual jokes, photos, touching, or requests for sexual favors
  - Non-sexual conduct that is based on gender – *e.g.*,
    - Comments that men or women do not belong in certain jobs
    - Comments questioning men's or women's skills or abilities
- Includes discrimination based on:
  - Sexual orientation
  - Gender identity/transgender status
  - Pregnancy
- A harasser can be same sex as harassed employee or a different sex

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Other "HR" Laws

- Leaves of absence
  - Family Medical Leave Act (≥ 50 EEs)
  - Pregnancy Discrimination Act
  - Uniformed Services and Reemployment Rights Act
- Protections for whistleblowers
- Wage and hour laws
  - Laws dictating wages & hours of employees (DOL)
    - Fair Labor Standards Act

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Other "HR" Laws

- Employee benefits laws
  - Employees' access to benefits
    - Affordable Care Act (healthcare coverage & insurance)
    - COBRA (Consolidated Omnibus Budget Reconciliation Act)
      - Provide eligible employees access to continued health coverage post-termination
    - ERISA (Employee Retirement Income Security Act)
      - Requirements relating to pension plans (if employer offers)
- Workplace safety laws
  - OSHA (Occupational Safety and Health Act): Safe working conditions
  - State worker compensation laws

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Other HR-Related Areas

- Employee rights under the National Labor Relations Act (NLRA)
  - Rights of employees to engage in "concerted activity"
    - Two or more employees may take action for their mutual protection regarding terms & conditions of employment
    - Even if not unionized
    - Examples:
      - Address employer about improving pay
      - Discuss work-related issues – *e.g.*, safety concerns
- Consider NLRA rights in trying to implement social media policies

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Don't Forget About State HR Laws!

- States actively regulate HR
  - State law often is more expansive than federal law
    - *E.g.*, lower thresholds (numbers of employees) for certain anti-discrimination laws to apply
  - **~13 states/jurisdictions**: No employee minimum to file a claim under state law
  - **> 20 states**: Lower threshold than federal law to file state law discrimination claim
    - *E.g.*, AK (2 employees for state law to apply)

Specific info on employee thresholds at https://www.workplacefairness.org/minimum

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State HR Laws Continue to Change

- Recent/new state laws:
  - Mandated sick leave
  - Family leave
  - Anti-discrimination:
    - Natural hairstyles as a protected characteristic
    - Gender identity/expression/sexual identity as a protected class
    - Off-duty conduct (marijuana use) as protected conduct
  - Limiting length/enforceability of noncompetes
  - Nondisparagement agreements & NDAs
  - Mandating religious exemptions to vaccine mandates
  - Creating a wage theft crime (covers independent contractors, as well)
  - Lactation breaks

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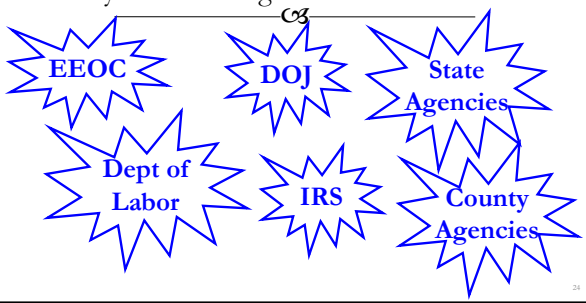
Many Different Agencies Enforce HR Laws



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Attorneys' Fees & Fee Shifting

- All federal anti-discrimination, anti-harassment, & anti-retaliation laws provide that the prevailing party may recover reasonable attorneys' fees
  - Plaintiffs also can recover damages – *e.g.,* back pay, lost benefits
- The ability to recover attorneys' fees makes these cases attractive for plaintiffs' counsel

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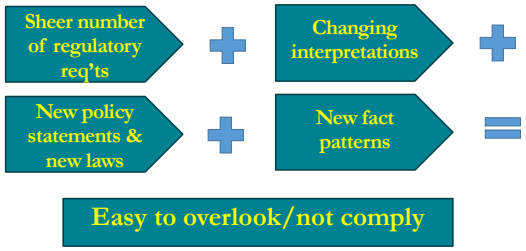
Why HR Compliance Is So Important



Easy to overlook/not comply

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Why HR Processes are Important

- For both an anesthesia group ("Group") & an ASC, failing to implement/ enforce HR policies:
  - Exposes ASC/Group to legal claims, expense
    - Legal fallout (agency enforcement, penalties, lawsuits)
    - Or "bad press" that harms ASC/Group
  - For Group, can result in adverse facility reactions
    - Due to Group's failure to monitor behavior
    - Can result in loss of Group's contract(s)
  - Drains ASC's/Group's attention from more important issues
    - Drain on ASC/Group resources – Investigation costs, legal fees, PR costs

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Steps to Setting HR Policies & Processes

- Critically important to have the resources & processes in place & available before they are needed
  - Set ASC policy
    - Without specific individuals coloring the decision on policy
  - Set ASC expectations
    - Applicable to all ASC personnel
      - NOTE: Must enforce policy consistently
  - Set ASC processes
  - Identify in advance who has what authority
    - Who makes key decisions – hiring, discipline, termination

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Steps to Setting HR Policies & Processes

- When drafting policies, especially on prohibited conduct, important to include
  - Clear expectations
  - Details on consequences for the prohibited conduct
    - Need to consider state law
- After develop policies:
  - Must train ASC personnel on the policies & expectations

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Who in ASC is Responsible for HR?

- For a Medical Director, want clarity on who in the ASC is responsible for HR issues, both day-to-day & when issues arise
  - What responsibility (if any) does the Medical Director have?
  - What does the Medical Director agreement say about HR responsibility?
  - Is role a supporting role, to participate with ASC in its oversight of personnel?
  - Or is the Medical Director directly responsible to hire/fire ASC personnel?

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What ASC Medical Directors Need to Know About Employment Law – Termination – HR

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What is the Role of the ASC Medical Director vis-à-vis Employment Issues?

- What an ASC Medical Director needs to know about employment depends on the ASC Medical Director's role
  - Is the Medical Director responsible just for clinical issues, or for overseeing ASC personnel?
  - Who is responsible for overseeing ASC personnel?
  - Is there different oversight over ASC clinical personnel vs. administrative personnel?
  - Who employs the ASC personnel?
- Difficult to generalize

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What is the Role of the ASC Medical Director vis-à-vis Employment Issues?

- First task: An ASC Medical Director must understand the duties of the position and:
  - Who at the ASC is responsible for addressing personnel issues involving independent Medical Staff members
  - Who at the ASC is responsible for addressing personnel issues involving ASC personnel
  - If the Medical Director is employed by an entity other than the ASC (*e.g.*, a private anesthesia group), the extent of that entity's obligations
  - Who serves as legal counsel for employment issues for the ASC?
  - Who has authority to contact legal counsel on HR issues?

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What is the Role of the ASC Medical Director vis-à-vis Employment Issues?

- Whether a Medical Director needs to know about HR processes/termination/employment laws really depends on the Medical Director's duties
  - Who has responsibility for:
    - Interviewing & hiring ASC personnel?
    - Evaluating ASC personnel on an ongoing basis?
    - Disciplining ASC personnel?
    - Terminating ASC personnel?

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What is the Role of the ASC Medical Director vis-à-vis Employment Issues?

- In general, do not anticipate that an ASC Medical Director will have front-line authority on overseeing ASC employees
  - ASC Administrator, other ASC staff typically have that responsibility
  - Some ASC Medical Director duties may overlap
  - Understand/delineate roles to minimize
    - Confusion over responsibilities
    - Potential liability

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What is the Role of the ASC Medical Director vis-à-vis Employment Issues?

- A Medical Director likely has certain responsibilities relating to oversight of ASC Medical Staff members
  - Is the Medical Director responsible for overseeing all Medical Staff members, including surgeons & proceduralists?
    - Politically a tough position
  - Is the Medical Director responsible only for overseeing/evaluating only anesthesia personnel?
- Key difference in overseeing ASC personnel vs. Medical Staff members
  - Medical Staff members typically are not employees of the ASC
    - (Often are owners)

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What is the Role of the ASC Medical Director vis-à-vis Employment Issues?

- Evaluation and discipline of Medical Staff members, and decisions relating to credentialing, often will not occur in the employment context
  - Employment laws will not apply

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NPDB Considerations

- Discipline & credentialing of Medical Staff members involves possible reporting to the National Practitioner Data Bank ("NPDB")
- A permanent "black mark" on a physician's record

Resources at: https://www.npdb.hrsa.gov/helpCenter/policy.jsp & https://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp

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NPDB Considerations

- Clinical matters may be the subject of peer review
  - Immunity under the Health Care Quality Improvement Act ("HCQIA") for peer review that satisfies the conditions of the statute
  - But: Immunity does not mean that unhappy Medical Staff members will not file suit to challenge decisions & test immunity
- Behavioral/conduct issues do not necessarily undergo peer review
  - No immunity
  - Standard ability to challenge

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Protection for Medical Director Duties vis-à-vis Employment & Other Issues

- The ASC should provide liability protection (insurance, indemnification) for the Medical Director's administrative duties
  - Not necessarily covered by professional liability insurance
- A key risk area: Evaluating ASC personnel
  - Claims by ASC personnel based on negative evaluations by the Med. Dir. likely are not covered under a professional liability policy
- Key risk area #2: Disciplining/Evaluating Medical Staff members
- Pointer: Any commitment by the ASC must survive termination

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Specifics: What HR Documents & Processes?

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Setting Expectations

Policies

Handbook

Code of Conduct

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Setting Expectations

- Critically important to set expectations
- Often reflected in a Code of Conduct
  - Integrity in personal & professional conduct
  - Civility
  - Confidentiality
  - Avoid conduct that could cast negative light on ASC
  - Comply with law & ASC policies

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Policies: Consequences for Failure to Comply

- Important to have policies** to deal with ASC personnel & Medical Staff members who fail to follow rules
  - In advance
  - Before problem behavior begins
- Identify who in ASC will act
  - Is that the Medical Director?

** If ASC adopts policies, the ASC must follow them!

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Employee Handbook

- ASC may want to develop (if it has not already) an employee handbook
  - Key policies
  - Operational issues
  - Compliance with state law
- Handbook: Employees are intended audience
- Caution: Changing NLRB decisions/guidance on handbooks & what employer rules are permissible
  - Focus of concern: Impact on NLRA rights

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Operational Policies

- Policies/procedures typically intended
  - To assist in managing operations
  - Provide for consistency in addressing situations
  - May be some overlap with handbook
- Examples of policies:
  - Hiring & termination
    - Who has authority
    - Legal considerations
    - Position descriptions & competencies (beyond clinical)
  - Leave

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Other Policies

- Among other policies the ASC will want to have, which may facilitate the Medical Director's ability to carry out the role
  - Disruptive conduct policy – detail disciplinary steps/consequences
  - Employee scheduling – who makes the schedule, exceptions
    - Goal: Promote fairness
  - Leave/vacation – accrual, restrictions, personal holidays
  - Job-sharing

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Operational Tip

- Make sure the ASC provides training on its policies and on substantive areas – *e.g.:*
  - Harassment/hostile work environment
  - HIPAA & confidentiality
  - Employment discrimination – including concrete examples of behavior that may lead to claims & liability (not obvious actions)
  - Workplace etiquette and the Code of Conduct

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But What Does All This Mean to an ASC Medical Director?

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HR Risk Areas for ASC Medical Directors

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HR Risk Areas

- To highlight risks of noncompliance with HR laws, will review several "Myths" relating to HR/legal compliance
  - Misconceptions about how policies apply to physicians, ASCs, and ASC personnel

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HR Risk Areas

Myth 1:

THERE IS NO RISK IF IT'S NOT IN WRITING

- Too often, physicians think that they can avoid legal exposure if communication is oral, not written
- FACT: Liability can stem from actions, not just documents

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HR Risk Areas

Myth 2:

IF I ACT IN GOOD FAITH, MY CONDUCT CANNOT BE DEEMED TO BE HARASSMENT OR DISCRIMINATORY

- FACT: Perception is more important that intent
- Intent alone does not drive findings of discrimination
- Critical to have training to develop common understandings of conduct and/or statements that can be deemed offensive
- The "but I hug everyone" or "I was just joking" will not preclude liability

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HR Risk Areas

- Liability can stem from an ASC employee's/Group member's actions outside the ASC/Group – *e.g.*
  - Harassment of ASC personnel
  - Discussion of confidential ASC (or Group) info w/spouses, surgeons, others
  - Posting inappropriate items on social media

Myth 3:

ASC/GROUP'S HR & OTHER POLICIES DO NOT APPLY TO ACTIONS OUTSIDE ASC/ GROUP

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HR Risk Areas

Myth 4:

THESE POLICIES DO NOT HAVE ANY REAL ABILITY TO PROTECT THE ASC/GROUP

- FACT: Policies & training can protect ASC/Group
- Actively taking steps to comply can lead to lower penalties (*e.g.*, HIPAA)
- Effective compliance programs can result in reduced penalties (*e.g.*, False Claims Act)

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HR Risk Areas

- FACT: Policies & compliance plans alone do not protect the ASC or Group
- Ongoing training and ongoing implementation are critical

Myth 5:

OUR ASC/GROUP IS PROTECTED BECAUSE WE HAVE POLICIES/ COMPLIANCE PLAN

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Termination & Documentation

- Risks associated with terminating ASC personnel:
  - Claims of wrongful termination
  - Claims of illegal discrimination
- If there are performance issues with an employee:
  - **Document, document, document**
    - Need a record of what has occurred
    - Important to defend claims of illegal discrimination or wrongful termination

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Termination & Documentation

- Documentation important on several levels
- Need to document notice to employee of ASC's concerns
  - Expectation of fairness & due process
  - Even if employment agreement does not mandate
  - Juries will still expect notice & opportunity to cure
- Dispute likely, so must document ASC's view of what occurred
  - Juries expect employers to keep records of employee issues
  - Absence of records leads to conclusion that claimed event is pretextual; will impede ASC's ability to defend

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Discipline & Termination: Get Help Early On

- When a problem arises: Consult experienced counsel (employment law) early on to:
  - Plan strategy
  - Identify options
  - Identify risks
- Best investment: understand land mines ahead

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Conclusion

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Conclusion

- There's a lot to know
- Don't expect to know it all
- Understand the scope of your duties as a Medical Director
- If you have any responsibility for HR matters, identify the ASC staff who will work with you on HR matters
- Document concerns and be fair in implementation of policies
- Get legal help early on

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