SAAA
Society of Academic Anesthesiology Associations





SAAA 2012 Annual Meeting

November 2-3, 2012 ♦ Hyatt Regency San Francisco ♦ San Francisco, CA

American Society of Anesthesiologists

Jointly sponsored by the American Society of Anesthesiologists (ASA) and Society of Academic Anesthesia Associations (SAAA).

Table of Contents

Program Information

Faculty

Faculty Disclosures

Officers

SAAA Council Members
AAAC Council Members
AACPD Council Members
AASPD Council Members

Membership Application

AAAC Membership Application
AACPD Membership Application
AASPD Membership Application

Membership Lists

AAAC Members
(Alphbetical by last name)
(Alphbetical by institution)
AACPD Members
(Alphbetical by last name)
(Alphbetical by institution)
AASPD Members
(Alphbetical by last name)
(Alphbetical by institution)
(Alphbetical by subspecialty)

RRC Consultation

Future Meetings

Program Schedule

Presentations
Friday
• AAAC
• AACPD
• AASPD
Saturday

Program *Information*

Jointly sponsored by:

American Society of Anesthesiologists

and

SAAA

Registration Information

The registration fee for the SAAA 2012 Annual Meeting includes the course syllabus, all educational presentations, coffee breaks, lunches, and Saturday reception. Registrations that are either faxed, mailed, or made via the website to the SAAA office must be received by October 1st. After October 1st, only late registration fees will be applied.

About This Meeting

Topics for this meeting were selected by various methods. Suggestions for topics were derived from evaluations of the 2011 and other previous Annual Meeting Council members, the membership at large, reviews of the published literature with the highest impact on the anesthesia specialty.

These suggestions were discussed by our authorities in the field of anesthesia education or previous meetings.

The purpose of this Annual Meeting is to educate and share information that will enable academic anesthesia departments to improve management and care.

Target Audience

This meeting is designed for anesthesiologists in Chair, Core Program and Subspecialty Program Director positions. Members may invite physician and non-physician guests for whom separate registration rates are available. The program is designed to present and discuss areas of topical interest to attendees in keeping with our collective attempt to improve academic department's structure, function and the educational programs associated with academic learning.

CME Accreditation

This activity has been planned and implemented in accordance with the essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the American Society of Anesthesiologists and the Society of Academic Anesthesia Associations. 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 *11.50 AMA PRA Category 1 Credit(s)*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This meeting will provide:

- Institutional resources to support the educational, research and clinical missions essential to the day to day management of a successful academic anesthesiology department.
- Solutions to challenges in educating the next generation of trainees on issues of interpersonal communication skills, professionalism and systems-based practice.
- Ideas to design new modalities to incentivize their faculty to become best performers in fulfilling the educational and/or research missions of a successful anesthesiology department.

Meeting Objectives:

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

- Repeat and interpret new and current regulatory and management information.
- Translate current and future state of departmental and healthcare financing.
- Analyze future trends in anesthesiology training.
- Renew and describe evaluations and methods to handle anesthesia faculty.

Disclaimer

The information provided at the above CME activities is for continuing medical education purposes only and is not meant to substitute for the independent medical judgment of a physician relative to diagnostic and treatment options of a specific patient's medical condition.

Disclosure

The American Society of Anesthesiologists and the Society of Academic Anesthesia Associations adheres to ACCME Essential Areas, Standards, and Policies regarding industry support of continuing medical education. Disclosure of the planning committee and faculty's commercial relationships will be made known at the activity. Faculty are required to openly disclose and limitations of data and/or any discussion of any off label, experimental, or investigational uses of drugs or devices in their presentations.

In accordance with the ACCME Standards for Commercial Support of CME, the American Society of Anesthesiologists will implement mechanisms, prior to the planning and implementation of this CME activity, to identify and resolve conflicts of interest for all individuals in a position to control content of this CME activity.

Special Needs

SAAA is committed to making its activities accessible to all individuals. If you are in need of an accommodation, please do not hesitate to call and/or submit a description of your needs in writing in order to receive service.

Faculty

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SAAA adheres to ACCME Essential Areas and Policies regarding industry support of continuing medical education. Disclosure of faculty and commercial relationships will be made known at the activity. Speakers are also expected to openly disclose any discussion of off-label, experimental or investigational uses of drugs or devices in their presentations.

Key

1 Salary
2 Ownership
3 Royalties
4 Equity Position
5 Stock Options
6 Funded Research
7 Consulting Fees
8 Honoraria
9 Other Material Support

SAAA Annual Meeting faculty who made proper disclosure with no financial relationships to disclose:

Faculty	Disclosure	Notes
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John Allyn, M.D.	2	Spectrum Medical Group - FIDES
Steven J. Barker, Ph.D., M.D.	5	Masimo, Inc.
Deborah J. Culley, M.D.	8	American Board of Anesthesiology
Mervyn Maze, M.D.	6	Air Products
Theodore J. Sanford, Jr., M.D.	6	Medsleuth
Stanley W. Stead, M.D., M.B.A.	1,2,4	Stead Health Group, Inc.

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APPLICATION AAAC MEMBERSHIP FOR 2013
Departmental Dues Amount: $775

Note each department will pay dues, only once to SAAA, Society of Academic Anesthesia Associations. Applications must be filled out to register for the AAAC if you are a Chair (this form), or AACPD if you are a Program Director (AACPD form).

Please make check payable to:
Society of Academic Anesthesiology Associations (SAAA)
Application and Applicable Payment is requested by June 30, 2013.
Please complete the following contact information:

Name: _____

Title: _____ Institution: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone: _____ Fax: _____

Email: _____

☐ Department has paid dues for SAAA this year (formerly SAAC/AAPD)
☐ Department has not paid dues for SAAA this year and I have enclosed payment to SAAA.

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520 N. Northwest Highway
Park Ridge, IL 60068-2573
Fax: (847) 825-5658
Telephone: (847) 825-5586

APPLICATION FOR AACPD MEMBERSHIP FOR 2013
Departmental Dues Amount: $775

Note each department will pay dues, only once to SAAA, Society of Academic Anesthesia Associations. Applications must be filled out to register for the AAAC if you are a Chair, Or AACPD (this form) if you are a Program Director.

Please make check payable to:
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Application and Applicable Payment is requested by June 30, 2013.
Please complete the following contact information:

Name: _____

Title: _____ Institution: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone: _____ Fax: _____

Email: _____

- ☐ Department has paid dues for SAAA this year (formerly SAAC/AAPD)
- ☐ Department has not paid dues for SAAA this year and I have enclosed payment to SAAA.

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APPLICATION FOR AASPD MEMBERSHIP FOR 2013

Please complete the following contact information:

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ACGME Approved Subspecialty Program – MUST be completed

☐ Pain Medicine ☐ Adult Cardiothoracic Anesthesiology

☐ Critical Care Medicine ☐ Pediatric Anesthesiology

Title: _____ Institution: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone: _____ Fax: _____

Email: _____

☐ Anesthesiology Chair to whom you report: _____

☐ I do not report to an anesthesiology chair**

PAYMENT INFORMATION**

Departmental Dues Amount: $775

Please make check payable to: *Society of Academic Anesthesiology Associations (SAAA)*

Application and Payment (if required) is received by June 30, 2013.

Note each integrated department will pay dues, only once to SAAA, Society of Academic Anesthesia Associations. Applications must be filled out to register for the AAAC if you are an academic Chair, or AASPD (this form) if you are a Subspecialty Program Director that does not report to an academic chair. If you do not directly report to an anesthesiology chair, please complete payment information below and provide a dues payment of $220.

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City: _____ State: _____ ZIP Code: _____

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Gary J. Brenner, M.D., Ph.D.	Massachusetts General Hospital	Pain Medicine
Charles W. Brock, M.D.	University of South Florida Department of Anesthesiology	Pain Medicine
Matthew D. Caldwell, M.D.	University of Michigan Cardiovascular Center	Adult Cardiothoracic Anesthesia
Michelle Capdeville, M.D.	Cleveland Clinic	Adult Cardiothoracic Anesthesia
Mark A. Chaney, M.D.	University of Chicago	Adult Cardiothoracic Anesthesia
Grace Chen, M.D.	OHSU Department of Anesthesiology	Pain Medicine
Albert T. Cheung, M.D.	University of Pennsylvania	Adult Cardiothoracic Anesthesia
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Ira Todd Cohen, M.D., M.Ed.	Children's National Medical Center	Pediatric Anesthesiology
Marco Corridore, M.D.	Nationwide Children's Hospital	Pediatric Anesthesiology
William C. Culp, Jr., M.D.	Scott & White Hospital	Adult Cardiothoracic Anesthesia
Sukdeb Datta, M.D.	New Jersey Spine and Rehabilitation	Pain Medicine
Miles R. Day, M.D.	Texas Tech University Health Sciences Center	Pain Medicine
Oscar A. De Leon-Casasola, M.D.	Roswell Park Cancer Institute	Pain Medicine
Steven A. Deem, M.D.	University of Washington - Harborview Medical Center	Critical Care Medicine
Galina T. Dimitrova, M.D.	Ohio State University	Adult Cardiothoracic Anesthesia
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Sylvia Y. Dolinski, M.D.	Medical College of Wisconsin - Froedtert Memorial	Critical Care Medicine
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Michael P. Eaton, M.D.	Strong Memorial Hospital, University of Roch	Adult Cardiothoracic
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Khaldoun Faris, M.D.	University of Massachusetts Medical School	Critical Care Medicine
F. Michael Ferrante, M.D.	Ferrante & Associates	Pain Medicine
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Louise Furukawa, M.D.	Stanford University School of Medicine	Pediatric Anesthesiology
Naveen Gandreti, M.D.	Henry Ford Hospital Department of Anesthesiology	Adult Cardiothoracic
Frederic Gerges, M.D.	St. Elizabeth's Medical Center	Pain Medicine
Steven H Ginsberg, M.D.	UMDNJ Anesthesia	Adult Cardiothoracic Anesthesia
Nancy Glass, M.D., M.B.A.	Baylor College of Medicine	Pediatric Anesthesiology
Kurt W. Grathwohl, M.D.	San Antonio Uniformed Services Health Education Consortium	Critical Care Medicine
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Salim M. Hayek, M.D., Ph.D.	University Hospitals of Cleveland	Pain Medicine
Frederick A. Hensley, M.D.	University of Alabama at Birmingham	Adult Cardiothoracic Anesthesia
Shanna S. Hill, M.D.	NY Presbyterian Hospital, Cornell Campus	Adult Cardiothoracic Anesthesia
Bryan Hoelzer, M.D.	Mayo School of Graduate Medical Education	Pain Medicine
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Clarence S. Ivie, III, D.O.	Fletcher Allen Health Care	Pain Medicine
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Tabitha A. Washington, M.D.	Dartmouth Hitchcock Medical Center	Pain Medicine
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Michael L. Weinberger, M.D.	New York Presbyterian Hospital, Columbia	Pain Medicine
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Cynthia A. Wong, M.D.	Northwestern University	Obstetric Anesthesiology
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Saleem A. Zaidi, M.D.	Methodist Hospital	Critical Care Medicine
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David Geffen School of Medicine UCLA	F. Michael Ferrante, M.D.	Pain Medicine
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Duke University Medical Center	Christopher Young, M.D.	Critical Care Medicine
Duke University Medical Center	David R. Lindsay, M.D.	Pain Medicine
Duke University Medical Center	B. Craig Weldon, M.D.	Pediatric Anesthesiology
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George Washington University Program	Ira Todd Cohen, M.D., M.Ed.	Pediatric Anesthesiology
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Johns Hopkins Hospital	Dolores B. Njoku, M.D.	Pediatric Anesthesiology
Loma Linda University	Linda J. Mason, M.D.	Pediatric Anesthesiology
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Mayo School of Graduate Medical Education	Bryan Hoelzer, M.D.	Pain Medicine
Mayo School of Graduate Medical Education	Christina M. Pabelick, M.D.	Pediatric Anesthesiology
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Medical University of South Carolina	James H. Abernathy, III, M.D., M.P.H.	Adult Cardiothoracic Anesthesia
Mount Sinai School of Medicine	Marc Stone, M.D.	Adult Cardiothoracic Anesthesia
Mount Sinai School of Medicine	Andrew B. Leibowitz, M.D.	Critical Care Medicine
Mount Sinai School of Medicine	Stelian I. Serban, M.D.	Pain Medicine
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St Elizabeth's Medical Center	Frederic Gerges, M.D.	Pain Medicine
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Stanford University Medical Center	Frederick G. Mihm, M.D.	Critical Care Medicine
Stanford University Medical Center	Sean C. Mackey, M.D., Ph.D.	Pain Medicine

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University of California, San Fran	Pamela Flood, M.D.	Obstetric Anesthesiology
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University of Florida Medical Center	Abraham Layon, M.D.	Critical Care Medicine
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University of Louisville Hospital	Sujittra Tongprasert, M.D.	Pain Medicine
University of Maryland School of Medicine	Wendy K. Bernstein, M.D.	Adult Cardiothoracic Anesthesia
University of Maryland School of Medicine	Vadivelu Sivaraman, M.B.,B.S.	Critical Care Medicine
University of Maryland School of Medicine	Thelma B. Wright, M.D.	Pain Medicine
University of Massachusetts Medical School	Khaldoun Faris, M.D.	Critical Care Medicine
University of Miami School of Medicine	John C. Sciarra, M.D.	Adult Cardiothoracic Anesthesia
University of Miami School of Medicine	Ricardo Martinez-Ruiz, M.D.	Critical Care Medicine

University of Miami School of Medicine	William T. Peruzzi, M.D., FCCM	Critical Care Medicine
University of Miami School of Medicine	Constantine D. Sarantopoulos, M.D., Ph.D.	Pain Medicine
University of Miami School of Medicine	Jacqueline L. Tutiven, M.D.	Pediatric Anesthesiology
University of Michigan Health System	Matthew D. Caldwell, M.D.	Adult Cardiothoracic Anesthesia
University of Michigan Health System	James M. Blum, M.D.	Critical Care Medicine
University of Michigan Health System	Srinivas Chiravuri, M.B.,B.S.	Pain Medicine
University of Michigan Health System	Suvarchala D. Chiravuri, M.D.	Pediatric Anesthesiology
University of Minnesota	Ioanna Apostolidou, M.D.	Adult Cardiothoracic Anesthesia
University of New Mexico School of Medicine	Eugene Koshkin, M.D.	Pain Medicine
University of New Mexico School of Medicine	Joyce F. Phillips, M.D.	Pediatric Anesthesiology
University of North Carolina Hospital	William S. Blau, M.D., Ph.D.	Pain Medicine
University of North Carolina Hospital	Robert D. Valley, M.D.	Pediatric Anesthesiology
University of Pennsylvania	Albert T. Cheung, M.D.	Adult Cardiothoracic Anesthesia
University of Pennsylvania	Benjamin A. Kohl, M.D., FCCM	Critical Care Medicine
University of Pennsylvania	Alan Jay Schwartz, M.D., M.S.	Pediatric Anesthesiology
University of Pittsburgh Medical Center	Erin Sullivan, M.D.	Adult Cardiothoracic Anesthesia
University of Pittsburgh Medical Center	Ata M. Kaynar, M.D.	Critical Care Medicine
University of Pittsburgh Medical Center	Nashaat N. Rizk, M.D.	Obstetric Anesthesiology
University of Pittsburgh Medical Center	Doris K. Cope, M.D., M.S.	Pain Medicine
University of Pittsburgh Medical Center	Franklyn P. Cladis, M.D.	Pediatric Anesthesiology
University of South Florida	Charles W. Brock, M.D.	Pain Medicine
University of Southern California	Steven M. Haddy, M.D.	Adult Cardiothoracic Anesthesia
University of Southern California	Samuel Yanofsky, M.D., M.Ed.	Pediatric Anesthesiology
University of Texas Med Branch Hospital	Christopher McQuitty, M.D.	Adult Cardiothoracic Anesthesia
University of Texas Med Branch Hospital	Aristides Koutrouvelis, M.D.	Critical Care Medicine
University of Texas Med Branch Hospital	Gulshan Doulatram, M.D.	Pain Medicine
University of Texas Med Branch Hospital	Adolph J. Koska, M.D., Ph.D.	Pediatric Anesthesiology
University of Texas Medical School, Houston	Roy Sheinbaum, M.D.	Adult Cardiothoracic Anesthesia
University of Texas Medical School, Houston	Saleem A. Zaidi, M.D.	Critical Care Medicine
University of Texas Medical School, Houston	Krishna Boddu, M.D., M.B.,B.S.	Pain Medicine
University of Texas Medical School, Houston	Maria E. Matuszczak, M.D.	Pediatric Anesthesiology
University of Washington Medical Center	Steven A. Deem, M.D.	Critical Care Medicine
University of Washington Medical Center	Andrea Trescot, M.D.	Pain Medicine
University of Washington Medical Center	Michael J. Richards, M.B.,B.S.	Pediatric Anesthesiology
University Oklahoma Health Science Center	Gretchen M. Wienecke, M.D.	Pain Medicine
University Oklahoma Health Science Center	Mohanad Shukry, M.D.	Pediatric Anesthesiology
University Texas Health Science Center San Antonio	Steven G. Venticinque, M.D.	Critical Care Medicine
University Texas Southwestern Med Ct	Adebola O. Adesanya, M.B.,B.S.	Critical Care Medicine
University Texas Southwestern Med Ct	Chandramouli P. Iyer, M.D., M.S.	Pain Medicine
University Texas Southwestern Med Ct	Jeffrey W. Steiner, D.O.	Pediatric Anesthesiology
University Texas Southwestern Medical Center	Philip E. Greilich, M.D.	Adult Cardiothoracic Anesthesia
University Virginia Health System	Kevin Vorenkamp, M.D.	Pain Medicine
Vanderbilt University Medical Center	Annemarie Thompson, M.D.	Adult Cardiothoracic Anesthesia
Vanderbilt University Medical Center	Liza M. Weavind, M.B.,B.Ch.	Critical Care Medicine
Vanderbilt University Medical Center	Sukdeb Datta, M.D.	Pain Medicine
Vanderbilt University Medical Center	Ira S. Landsman, M.D.	Pediatric Anesthesiology
Virginia Commonwealth University	Jeffrey Green, M.D.	Adult Cardiothoracic Anesthesia
Virginia Commonwealth University	Maged S. Hamza, M.D., M.B.,B.S.	Pain Medicine
Virginia Mason Medical Center	Daniel T. Warren, M.D.	Pain Medicine

Wake Forest University School of Medicine	Thomas F. Slaughter, M.D.	Adult Cardiothoracic Anesthesia
Wake Forest University School of Medicine	William R. Andrews, M.D.	Critical Care Medicine
Washington University St. Louis	Anshuman Sharma, M.D.	Pediatric Anesthesiology
Wayne State University	Todd E. Lininger, M.D.	Pain Medicine
Wayne State University	Maria M. Zestos, M.D.	Pediatric Anesthesiology
Western Pennsylvania Hospital	Brenda MacKnight, M.D.	Adult Cardiothoracic Anesthesia
Western Pennsylvania Hospital	Abraham J. Kabazie, M.D.	Pain Medicine
Yale New Haven Medical Center	Raj K. Modak, M.D.	Adult Cardiothoracic Anesthesia
Yale New Haven Medical Center	Stanley H. Rosenbaum, M.D.	Critical Care Medicine
Yale New Haven Medical Center	J. Lance Lichtor, M.D.	Pediatric Anesthesiology

Membership
Lists

AASPD Members by Specialty

Adult Cardiothoracic Anesthesia	James H. Abernathy, III, M.D., M.P.H.	Medical University of South Carolina
Adult Cardiothoracic Anesthesia	James M. Anton, M.D.	Baylor College of Medicine
Adult Cardiothoracic Anesthesia	Ioanna Apostolidou, M.D.	University of Minnesota
Adult Cardiothoracic Anesthesia	Dalia Banks, M.D.	University of California, San Diego
Adult Cardiothoracic Anesthesia	Wendy K. Bernstein, M.D.	University of Maryland School of Medicine
Adult Cardiothoracic Anesthesia	Matthew D. Caldwell, M.D.	University of Michigan Health System
Adult Cardiothoracic Anesthesia	Michelle Capdeville, M.D.	Cleveland Clinic Foundation
Adult Cardiothoracic Anesthesia	Mark A. Chaney, M.D.	University of Chicago Hospital
Adult Cardiothoracic Anesthesia	Albert T. Cheung, M.D.	University of Pennsylvania
Adult Cardiothoracic Anesthesia	William C. Culp, Jr., M.D.	Scott & White Memorial Hospital
Adult Cardiothoracic Anesthesia	Galina T. Dimitrova, M.D.	Ohio State University Hospital
Adult Cardiothoracic Anesthesia	Michael P. Eaton, M.D.	Strong Memorial Hospital, University of Roch
Adult Cardiothoracic Anesthesia	Michael G. Fitzsimons, M.D.	Massachusetts General Hospital
Adult Cardiothoracic Anesthesia	Naveen Gandreti, M.D.	Henry Ford Health System
Adult Cardiothoracic Anesthesia	Steven H. Ginsberg, M.D.	UMDNJ-Robert W Johnson Medical School
Adult Cardiothoracic Anesthesia	Jeffrey Green, M.D.	Virginia Commonwealth University
Adult Cardiothoracic Anesthesia	Philip E. Greilich, M.D.	University Texas Southwestern Medical Center
Adult Cardiothoracic Anesthesia	Steven M. Haddy, M.D.	University of Southern California
Adult Cardiothoracic Anesthesia	Frederick A. Hensley, M.D.	University of Alabama at Birmingham
Adult Cardiothoracic Anesthesia	Shanna S. Hill, M.D.	New York Pres-Weill Cornell
Adult Cardiothoracic Anesthesia	Robert P. Hunsaker, M.D.	St Elizabeth's Medical Center
Adult Cardiothoracic Anesthesia	Pierre T. Levan, M.D.	Loyola University Medical Center
Adult Cardiothoracic Anesthesia	Brenda MacKnight, M.D.	Western Pennsylvania Hospital
Adult Cardiothoracic Anesthesia	Aman Mahajan, M.D., Ph.D.	David Geffen School of Medicine UCLA
Adult Cardiothoracic Anesthesia	Christopher McQuitty, M.D.	University of Texas Med Branch Hospital
Adult Cardiothoracic Anesthesia	Nanhi R. Mitter, M.D.	Johns Hopkins Hospital
Adult Cardiothoracic Anesthesia	Raj K. Modak, M.D.	Yale New Haven Medical Center
Adult Cardiothoracic Anesthesia	Christina T. Mora Mangano, M.D.	Stanford University Medical Center
Adult Cardiothoracic Anesthesia	Nader D. Nader, M.D., Ph.D.	Suny at Buffalo
Adult Cardiothoracic Anesthesia	Yong G. Peng, M.D.	University of Florida Medical Center
Adult Cardiothoracic Anesthesia	Ferenc Puskas, M.D.	University of Colorado, Denver
Adult Cardiothoracic Anesthesia	John C. Sciarra, M.D.	University of Miami School of Medicine
Adult Cardiothoracic Anesthesia	Valerie A. Sera, M.D., D.D.S.	Oregon Health & Science University
Adult Cardiothoracic Anesthesia	Jack S. Shanewise, M.D.	New York Pres Hospital, Columbia
Adult Cardiothoracic Anesthesia	Roy Sheinbaum, M.D.	University of Texas Medical School, Houston
Adult Cardiothoracic Anesthesia	Douglas C. Shook, M.D.	Brigham & Women's Hospital
Adult Cardiothoracic Anesthesia	Linda Shore-Lesserson, M.D.	Albert Einstein/Montefiore
Adult Cardiothoracic Anesthesia	Thomas F. Slaughter, M.D.	Wake Forest University School of Medicine
Adult Cardiothoracic Anesthesia	Roman Sniecinski, M.D.	Emory University School of Medicine
Adult Cardiothoracic Anesthesia	Wayne Soong, M.D.	NW University Feinberg School of Medicine

Adult Cardiothoracic Anesthesia	Mark Stafford-Smith, M.D.	Duke University Medical Center
Adult Cardiothoracic Anesthesia	Marc Stone, M.D.	Mount Sinai School of Medicine
Adult Cardiothoracic Anesthesia	Erin Sullivan, M.D.	University of Pittsburgh Medical Center
Adult Cardiothoracic Anesthesia	Sugantha Sundar, M.D.	Beth Israel Deaconess Medical Center
Adult Cardiothoracic Anesthesia	Annemarie Thompson, M.D.	Vanderbilt University Medical Center
Adult Cardiothoracic Anesthesia	Kevin C. Thornton, M.D.	University of California, San Fran
Adult Cardiothoracic Anesthesia	Aubrey Yao, M.D.	University California Medical Center- Davis
Critical Care Medicine	Adebola O. Adesanya, M.B.,B.S.	University Texas Southwestern Med Ct
Critical Care Medicine	William R. Andrews, M.D.	Wake Forest University School of Medicine
Critical Care Medicine	Michael L. Ault, M.D.	NW University Feinberg School of Medicine
Critical Care Medicine	Edward Bittner, M.D., Ph.D.	Massachusetts General Hospital
Critical Care Medicine	James M. Blum, M.D.	University of Michigan Health System
Critical Care Medicine	Steven A. Deem, M.D.	University of Washington Medical Center
Critical Care Medicine	Sylvia Y. Dolinski, M.D.	Med College of Wisconsin
Critical Care Medicine	T. Miko Enomoto, M.D.	Oregon Health & Science University
Critical Care Medicine	Khaldoun Faris, M.D.	University of Massachusetts Medical School
Critical Care Medicine	Larry C. Field, M.D.	Med University of South Carolina
Critical Care Medicine	Kurt W. Grathwohl, M.D.	SAUSHEL
Critical Care Medicine	Theresa L. Hartsell, M.D., Ph.D.	Johns Hopkins Hospital
Critical Care Medicine	Christopher D. Junker, M.D.	George Washington University Hospital
Critical Care Medicine	Ata M. Kaynar, M.D.	University of Pittsburgh Medical Center
Critical Care Medicine	John C. Klick, M.D.	University Hospital Cleveland-Case Western
Critical Care Medicine	Benjamin A. Kohl, M.D., FCCM	University of Pennsylvania
Critical Care Medicine	Aristides Koutrouvelis, M.D.	University of Texas Med Branch Hospital
Critical Care Medicine	Abraham Layon, M.D.	University of Florida Medical Center
Critical Care Medicine	Andrew B. Leibowitz, M.D.	Mount Sinai School of Medicine
Critical Care Medicine	Linda L. Liu, M.D.	University of California, San Fran
Critical Care Medicine	Ricardo Martinez-Ruiz, M.D.	University of Miami School of Medicine
Critical Care Medicine	Frederick G. Mihm, M.D.	Stanford University Medical Center
Critical Care Medicine	Michael F. O'Connor, M.D., FCCM	University of Chicago Hospital
Critical Care Medicine	James A. Onigkeit, M.D.	Mayo School of Graduate Medical Education
Critical Care Medicine	James A. Osorio, M.D.	New York Pres-Weill Cornell
Critical Care Medicine	Peter J. Papadakos, M.D.	Strong Memorial Hospital, University of Roch
Critical Care Medicine	Thomas J. Papadimos, M.D.	Ohio State University Hospital
Critical Care Medicine	William T. Peruzzi, M.D., FCCM	University of Miami School of Medicine
Critical Care Medicine	Marc Popovich, M.D.	Cleveland Clinic Foundation
Critical Care Medicine	James G. Ramsay, M.D.	Emory University School of Medicine
Critical Care Medicine	Athos J. Rassias, M.D.	Dartmouth Hitchcock Medical Center
Critical Care Medicine	Stanley H. Rosenbaum, M.D.	Yale New Haven Medical Center
Critical Care Medicine	Nicholas Sadovnikoff, M.D.	Brigham & Women's Hospital
Critical Care Medicine	Todd Sarge, M.D.	Beth Israel Deaconess Medical Center
Critical Care Medicine	Vadivelu Sivaraman, M.B.,B.S.	University of Maryland School of Medicine
Critical Care Medicine	Robert N. Sladen, M.B.,Ch.B., FCCM	New York Pres Hospital, Columbia
Critical Care Medicine	Steven G. Venticinque, M.D.	University Texas Health Science Center San Antonio
Critical Care Medicine	Liza M. Weavind, M.B.,B.Ch.	Vanderbilt University Medical Center
Critical Care Medicine	Samrat H. Worah, M.D.	Suny Downstate Medical Center
Critical Care Medicine	Christopher Young, M.D.	Duke University Medical Center
Critical Care Medicine	Saleem A. Zaidi, M.D.	University of Texas Medical School, Houston

Obstetric Anesthesiology	Pamela Flood, M.D.	University of California, San Fran
Obstetric Anesthesiology	Nashaat N. Rizk, M.D.	University of Pittsburgh Medical Center
Obstetric Anesthesiology	Richard M. Smiley, M.D., Ph.D.	New York Pres Hospital, Columbia
Obstetric Anesthesiology	Cynthia A. Wong, M.D.	NW University Feinberg School of Medicine
Pain Medicine	Magdalena Anitescu, M.D.	University of Chicago Hospital
Pain Medicine	William S. Blau, M.D., Ph.D.	University of North Carolina Hospital
Pain Medicine	Krishna Boddu, M.D., M.B.,B.S.	University of Texas Medical School, Houston
Pain Medicine	Gary J. Brenner, M.D., Ph.D.	Massachusetts General Hospital
Pain Medicine	Charles W. Brock, M.D.	University of South Florida
Pain Medicine	Grace Chen, M.D.	Oregon Health & Science University
Pain Medicine	Srinivas Chiravuri, M.B.,B.S.	University of Michigan Health System
Pain Medicine	Doris K. Cope, M.D., M.S.	University of Pittsburgh Medical Center
Pain Medicine	Sukdeb Datta, M.D.	Vanderbilt University Medical Center
Pain Medicine	Miles R. Day, M.D.	Texas Tech University Lubbock
Pain Medicine	Oscar A. De Leon-Casasola, M.D.	Suny at Buffalo
Pain Medicine	Sudhir A. Diwan, M.D.	New York Pres-Weill Cornell
Pain Medicine	Gulshan Doulatram, M.D.	University of Texas Med Branch Hospital
Pain Medicine	Michael A. Erdek, M.D.	Johns Hopkins Hospital
Pain Medicine	F. Michael Ferrante, M.D.	David Geffen School of Medicine UCLA
Pain Medicine	Frederic Gerges, M.D.	St Elizabeth's Medical Center
Pain Medicine	William D. Hammonds, M.D.	Medical College of Georgia
Pain Medicine	Maged S. Hamza, M.D., M.B.,B.S.	Virginia Commonwealth University
Pain Medicine	Salim M. Hayek, M.D., Ph.D.	University Hospital Cleveland-Case Western
Pain Medicine	Bryan Hoelzer, M.D.	Mayo School of Graduate Medical Education
Pain Medicine	Robert W. Hurley, M.D., Ph.D.	University of Florida Medical Center
Pain Medicine	Clarence S. Ivie, III, D.O.	Fletcher Allen Health Care
Pain Medicine	Chandramouli P. Iyer, M.D., M.S.	University Texas Southwestern Med Ct
Pain Medicine	Abraham J. Kabazie, M.D.	Western Pennsylvania Hospital
Pain Medicine	Danielle Perret Karimi, M.D.	University of California, Irvine
Pain Medicine	Eugene Koshkin, M.D.	University of New Mexico School of Medicine
Pain Medicine	Henry R. Kroll, M.D.	Henry Ford Health System
Pain Medicine	Erin F. Lawson, M.D.	University of CA - San Diego Medical Center
Pain Medicine	David R. Lindsay, M.D.	Duke University Medical Center
Pain Medicine	Todd E. Lininger, M.D.	Wayne State University
Pain Medicine	Timothy R. Lubenow, M.D.	Rush University Medical Center
Pain Medicine	Sean C. Mackey, M.D., Ph.D.	Stanford University Medical Center
Pain Medicine	Gagan Mahajan, M.D.	University California Medical Center- Davis
Pain Medicine	Anne M. McKenzie-Brown, M.D.	Emory University School of Medicine
Pain Medicine	Jyotsna V. Nagda, M.D.	Beth Israel Deaconess Medical Center
Pain Medicine	Peter A. Nagi, M.D.	University of Alabama at Birmingham
Pain Medicine	Srdjan S. Nedeljkovic, M.D.	Brigham & Women's Hospital
Pain Medicine	Julie J. Niezgoda, M.D.	Cleveland Clinic Foundation
Pain Medicine	Michael Osborne, M.D.	Mayo Clinic Florida
Pain Medicine	George W. Pasvankas, M.D.	University of California, San Fran
Pain Medicine	Meda Raghavendra, M.D.	Loyola University Medical Center
Pain Medicine	Sarah E. Rebstock, M.D., Ph.D.	Penn State Milton S Hershey
Pain Medicine	Charles A. Roberts, M.D.	Louisiana St University Health Science Center

Pain Medicine	Constantine D. Sarantopoulos, M.D., Ph.D.	University of Miami School of Medicine
Pain Medicine	Stelian I. Serban, M.D.	Mount Sinai School of Medicine
Pain Medicine	Hariharan Shankar, M.B.,B.S.	Med College of Wisconsin
Pain Medicine	Paul Sloan, M.D.	University Kentucky Chandler Medical Center
Pain Medicine	Anshuman R. Swain, M.D.	Ohio State University Hospital
Pain Medicine	Donna-Ann M. Thomas, M.D.	Suny Upstate Med University
Pain Medicine	Sujittra Tongprasert, M.D.	University of Louisville Hospital
Pain Medicine	Maria D. Torres, M.D.	John H. Stroger Jr., Hospital
Pain Medicine	Andrea Trescot, M.D.	University of Washington Medical Center
Pain Medicine	Kevin Vorenkamp, M.D.	University Virginia Health System
Pain Medicine	Dennis L. Wagner, M.D.	Indiana University School of Medicine
Pain Medicine	David R. Walega, M.D.	NW University Feinberg School of Medicine
Pain Medicine	Mark S. Wallace, M.D.	University of California, San Diego
Pain Medicine	Dajie Wang, M.D.	Thomas Jefferson University Hospital
Pain Medicine	Daniel T. Warren, M.D.	Virginia Mason Medical Center
Pain Medicine	Tabitha A. Washington, M.D.	Dartmouth Hitchcock Medical Center
Pain Medicine	Michael L. Weinberger, M.D.	New York Pres Hospital, Columbia
Pain Medicine	Gretchen M. Wienecke, M.D.	University Oklahoma Health Science Center
Pain Medicine	Thelma B. Wright, M.D.	University of Maryland School of Medicine
Pediatric Anesthesiology	Rita Agarwal, M.D.	University of Colorado, Denver
Pediatric Anesthesiology	Jennifer P. Aunspaugh, M.D.	University of Arkansas for Medical Science
Pediatric Anesthesiology	Catherine R. Bachman, M.D.	University of Chicago Hospital
Pediatric Anesthesiology	Carolyn F. Bannister, M.D.	Emory University School of Medicine
Pediatric Anesthesiology	Suvarchala D. Chiravuri, M.D.	University of Michigan Health System
Pediatric Anesthesiology	Franklyn P. Cladis, M.D.	University of Pittsburgh Medical Center
Pediatric Anesthesiology	Ira Todd Cohen, M.D., M.Ed.	George Washington University Program
Pediatric Anesthesiology	Marco Corridore, M.D.	Nationwide Children's Hospital
Pediatric Anesthesiology	Louise Furukawa, M.D.	Stanford University Medical Center
Pediatric Anesthesiology	Nancy Glass, M.D., M.B.A.	Baylor College of Medicine
Pediatric Anesthesiology	Courtney Alan, Hardy M.D.	NW University Feinberg School of Medicine
Pediatric Anesthesiology	Aman Kalra, M.D.	Tufts-New England Medical Center
Pediatric Anesthesiology	Richard F. Kaplan, M.D.	Children's National Medical Center
Pediatric Anesthesiology	Adolph J. Koska, M.D., Ph.D.	University of Texas Med Branch Hospital
Pediatric Anesthesiology	Kirk Lalwani, M.D.	Oregon Health & Science University
Pediatric Anesthesiology	Cathleen R. Lammers, M.D.	University California Medical Center- Davis
Pediatric Anesthesiology	Ira S. Landsman, M.D.	Vanderbilt University Medical Center
Pediatric Anesthesiology	J. Lance Lichtor, M.D.	Yale New Haven Medical Center
Pediatric Anesthesiology	Linda J. Mason, M.D.	Loma Linda University
Pediatric Anesthesiology	Maria E. Matuszczak, M.D.	University of Texas Medical School, Houston
Pediatric Anesthesiology	Dolores B. Njoku, M.D.	Johns Hopkins Hospital
Pediatric Anesthesiology	Christina M. Pabelick, M.D.	Mayo School of Graduate Medical Education
Pediatric Anesthesiology	Joyce F. Phillips, M.D.	University of New Mexico School of Medicine
Pediatric Anesthesiology	Michael J. Richards, M.B.,B.S.	University of Washington Medical Center
Pediatric Anesthesiology	Stefanie F. Schrum, M.D.	Mayo Jacksonville
Pediatric Anesthesiology	Alan Jay Schwartz, M.D., M.S.	University of Pennsylvania
Pediatric Anesthesiology	Anshuman Sharma, M.D.	Washington University St. Louis
Pediatric Anesthesiology	Mohanad Shukry, M.D.	University Oklahoma Health Science Center
Pediatric Anesthesiology	Susan Staudt, M.D.	Med College of Wisconsin

Pediatric Anesthesiology	Jeffrey W. Steiner, D.O.	University Texas Southwestern Med Ct
Pediatric Anesthesiology	Lena S. Sun, M.D.	New York Pres Hospital, Columbia
Pediatric Anesthesiology	Rosalie F. Tassone, M.D., M.P.H.	University of Illinois Chicago
Pediatric Anesthesiology	Paul A. Tripi, M.D.	University Hospital Cleveland-Case Western
Pediatric Anesthesiology	Jacqueline L. Tutiven, M.D.	University of Miami School of Medicine
Pediatric Anesthesiology	Robert D. Valley, M.D.	University of North Carolina Hospital
Pediatric Anesthesiology	David B. Waisel, M.D.	Harvard Medical School Children's Hospital
Pediatric Anesthesiology	Scott G. Walker, M.D.	Indiana University School of Medicine
Pediatric Anesthesiology	Stacey A. Watt, M.D.	SUNY at Buffalo
Pediatric Anesthesiology	B. Craig Weldon, M.D.	Duke University Medical Center
Pediatric Anesthesiology	William C. Wilson, M.D.	University of California, San Diego
Pediatric Anesthesiology	Samuel Yanofsky, M.D., M.Ed.	University of Southern California
Pediatric Anesthesiology	Maria M. Zestos, M.D.	Wayne State University
Pediatric Anesthesiology	Maurice S. Zwass, M.D.	University of California, San Fran

RRC *Consultations*

Saturday, November 3
7:00-9:15 a.m.

Registration Required

The RRC for Anesthesiology will offer Core and Subspecialty program directors who attend the SAAA annual meeting a unique opportunity for one on one interaction with RRC members and staff to clarify questions, citations, etc., in a private setting.

Features of this program will be as follows:

- Individual private program guidance sessions with committee members and staff for RRC Anesthesiology. **These will be guidence sessions only and no entries will be made into the program's official files.**
- First-come, first-serve; programs to be notified of their date/time via email prior to arrival at the annual meeting.
- Sessions will each be 15 minutes in length.
- Only one session per program.
- Programs may take written notes but may **not** electronically record the session.
- ACGME staff will have on hand copies of Letters of Notification (LONs) and access to program files.
- The service will be provided solely for **Core and Subspecialty** program directors this year.
- Most sessions are expected to address issues such as understanding a citation, getting a sense of whether a proposal would be acceptable, etc.; it is expected that some questions may be very complex and would have to be researched and pursued later by staff.

Save These Dates

Future *Meetings*

Concurrent *Schedules*

Thursday, November 1

5:00 p.m. – 7:30 p.m. Annual Meeting Early Registration

Friday, November 2

7:30 a.m. - 6:00 p.m. Annual Meeting Registration

AAAC Concurrent Session - *Morning*

New Chairs Session
Moderator: Jeffrey R. Kirsch, M.D.

8:00 a.m. - 8:30 a.m. **Show Me the Money**
Michael K. Cahalan, M.D.

8:30 a.m. - 9:00 a.m. **Making Your Mark: Building an Infrastructure for Faculty Development and Interdisciplinary Care Improvement**
Brett A. Simon, M.D., Ph.D.

9:00 a.m. - 9:30 a.m. **Professionalism Program and the Disruptive Employee**
Krista M. Curell, Esq., RN

9:30 a.m. - 10:00 a.m. **Question and Answer Session**

10:00 a.m. - 10:30 a.m. **Coffee Break and Networking**

General Session: All Chair Session
Moderator: Berend Mets, M.B., Ch.B., Ph.D., FRCA, FFA(SA)

10:30 a.m. - 10:50 a.m. **Perfect Storm**
Kevin K. Tremper, M.D., Ph.D.

10:50 a.m. - 12:30 p.m. **Running a Successful Anesthesia Department**

10:50 a.m. - 11:25 a.m. **American Perspective**
Ronald G. Pearl, M.D., Ph.D.

11:25 a.m. - 12:00 p.m. **European/British Perspective**
Mervyn Maze, M.D.

12:00 p.m. - 12:30 p.m. **Canadian Perspective**
Davy Cheng, M.D., MSc., FRCPC, FCAHS

12:30 - 1:30 p.m. **Luncheon and Networking**

AAAC Concurrent Session - *Afternoon*

Manpower, CMS, Legal Issues
Moderator: Berend Mets, M.B., Ch.B., Ph.D., FRCA, FFA(SA)

1:30 p.m. - 2:00 p.m. **Developing a Staffing Plan for an Anesthesiology Department**
Amr E. Abouleish, M.D.

2:00 p.m. - 2:30 p.m. **CMS: Implementation of Interpretive Guidelines: Best Practices**
Norman A. Cohen, M.D.

2:30 p.m. - 3:00 p.m. **Case Based Scenarios**
Judith Semo, Esq.

3:00 p.m. - 3:30 p.m. **Coffee Break and Networking**

Value Based Purchasing and Ongoing Professional Practice Evaluation
Moderator: Berend Mets, M.B., Ch.B., Ph.D., FRCA, FFA(SA)

3:30 p.m. - 4:00 p.m. **Value Based Purchasing**
Thomas F. Slaughter, M.D., M.H.A.

4:00 p.m. - 5:00 p.m. **Ongoing Professional Practice Evaluation**

4:00 p.m. - 4:20 p.m. **Painless OPPE: Leveraging Existing Quality Reports for Faculty Assessment**
David L. Reich, M.D.

4:20 p.m. - 4:40 p.m. **Inviting the Wolf to Dinner: How and Why Physician Performance Evaluations Must Include CRNA Input**
David A. Zvara, M.D.

4:40 p.m. - 5:00 p.m. **What REALLY Happens Inside the Principal's Office: Examples of the What, How and Who of FPPE from Multiple Institutions**
Warren S. Sandberg, M.D., Ph.D.

5:00 p.m. - 5:15 p.m. **Question and Answer Session**

5:15 p.m. - 6:00 p.m. **AAAC Business Meeting**
*AAAC Members Only

AAAC

Concurrent *Schedules*

Thursday, November 1

5:00 p.m. – 7:30 p.m. Annual Meeting Early Registration

Friday, November 2

7:30 a.m. - 6:00 p.m. Annual Meeting Registration

*Choose One Session

AACPD Concurrent Session - *Morning*

New CPD's Session*
Moderator: Catherine M. Kuhn, M.D.

8:00 a.m. - 8:30 a.m. **Job Description: What Your Mission/Charge Is**
Jeffrey S. Berger, M.D., M.B.A.

8:30 a.m. - 9:00 a.m. **Due Process and Correction Action**
Catherine M. Kuhn, M.D.

9:00 a.m. - 9:30 a.m. **Question and Answer Session**

Experienced CPD's Session*
Moderator: Joy L. Hawkins, M.D.

8:00 a.m. - 8:25 a.m. **Establishing Educational Research in Your Department**
Randall M. Schell, M.D., MACM

8:25 a.m. - 8:50 a.m. **Faculty Development in Education**
Manuel C. Pardo, Jr., M.D.

8:50 a.m. - 9:15 a.m. **Avoiding Burnout in Your Position**
Leila M. Pang, M.D.

9:15 a.m. - 9:30 a.m. **Question and Answer Session**

9:30 a.m. - 10:00 a.m. **Coffee Break**

All CPD's Session
Moderator: Karen J. Souter, M.D.

10:00 a.m. - 10:50 a.m. **Best Practices**
Harendra Arora, M.B.,B.S.; Peter M. Fleischut, M.D.; Mojca Remskar Konia, M.D.

10:50 a.m. - 11:00 a.m. **Question and Answer Session**

11:00 a.m. - 11:45 a.m. **Milestones**
Deborah J. Culley, M.D.

11:45 a.m. - 12:00 p.m. **Question and Answer Session**

12:00 - 1:30 p.m. **Luncheon and Networking**

AACPD Concurrent Session - *Afternoon*

Panel: Enhancing Your Residency Program
Moderator: Robert M. Craft, M.D.

1:30 p.m. - 1:55 p.m. **Incorporating a Global Health Rotation**
L. Jane Easdown, M.D.

1:55 p.m. - 2:20 p.m. **Developing a "Resident as Teacher" Rotation**
Jeffrey S. Berger, M.D., M.B.A.

2:20 p.m. - 2:45 p.m. **Using the Cloud and the Internet to Enhance Your Residency Program**
Larry Chu, M.D., M.S. (BCHM), M.S.

2:45 p.m. - 3:00 p.m. **Question and Answer Session**

3:00 p.m. - 3:30 p.m. **Coffee Break and Networking**

Panel: Challenges Facing Your Residency Program
Moderator: Theodore J. Sanford, Jr., M.D.

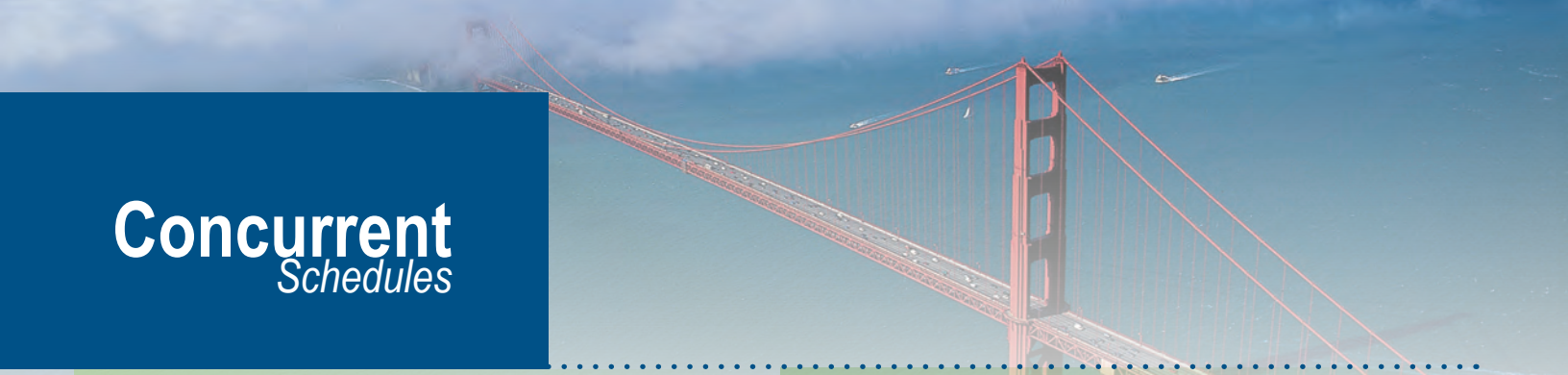
3:30 p.m. - 3:50 p.m. **Healthcare Reform and Funding for GME**
Theodore J. Sanford, Jr., M.D.

3:50 p.m. - 4:10 p.m. **SBP: Education Your Residents About the Survey and NAS**
Robert M. Craft, M.D.

4:10 p.m. - 4:30 p.m. **How To Cope With the 2 Part ABA Written Exam**
Catherine M. Kuhn, M.D.

4:30 p.m. - 5:00 p.m. **Question and Answer Session**

5:00 p.m. - 6:00 p.m. **AACPD Business Meeting**
*AACPD Members Only



Concurrent *Schedules*

Friday, November 2

7:30 a.m. - 6:00 p.m. Annual Meeting Registration

AASPD Concurrent Session - *Morning*

Moderator: Robert N. Sladen, M.B.Ch.B., F.C.C.M.

8:30 a.m. - 9:30 a.m.	**Innovative Programming**
8:30 a.m. - 8:40 a.m.	**The Critical Care Experience** Christopher E. Swide, M.D.
8:40 a.m. - 8:50 a.m.	**The Pain Proposal** Gary J. Brenner, M.D., Ph.D.
8:50 a.m. - 9:00 a.m.	**Advanced Curriculum Pediatric Anesthesia Training** Scott G. Walker, M.D.
9:00 a.m. - 9:10 a.m.	**The Apgar Scholars Program** Margaret Wood, M.B., Ch.B.
9:10 a.m. - 9:30 a.m.	**Question and Answer Session**
9:30 a.m. - 10:00 a.m.	**Update 2012: The New RRC Program Requirements**
9:30 a.m. - 9:40 a.m.	**Milestones Update** Linda J. Mason, M.D.
9:40 a.m. - 9:50 a.m.	**RRC Update** Margaret Wood, M.B., Ch.B.
9:50 a.m. - 10:00 a.m.	**Question and Answer Session**
10:00 a.m. - 10:30 a.m.	**Coffee Break and Networking**
10:30 a.m. - 11:15 a.m.	**New Kid on the Block: Hopes and Aspirations for the Newly Accredited Obstetric Anesthesiology Fellowship** Robert R. Gaiser, M.D.
11:15 a.m. - 12:00 p.m.	**How Do We Match Up? (Part 1)**
11:15 a.m. - 11:30 a.m.	**NRMP Representative** Mona M. Signer, M.P.H.
11:30 a.m. - 11:45 a.m.	**San Francisco Match** Jack Shanewise, M.D.
11:45 a.m. - 12:00 p.m.	**Question and Answer Session**
12:00 p.m. - 1:30 p.m.	**Luncheon and Networking or Program Director Lunches by Specialty*** **Subspecialty Program Directors will be contacted by their Specialty Director should a lunch be organized.*

AASPD Concurrent Session - *Afternoon*

1:30 p.m. - 3:00 p.m.	**Program Directors Break-Out: Focus: The Match *(Meetings by Specialty)***
	Pain Medicine Moderator: Gary J. Brenner, M.D., Ph.D.
	Critical Care Moderator: Benjamin A. Kohl, M.D., F.C.C.M.
	Pediatric Anesthesiology Moderator: Scott G. Walker, M.D.
	Adult Cardiothoracic Anesthesiology Moderator: Mark Stafford-Smith, M.D., C.M., FRCPC, F.A.S.E.
	Informal OB Anesthesia Breakout Session Moderator: Robert N. Sladen, M.B.Ch.B., FCCM
3:00 p.m. -3:30 p.m.	**Coffee Break and Networking**
3:30 p.m. - 4:30 p.m.	**Plenary Session: How Do We Match Up? (Part 2)** Moderators of Break Outs Report Back
	Pain Medicine Moderator: Gary J. Brenner, M.D., Ph.D.
	Critical Care Moderator: Benjamin A. Kohl, M.D., F.C.C.M.
	Pediatric Anesthesiology Moderator: Scott G. Walker, M.D.
	Adult Cardiothoracic Anesthesiology Moderator: Mark Stafford-Smith, M.D., C.M., FRCPC, F.A.S.E.
	Obstetric Anesthesia Moderator: Robert N. Sladen, M.B.Ch.B., FCCM
4:30 p.m. - 5:00 p.m.	**AASPD Business Meeting** *AASPD Members Only

AASPD

Program *Schedule*

Saturday, November 3

7:00 a.m. - 6:00 p.m.	**Registration**
7:00 a.m. - 9:15 a.m.	**RRC Consultations for AACPD and AASPD Members** Registration Closed
8:00 a.m. - 9:15 a.m.	**General Session 1: Developing a Quality Program in a Department of Anesthesiology: Two Approaches** Moderator: Berend Mets, M.B., Ch.B., Ph.D., FRCA, FFA(SA)
8:00 a.m. - 8:30 a.m.	**Approach 1** John Allyn, M.D.
8:30 a.m. - 9:00 a.m.	**Approach 2** Richard P. Dutton, M.D., M.B.A.
9:00 a.m. - 9:15 a.m.	**Question and Answer Session**
9:15 a.m. - 9:30 a.m.	**Coffee Break and Networking**
9:30 a.m. - 11:30 a.m.	**General Session 2: Succession Planning, Healthcare Reform, Digital Era** Moderator: Berend Mets, M.B., Ch.B., Ph.D., FRCA, FFA(SA)
9:30 a.m. - 10:15 a.m.	**Succession Planning**
9:30 a.m. - 9:45 a.m.	**Choosing and Mentoring a Prospective Chair** Raymond C. Roy, M.D., Ph.D.
9:45 a.m. - 10:00 a.m.	**Choosing and Mentoring a Prospective Program Director** Robert R. Gaiser, M.D.
10:00 a.m. - 10:15 a.m.	**Question and Answer Session**
10:15 a.m. - 10:45 a.m.	**Trends in Compliance Enforcement and Academia: Lessons Learned from Recent OIG, RAC, and CMS Contractor Audits** Stanley W. Stead, M.D., M.B.A.
10:45 a.m. - 11:15 a.m.	**Innovation and Transition to a Digital Era in Anesthesiology** David L. Reich, M.D.
11:15 a.m. - 11:30 a.m.	**Question and Answer Session**
11:30 a.m. - 12:30 p.m.	**General Session 3: Milestones Update and Questions** Moderator: Catherine M. Kuhn, M.D. Neal H. Cohen, M.D., M.P.H., M.S.; Lorraine C. Lewis, Ed.D., R.D.; Billy Hart
12:30 p.m. - 1:30 p.m.	**Luncheon and Networking**
1:30 p.m. - 3:00 p.m.	**General Session 4: Updates** Moderator: Berend Mets, M.B., Ch.B., Ph.D., FRCA, FFA(SA)
1:30 p.m. - 2:25 p.m.	**ACGME Update** Thomas J. Nasca, M.D., M.A.C.P.
2:25 p.m. - 3:00 p.m.	**RRC Updates** Margaret Wood, M.D., Ch.B.
3:00 p.m. - 3:20 p.m.	**Coffee Break and Networking**
3:20 p.m. - 6:00 p.m.	**General Session 5: Updates** Moderator: Jane C.K. Fitch, M.D.
3:20 p.m. - 4:00 p.m.	**ASA Update** Jane C.K. Fitch, M.D.
4:00 p.m. - 4:30 p.m.	**Update from SAAA Directors to ASA** Steven J. Barker, Ph.D., M.D.; Zeev Kain, M.D., M.B.A.
4:30 p.m. - 5:00 p.m.	**ABA Update** J. Jeffrey Andrews, M.D.
5:00 p.m. - 5:30 p.m.	**ITE Update** Cynthia Lien, M.D.
5:30 p.m. - 6:00 p.m.	**SAAA Business Meeting**
6:30 p.m. - 8:00 p.m.	**President's Reception**

AAAC
Concurrent Sessions

New Chairs Session
Moderator: Jeffrey R. Kirsch, M.D.

Show Me the Money
Michael K. Cahalan, M.D.

Making Your Mark: Building an Infrastructure for Faculty Development and Interdisciplinary Care Improvement
Brett A. Simon, M.D., Ph.D.

Professionalism Program and the Disruptive Employee
Krista M. Curell, Esq., RN

Show Me the Money

Michael K. Cahalan, M.D.

Notes: _____

Show Me the Money!

Michael K. Cahalan, MD
Professor and Chair
Department of Anesthesiology
University of Utah

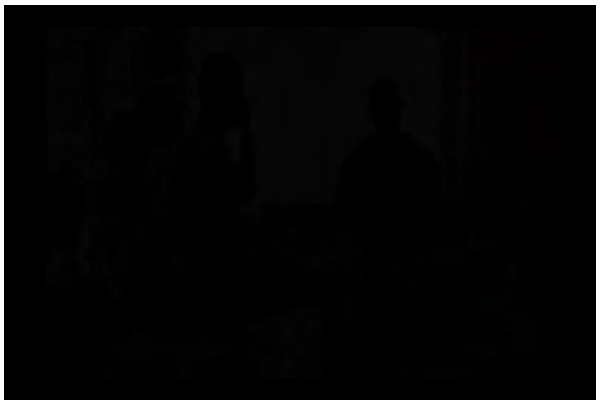
Lecture Objectives

- Fiscal competency & credibility
- Departmental accounting 101
- Billing & collections basics
- Good business practices & fraud

You are a CEO!

No Conflicts of Interest

New Chair Requesting Funding



If you have seen one academic department …

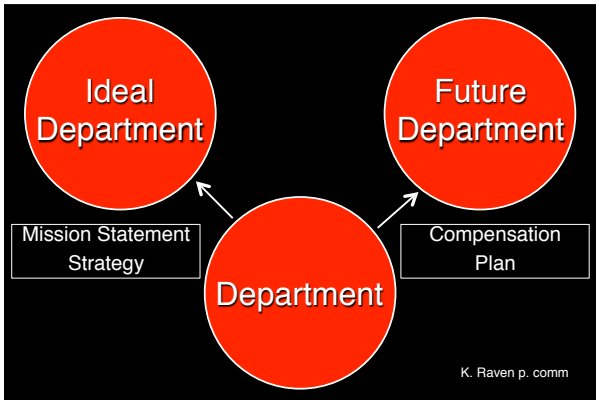
you have seen one academic department.

But …

Some Universal Facts

- Big money at stake ~$20-$100 million
- $120,000 institutional support/FTE*
- Health care expenditure under siege
- Uncertainty with insurance reform
- Greater demands for service

*Kheterpal: A&A 2011



Ideal Compensation Plan

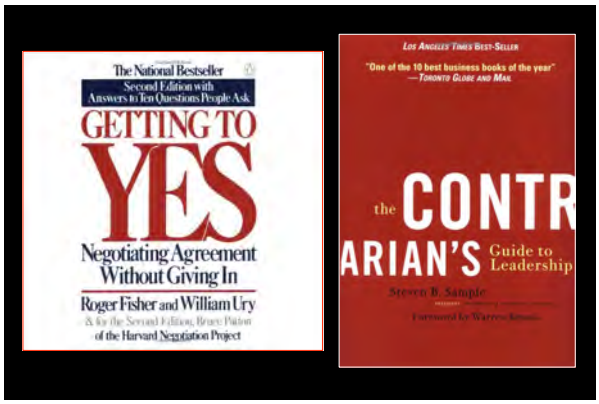
- Easy to understand
- Incents desired behavior
- Objective & consistent (fair)
- Transparent
- Market sensitive (AAMC, NIH)*

Fiscal Competency

- Money physiology
- Where does every $ come from?
- Where does every $ go?
- Are there $ left behind?
- Are the $ best spent?

Is your department a good value?

Fiscal Competency
↓
Credibility
↓
Negotiating Success



Core Principles

Objectivity

Consistency

Transparency

Accounting 101

- Cash vs. accrual: cash by account
- Profit and loss reports (annualized)
- Revenue must cover expenses
- Special deals aren't
- Bad news rarely gets better

Why Do You Cost So Much?

Benchmarking

- AAMC 2012 50th percentile salaries:
  - Instructor $298,920
  - Assistant Professor $323,300
  - Associate Professor $347,680
  - Professor $364,640

MGMA: 80% Clinical Commitment

Faculty Cost/OR

- 215 available workdays/yr
- 0.8 x 215 = 172 clinical days/yr
- Rank averaged salary $340,000
- 17% benefit costs $57,800
- 249/172 = 1.45 faculty/site

1.45 x ($397,800) = $576,810/OR

Benefits of Benchmarks

- National standards
- Easily available
- Fairness argument & perception
- BANTA resource – your red line

But …

OR Utilization

- 80% occupancy about "ideal" (7-3)
  - In room time during benchmark period
  - No credit for use at other times/give backs
- Units/hr OR, service & surgeon/OR (7-3)
- $/hr by service & surgeon/OR (7-3)
- $ & units/hr by service & surgeon (>3)
- $ & units/hr for call team nites & wkends

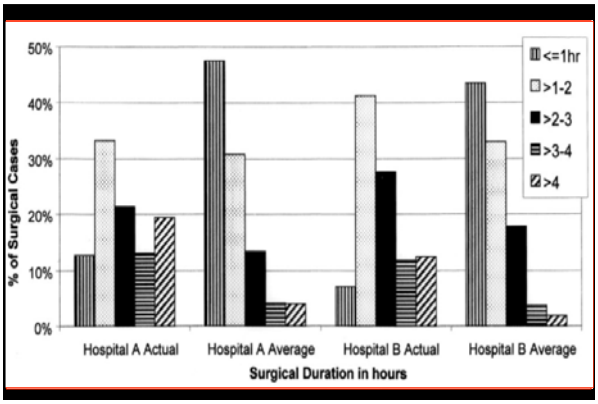
ECONOMICS

Anesthesiology 2004; 100:403-12

Quantifying Net Staffing Costs Due to Longer-than-average Surgical Case Durations

Amr E. Abouleish, M.D., M.B.A., Franklin Dexter, M.D., Ph.D.,† Charles W. Whitten, M.D.,‡ Jeffery R. Zavaleta, M.D.,§ Donald S. Prough, M.D.‖*

- CMS assigned time for CPT code vs. actual
- 1 yr data from 2 academic hospitals
- Additional costs $672,000 to $1,688,000



Financial Issues

Perspective: **Hospital Support for Anesthesiology Departments: Aligning Incentives and Improving Productivity**

Laureen L. Hill, MD, MBA, and Alex S. Evers, MD

Acad Med. 2012;87:348–355.

Risk sharing?

Medicare Inequities

- July 2007 GAO report:
  - Anesthesia paid 33% of market
  - Other physicians 80% of market
- 3 or 4 residents: payment decrease
- Bundling all services

Uniform % Medicare – No Go Zone

Billing & Collections Basics

Is every billable service billed?

Reconciliations

Surgery Schedule

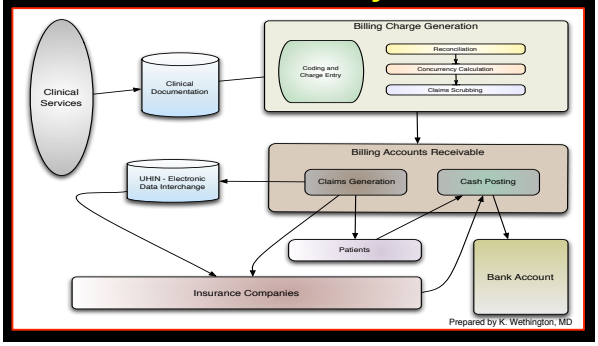
Anesthesia Records

Pharmacy Billings

Operative Notes

Procedure Notes

Revenue Cycle



Accounts Receivable (AR)

Billed amount:

✓not yet paid

✓not yet written off

Days in AR

Ratio: AR ÷ average daily collections

Reconciliations

Primary payment

Amount Billed

Co-insurance

Contractuals

Collections

Billing & Collections Report

- By provider, site, and service
  - Current, Δ, %FYTD, vs. Prior FYTD
- Payer metrics
  - Ditto plus AR, AR>120 days, AR days
  - Contract performance

Contracting Committee

Billing Performance

- Lag times: yours (3) & theirs (7-10)
- Collections: gross, net, to collections
- Rejections: causes and outcomes
- Costs: fixed or % collections
- AR days, aged AR, write offs

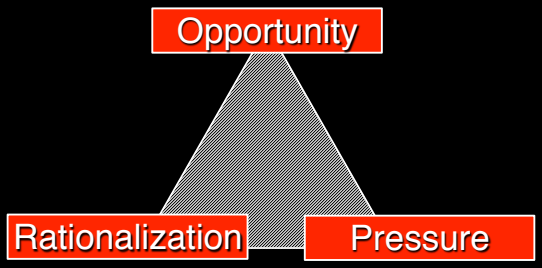
Billing &Collections

- Easiest place to lose money
- Best place to find money
- Easiest place to break the law
  - » Start and stop times
  - » Concurrency
  - » Modifiers

Good Business Practice & Fraud

Fraud

$ Fraud in Academics



Opportunity

- Access to:
  - ✓ Funds
  - ✓ Inventory
  - ✓ Transactions
  - ✓ Purchasing Cards

Examples

- Billing agent creates phony insurance companies – sends refunds to them.
- Purchasing agent buys computers & documents deliveries that never occurred.

Implications

- Loss of department resources
- Legal entanglements
- Prison time for perpetrator
- Department demoralization
- Loss of your business credibility
- Loss of your job

Good Business Practices

- University Policies & Procedures
- Separation of duties
- Reconciliation documentation:
  Orders, payments, deliveries
- Reporting system – shadow system
- Impromptu audits

Other Preventive Measures

- Leadership sets the tone
- Welcome inquires (40% tips)
- Financial transparency
- Cross training of personnel
- Document financial P&P

Summary

- Financial competency vital
- Benchmarking is your friend
- Financial reporting crucial
- Billing & collections best bet
- Fraud can be prevented

Fiscal Competency

↓

Credibility

↓

Negotiating Success

Core Principles

Objectivity

Consistency

Transparency

New Chair Concluding Negotiations


The End

Making Your Mark: Building an Infrastructure for Faculty Development and Interdisciplinary Care Improvement

Brett A. Simon, M.D., Ph.D.

Objectives

1. Describe common operational, political, and cultural challenges encountered by new academic anesthesiology chairs in the current environment of healthcare reform
2. Analyze the elements of a perioperative model designed to provide the infrastructure, capability, and agility to capitalize on new opportunities for change and improvement
3. Articulate ways to adapt and implement the model locally.

Making your Mark: Building an Infrastructure for Faculty Development and Interdisciplinary Care Improvement

SAAC 2012 Annual Meeting

Brett A. Simon, MD, PhD
Anesthetist-in-Chief, BIDMC
Edward Lowenstein Professor of Anaesthesia
Harvard Medical School

Disclosures

- I have no conflicts to disclose

Overview

- Anesthesia leadership
- Learning organizations
- Partnerships for Periop Performance Excellence "P^{3}E"
  - an infrastructure for interdisciplinary care improvement

Anesthesia Leadership in Quality Improvement

- We touch every aspect of the perioperative process
- Expertise
  - Quality and safety, efficiency, clinical care, patient experience, management, education
- Surgical home

Health Care Reform

- Improve quality
- Reduce cost
- Improve health

- Shift risk
- Reimburse results
- Reward performance

ACOs, risk contracts, global payments….

JAMA The Journal of the American Medical Association

Implementing Accountable Care Organizations
Ten Potential Mistakes and How to Learn From Them

Sara Singer, PhD, MBA
Stephen M. Shortell, PhD, MPH, MBA

JAMA 306: 758-9, 2011

- Overestimation of organizational capabilities
- Failure to balance interests and engage stakeholders
- Failure to recognize interdependencies

JAMA The Journal of the American Medical Association

Implementing Accountable Care Organizations
Ten Potential Mistakes and How to Learn From Them

Sara Singer, PhD, MBA
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JAMA 306: 758-9, 2011

- The way forward:
  - Measurement and Management
  - Adapt to local contexts
  - Promote "learning systems"
  - Mature performance measurement systems

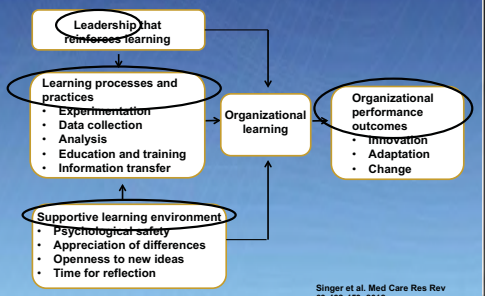
Become a learning organization…

Organizational Learning

A process by which outcomes, such as adaptation to change, greater understanding, or improved performance in groups and organizations can be achieved

Singer et al., Med Care Res Rev, 69: 432-59, 2012

Model for organizational learning and performance



Singer et al. Med Care Res Rev 69:432-459, 2012.

What are barriers to improving care?

- Communication
- Consensus
- Respect and collaboration
- **Time**

Solution: Carve out time for improvement - start the ORs 30 minutes later one day per week

---

P^3E

affords anesthesiologists, surgeons, nurses, and others the opportunity to meet at the start of the day once each week…

- to advance quality and outcomes for patients
- to accelerate learning and innovation
- to foster mutual joy in work

ALL HIGH-PERFORMING ORGANIZATIONS SET ASIDE TIME FOR LEARNING AND IMPROVEMENT

Each Tuesday…

- Start time for all operating rooms is moved forward by 30 minutes (8:00 a.m.)
- P3E: 6:45 – 7:30 a.m.
- This allows unopposed weekly 45-minute meetings for multiple groups.

Division Meetings
Staff Development
Chartered Teams

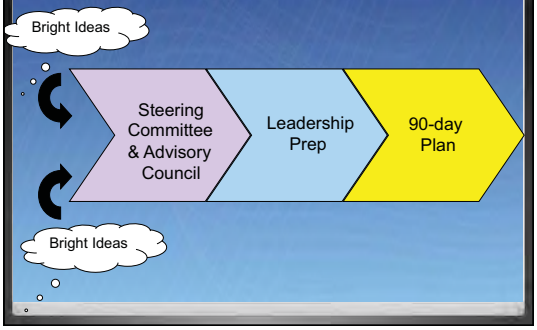
How it works:
Tuesdays in a 90-day Cycle by Week

	Month 1				Month 2				Month 3			
Interdisciplinary Chartered Teams	X	X	X	X	X	X	X	X	X	X	X	X
Interdisciplinary Division Meetings	X		X		X		X		X		X	
Faculty Development		X		X		X		X		X		
Quarterly Review												X

Balanced Scorecard

Adapted from Kaplan & Norton, Strategy Maps, 2004

Frontline staff drive P3E



Division Meetings
Staff Development
Chartered Teams

Single and Joint Division meetings

Division goals, measures, plans, and results are presented quarterly

Single and Joint Division Meetings

Examples:

- **Cardiac – standardized relaxant use and reduced mean time to extubation**
- **Neuro/Spine - created interdisciplinary OR handoff process**
- **OB – trained all faculty in ultrasound-guided TAP blocks**
- **SICU - Instituted 24/7 in-house coverage for optimal care around the clock**
- **Vascular - conducted TEE training for staff**

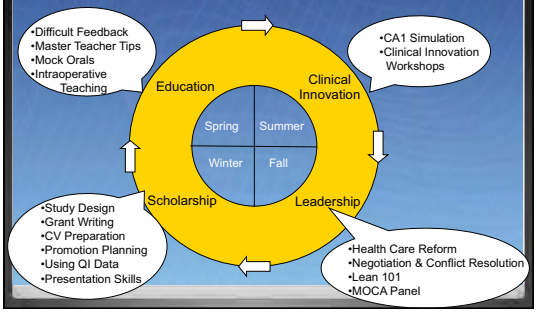
Division Meetings
Staff Development
Chartered Teams

Professional development sessions are tailored to each Department's needs

Examples:

- Nursing: **In-service education; teach safe passing of sharps to residents in the Simulation & Skills Center**
- Surgery: **Leadership council and resident education**
- Obstetrics and Gynecology: **Procedure updates; operating room best practices**

Faculty development in Anesthesia



Clinical Innovation Workshops

Division Meetings
Staff Development
Chartered Teams

Ajith J. Thomas, MD
Adam Lerner, MD
Aldo Rettagliati, RN
Amanda Monahan, MD
Drew Wagner, MD
Anne I. Riskin, RN
Arpan Goel, MD
Chip McIntosh, CCRN, ACNP
Ayesha Abdeen, MD
Babak Litkouhi, MD
Barbara DiTullio, RN, MA
Barbara L. Sarnoff (SW)
Barbara Stabile, RN
Barbara Sweeney, RN
Brett A. Simon, MD, PhD
Bridget Levon
Carrie Tibbles, MD
Katie Kil
Chuck Vi
Charlott
Cheryl D
Christop
Cynthia
Daniel B
Daniel Ti
Darren T
David Fe
David V.
Deborah
Deborah
Debra A. Martinez

Denis M. Gilmore, MD
Don P. DeSilva, MBBS
Dorothy (Dottie) Sarno, RN
Douglas K. Ayres, MD, MBA
E. Cale Hendricks, MD
Ekkehard M. Kasper, MD
Elena Canacari, RN, CNOR
Elliot Chaikoff, MD, PhD
Eswar Sundar, MBBS
Heidee Albano, RN
Holly L. Sanford, RN
Jean M. Campbell, RN
Jeff Keane, RN
Jennifer Larrivee, RN
John D. Mitchell, MD
Mark C. Wyers, MD

Mark Callery, MD
Mark Gebhardt, MD
Marsha Mauer, RN, MS
Mary Cedorchuk, RN
Mary C. Fay
Mary Ellis, RN
Mary Grzybinski, RN
Mary McDonough, LICSW
Matthew R. Ottaviani, LICSW
Maureen Doherty, LICSW
Maureen Houstle, RN
Michael J. Cahalane, MD
Michael Kent, MD
Michael McBride, RN
Nicholas Tawa, Jr., MD, PhD
Riki O. Kveraga, MD

Robert Andrews, MD
Robert Hagberg, MD
Robert Leckie, MD
Robert McKenna, PA
Robin Kalaidjian, RN
Roderick D. McArdle, RN
Roel Dusaban, RN
Ross Simon
Ruma Bose, MBBS, MD
Sajid Shahul, MD
Scott R. Johnson, MD
Sharon Brodie-Wright, MD
Sharon Muret-Wagstaff, PhD
Sheila M. Hunter, RN, CNOR
Sidhu Gangadharan, MD
Stephanie-Marie Jones
and many more…

Chartered teams

- Perceived need to improve something
- Sponsorship by steering committee
- Joint leadership
- Engage front-line staff
- 90-day rapid improvement cycle

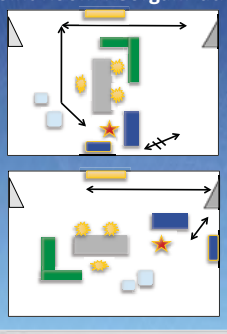
Chartered teams

Chartered teams	Efficiency	Quality & Safety	Patient experience	Staff	Finance
Joint replacement	X	X	X		X
Operating room team training with simulation		X		X	
Reduce hazards in the OR				X	
Spine surgical instrument use	X	X			X
East Campus patient flow	X		X		
Communicating for safety in the OR		X		X	
Clinician support in adverse event situations				X	
Cardiac SSI task force		X			
Patient- and family-centered communication with trauma patients	X	X	X		
Accelerated learning and efficiencies in robotics	X				X
Design CPOE for the Pre-operative holding area	X	X			
Eliminate barriers to closing counts		X			
Optimize West campus first case starts	X		X		X
Re-invigorate the DIEP flap surgery pathway	X	X	X	X	X
Optimize breast surgery/imaging interface	X		X		X
Optimize East campus first case starts	X		X		X
Tailoring care for the opioid-dependent patient		X	X		

OR Interdisciplinary Team Training with Simulation

designed and carried out monthly 6-hour training sessions

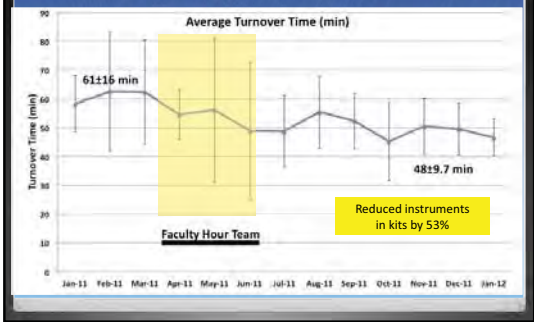
Joint Room Reorganization to Reduce Traffic



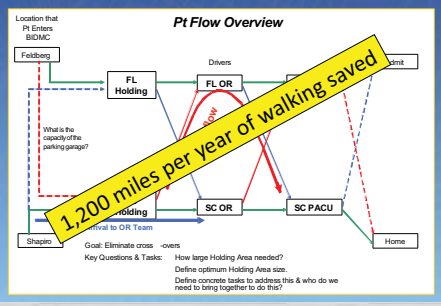
Team Members:
Douglas K. Ayres, MD, MBA (Orthopedics), Co-Leader
Don P. DeSilva, MBBS (Anesthesia), Co-Leader
Barbara L. DiTullio, RN, BSN, MA (Nursing), Co-Leader
Ayesha Abdeen, MD (Orthopedics)
E. Cale Hendricks, MD (Anesthesia)
Lisa J. Kunze, MD, PhD (Anesthesia)
Roderick D. McArdle, RN (SICU)
Robert McKenna, PA (Orthopedic Surgery)
Aldo Rettagliati, RN (Preop Services)
Anne I. Riskin, RN (Nursing)
Marc R. Shnider, MD (Anesthesia)
Elena G. Canacari, RN, CNOR (Nursing), Sponsor
Brett A. Simon, MD, PhD (Anesthesia), Sponsor
Ross Simon, Sr. Mgt Engineer

Accelerate Learning and Efficiencies in Robotics

Faculty Hour Team

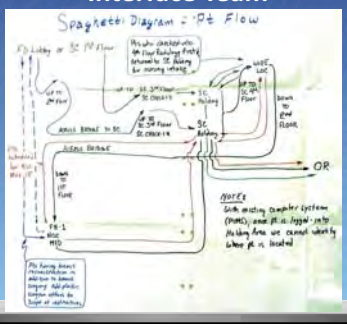


Optimize patient arrival in the OR

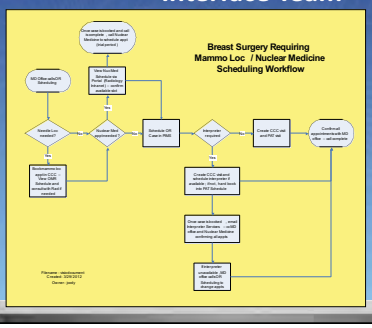


1,200 miles per year of walking saved

Optimize the Breast Surgery / Imaging Interface Team



Optimize the Breast Surgery / Imaging Interface Team



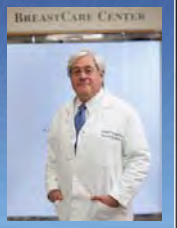
- Developed a **standardized, centralized process** for booking cases
- Developed a way to **track patient flow**
- Increased **delay-free patient experiences** from 61% to 84%

Optimize the Breast Surgery / Imaging Interface Team

"Waiting is the worst thing."
-Patient Advisor to the team

"...the day of surgery is a very stressful day.... You think your mind is working but it is not.... I very much appreciate that the team is looking for patient perspectives and taking this into account at BIDMC."
-Patient Advisor to the team

"The new process is excellent. It takes only 2 minutes to schedule a case!"
- Dottie Sarno, OR Scheduling



"Personally, things have improved dramatically with the changes."
-Mary Jane Houlihan, MD, Surgeon

"Wonderful collaborative work team!!!!!!!!!!"
-Michael Wertheimer, MD, Chief, Breast Surgery

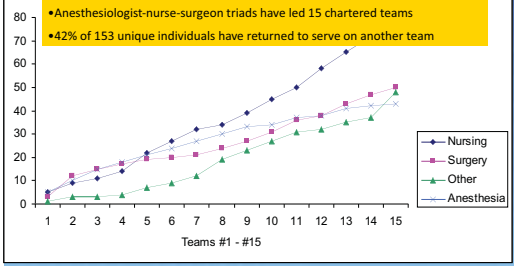
P3E

- **An infrastructure for interdisciplinary care improvement**
  - **Quality and safety**
  - **Patient experience**
  - **Staff development**
  - **Efficiency**

Anesthesiologists now identified as the "go to" group for problem solving and care improvement

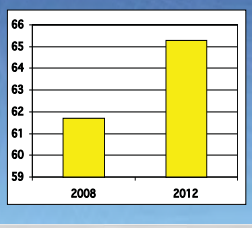
Cumulative numbers of chartered team voluntary participants (N=217)
April 2010 - March 2012

- Anesthesiologist-nurse-surgeon triads have led 15 chartered teams
- 42% of 153 unique individuals have returned to serve on another team



Safety Culture Survey 2008-2012

Significant improvement in overall perioperative safety culture survey score (p<.01)



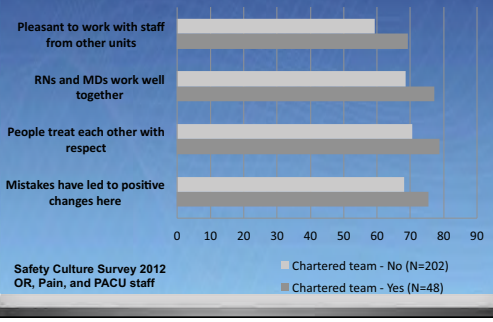
Safety Culture Survey: significant gains in 10 of 12 dimensions, 2008[1] vs. 2012[2]

Dimension	2008	Change	2012
Overall perception of safety	59.7	+5.6	65.3**
Frequency of events reported	61.4	+3.9	65.3**
Supervisor/manager expectation	62.0	+4.7	66.7**
Organizational learning	68.7	+1.4	70.1
Teamwork within units	68.4	+4.6	73.0**
Communication openness	62.4	+4.0	66.4**
Feedback/communication about error	67.5	-1.5	66.0
Non-punitive response to error	48.8	+3.1	51.9*
Staffing	56.1	+3.9	60.0**
Hospital management support	62.9	+6.0	68.9**
Teamwork across units	58.5	+2.6	61.1*
Handoffs and transitions	50.7	+5.8	56.5**

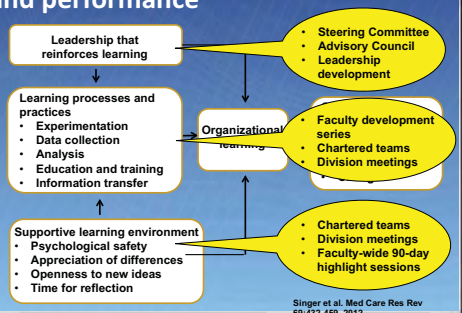
[1]N=427
[2]N=490

*p<.05
**p<.01

Effect of chartered team participation

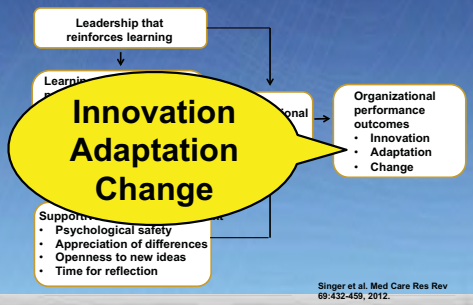


Model for organizational learning and performance



Singer et al. Med Care Res Rev 69:432-459, 2012.

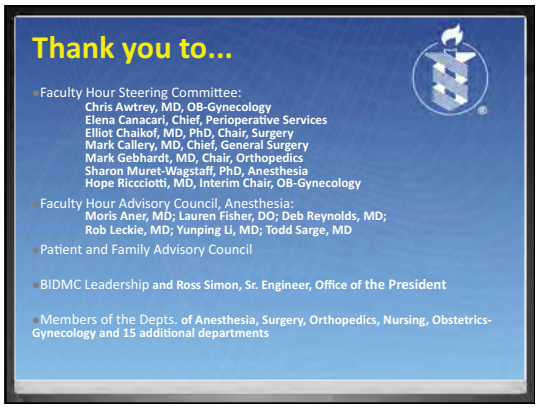
Model for organizational learning and performance



Singer et al. Med Care Res Rev 69:432-459, 2012.

In summary...

- We have instituted a replicable, sustainable platform for collaborative learning, innovation, and improvement to proactively address challenges.
- Staff participate in professional development and hold new leadership roles.
- Interdisciplinary chartered teams, divisions, and departmental initiatives demonstrate agility and measurable results.
- We can measure striking evidence of change in organizational performance and culture.
- P3E has now engaged nearly as many individuals beyond the perioperative arena as in each primary Department.


Thank you to...
Faculty Hour Steering Committee:
Chris Awtrey, MD, OB-Gynecology
Elena Canacari, Chief, Perioperative Services
Elliot Chaikof, MD, PhD, Chair, Surgery
Mark Callery, MD, Chief, General Surgery
Mark Gebhardt, MD, Chair, Orthopedics
Sharon Muret-Wagstaff, PhD, Anesthesia
Hope Ricciotti, MD, Interim Chair, OB-Gynecology
Faculty Hour Advisory Council, Anesthesia:
Moris Aner, MD; Lauren Fisher, DO; Deb Reynolds, MD;
Rob Leckie, MD; Yunping Li, MD; Todd Sarge, MD
Patient and Family Advisory Council
BIDMC Leadership and Ross Simon, Sr. Engineer, Office of the President
Members of the Depts. of Anesthesia, Surgery, Orthopedics, Nursing, Obstetrics-Gynecology and 15 additional departments

Professionalism Program and the Disruptive Employee

Krista M. Curell, Esq., RN

Notes: _____

THE UNIVERSITY OF CHICAGO MEDICINE

Professionalism Program and the Disruptive Employee

Krista Curell, Esq., RN, MSN
Vice President, Chief Compliance Officer

Disclosure Statement

- I have no affiliations or conflicts to report.

http://search.dilbert.com/comic/Conflict%20Of%20Interest

Agenda

- Statistics Summary: Frequency & Impact
- Goals and Objectives of a Professionalism Program
- UCMC Overview and Implementation Pathway
  - Policy Development
  - Infrastructure
  - Accountability
- The Disruptive Employee
- Outcomes
- Appendix: "Don'ts"

UCM Overview

- Faculty members of the Medical Staff Organization
  - 850 physicians
  - Employees of the University of Chicago, Biological Sciences Division
- Resident Physicians
  - 940 physicians
  - Employees of the University of Chicago Medical Center
- Unionized Labor Forces
  - National Nurses United
    - Inpatient Nursing, Perioperative Services Nursing, 3 Ambulatory Clinics
  - Teamsters Union Division 743
    - EVS, Transportation, Coders, Clinic Coordinators

What is the problem?

Look or Sound Familiar?

"Scalpel-Throwing Surgeons Stun Anger Management Pioneer"

Police notification after a "physical" altercation with a nurse.

Inappropriate physical contact

Inappropriate yelling, swearing, gesturing

http://www.bloomberg.com/news/2012-08-02

What is the Frequency of Disruptive Behavior?

- Disruptive behavior is confined to 5% of the total population of clinicians

(Weber, 2004; Rosenstein & O´Daniel, 2005; Linney, 1997)

- 64% of nurses report verbal/physical abuse from a physician at least once every 2-3 months
- 23% of nurses report one instance of physical threat

Diaz & McMillin, 1991

- 96% of nurses in the VHA system witnessed or experienced disruptive behavior; 68% of non nursing providers witnessed disruptive behavior by nurses

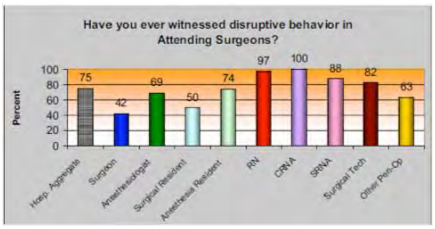
Rosenstein, 2002

- Most common intimidation behaviors include:
  - –Condescending language or intonation 88%
  - –Impatience with questions 87%
  - –Reluctance or refusal to answer questions or phone calls 79%
  - –Strong verbal abuse 48%
  - –Threatening body language 43%
  - –Physical abuse 4%

ISMP 2003

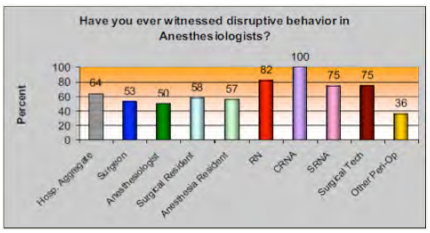
http://www.psqh.com/julaug06/disruptive.html

Frequency of Disruptive Behavior



Rosenstein and O'Brien, J Am Coll Surg, 2006;203:96–105

Frequency of Disruptive Behavior



Rosenstein and O'Brien, J Am Coll Surg, 2006;203:96–105

What is the Impact of Disruptive Behavior?

- Medical Errors
- Low Patient Satisfaction Scores
- Preventable Adverse Outcomes
- Staff Turnover
- Loss of Productivity
- Reports to External Agencies including
  - The Joint Commission
  - State Departments of Public Health
  - Office of Civil Rights
  - Local Law Enforcement

Joint Commission Sentinel Event Alert Issue 40 7/9/08

How do we solve the problem?

Goals & Objectives of a Professionalism Program

- Commit to Eliminate the Disruptive Behavior
- Professionalism Infrastructure
  - Policy & Procedure
  - Medical Staff Bylaws
  - Professionalism Committee
- Educate & Remediate
- Accountability
  - Consistent application of the policy is KEY
  - Zero tolerance policy for retaliation

UCMC: Goals & Objectives

What was our end game?

- ✓ To promote and support a Medical Center community in an environment of professionalism which is free of abusive or demeaning treatment.
- ✓ To provide quality patient care in an environment of professionalism, respect, tolerance, understanding and goodwill.
- ✓ To construct an infrastructure to provide a systematic and timely means for documenting, communicating, investigating and resolving Medical Staff Member and Resident/Fellow behavioral complaint reports.
- ✓ To demonstrate measurable improvement on defined quality, safety, and experience metrics.

UCMC Professionalism/Disruptive Behavior Policy

UCMC Anticipated Outcomes

- Increase in Reported Number of Disruptive Events
  - ❖ Increase in Psychosocial Evaluations and Professional Coaching
    - o Cost Implication
  - ❖ Long Term Metric: Decrease in Disruptive Behavior Events
- Increase in Patient Satisfaction Scores
  - ❖ Decrease in Patient Complaints
- Increase in Performance on Culture of Safety Survey

UCMC Professionalism Program: Policy & Bylaws

- Medical Staff Organization Policy and Procedure
  - Medical Staff Bylaws
    - Article 4.8: Civil Behavior – "All Medical Staff members are expected to provide quality patient care in an environment of professionalism, respect, tolerance, understanding and goodwill."
  - Medical Staff Organization Policy: Professionalism/Disruptive Behavior
  - UCMC and University Civility and Code of Conduct Policies
- Faculty Committee on Professionalism
  - Incorporated into the Medical Staff Bylaws as a quality committee under the Executive Committee of the Medical Staff
  - Peer Mentors

Accountability is the KEY to success.

UCMC Policy Development

- Medical Staff Organization Policy
- Policy Development Committee
  - Faculty
  - Residents
  - Nursing Staff
  - Ancillary Staff
  - Legal & Human Resources
    - University of Chicago
    - University of Chicago Medical Center
  - Human Resources

UCMC Policy Development

What is Disruptive Behavior?

- Define behavioral categories

Most physicians will tell you:
"I know it when I see it…."

Reality:

- "Righteous Indignation"
- "Shock & Awe"
- "Well what words can I say?
- "When did you tell us we couldn't touch people?"

UCMC Policy Development

Behavioral Definitions

•Disruptive Behavior: Personal conduct, whether verbal or physical, that affects or that potentially may affect patient care negatively. This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team.

- Disruptive (Unprofessional/Uncivil Behavior)
- Illegal Discrimination & Harassment
  - Retaliation
  - Hostile Environment
    - Stop the Conduct and Educate Your Staff
- Impairment: inability to practice medicine with reasonable skill and safety due to physical or mental disabilities including aging, loss of motor skill, substance abuse or mental illness

Question #1: Have you seen or experienced disruptive behavior?

- Examples include
  - Physically threatening language directed at someone
  - Physical contact that is threatening, intimidating or unwanted
  - Throwing instruments, charts or other things; punching a wall or similar physical acts
  - Name calling, use of profanity or disrespectful language
  - Degrading comments regarding to or about patients and their families, nurses, physicians, hospital personnel
  - Racial or ethnic jokes
  - Violation of confidentiality policies
  - Intimidating behavior

http://www.psqh.com/julaug06/disruptive.html; accessed 9/5/12

UCMC Policy Development

- Appropriate Behavior: Criticism or expression of concern may be appropriate when communicated in good faith and in a reasonable and professional manner. Examples include:
  - Criticism offered with the aim of improving patient care and safety
  - Expressions of dissatisfaction with policies through appropriate grievance channels or other civil non-personal means of communication
  - Use of cooperative approach to problem resolution
  - Constructive criticism conveyed without public finger pointing or humiliation
  - Frank and rigorous discussion at departmental Morbidity & Mortality meetings and Quality Assurance meetings
  - Delivery of appropriate feedback and counseling for practices, behaviors and actions that fail to meet performance expectations

UCMC Infrastructure: Committee Structure

UCMC Committee of Professionalism (The COP)

- Incorporated into the Medical Staff Bylaws as a quality committee under the Executive Committee of the Medical Staff
- Intervention Tiers
  - Immediate referral for disciplinary intervention
  - Peer to Peer counseling
    - Level 1: Isolated incident - no significant or imminent threat to safety or well being of an individual = Peer to Peer counseling
    - Level 2: Second compliant = counseling with the faculty peer and the Department Chair
    - Level 3: Significant complaint or persistent pattern; Mandated remedial action recommended by the Committee to the Department Chair

UCMC Infrastructure: Peer Mentors

Messenger Peer Physicians

- Nominated based on
  - Distribution among practice types
  - Clinically active
  - Respected by colleagues
  - Willingness to serve
  - Complaint scores low/satisfaction high and personal professional issues low
    - Success stories

UCMC Accountability

- If behavior persists or if conduct is severe, the matter is referred to the Dean and to the President of the Medical Staff for initiation of corrective action under the Medical Staff ByLaws.
- If no corrective action is taken, a confidential memorandum summarizing the disposition of the complaint, along with copies of any other relevant correspondence is in the physician's file for two year
  - Expunge if no further action is pending
- Level I and Level II interventions and informal rehabilitation, a written apology, issuance of a warning as a Level III intervention, or referral to Physician Assistance Committee will not constitute corrective action.
  - No report to IDFPR

UCMC Staff Accountability

- Union contracts typically contain management rights clauses and general expectations for professional practice.
  - Staff may be held accountable up to termination if the HR decision can be supported by documentation.
- Physicians must: Report and Document to staff managers

Physician and Staff Interactions

- Tips for Physicians:
  - Do not engage. Walk away if possible.
  - Report & Document
  - Never touch. Patting one's shoulder to de-escalate a situation is inappropriate touching.
  - Keep it at the professional level – never make it personal.
  - Bring a witness to any counseling session
  - Excuses related to hospital operations do not justify disruptive behaviors:
    - Frustration & pressures to produce

Patient Complaint Process – Separate & Distinct

- UCMC collaborates with the Vanderbilt Center for Professional Advocacy to review complaints
- Committee of the Medical Staff: Patient Compliant Monitoring Committee
- Complaint Categories
  - Communication
  - Care and Treatment
  - Concern for Patient/Family
  - Accessibility & Availability
  - Money or Payment Issues
  - Environment Problems
- Complaints can identify and track:
  - Liability risks
  - Patient dissatisfaction
  - System issues

Tenets of Professionalism

- Accountability
  - MD places the needs of the patient above self interest
- Humanism
  - Foster the doctor patient relationship
- Ethical Behavior
  - Honesty and morality
- Physician Well Being
  - Recognize need for physical and mental health

Swearing – DON'T

- "What words can I use?"
  - The continuum of "bad words" and "really really bad words" is different for everyone.
- **General Principal**: Profanity should not be used in the work place and is incredibly offensive to some.

Realistic Tips:

- Try to eliminate swearing from routine conversation.
- Never direct profanity towards someone.
- Refrain from incorporating religious terms in certain phrases.

Touching – DON'T

- Refrain from touching in good times and bad.
- Never touch during an argument or heated exchange.
  - De-escalation techniques do not include touching. It will be construed as an act of aggression.

- Respect the dignity of the patient's body while under sedation/anesthesia.
  - Refrain from making derogatory remarks regarding body habitus or general appearance

Jokes – DON'T

- Maintain a professional environment.
- Most jokes can be misinterpreted.
- Never tell jokes that may be construed as ridiculing
- Avoid all jokes that reference:
  - Gender, race, and national origin
  - Body habitus
  - Religious affiliation
  - Socioeconomic status

Acts of Aggression – DON'T

- Refrain from pointing or using your body to gesture and display anger
- Don't step towards someone especially in a closed room
  - "I was cornered"
  - I was trapped in the room"
- Don't pound your fists on the table when addressing your staff
- Don't threaten someone's livelihood
  - "I'll get you fired."
  - "You just lost that bonus you've been looking forward to."

Questions & Comments

- Contact Information:

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AAAC
Concurrent Sessions

General Session: All Chair Session
Moderator: Berend Mets, M.B., Ch.B., Ph.D., FRCA, FFA(SA)

Perfect Storm
Kevin K. Tremper, M.D., Ph.D.

Running a Successful Anesthesia Department

- **American Perspective**
  Ronald G. Pearl, M.D., Ph.D.
- **European/British Perspective**
  Mervyn Maze, M.D.
- **Canadian Perspective**
  Davy Cheng, M.D., MSc., FRCPC, FCAHS

Perfect Storm

Kevin K. Tremper, M.D., Ph.D.

Learning Objectives

1. To be knowledgeable of the current demographics of the U.S. training programs with respect to faculty, faculty openings, covered ratios for ORs, and institutional support.
2. To be aware of the current status of the implementation of AIMS in academic training programs and their possible involvement in litigation cases.

From the early 1980s to 1995 medical student interest in Anesthesiology was high and the number of resident graduates increased progressively. For a variety of reasons related to "healthcare reform," interest in capitated healthcare, and an ASA workforce report there was a general consensus (especially among medical students) that there was an oversupply of anesthesiologists. This resulted in a dramatic drop in the match class of 1996. The graduating resident class of 1996 was over 1,800 while the class matching into anesthesiology was only 143! This class added non-match residents (predominately IMG applicants) to bring the class size up to approximately 800, but this was still 1,000 fewer than the classes of the previous years. Consequently, the graduating classes of the early 2000s were very small, producing an estimated national shortage of roughly 3,000 anesthesiologists.

This shortage produced salary pressure noted most significantly in the academic departments.

At the same time departments were being asked to provide more services at inefficient locations out of the ORs. It was clear in 1999 that many academic departments would be placed in an untenable financial situation and would require financial support from their institution (most likely the hospital) if they were going to be able recruit and retain academic faculty.

Seeing this problem looming on the horizon the SAAC/AAPD council (now the SAAA) designated a small committee to develop a position paper describing the problems facing academic anesthesia chairs so that the chairs would have a resource when they would approach their institution for support. Otherwise it was felt that any one institution may come to the conclusion that the financial problems facing their Department of Anesthesiology was just a business/leadership problem of their department chair, and concluded that getting a new department chair could fix this problem.

The committee charged with producing this White Paper determined that they would need to research the origins of the situation and provide data which would require a survey to determine the current state of the faculty and finances of the U.S. academic training programs. The survey was distributed by e-mail to all the academic chairs in the fall of 1999. The results were incorporated in a report titled, "The Perfect Storm," which was presented at the fall 2000 meeting of the Chairs. The title was taken from a recent movie of the same name and represented the confluence of several factors producing a severe financial situation facing our academic departments. It was decided at this meeting that it would be very useful to have current survey data of this type every year to provide our chairs with evidence of need during their negotiations with their institution. Hence the "Perfect Storm" follow-up surveys have been distributed every fall since 2000. Because these survey data primarily involve the faculty and finances related to running an academic department, the resulting publications (appearing in Anesthesia & Analgesia) have had Faculty & Finance in the title. We therefore now call this yearly survey the SAAA Faculty & Finances Survey. This yearly survey should not be confused with the SAAC Salary Survey conducted by the University of Florida. This annual salary survey was started in 1974, by Dr. Jerry Modell, to provide up-to-date academic salary data. This year's SAAA Faculty & Finances survey has been sent out again in the first week of September and the results will be presented at the November meeting of the SAAA. For the results to be valid the response rate needs to be high so we encourage the chairs to respond. The results are e-mailed to the respondents monthly. The non- respondents are sent reminders every two weeks until December. Thank you to all the chairs who have contributed to this useful report by responding to the surveys.

Running a Successful Anesthesia Department: American Perspective

Ronald G. Pearl, M.D., Ph.D.

Defining success: U.S. News and World Report ranks colleges, medical schools, hospitals, and even nursing homes. In doing so, they create objective metrics to measure success, and the "successful" entities tend to resemble each other. There is no U.S. News and World Report ranking for anesthesia departments. Instead, each anesthesia department has the freedom to determine its own definition of success. Although all successful departments must address the four major missions of an academic department (clinical care, education, research, and administration), the emphasis on each mission can vary depending upon local culture and resources. For some departments, the primary goal is to be the best in providing clinical care; for others it is to be the national leader in education; for others, in research; and finally, for others it is the overall mix which is the goal. From my experience in observing leading anesthesia department in the United States, the deliberate decision on the definition of success is the core element in running a successful anesthesia department.

Developing a vision: The process by which an individual department creates their definition of success varies. Some departments develop a vision or mission statement using a structured format, while other departments do not. The strategic vision must be based on departmental strengths, be exciting but realistic, and serve as an opportunity to transform the department and its culture over time. In order to be successful, the chair must embrace and promote the department's vision at every opportunity, whether it be through his or her individual activities in clinical care, research, and education, or through faculty meetings, departmental newsletters, appointment and promotion decisions, choice of leadership positions, annual faculty reviews, individual faculty discussions, or resource allocation decisions. Second, this definition of success must become a part of the department's culture. It is not necessary that each individual faculty member have the same priorities for his or her career, but it is necessary for departmental success that each faculty member feel that his or her individual contributions are an important contributor to the success of the department. Departments in which each faculty member feels valued will have greater overall success and better faculty retention.

In general, a new chair enjoys a honeymoon period during which resources are plentiful and questionable actions are given the benefit of the doubt. A new chair is expected to make changes in the department, and it is inevitable that some faculty (or staff or residents) will not be supportive of those changes. However, a chair must moderate the rate of change and justify the need for change with the department in such a way that s/he maintains the confidence of the majority of the department. This can be done by individual discussions, faculty meetings, retreats, newsletters, etc., but the job of the department chair is to communicate effectively with the faculty.

Role of the chair: Successful anesthesia departments have outstanding chairs. The job of an anesthesia chair is complex and requires leadership skills, financial knowledge, interpersonal skills, and long hours. Successful chairs understand that innovation and change are the only way to maintain success over time. Chairs of successful departments have a commitment to stewardship which is defined as "the careful and responsible management of something entrusted to one's care." Successful chairs model two important applications of this concept. First, they make individual decisions on the basis of what is beneficial to the department, rather than for their own personal or professional benefit. Second, they plan for the future of the department rather than focusing only on the current, most pressing issues. As above, part of that planning should be developing a vision which allows the department to be successful throughout the next decade. Although many chairs have such a vision, it is critical that this be the department's vision, and it can be a challenge to lead a department to the right vision. Although different chairs approach the issue of stewardship differently, a common theme is to periodically set goals for the department and then be sure to meet them.

Securing and managing resources: Successful anesthesia departments require adequate resources to accomplish their goals. In the United States, the three major sources of revenue are clinical income, institutional support, and research grants and contracts, and the major sources of expense are faculty salaries, administrative salaries, and research. Although many successful chairs do not have an MBA degree, running a successful anesthesia department does require significant attention to financial details since the bottom line for the department drives what the department is able to accomplish. Increasingly, successful department chairs are able to take a business perspective which emphasizes teamwork within the department and the ability to function across departments to integrate with service lines, programs, centers, and institutes within the hospital and medical school. An important attribute is the creation of a financial roadmap and budget--and then having the discipline to follow it. Almost all successful departments have adopted an incentive plan which is aligned with the overall department vision. Although incentive and compensation plans originally focused on clinical productivity, most plans now account for individual contributions to each of the department's missions, thereby aligning goals and incentives. Incentive plans link compensation with results and allow departments to attract and retain top talent, increase productivity, and enhance mission-based metrics. Compensation plans are also a mechanism by which chairs recognize the existing culture and provide an opportunity to change it over time. Although incentive plans in some departments have focused on paying for time, most successful departments link pay to what is actually produced. In addition to a focus on financial performance, running a successful department requires continued

Running a successful anesthesia department requires a focus on the delivery of high-quality clinical care in an efficient and cost-effective manner which allows the hospital and the surgical departments to also be successful. Although many chairs appoint a vice-chair for clinical affairs, the ultimate responsibility remains with the department chair who must be able to defend the management of the clinical enterprise which is the core of a department.

Academic success. Departmental success is largely assessed by the medical school and university in terms of research accomplishments and funding. Successful departments often organize their research around exceptional individuals, areas with a critical mass of investigators or research, or themes which allow collaboration with other departments. Although many departments have achieved large increases in funding by recruiting an established investigator, most successful departments have invested in and developed their own investigators. A study by Bland et al. looking at factors responsible for research productivity in academic institutions highlighted the interaction between individual, institution, and leadership variables and emphasized the need for research-oriented leaders who would recruit faculty with a passion for research, provide them with formal mentoring, facilitate their networks, and provide adequate protected time for their research.

Managing multiple responsibilities: The chair is responsible for everything which occurs in the department, including clinical care, education, research, finances, appointments and promotions, and fundraising. No one can do it all. Departments are simply too large to be micromanaged by a chair, and the chair has multiple other more important responsibilities. The most challenging job for a successful chair is to develop a strong infrastructure within the department and then delegate major responsibilities to faculty and staff that have the appropriate skills and commitment. As part of stewardship, the chair has an obligation to promote the careers of his or her faculty and staff, so it is also a chair responsibility to allow them to take on increasing responsibilities. At the same time, the chair must remain knowledgeable about what is occurring in the department, since pointed questions will be asked by the dean and the hospital CEO.

Working in collaboration: Successful anesthesia departments are part of a larger organization which includes the medical school, the hospital, and the university. The chair, the department leaders, and the faculty should be part of extensive collaborations which will enhance the clinical, educational, and research missions of the department but will also form a support network when problems occur.

Successful anesthesia departments are viewed as critical to the success of the institution and therefore are able to request significant resources to allow them to succeed.

Faculty development: Finally, a major theme throughout the topic of running a successful department is faculty development. This begins with hiring faculty who are not only exceptionally talented but who also fit into the departmental culture and are committed to the department's vision for the future. Faculty development then requires that the department provide the right opportunities for the faculty member to succeed as planned, which may include time, funding, space, collaborators, and the right opportunities. However, the most critical aspect of faculty development is mentorship. Many successful departments are now adopting the concept of having dual mentors, one or more specific for the faculty member's focus (e.g., a research mentor for research-oriented faculty; a clinical mentor for a clinician-educator) and a separate mentor to provide overall career advice. In addition, running a successful anesthesia department requires being a mentor to all the faculty, whether it is the promising junior faculty member embarking on a research career, the mid-level faculty member who is developing innovative approaches to education, the division chief who is contemplating the next stage in their career, or the senior faculty member who is contemplating winding down their career. In the end, their success is your success, and it is the ultimate reason for everything we do as chairs of successful departments.

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Running a Successful Anesthesia Department: European/British Perspective

Mervyn Maze, M.D.

Notes: _____

Running a Successful Anesthesia Department: Canadian Perspective

Davy Cheng, M.D., MSc., FRCPC, FCAHS

Notes:

AAAC
Concurrent Sessions

Manpower, CMS, Legal Issues
Moderator: Berend Mets, M.B., Ch.B., Ph.D., FRCA, FFA(SA)

Developing a Staffing Plan for an Anesthesiology Department
Amr E. Abouleish, M.D.

CMS: Implementation of Interpretive Guidelines: Best Practices
Norman A. Cohen, M.D.

Case Based Scenarios
Judith Semo, Esq.

Developing Staffing Model for an Anesthesiology Department

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Anesthesia is the Practice of Medicine

- Therefore, CRNA working independently is not included in this discussion. Further, "medical supervision" is also not considered.
- The staffing model will only include physician only or the anesthesia care team using medical direction.
- Further, for a full service hospital, the staffing cost may similar to hire another anesthesiologist to MD-only room rather than hiring additional CRNA to work "independently". Anesthesiologist can also provide additional services including call, late room, education, committee duties, and administration.[1]

1 ASA Newsletter 2010; 74(12):30-34

2001 Newsletter Article


Estimating Staffing Requirements: How Many Anesthesia Providers Does Our Group Need?

- Includes excel sheet downloadable.
- Accessible at special link.

2001 Newsletter Article


Estimating Staffing Requirements: How Many Anesthesia Providers Does Our Group Need?

- Includes excel sheet downloadable.
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http://www.asahq.org/Home/For%20Healthcare%20Professionals/Publications%20and%20Research/Other%20Publications/Estimating%20Staffing%20Requirements.asp

- Excel sheet downloadable
- Instructions, staffing model, sheet to list staff and clinical commitment

http://www.asahq.org/~/media/For%20Members/Publications/Other/Abouleish_excel.ashx

Telling Noah about the Flood

- Budget reality[1-2]
  - Clinical revenue does not cover the staffing costs
  - Requirement for institutional support
- Clinical revenue is impacted by payer mix[3], surgical duration (units per hour of care), operating room utilization, hours worked, and Dean's tax
- Major determinants of Staffing Costs are compensation and number of providers.

1 Anesth Analg 2011;112:1480–6
2 Anesthesiology 100:403-412; 2004
3 2012 ASA Abstract, Abouleish et al.

Institutional Perspective: "Since we are paying, …"

- "How do we know we are getting our money's worth?"
- Institutional Support negotiations end up focusing on
  - Incentives to "work more and better"
  - Focus on number of providers
- Hire Consultant
  - Often try to apply "per FTE" measurements to determine if staffing numbers
  - The "Dean's Logic"
  - … Benchmarking using "per FTE" does not work for Anesthesiology Groups[1-2]

1 Anesth Analg 96: 802-812; 2003
2 2011 MGMA Cost Survey of Anesthesia Practices

"Per FTE" vs. "Per OR"

		Physician Only	>1 CRNA/MD
Cases	Per FTE		
	Per OR		
tASA	Per FTE		
	Per OR		
Hours per Day	Per FTE		
	Per OR		

tASA = total ASA units

Hours per day = (time units/4) / 220 days
*billed time only

2011 MGMA Cost Survey of Anesthesia Practices

"Per FTE" vs. "Per OR"

		Physician Only	>1 CRNA/MD
Cases	Per FTE	907	1,653
	Per OR		
tASA	Per FTE	8,769	16,647
	Per OR		
Hours per Day	Per FTE	4.7	8.8
	Per OR		

tASA = total ASA units

Hours per day = (time units/4) / 250 days
*billed time only

2011 MGMA Cost Survey of Anesthesia Practices

"Per FTE" vs. "Per OR"

		Physician Only	>1 CRNA/MD
Cases	Per FTE	907	1,653
	Per OR	933	915
tASA	Per FTE	8,769	16,647
	Per OR	9,157	9,323
Hours per Day	Per FTE	4.7	8.8
	Per OR	5.1	5.1

* physician only, FTE ≠ OR

tASA = total ASA units

Hours per day = (time units/4) / 250 days
*billed time only

2011 MGMA Cost Survey of Anesthesia Practices

What determines how many providers you need?

- Primary determinants
  - Number of clinical sites
  - Staffing Ratio (Concurrency)
  - 2nd Shift? – Hours of operations
  - Call and Post-Call
- What is not relevant?
  - Number of cases in each room
  - Amount of charges
  - Productivity measurements

ASA Newsletter August 2001;65:14

Making Staffing Model

- Obvious: the controlled variables
  - Staffing ratio
  - Call coverage
  - Non-clinical time
  - Non-OR rotations for Faculty and Residents
- Subtle: the independent variables
  - Non-clinical time
  - Away time for faculty and for CRNA
  - Remote sites
  - Need for breaks
  - Late rooms
- Define the parameters and include Faculty, Residents, CRNAs/AAs
- Steps to Complete (use Excel!)
  1. Clinical Services
  2. Non-clinical FTE
  3. Away FTE
  4. FTE needed
  5. FTE available (expected hire, expected departure)

Example Simple Staffing Model
Academic Department serving one AMC

The complete list of all the parameters of the model is listed at the beginning of your handout.

We will discuss in details.

Example Simple Staffing Model
Academic Department serving one AMC

- Staff
  - 30 full time anesthesiologists
  - 36 residents (12 in each CA year)
  - 10 CRNA or AA
- Academic Medical Center
  - 19 OR suite (Main OR)
  - 2 Remote Sites Daily
  - Labor Delivery with 2 ORs
  - Preoperative clinic
  - SICU
  - Acute Pain Management/Regional Block service
  - Chronic Pain Management service

Example Simple Staffing Model
Academic Department serving one AMC

- Staff
  - 30 full time anesthesiologists
  - 36 residents (12 in each CA year)
  - 10 CRNA or AA
- Academic Medical Center
  - 19 OR suite (Main OR)
  - 2 Remote Sites Daily
  - Labor Delivery with 2 ORs
  - Preoperative clinic
  - SICU
  - Acute Pain Management/Regional Block service
  - Chronic Pain Management service
- Away time

Per Year	Meeting	Vacation/Sick
Faculty	2 wks	4 wks
CRNA/AA	1 wk	4 wks
Resident	0.33 wk	2 wks

- In-house call
  - 2 Faculty FTE (Main OR, L&D)
  - 3 residents in Main OR
  - 2 in L&D
  - 1 in SICU
  - Postcall day off
- Ratio 1:2
  - Except schedule runner and one other faculty, both 1:1
- Clinical FTE
  - Average for Faculty is 0.75
  - CRNA or AA work 4 10-hr days (=0.8 clinical FTE)
  - 4 residents are doing rotations outside the department, hence each resident =0.89 clinical FTE
- Sick leave. Assume each week,
  - 1 Faculty FTE out sick
  - 1 Resident
  - 0.5 CRNA

Clinical Services

What services must you cover each day 7 am?

- Match with Nursing service staffing!
- For something that you cover some days, divide days by 5 to determine the daily site. Example: MRI 2 days week = 0.4 daily site
- If a provider comes in later, then included as separate service. Example: Call Faculty
- Don't forget post-call personnel.

Clinical Services	Sites	Faculty	Residents	CRNA or AA
Main OR				
Remote				
1:1 rooms				
Faculty Rm				
Schedule Runner				
Total Anes Sites	21			
Preop Clinic				
L&D				
Acute Pain/Block				
Chronic Pain Clinic/ Procedures				
SICU				
Call				
Post Call				
Daily Clinical FTEs needed				

Clinical Services

- Number of CRNA is adjusted based on number of residents available.
- 4 on away rotation, so have 32 available?
  - But have some away (vacation, meetings, sick)
  - Initially, you have to "guess-timate".
  - Then go back and adjutst up or down.
  - Suggest start with estimate that 10% estimate away; 90% available to work
  - 90% of 32 = 29

Clinical Services	Sites	Faculty	Residents	CRNA or AA
Main OR				
Remote				
1:1 rooms				
Faculty Rm				
Schedule Runner				
Total Anes Sites	21			
Preop Clinic				
L&D				
Acute Pain/Block				
Chronic Pain Clinic/ Procedures				
SICU				
Call				
Post Call				
Daily Clinical FTEs needed				

Goal 29 residents

Clinical Services: Non-OR

- Preop Clinical has nurse practitioner
- L&D. Number depends on workload.

Clinical Services	Sites	Faculty	Residents	CRNA or AA
Main OR				
Remote				
1:1 rooms				
Faculty Rm				
Schedule Runner				
Total Anes Sites	21			
Preop Clinic	NP	1	1	-
L&D		1	3	-
Acute Pain/Block		1	1	-
Chronic Pain Clinic/ Procedures	Fellow	2	1	-
SICU	Fellow	1	3	-
Call		2	**	
Post Call		2	6	-
Daily Clinical FTEs needed			15	

Goal 29 residents

In-House Call Coverage

- Constant Variables
  - OR/OB or OR and OB
  - Post call day off
- Independent variable is how is day of call is treated
  - Part of call
  - Non-clinical time scheduled on day of call
- Call in this model
  - Faculty come in at 4 pm
  - Residents work from 7 am

Clinical Services	Sites	Faculty	Residents	CRNA or AA
Main OR				
Remote				
1:1 rooms				
Faculty Rm				
Schedule Runner				
Total Anes Sites	21			
Preop Clinic	NP	1	1	-
L&D		1	3	-
Acute Pain/Block		1	1	-
Chronic Pain Clinic/ Procedures	Fellow	2	1	-
SICU	Fellow	1	3	-
Call		2	**	
Post Call		2	6	-
Daily Clinical FTEs needed			15	

Goal 29 residents

ARS Question:
Do your in-house call faculty come in later in the day?

- Yes
- No

ARS Question:
For those that come in late, is the day of call considered non-clinical time or considered part of call?

- Non-clinical time: part of the defined academic time faculty is allotted
- Part of call: no academic duties expected; academic time separate to day of in-house call

Late Starting Staff

- Any staff starting later in the day needs to be included.
  - Late arrival for call
  - Late shift staff
- Because this requires increased staffing for same number of anesthetizing sites, you must show it's necessary and not "a luxury"!
- Late arrival for call
  - Time is a form of compensation
  - Example. Department covers two hospitals.
    - One that is Level 1 trauma, the other a community hospital.
    - Both with in-house call
    - Call pay the SAME, but …
      - Level 1 trauma: Call faculty reports at 5 PM
      - Community hospital: Call faculty starts at 7 AM
- Late shift staff
  - Late room faculty: Impact of running more than 2 rooms past 7 PM due to maximum staffing ratio of 1:2
  - Late room coverage with CRNA
    - Examples of 8-hr shifts:
    - Come in at noon till 8 pm, give breaks and cover late rooms.
    - Come in at 3 pm till 11 pm

Clinical Services: Main OR

- 21 sites, 14 residents
- Staffing ratio?

Clinical Services	Sites	Faculty	Residents	CRNA or AA
Main OR				
Remote				
1:1 rooms				
Faculty Rm				
Schedule Runner				
Total Anes Sites	21			
Preop Clinic	NP	1	1	-
L&D		1	3	-
Acute Pain/Block		1	1	-
Chronic Pain Clinic/ Procedures	Fellow	2	1	-
SICU	Fellow	1	3	-
Call		2	**	
Post Call		2	6	-
Daily Clinical FTEs needed			15	

Goal 29 residents

Staffing Ratio: Academic Limitations

- Billing rules for Medical Direction
  - Medicare allows an anesthesiologist to medical direct the care for up to 4 concurrent patients
- ACGME RRC rule II.B.2.a)
  - "The number of faculty must be sufficient to provide each resident with adequate supervision, which shall not vary substantially with the time of day or the day of the week.
  - In the clinical anesthesia setting, faculty members should not direct anesthesia at more than two anesthetizing locations simultaneously."

http://www.acgme.org/acWebsite/downloads/RRC_progReq/040_anesthesiology_f07012011.pdf

Faculty to Anesthetizing Locations Ratio
1:2 is Max but not the Median

- During regular weekday, median ratio of 1:1.7 but may vary from 1.5-1.9
- Why less than 1:2?
  - Some faculty only cover 1 OR
  - "Schedule Runner"
    - Administration duties
    - Flexibility to help out
  - Patients need 1:1 care
  - Remote sites inefficient
- Max ratio also impacts number of faculty staying late and on call

Anesth Analg 96: 802-812; 2003

Clinical Services: Main OR

- 21 sites, 14 residents

Clinical Services	Sites	Faculty	Residents	CRNA or AA
Main OR				
Remote				
1:1 rooms				
Faculty Rm				
Schedule Runner				
Total Anes Sites	21			
Preop Clinic	NP	1	1	-
L&D		1	3	-
Acute Pain/Block		1	1	-
Chronic Pain Clinic/ Procedures	Fellow	2	1	-
SICU	Fellow	1	3	-
Call		2	**	
Post Call		2	6	-
Daily Clinical FTEs needed			17	

Goal 29 residents

Clinical Services: Main OR

- 21 sites, 14 residents
- 1:1 faculty coverage
  - Schedule runner
  - One 1:1 rooms
- 19 sites, 12 residents
- 18 sites 1:2 ratio
- 1 site
  - Either another 1:1 or faculty room.
  - Inefficient …

Clinical Services	Sites	Faculty	Residents	CRNA or AA
Main OR				
Remote				
1:1 rooms			1	
Faculty Rm				
Schedule Runner	1	1	1	
Total Anes Sites	21			
Preop Clinic	NP	1	1	-
L&D		1	3	-
Acute Pain/Block		1	1	-
Chronic Pain Clinic/ Procedures	Fellow	2	1	-
SICU	Fellow	1	3	-
Call		2	**	
Post Call		2	6	-
Daily Clinical FTEs needed			17	

Goal 29 residents

Odd Number of Rooms & Remote Sites

- Inefficient staffing ratio
  - During the day, distance and patient type might make covering OR case as second room difficult. Example: pedi MRI
  - Even if covering 2 sites, e.g., in Endo, when down to one, back to inefficient ratio
  - Might be less expensive to cover as MD-only
- Late rooms can be very expensive
  - Can be very expensive to run 3 rooms rather than 2 rooms
  - Need another anesthesiologist in house
  - Direct & indirect costs to adding additional late rooms and call coverage

1 ASA Newsletter 2010; 74(12):30-34

Clinical Services: Main OR

Next: Non Clinical FTEs. Based on number of clinical FTE.

- 21 sites, 14 residents
- 1:1 faculty coverage
  - Schedule runner
  - One 1:1 rooms
- 19 sites, 12 residents
- 18 sites 1:2 ratio
- 1 site
  - Either another 1:1 or faculty room.
  - Inefficient …

Clinical Services	Sites	Faculty	Residents	CRNA or AA
Main OR	16	8	11	5
Remote	2	1	1	1
1:1 rooms	1	1	1	-
Faculty Rm	1	1	-	-
Schedule Runner	1	1	1	-
Total Anes Sites	21			
Preop Clinic	NP	1	1	-
L&D		1	3	-
Acute Pain/Block		1	1	-
Chronic Pain Clinic/ Procedures	Fellow	2	1	-
SICU	Fellow	1	3	-
Call		2	**	
Post Call		2	6	-
Daily Clinical FTEs needed		22	29	6

Non-Clinical FTE: Not providing clinical care

- For any residency program, a necessity for academic faculty.
  - Argue basic academic time is part of the clinical staffing model. Without it, no residents available, and have to hire CRNAs.
- 1.0 = Clinical FTE + Non-Clinical FTE
- Faculty, non-Clinical FTE is academic time

ARS Question: For the "Work Bubba" Faculty, what is Clinical FTE?

- Example. Clinical FTE of 0.8 = in the OR 4 days a week, and 1 day/wk academic time.
- A) 0.7
- B) 0.8
- C) 0.9
- D) 1.0 (no academic time)

ARS Question:
Do you count post-call day as "academic time"?

- Post call day is academic time
- Post call day is not academic time

ARS Question:
For only those that that say post call day is NOT academic time,
For the "Work Bubba" Faculty, what is Clinical FTE?

- Example. Clinical FTE of 0.8 = in the OR 4 days a week, and 1 day/wk academic time.
- A) 0.7
- B) 0.8
- C) 0.9
- D) 1.0 (no academic time)

Non-Clinical FTE:
Not providing clinical care

- 1.0 = Clinical FTE + Non-Clinical FTE
- Faculty, non-Clinical FTE is academic time
- Residents: % rotations not available to cover department clinical sites (out of department rotations)
- CRNA: trickier to determine "non-Clinical" time
  - It's not academic time, instead, out of a 5 day work-week, how many days is the CRNA NOT available to work?
  - 5 8-hr days, then Clinical FTE = 1.0, non-Clinical 0
  - 4 10-hr days, then Clinical FTE = 0.8, non-Clinical 0.2
    - Need 1.2 FTE to cover all 5 days
  - 3 12-hr days, then Clinical FTE = 0.6, non-Clinical 0.4
  - Obviously, similar calculation if 50-hr CRNA (but more $$$)

Calculate Non-Clinical FTE from Clinical FTE needed

$$\%\ \text{Clinical FTE} = \frac{\#\ \text{Clinical FTE}}{\#\text{Clinical FTE} + \#\text{non-Clinical FTE}}$$

$$\#\ \text{non-Clinical FTE} = \left\{ \frac{\#\ \text{Clinical FTE}}{\%\ \text{Clinical FTE}} \right\} - \#\text{Clinical FTE}$$

Example: If % Clinical FTE is 0.75 and Clinical FTE = 75, then

$$\#\ \text{non-Clinical FTE} = \left\{ \frac{75}{0.75} \right\} - 75 = 25$$

Calculate Non-Clinical FTE

$$\#\text{non-Clinical FTE} = \frac{\#\ \text{Clinical FTE} - \#\text{Clinical FTE}}{\%\ \text{Clinical FTE}}$$

Clinical FTE

- Faculty, although bubba's work 0.8 or 0.9, some faculty are less. In this example 0.75.
- Residents: 4 Residents of 36 not available for department clinical work. Hence, 29/36= 0.89
- CRNA: 4 10-hr days. Hence, 4/5 = 0.8

Clinical Services	Sites	Faculty	Residents	CRNA or AA
Main OR	16	8	11	5
Remote	2	1	1	1
1:1 rooms	1	1	1	-
Faculty Rm	1	1	-	-
Schedule Runner	1	1	1	-
Total Anes Sites	21			
Preop Clinic	NP	1	1	-
L&D		1	3	-
Acute Pain/Block		1	1	-
Chronic Pain Clinic/ Procedures	Fellow	2	1	-
SICU	Fellow	1	3	-
Call		2	**	
Post Call		2	6	-
Daily Clinical FTEs needed		22	29	6

Calculate Non-Clinical FTE

$$\#\text{non-Clinical FTE} = \frac{\#\ \text{Clinical FTE} - \#\text{Clinical FTE}}{\%\ \text{Clinical FTE}}$$

Clinical FTE

- Faculty, although bubba's work 0.8 or 0.9, some faculty are less. In this example 0.75.
- Residents: 4 Residents of 36 not available for department clinical work. Hence, 29/36= 0.89
- CRNA: 4 10-hr days. Hence, 4/5 = 0.8

Non-Clinical Time	Faculty	Residents	CRNA or AA
Ave Clinical FTE % of FTE	0.75	0.89	0..8
non-Clinical FTE			
Rounded non-Clinical FTE			

Clinical Services	Sites	Faculty	Residents	CRNA or AA
Main OR	16	8	11	5
Remote	2	1	1	1
1:1 rooms	1	1	1	-
Faculty Rm	1	1	-	-
Schedule Runner	1	1	1	-
Total Anes Sites	21			
Preop Clinic	NP	1	1	-
L&D		1	3	-
Acute Pain/Block		1	1	-
Chronic Pain Clinic/ Procedures	Fellow	2	1	-
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non-Clinical FTE	7.3	3.6	1.5
Rounded non-Clinical FTE	8	4	1.5

Total Staff Needed?

Staffing Model Totals	Faculty	Residents	CRNA or AA
Total FTEs NEEDED	30	33	7.5

What about people who are on vacation, meetings, and sick?

- Determine number weeks away.
  - Example 6 weeks
- % weeks away
  - 6/52 = 11.5%
- If 30 FTE needed then estimate away, 3.45 FTE (11.5%) away at any one time.
- Rounding up since away time is not constant, but seasonal.
- Sick leave harder. Rule of thumb…
  - Wild card!
  - 1 FTE for every 20-30 FTE

ARS Question: Away Time

Do your faculty accrue sick leave and vacation time separately or as one "away time"

- Sick Leave and Vacation separate
- Only accrue AWAY time that covers both

ARS Question: Away Time

Assume 2 weeks for Sick Leave

How much vacation time does a typical faculty accrue every year?

- <=4 weeks
- >4 weeks, <= 6 weeks
- > 6 weeks

ARS Question: Away Time

Do faculty and CRNA have the same away time (vacation, sick, meeting)?

- Yes
- No

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Staffing Model Totals	Faculty	Residents	CRNA or AA
Total FTEs NEEDED	30	33	7.5

Per Year	Meeting	Vacation	Sick FTE
Faculty	2 wks	4 wks	1
CRNA/AA	1 wk	4 wks	0.5
Resident	0.33 wk	2 wks	1

Away Time	Faculty	Residents	CRNA or AA
Meeting	1.15	0.21	0.19
Vacation	2.31	1.38	0.77
Sick	1	1	0.5
Total Away FTE	4.46	2.59	1.46
Rounded Away FTE	5	3	1.5

Staffing Model Totals	Faculty	Residents	CRNA or AA
Total FTEs NEEDED	35	36	9

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- Rounding up gives you some flexibility in staffing
  - Unexpected sick leave
  - 1:1 cases
  - Seasonal vacation
  - Jury duty

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Do you need to hire anyone?

Estimate Staffing Needs	Faculty	Residents	CRNA or AA
Current	30	36	10
Expected Departures	-3	-12	-1
Expected Hires	6	12	0
Expected Staff Next Year	31	36	9
Excess or (Deficit) FTE	(2)	-	-

Example Simple Staffing Model
Academic Department serving one AMC

- Staff
  - 30 full time anesthesiologists
  - 36 residents (12 in each CA year)
  - 10 CRNA or AA
- Academic Medical Center
  - 19 OR suite (Main OR)
  - 2 Remote Sites Daily
  - Labor Delivery with 2 ORs
  - Preoperative clinic
  - SICU
  - Acute Pain Management/Regional Block service
  - Chronic Pain Management service
- Away time

Per Year	Meeting	Vacation/Sick
Faculty	2 wks	4 wks
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Resident	0.33 wk	2 wks

- In-house call
  - 2 Faculty FTE (Main OR, L&D)
  - 3 residents in Main OR
  - 2 in L&D
  - 1 in SICU
  - Postcall day off
- Ratio 1:2
  - Except schedule runner and one other faculty, both 1:1
- Clinical FTE
  - Average for Faculty is 0.75
  - CRNA or AA work 4 10-hr days (=0.8 clinical FTE)
  - 4 residents are doing rotations outside the department, hence each resident =0.89 clinical FTE
- Sick leave. Assume each week,
  - 1 Faculty FTE out sick
  - 1 Resident
  - 0.5 CRNA

Making Staffing Model

- Obvious: the controlled variables
  - Staffing ratio
  - Call coverage
  - Non-clinical time
  - Non-OR rotations for Faculty and Residents
- Subtle: the independent variables
  - Non-clinical time
  - Away time for faculty and for CRNA
  - Remote sites
  - Need for breaks
  - Late rooms
- Define the parameters and include Faculty, Residents, CRNAs/AAs
- Steps to Complete (use Excel!)
  1. Clinical Services
  2. Non-clinical FTE
  3. Away FTE
  4. FTE needed
  5. FTE available (expected hire, expected departure)

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Estimate Staffing Needs	Faculty	Residents	CRNA or AA
Current	30	36	10
Expected Departures	-3	-12	-1
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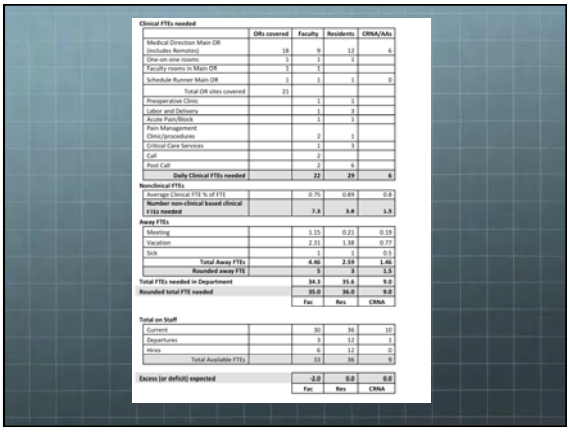
Expected Staff Next Year	31	36	9
Excess or (Deficit) FTE	(2)	-	-



Clinical FTEs needed

	ORs covered	Faculty	Residents	CRNA/AAs
Medical Direction Main OR (includes Remotes)	18	9	12	6
One-on-one rooms	1	1	1	
Faculty rooms in Main OR	1	1		
Schedule Runner Main OR	1	1	1	0
Total OR sites covered	21			
Preoperative Clinic		1	1	
Labor and Delivery		1	1	
Acute Pain/Block		1	1	
Pain Management Clinic/procedures		2	1	
Critical Care Services		1	1	
Call		2		
Post Call		2	1	
Daily Clinical FTEs needed		**22**	**29**	**6**

Nonclinical FTEs

Average Clinical FTE % of FTE		0.75	0.89	0.8
Number non-clinical based clinical FTEs needed		**7.3**	**3.4**	**1.3**

Away FTEs

Meeting		1.15	0.21	0.19
Vacation		2.31	1.38	0.77
Sick		1	1	0.5
Total Away FTEs		**4.46**	**2.59**	**1.46**
Rounded away FTE		**5**	**3**	**1.5**
Total FTEs needed in Department		**34.3**	**35.6**	**9.0**
Rounded total FTE needed		**35.0**	**36.0**	**9.0**
		Fac	**Res**	**CRNA**

Total on Staff

Current		30	36	10
Departures		3	12	1
Hires		6	12	0
Total Available FTEs		33	36	9
Excess (or deficit) expected		**-2.0**	**0.0**	**0.0**
		Fac	**Res**	**CRNA**

CMS: Implementation of Interpretive Guidelines: Best Practices

Norman A. Cohen, M.D.

Objective

1. Describe the legislative and regulatory basis for hospital compliance with the Medicare Conditions of Participation (COP)
2. Differentiate between the COP and Interpretive Guidelines (IG)
3. Cite the agencies and organizations who may survey a hospital for compliance with Medicare regulations
4. Delineate the requirements for anesthesia services in hospitals, including provider requirements and quality review
5. Report the key recent revisions to the COP
6. Summarize the obligations of directors of anesthesia services in implementing the COP and IG

Contents

- CMS: Implementation of Interpretive Guidelines: Best Practices
- Objectives
- Legislative and Regulatory Basis
- Surveying for Compliance
- Anesthesia Services
- Recent Revisions
- Interpretive Guidelines
- Conditions of Participation
- Key Implementation Issues
- Director of Anesthesia
- Single Anesthesia Service
- Rescue Capacity
- Anesthesia vs Analgesia and Privileging
- Quality Improvement
- Service Delivery
- Pre-, Intra-, and Post-Anesthesia Requirements
- Immediate Availability
- Informed Consent
- Summary

CMS: IMPLEMENTATION OF INTERPRETIVE GUIDELINES: BEST PRACTICES

OBJECTIVES

To participate in the Medicare program, hospitals must meet certain requirements mandated by legislation and regulation. This lecture will enable those in attendance to:

- Describe the legislative and regulatory basis for hospital compliance with the Medicare Conditions of Participation (COP);
- Differentiate between the COP and Interpretive Guidelines (IG);
- Cite the agencies and organizations who may survey a hospital for compliance with Medicare regulations;
- Delineate the requirements for anesthesia services in hospitals, including provider requirements and quality review;
- Report the key recent revisions to the COP;
- Summarize the obligations of directors of anesthesia services in implementing the COP and IG.

LEGISLATIVE AND REGULATORY BASIS

The *legislative* foundation for the Medicare program is the Social Security Act (SSA). Congress amended this act in 1965[1] to create the Medicare program. At that time, Medicare consisted of two parts – Part A, which covers hospital services, and Part B, which covers supplementary medical services including physician and ambulatory care. Congress has also passed additional amendments that created Medicare managed care (Part C), a Medicare prescription drug benefit (Part D) and various miscellaneous provisions (Part E).[2]

In part E of the SSA (Sec. 1861. [42 U.S.C. 1395x] paragraph e)[3], Congress defines what a *hospital* is from a legislative perspective and what a hospital must do to be recognized by Medicare. A sampling of these requirements includes having physicians supervise the delivery of diagnostic and therapeutic services for medical diagnosis, treatment and care to injured, sick or disabled patients; maintaining clinical records; having bylaws in effect for the medical staff; assuring that care is under the supervision of a physician; providing 24 hour nursing services; employing a utilization review plan; and maintaining state licensure if the state in which the hospital operates requires such licensure. For purposes of this lecture, an important provision of this section is

(9) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.

Whenever Congress includes language like "the Secretary finds…", this opens the door for the Executive Branch to promulgate broad regulations. The Conditions of Participation[4](COP) are *regulations* that put flesh on this legislative skeleton. In addition, the COP also implement other aspects of the enabling legislation. These regulations have the force of law, just as Congressional legislation does. The Executive Branch must follow certain procedures when implementing or revising these regulations,[5] such as publishing proposed regulations (Notice of Proposed Rule-making [NPRM] in the Federal Register), offering a comment

1 http://www.ssa.gov/history/lbjsm.html
2 http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm
3 http://www.socialsecurity.gov/OP_Home/ssact/title18/1861.htm
4 http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf
5 https://www.federalregister.gov/uploads/2011/01/the_rulemaking_process.pdf

period, responding to public comment and publishing final regulations. The law governing these activities is known as the *Administrative Procedures Act* (APA).

Legislation leads to the creation of regulation. Regulations are often complex, occasionally vague and sometimes open to interpretation. In many cases, the executive agency or department issues *interpretive rules*, in which the agency explains how it interprets an existing regulation or statute, how a rule may apply in a given instance, and what things a person or corporation must do to comply. The *interpretive guidelines (IG)* related to the COP are interpretive rules. The IG are not subject to the requirements of formal rule-making, and interpretive rules are not allowed to create a new legal standard. Although not required, in some cases the executive agency may request public comment. The APA does not require that these interpretive rules be published in the federal register. Typically, they may only exist as guidance documents on the agency's web site or may be available from the *Government Printing Office* (GPO).[6]

For purposes of this monograph, the applicable COP and IG for anesthesia services refer to those related to hospital care. While rules for other settings such as Ambulatory Surgery Centers are similar, they do differ in some specifics. The locations for relevant regulations for these other settings are typically available at the CMS web site. **Caveat emptor!** When it comes to requirements for anesthesia services, those responsible for managing anesthetic practices need to be very familiar with relevant sections of the SSA, COP and IG dealing with hospital care and anesthesia services.

SURVEYING FOR COMPLIANCE

The Department of Health and Human Services (HHS), through its agency, the Centers for Medicaid and Medicare Services (CMS), has an obligation to assure that entities providing care to Medicare beneficiaries are compliant with Federal law and regulation. The federal government delegates this responsibility to either state surveying agencies (SA) or accreditation organizations (AO) that have received approval to perform these reviews. Examples of organizations with such delegated authority include The Joint Commission (TJC) and Det Norske Veritas (DNV). Previously, TJC had special legislative standing as an AO; however the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) removed that status effective in 2010. Now, any organization that meets **or exceeds** CMS survey and oversight requirements has "equal footing" in achieving recognition from CMS as an AO.

Organizations reviewing hospital operations must, at a minimum, survey in accordance with Medicare's State Operations Manual (SOM). The SOM includes the Conditions of Participation, Interpretive Guidelines and guidelines for surveying. The SOM for hospitals is available online[7] as is the list of deemed organizations[8] allowed to perform Medicare site surveys for various types of healthcare organizations. Hospitals choosing to use an AO are not typically surveyed by the state surveying agencies; however, using an AO is optional. If an AO does not perform the survey, then the SA will. In some cases, the SA will perform a "validation survey" at the direction of CMS following a survey by an AO. If the SA determines non-compliance with the COP, then the SA assumes authority for ongoing compliance; otherwise, ongoing compliance review rests with the AO.

ANESTHESIA SERVICES

The COP have specific requirements for how anesthesia services must be delivered to meet Federal requirements. Historically, federal regulators identified anesthesia as a high risk service. As a result, provision of anesthesia services is one of the identified areas covered in the COP.

§482.52 Condition of Participation: Anesthesia Services. If the hospital furnishes anesthesia services, they must be provided in a well-organized manner under the direction of a qualified doctor of medicine or osteopathy. The service is responsible for all anesthesia administered in the hospital.[9]

The Conditions of Participation related to anesthesia services includes the following sub-parts:

a. *Organization and Staffing*

b. *Delivery of Services* with subsections addressing requirements for:

- Pre-anesthesia evaluation
- Intraoperative anesthesia record
- Post-anesthesia evaluation

c. *State Exemption* (refers to state-based opt-out for CRNA supervision requirements)

The State Operations Manual includes interpretive guidelines for each of these parts and sub-parts as well as survey procedures that SA or AO surveyors should follow. Other parts of the COP and IG also affect anesthesia delivery, including surgical, pharmaceutical, laboratory, radiological, and transfusion services as well as medical staff organization and the hospital wide Quality Assessment and Performance Improvement (QAPI) program requirements.

RECENT REVISIONS

In May 2012, CMS published a number of updates to the COP in the Federal Register.[10] These changes followed some substantial revisions to the interpretive guidelines for anesthesia services, introduced in 2010 and 2011. We will first address the changes to the IG and then address changes in the COP.

INTERPRETIVE GUIDELINES

Possibly the most significant change found in the IG revisions was that all anesthesia services would be under the direction a single physician; furthermore, CMS specifically noted that anesthesia services included all anesthesia and analgesia techniques, which include topical anesthesia, all forms of sedation, monitored anesthesia care (MAC), and regional and general anesthesia. Also, the hospital's governing body, with recommendations from the medical staff, determines the qualifications for a director of anesthesia.

Another important revision was differentiating anesthesia from analgesia. While anesthesia services require physician supervision of nurse anesthetists or performance by a physician in states that have not exercised an "opt-out", CMS specifically notes that analgesia does not. CMS classified neuraxial procedures for labor as analgesia, thus not being subject to Medicare supervision requirements. General, regional and monitored anesthesia care (**which includes deep sedation**) are considered anesthesia; whereas, moderate sedation, minimal sedation and topical and local anesthesia are considered analgesia. The governing body is also expected to define policies to define whether services provided in various locations are classified as anesthetics or analgesics, but this determination needs to consider "nationally recognized guidelines." Although the IG describe the differences between anesthesia and analgesia, hospital policies and procedures must address "qualification and supervision requirements for each category of practitioner who is permitted to provide analgesia services, particularly moderate sedation." The anesthesia quality program for the hospital must address both anesthesia services as well as analgesia care.

Addressing confusion regarding evaluation both before and after moderate sedation, the revised IG note that **neither a pre-anesthesia evaluation nor a post-anesthesia visit performed by a qualified anesthesia provider** is a requirement for moderate sedation services.

CMS provided clarifications regarding the timing of required elements of the pre-anesthesia evaluation. Within 48 hours of the administration of the first medication used to induce anesthesia, a review of the medical history, including anesthesia, drug and allergy history; an interview, if possible based on patient condition; and an examination. One may obtain other required elements between 30 days and 48 hours of anesthesia start, provided they are reviewed and updated within the 48 hour timeframe. These include discussion of risk, identification of potential anesthesia problems, other data or information that may be required (e.g., cardiac

6 http://metalib.gpo.gov/

7 http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

8 http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter09-08.pdf

9 http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_a_hospitals.pdf

10 Federal Register/Vol. 77, No. 95/Wednesday, May 16, 2012/Rules and Regulations p29034-29076

testing), and development of an anesthesia plan. Note that the pre-anesthesia evaluation must be "**updated, completed and documented**" before anesthesia start.

For the post-anesthesia evaluation, CMS recently updated the IG to allow for assessment in the PACU, provided the patient has sufficiently recovered from the anesthetic to participate in the assessment. The revisions also address patients who may not be able to participate due to ongoing sedation, mechanical ventilation or other reasons. In these circumstances, the evaluation must still take place within 48 hours of the end of anesthesia and documentation must reflect that the patient was unable to participate. Similarly, for patients receiving long-acting regional anesthetics (epidurals, continuous nerve blocks), the note should indicate that resolution of the block is not expected to resolve within the 48 hours; however, the qualified provider performing the evaluation must document the other required elements.

CONDITIONS OF PARTICIPATION

In May, 2012, CMS published a final rule in the Federal Register,[11] updating several provisions of the Conditions of Participation for Hospitals and Critical Access Hospitals.[12] CMS noted that provisions of a Presidential Executive Order[13] from early 2011 to reduce burdensome and costly regulations drove the process.

While the final rule was wide ranging, the key issues impacting anesthesiology departments included changes to medical staff organization allowing health systems with multiple hospitals to operate under a single medical staff structure, expansion of the medical staff to include non-physicians as consistent with state law, allow for patient self-administration of their own medications subject to certain requirements, reduction in regulations related to transfusion and medication administration practices, broadened prescriptive authority for non-physicians, greater flexibility in using standing order sets, and removing the requirement for authentication of verbal orders within 48 hours (deferring to state law).

KEY IMPLEMENTATION ISSUES

It is important to note that the COP and IG address requirements for the hospital's (Medicare Part A) provision of anesthesia services. These regulations are separate and distinct from those governing payments for professional services (Medicare Part B). The discussion below will not address surgical or anesthesia teaching rules, medical direction requirements or other billing and compliance matters; however, the interested reader may refer to the Medicare Claims Processing Manual, Chapter 12 for further information.[14] The following sections will focus on some key implementation requirements academic anesthesia departments face in addressing the COP and IG for anesthesia.

DIRECTOR OF ANESTHESIA

The COP require that a physician serve as director of anesthesia services at each hospital. While CMS does not require the director to be an anesthesiologist, in most cases in academic practice, the Chair of Anesthesiology or her designee serves in this role. The hospital's governing board establishes criteria for qualifications of the director of anesthesia services, which must consider medical staff recommendations and meet the requirement that the director be an MD or DO. These criteria must also be consistent with State laws and acceptable standards of practice, such as guidance from professional organizations. For example, the American Society of Anesthesiologists (ASA) has a resource web page[15] that includes relevant policies and procedures, templates and the Manual for Anesthesia Department Organization and Management (MADOM). The hospital's policies may be more restrictive than these minimums by, for example, requiring that the director be an anesthesiologist, be board certified or possess specific experience requirements. Surveyors will confirm that the director of anesthesia is an MD or DO and has at least the following responsibilities:

- Planning, directing, and supervising all activities of the service;
- Evaluating the quality and appropriateness of the anesthesia services provided to patients as part of the hospital's Quality Assessment/ Performance Improvement (QAPI) program.

SINGLE ANESTHESIA SERVICE

All anesthesia and analgesia services throughout the hospital including off-site locations must be organized into the "single anesthesia service" under the direction of a single physician. CMS expects this service to be well organized and encourages, but does not require, that the anesthesia policies and procedures be developed collaboratively with other hospital participants involved in the delivery of anesthesia and analgesia care. These other services may include surgery, pharmacy, nursing, safety experts, etc.). The hospital's QAPI program must fully integrate anesthesia quality activities.

RESCUE CAPACITY

The IG address the concept of rescue capacity, noting that there is no "clear boundary" between the levels of sedation on the sedation continuum. Specifically, hospitals must have policies to address rescue from deeper than intended levels of sedation, including provider qualifications in airway management and advanced life support as well as managing the physiological consequences of deeper levels of sedation while returning to the desired level. Rescue is not only a requirement for anesthesia services, it is also consistent with Patient's Rights requirements (§482.13(c)(2)) regarding safe settings of care. The director of anesthesia services must assure that these policies both exist and are utilized.

ANESTHESIA VS ANALGESIA AND PRIVILEGING

The COP include specific requirements for those providing anesthesia services, and the interpretive guidelines also distinguish between anesthesia and analgesia services as described previously. The COP specifically delineates who may provide anesthesia – a qualified anesthesiologist, a doctor of medicine or osteopathy, a dentist, oral surgeon or podiatrist if permitted by state law, a CRNA (supervised by the operating practitioner or an immediately available anesthesiologist in non-opt-out states) and an anesthesiologist assistant supervised by an immediately available anesthesiologist. The interpretive guidelines further state that hospital policies for anesthesia services must address the circumstances in which a non-anesthesiologist MD or DO may provide anesthesia services, as well as being compliant with State law for podiatrists, dentists and oral surgeons. Since deep sedation is considered part of MAC and therefore an anesthesia service, emergency physicians, intensivists and others may request anesthesia privileges for deep sedation or even general anesthesia.

For analgesia services (topical anesthesia, and minimal or moderate sedation), the IG note that the hospital **must** have policies and procedures governing the provision of these services. The hospital must also assure that patients receive all anesthesia services, including analgesia, from qualified providers in a safe, well-organized manner.

Hospitals must establish privileging policies for each type of anesthesia or analgesia service offered. Privileging policies typically include requirements for training and experience supporting the request.

If the hospital allows the operating practitioner to supervise a CRNA, the medical staff bylaws or rules and regulations must stipulate for each category of operating provider the type and complexity of services that may be supervised. This addresses differences in what a physician-surgeon may supervise versus podiatrists, dentists or other non-physicians. The IG do not **require** specific privileges for supervision; however, a hospital may elect to require privileges for this activity.

11 http://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Downloads/som107ap_aa_psyc_hospitals.pdf

12 http://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Hospitals.html

13 http://www.gpo.gov/fdsys/pkg/FR-2011-01-21/pdf/2011-1385.pdf

14 http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

15 http://www.asahq.org/for-members/practice-management/quality-management-and-departmental-administrative-toolkit.aspx

QUALITY IMPROVEMENT

The IG specifically note the expectation that results of ongoing quality improvement activities will drive the periodic review of anesthesia policies for the hospital. Specifically, adverse event monitoring, medication errors, and other quality and safety indicators both for anesthesia services and for analgesia services will lead to updates in policies. This expectation is also consistent with general requirements of QAPI (COP §482.21).

SERVICE DELIVERY

The COP and IG address the minimum requirements for anesthesia service delivery. Consistent with the needs and resources of the facility, anesthesia service policies must address how anesthesia services will be met and that delivery of such services will be consistent with recognized standards. Specific elements that should be addressed include patient consent; infection control; safety practices in anesthetizing locations; response for cardiac, respiratory and other emergencies; reporting and documentation requirements; equipment requirements including ongoing testing and maintenance; and delineated staff responsibilities for pre- and post-anesthesia care.

PRE-, INTRA-, AND POST-ANESTHESIA REQUIREMENTS

COP sections §482.52(b) (1)-(3) specify the requirements for the pre-anesthesia evaluation, intraoperative anesthesia service documentation, and post-anesthesia evaluation. These requirements specify who is qualified, what must be accomplished and documented, and any time constraints for accomplishing these activities. The recent revisions section of this document describe some important changes in this area.

IMMEDIATE AVAILABILITY

The interpretive guidelines define "immediately available" in reference to anesthesiologist supervision as:

An anesthesiologist is considered immediately available when needed by a CRNA under the anesthesiologist's supervision only if he/she is physically located within the same area as the CRNA, e.g., in the same operative/ procedural suite, or in the same labor and delivery unit, and not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed.

It is important to note that the scenarios given to illustrate "same area" are **examples** as indicated by the use of "e.g." Absent such explicit definition, anesthesia policies may and probably should specifically define immediate availability consistent with the IG and with local conditions, considering factors such as physical layout, patient condition, and experience and qualifications of the anesthetist or trainee. The hospital may establish a specific response time; however, the COP and IG do not require this action. Assigning responsibility to the supervising anesthesiologist based on their independent judgment could be part of the policy and may provide needed flexibility, provided that the QAPI program for anesthesia periodically assesses this approach for adequacy.

INFORMED CONSENT

The COP for surgical services includes a section addressing informed consent (§482.51(b)(2)). The IG associated with this section addresses requirements for anesthesia consent:

It should be noted that there is no specific requirement for informed consent within the regulation at §482.52 governing anesthesia services. However, given that surgical procedures generally entail use of anesthesia, hospitals may wish to consider specifically extending their informed consent policies to include obtaining informed consent for the anesthesia component of the surgical procedure.

If one chooses to have a separate anesthesia consent, one should carefully review the "Example of a Well-Designed Informed Consent Process" in §482.51(b)(2) (approximately page 370 of the State Operations Manual[16]). It is also important to note that certain services performed by anesthesiologists are classified as surgical services and are subject to the COP and IG for surgical services. These would include, for example, placement of invasive lines, separately reported nerve block procedures, and TEE. Thus department specific policies for these services must be consistent with hospital surgical services policies.

SUMMARY

Academic anesthesiology department chairs often serve as the designated hospital director of anesthesia services. The hospital's continued participation as a Medicare accredited facility depends in part on having a well-functioning single anesthesia service covering all analgesia and anesthesia activities within the institution. Directors of anesthesia service must have a good understanding of the legislative and regulatory basis for these requirements, which arise from the Social Security Act, the Conditions of Participation and the relevant Interpretive Guidelines. Failure to follow these requirements may lead to loss of hospital certification from the Medicare program, with substantial implications to all associated with the institution and particularly for those deemed responsible.

This monograph has highlighted a number of important recent changes to requirements for anesthesia service delivery as well as key implementation issues directors should know. It is essential to refer to the primary source material referenced throughout the document and found in the Endnotes section. Finally, hospitals frequently utilize approved Accreditation Organizations, such as The Joint Commission. While the rules associated with the designated AO must at a minimum meet expectations found in the COP and IG, additional requirements may also be present. The director of anesthesia services must also be knowledgeable in the specific requirements of the AO responsible for surveying their institution.

16 http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

Case-Based Scenarios

SAAA 2012 Annual Meeting

November 2, 2012

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Disclosures

- In private law practice
  - ➔Advise clients on regulatory compliance & transactions
- Objectives
  - ➔Sensitize Dep't Chairs to legal issues in everyday practice
  - ➔Suggest strategies to address them

Overview

- Focus on two primary areas
  - ➔Aging Department members
  - ➔References for former residents & faculty members

Dealing With Aging Faculty Members

Growing Numbers

- According to AMA:
  - ➔In 2010, 20% of licensed U.S. physicians were older than 65

Scenario

- Faculty member who is 70 years old
  - ➔Works full time
  - ➔Takes call
  - ➔Surgeons complain regarding that s/he's slow
  - ➔Some difficulty handling sicker patients

Americans w/Disabilities Act

- Prohibits discrimination on basis of disability in employment
- Protects "*qualified individuals with disabilities*"
  - ➔ Physical or mental impairment that substantially limits one or more major life activities
  - ➔ Record of such an impairment, or
  - ➔ Is regarded as having such an impairment

Age Discrimination

- ADEA protects individuals who are 40 years of age or older from employment discrimination based on age
  - ➔ ADEA permits employers to favor older workers based on age even when doing so adversely affects a younger worker who is 40 or older

Age Discrimination

- Applies to employers w/20 or more employees
- Enforcement: EEOC
- Applies to
  - ➔ Applicants for employment
  - ➔ Current employees
  - ➔ Discharged former employees

Bans on Discrimination

- All actions covered:
  - ➔ Hiring & firing
  - ➔ Compensation, assignment, & leave
  - ➔ Transfer, promotion, layoff, or recall
  - ➔ Recruitment
  - ➔ Training
  - ➔ Fringe benefits
  - ➔ Other terms & conditions

Age Discrimination

- Are actions to deal with increasingly incompetent anesthesiologist
  - ➔ Based upon a documented record of inability to perform, or
  - ➔ Seemingly sudden decision to change work assignment or take other action
    - ⏩ Without documentation
    - ⏩ Without fair process

Age-Based Requirements

- Requirements to pass annual medical exams at a given age (*e.g.*, 70 yrs) as a condition of continued employment found to violate ADEA
  - ➔ Courts: Fitness for a job is based on many factors
    - ⏩ Age is only one factor

Age-Based Requirements

- Even seemingly age-neutral req'ts can violate the ADEA based upon
  - ➔ Disparate impact on older workers
    - ⏩ Physicians/other clinical staff over a certain age probably more likely to fail physical & mental fitness assessments

Age-Based Requirements

- ADEA prohibits policies & practices that have effect of harming older individuals more than younger individuals
  - ➔ Unless employer can demonstrate policy/practice based on "reasonable factor other than age" ("RFOA")

Disparate Impact

- No intent needed to find disparate impact
  - ➔ Employer's lack of intent to discriminate is not relevant for disparate impact case
  - ➔ Only overall impact on older workers is relevant
    - ⏩ Regardless of employer's intention

Age-Based Requirements

- Defenses:
  - ➔ Bona fide occupational qualification ("BFOQ") reasonably necessary to the particular business
    - ⏩ Age-based req't must be reasonably necessary to essence of business
    - ⏩ *Individualized approach would be pointless or impractical*

Age-Based Requirements

- Defenses to claim of discrimination:
  - ➔ RFOA: reasonable factors other than age
  - ➔ Good cause – disciplining or discharging employee for good cause
  - ➔ Other non-age-based factors
    - ⏩ Job performance
    - ⏩ Business cutbacks
    - ⏩ Lack of qualifications

Stanford Policy

- Physical examination, cognitive screening, & peer assessment of clinical performance
  - ➔ Practitioners age 74.5 or older
    - ⏩ Applying for medical privileges
  - ➔ Current medical staff members ≥75
  - ➔ Completed every two years
  - ➔ Announced this year (2012)

Stanford Policy

- Policy based on data showing steep increase in Alzheimer's at 75 yrs. of age
  - ➔ Only 10% are ≤ 74
  - ➔ 44% ages 75-84
  - ➔ 46% are 85 or older
    - Source: Alzheimer's Association
    - http://www.alz.org/downloads/facts_figures_2012.pdf

Stanford Policy

- Legality?
  - ➔ Not yet tested
    - New policy adopted in 2012
- Stay tuned

TJC FPPE

- Focused professional practice evaluation ("FPPE") may provide a means to address aging faculty
  - ➔ Effective 1.1.09, FPPE performed for all new privileges
  - ➔ Also, must develop criteria to evaluate performance when issues affecting care are identified

Strategies

- Develop an inventory of physical & mental attributes needed to provide anesthesiology services
  - ➔ Provides a baseline against which to measure all Dep't members
- Perform 360 evaluations of all Dep't members
  - ➔ Can flag concerns/provide documentation

Strategies

- Implement policies to monitor physical & mental acuity of all Dep't members
  - ➔ Involve legal advisors in advance
  - ➔ Policies promote consistency – important in minimizing risk of discrimination claims
- Consider how Medical Staff policies on older physicians may assist – ***e.g.,***
  - ➔ Annual reappointment after certain age
  - ➔ FPPE

Post-Employment References

Scenario

- You receive request for reference on former resident
  - ➔Some erratic behavior
  - ➔Interpersonal difficulties
  - ➔Clinical skills adequate, not strong
  - ➔Often irritable late in the day
  - ➔Found excuses to work late/weekends

Scenario – Discussion

- How much can you/should you say?
- What legal risks?
  - ➔Did Dep't investigate?
  - ➔Any documented facts?
  - ➔What is Dep't's policy on references?
  - ➔What does state law provide?

Post-Employment References

- Liability associated with providing references
  - ➔What can you say when you are responding to a reference check?
  - ➔Answer largely depends on state law
    - ⁃⁃Does state law provide immunity?
      - ■Even so, potential claim that adverse information not given in good faith

Post-Employment References

- Grounds for liability (among others)
  - ➔Defamation
  - ➔Invasion of privacy
    - ⁃⁃Public disclosure of private facts
    - ⁃⁃False light privacy claims
  - ➔Negligent reference
  - ➔Possible state law claims

Truth not necessarily a defense

Post-Employment References

- Many lawyers recommend conservative approach
  - ➔Confirm dates of employment & position
  - ➔Refrain from additional comment
    - ⁃⁃If comment positively on some former employees, negative implication if do not on others

Post-Employment References

- How to balance
  - ➔Legal risk associated with disclosing information about former employee, &
  - ➔Promoting exchange of information regarding the former employee
    - ⁃⁃Enabling new employer to make an informed decision

Underlying Principles

- In general, no duty to warn
  - ➔Former employers do not have a duty to warn subsequent employers
  - ➔Check state law
- Liability for misrepresentations in providing a reference
  - ➔If you choose to go beyond confirming dates of employment/position

Kadlec v. Lakeview Anesthesia

- Read the 2008 decision in this case!
- Anesthesiologist diverted Demerol
- After confrontation, did not follow agreement & account for withdrawals
- On-duty practice while impaired
- Terminated by anesthesia group <u>for cause</u>
- Group's response to reference request?

Kadlec v. Lakeview Anesthesia

- Anesthesiologist 1:
  - ➔ Worked w/Dr. for 4 yrs
  - ➔ Excellent clinician
  - ➔"Would be an asset to any anesthesia service"
- Anesthesiologist 2:
  - ➔ "Recommended him highly as an anesthesiologist"

Kadlec v. Lakeview Anesthesia

- Lakeview Medical's response:
  - ➔Confirms dates of privileges
- Then: On-duty use of drugs at Kadlec results in catastrophic injury to patient
- Judgment: $8.24 million
- Kadlec sues Lakeview Medical & Lakeview Anesthesia

Kadlec v. Lakeview Anesthesia

- Court: "After choosing to write referral letters, the defendants [Anes. Group] assumed a duty not to make affirmative misrepresentations in the letters"
- Lakeview Medical: no duty to disclose
  - ➔No liability – letter not misleading
- Lakeview Anesthesia: Liable
  - ➔Letters were false & misleading

How Much Can/Must You Say?

- Under state law, do you have an obligation to disclose the misconduct?
  - ➔If not, substantial risk if you volunteer information
- Has former employee has executed a broad release?
  - ➔Useful, but may not immunize Group
    - ⁍Still opportunity for suit

Strategies to Minimize Liability

- Centralize authority for responding to requests for references
  - ➔ Small number of people, trained in risks
- Require written consent & a release
  - ➔ Provide adverse information only if it is factually based & verified as true
  - ➔ Balance discussion of any weaknesses with discussion of strengths

Strategies to Minimize Liability

- Establish & adhere to policy on responding to requests for references
- Call-back procedure
- Review the file before responding
- Limit remarks to truthful & documented information
- Answer the questions asked
- Document your response

Conclusion

Appreciate risks

- Older physicians
  - ➔ Age is just one factor to consider
    - ➔ Not by itself an issue
  - ➔ Consistency in dealing w/all employees
- References
  - ➔ Proceed with caution
  - ➔ Promote consistency in responding

Documentation

AAAC
Concurrent Sessions

Value Based Purchasing and Ongoing Professional Practice Evaluation
Moderator: Berend Mets, M.B., Ch.B., Ph.D., FRCA, FFA(SA)

Value Based Purchasing
Thomas F. Slaughter, M.D., M.H.A.

Ongoing Professional Practice Evaluation

- **Painless OPPE: Leveraging Existing Quality Reports for Faculty Assessment**
  David L. Reich, M.D.
- **Inviting the Wolf to Dinner: How and Why Physician Performance Evaluations Must Include CRNA Input**
  David A. Zvara, M.D.
- **What REALLY Happens Inside the Principal's Office: Examples of the What, How and Who of FPPE from Multiple Institutions**
  Warren S. Sandberg, M.D., Ph.D.

Value Based Purchasing

Thomas F. Slaughter, M.D., M.H.A.

Objectives:

1. To identify design features common to *Value Based Purchasing* initiatives
2. To appraise published evidence supporting *Value Based Purchasing*
3. To infer likely near-term modifications to *Value Based Purchasing* initiatives

Summary:

With U.S. per capita health care spending approaching $9,000 (in excess of $2.6 trillion annually) and recent estimates suggesting that health care will account for 20% of GDP by 2021 – questions remain as to the value received for these expenditures. Despite spending nearly twice that of other industrialized nations, evidence suggests that our overall health proves lacking in many regards. According to recent estimates, Americans receive only half of recommended care – with disparities and variance in care evident across the country. Few argue the necessity to curb health care spending or to improve efficiency of delivery. How best to accomplish these goals remains unclear; regardless, it's increasingly clear that *Value Based Purchasing* will underpin near-term health reform efforts.

No two *Value Based Purchasing* initiatives prove identical; however, most incorporate measures for (1) quality, (2) patient satisfaction, and (3) efficiency -- with incentives aligned to benchmark targets – much like pay-for-performance systems in non-health care settings. With origins in managed care plans of the 1980's, private payers have experimented with pay-for-performance schemes for decades. Only more recently have federal payers adopted this financing methodology supported by a succession of regulatory requirements culminating in a mandate for *Value Based Purchasing* -- as detailed in the PPACA legislation.

Despite limited supporting evidence, the concept of *Value Based Purchasing* has attained bipartisan support -- and certainly surpassed a "tipping point" -- with an implementation date of October 1, 2012 for CMS Hospital Value Based Purchasing. During this session, we will examine (1) factors driving adoption of *Value Based Purchasing*, (2) the evidence base underlying pay-for-performance in health care, and finally (3) expectations for the future of *Value Based Purchasing* in U.S. health care.

Selected References:

1. Jha AK, et al. The long-term effect of Premier pay for performance on patient outcomes. NEJM 2012;366:1606-15.
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3. Glasziou PG, et al. When financial incentives do more good than harm: a checklist. BMJ 2012;345:e5047.
4. Campbell SM, et al. Effects of pay for performance on the quality of primary care in England. NEJM 2009;361:368-78.
5. Werner RM, et al. The effect of pay-for-performance in hospitals: Lessons for quality improvement. Health Affairs 2011;30:690-8.
6. Emmert M, et al. Economic evaluation of pay-for-performance in health care: a systematic review. Eur J Health Econ 2011; DOI: 10.1007/s10198-011-0329-8, In press.

Ongoing Professional Practice Evaluation - Painless OPPE: Leveraging Existing Quality Reports for Faculty Assessment

David L. Reich, M.D.

Anesthesia Reports

1. 48 hour post-anesthetic mortality
2. Postop complications (standard CMS list) (self-reported)
3. Central line education
4. Postoperative Note Completeness and Timeliness
5. Anesthesia Record Required Element Completeness and Timeliness
6. PQRS Measures:
    a. Antibiotic timeliness
    b. Hypothermia prevention measures
    c. CLABS prevention program compliance (central line checklist completion)

Surgical and Perioperative Reports

1. Returns to OR
    a. Second operation within same hospitalization
2. Anastomotic leak
3. Surgical operation log
4. PACU statistics and pain at discharge
5. Median VNS score during hospitalization

Epic Documentation (Pain and ICU)

1. Co-signature by attending physician of housestaff notes with attestation
2. Timeliness of co-signature/attestation of consultations.

Ongoing Professional Practice Evaluation - Inviting the Wolf to Dinner: How and Why Physician Performance Evaluations Must Include CRNA Input

David A. Zvara, M.D.

The Joint Commission requires a peer review process for hospital accreditation. There are two levels of peer review: focused and ongoing. Focused Professional Practice Evaluation (FPPE) is defined as a period of focused professional practice evaluation for all initially requested privileges. This would mean all privileges for new practitioners and all new privileges for existing practitioners. The EP was published in January 2007 with an effective date of January 1, 2008. The elements of the evaluation may include periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, and/or discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing, and administrative personnel. The FPPE process must be defined, the process must be consistently implemented as defined, and all new privileges (new applicants and new privileges for existing applicants) must be reviewed in accordance with the defined process. Ongoing Professional Practice Evaluation (OPPE) requires organizations look at data on performance for all practitioners with privileges on an ongoing basis rather than at the two-year reappointment process allowing institutions to take steps to improve performance on a timelier basis. The parameters evaluated and the principles are the same as with the FPPE.

The University of North Carolina at Chapel Hill uses our AIMS (Anesthesia Information Management System) to satisfy the FPPE and OPPE requirement. We have instituted a Peer-to-Peer evaluation system that is defined, consistent and reviewed on a regular basis. The matrixes of evaluations include: physicians evaluating physicians, physicians evaluating CRNAs, CRNAs evaluating physicians, and CRNAs evaluating CRNAs. The frequency and the selection of who evaluates whom is determined by a computer generated randomization scheme such that on a monthly basis, every clinician receives three evaluations to complete and each clinician is evaluated at least once. All of the questions revolve around the core-competencies (table 1).

Including an evaluation of physicians by CRNAs is vital to the process. The CRNAs are in great position to evaluate physician skill. They work with a wide variety of physicians and are able to generate comparisons regarding effectiveness. In addition, including the CRNAs allowed a “voice” for the CRNAs to express both acclimation for exemplary behavior and criticism where appropriate. For the FPPE, each new physician is evaluated daily whenever working with a CRNA for 30 days. After the 30 day FPPE, the OPPE initiates and each physician is evaluated by a CRNA approximately twice in a month. Hence, at the end of a twelve-month period, each clinician will have approximately 24 CRNA to physician evaluations and twelve physician-to-physician evaluations. In the past two years we recorded 1067 evaluations on 70 physicians from 68 CRNAs. All questions are worded in the affirmative and answered on a 4-point scale: strongly agree (4), agree (3), disagree (2) and strongly disagree (1). There is an opportunity to comment with each question. When reviewing the data we look at the average score for the clinician compared to the group average, the standard deviation, and any comments received.

A committee composed of two physicians and one CRNA analyzes these data on a quarterly basis. Outliers are identified and a discussion occurs regarding intervention. First level intervention occurs with a member of committee. The Chair is unaware of the scoring and the intervention at this stage. A work plan is discussed for remediation. If the outlier continues to post unsatisfactory evaluations at the next quarter, the Chairman is notified and will counsel the physician. All physicians may review their evaluations at anytime. The Chair reviews the evaluations with the faculty at least once annually whether good or bad. A component of the annual academic performance bonus is based on the sum of the peer-to peer evaluations.

At the University of North Carolina at Chapel Hill we are satisfied with this program. It satisfies The Joint Commissions requirements and it provides us with actionable information to modify behavior.

References: http://www.jointcommission.org

Table 1: The Questions used for the CRNA to Physician Evaluation (FPPE and OPPE).

1. This clinician arrives on time to accept clinical responsibilities (Professionalism).
2. This clinician is organized and well prepared for his or her clinical assignment (Patient Care).
3. When requested, this clinician reliably and effectively provides clinical assistance and support to colleagues (Interpersonal).
4. This clinician exemplifies professional behavior (Professionalism).
5. This clinician adapts well to the changing clinical demands effecting manpower allocation during the day and/or when on call (Systems based practice).
6. This clinician demonstrates respect towards coworkers (interpersonal and communication).
7. This clinician exemplifies the very best in quality care (Patient Care).
8. I am comfortable “handing off” my patients to this clinician (Patient care).
9. This clinician practices evidence-based medicine with up to date knowledge of our field (Medical Knowledge).

Ongoing Professional Practice Evaluation - What REALLY Happens Inside the Principal's Office: Examples of the What, How and Who of FPPE from Multiple Institutions

Warren S. Sandberg, M.D., Ph.D.

Learning objectives:

1. Develop sufficient understanding of the OPPE or clinical performance events that would trigger an FPPE in an example academic anesthesia department.
2. Elucidate one department's organization of peer review, quality improvement and ongoing professional practice evaluation.
3. Review actual [deidentified] examples of FPPE plans and outcomes

Abstract: The Joint Commission now requires that as part of the process of maintaining or modifying medical privileges (i.e., 'credentialing'), an ongoing professional practice evaluation be performed more frequently than annually. Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.

The process for the ongoing professional practice evaluation includes the following: (1) There is a clearly defined process in place that facilitates the evaluation of each practitioner's professional practice, (2) The type of data to be collected is determined by individual departments and approved by the organized medical staff, and (3) Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s). These requirements obsoleted most of the traditional methods for demonstrating suitability for re-credentialing, and the frequency with which an OPPE must be performed seems at first to be onerous.

This lecture will explain what the OPPE and FPPE process means in practical terms, and will describe successful (and potentially unsuccessful) OPPE / FPPE processes. Different types of evaluation processes and evaluation metrics will be presented and critiqued. A structure for administration of OPPE and FPPE will be described. The Joint Commission gives health care organizations considerable latitude the construction and administration of FPPE. The FPPE serves at least 3 purposes, which inform the construction of the FPPE to be employed. FPPE are used for the initial evaluation supporting granting of privileges. An FPPE can be triggered by non-normative events or actions involving the evaluated individual. Finally, an FPPE can be triggered by the results of the OPPE process. In fact, it is expected that a robust and well-functioning OPPE process will periodically generate FPPE events.

Introduction:

Background – Ongoing Professional Practice Evaluation:

To satisfy increasing public demand for accountability of clinicians, The Joint Commission recently updated the requirements for the process of physician credentialing. These new standards, which call for an Ongoing Professional Performance Evaluation (OPPE), went into effect on January 1st, 2008 and require a competency-based evaluation of clinical performance that is both evidence-based and continuous.

The JC requires OPPE 'more frequently than annually' (i.e., at least every 6 months) using at least two and preferably multiple objective, discrete metrics capturing a relevant part of anesthesia practice applicable to all clinicians. For a full-service anesthesia department, this requirement is somewhat problematic, as intensivists, pain specialists and OR-based clinicians all have different processes of care.

Numerous methods could be used to evaluate physician performance by various specialties. Commonly used methods to review physician competency including (1) Simulated patients, (2) Video or direct observation, (3) Peer assessment, (4) Medical record audits, (5) Portfolio appraisals, (6) Monitoring of therapeutic and diagnostic techniques, and (7) 360° degree evaluations – evaluation of physicians by other individuals on the care team (consultants, surgeons, nurses, technicians, and administrative personnel).

In specialties where data are both objective and saved, 'over-reads' of samples of data can be used to assess whether clinicians are practicing according to norms. For example, radiologists double read films to evaluate concordance between clinicians. Internists perform chart reviews to assess completeness and appropriateness of therapeutic planning. Some physicians are directly observed while providing care. However, methods that employ direct observation have the potential to introduce an observation bias, because we know that individuals behave differently when they know they are being watched. Moreover each of these methods is time consuming, expensive, and difficult to perform on a continuous basis. Even over-reads of stored medical information such as radiology images or pathology samples require the direct effort of an experienced clinician. Removing clinicians from direct patient care to comply with OPPE mandates is a significant financial burden and reduces clinical efficiency.

The increasing presence of electronic patient records in the OR (known as Anesthesia Information Management Systems – or AIMS) creates the potential to automate the process of observing care and over-reading cases through electronic analysis of the AIMS record itself. Such an approach potentially relieves the requirement that observation and comparison to norm be performed by a physician, while at the same time allowing analyses of ALL cases instead of a sample.

How does one develop an OPPE system and credentialing metrics for a large full-service department? Leveraging the investment in electronic records should help minimize administrative and clinical burdens and reduce the effect of observation and bias in measurements. Reliance on electronically collected data allows the creation of an automatic, reliable process that would be cost-effective. Furthermore, this strategy allows the process to be applied continuously, and one can easily modify the process to replace or add additional metrics as needed over time.

Metrics used for OPPE and FPPE should be consistent with national practice, they should be centered on patient care, and, if possible, they should address the ACGME Core Competencies. Focusing on the standards requiring the presence of qualified personnel and for monitoring ventilation and circulation, a team at Massachusetts General Hospital (1) developed three novel metrics based on readily available, automatically gathered AIMS data:

- *Blood Pressure Monitoring*: Requires that a physician measure a blood pressure prior to induction of anesthesia.
- *End Tidal CO_2 Monitoring*: Requires monitoring End Tidal CO_2 level at least once during the provision of general anesthesia.
- *Timely Documentation of Compliance Statements*: Requires that a physician document all of the necessary case compliance / attestation statements no more than 120 minutes after the end of anesthesia care.

Each metric is completely within the control of the evaluated clinician. The results of each metric measurement are confidentially provided to each clinician on an ongoing, semi-annual basis, benchmarked against the performance of the entire department.

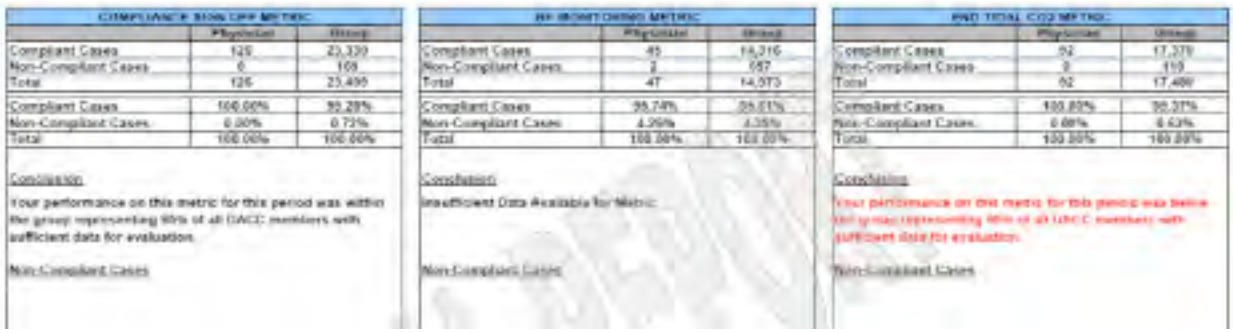


Figure 1. Sample Ongoing Professional Practice Evaluation (OPPE) Report

Alternatively, a team at University of North Carolina developed an electronically mediated 360° evaluation with peer-to-peer questions addressing the evaluated clinician's performance with respect to the core competencies (2). At Vanderbilt a combination of both systems is used. An example of Vanderbilt's questions and scoring system is given in the box.

Please evaluate the individual in the context of patient care.
Rate how you believe the individual demonstrates the following competencies on a scale from 1 to 4 where:

1=poor	3=good	Abstain= No basis for
2=fair	4=very good	knowledge to evaluate this competency.

1. Engages in evidence-based practice. Integrates new evidence to improve his/her own patient care practices (competency in practice-based learning and improvement)
2. Demonstrates medical knowledge about established and evolving science related to the practice of anesthesia care.
3. Behaves in a manner that exemplifies professionalism (honesty & integrity, work ethic, punctuality, altruism, bringing honor to our profession)
4. Communicates in a manner that demonstrates respect toward coworkers, facilitates interdisciplinary teamwork, & results in effective information exchange and optimal patient care (competency in interpersonal and communication skills)
5. Adapts well to changing clinical demands affecting workload and resource allocation (competency in systems-based practice)
6. Is organized and well-prepared for his/her clinical assignment. Provides excellent and compassionate patient care and demonstrates excellence in clinical skills (competency in patient care)
7. Appropriately seeks and accepts consultation from colleagues (competencies in practice-based learning and improvement, professionalism, & interpersonal and communication skills)
8. Makes you comfortable handing over care of a patient to him/her or accepting a hand-over of care from him/her (all competencies)
9. Makes you comfortable referring a friend or loved one for medical care by him/her (all competencies)

Focused Professional Practice Evaluation:

Focused Professional Practice Evaluation (FPPE) is a requirement when a clinician is newly joining the medical staff, or when they are requesting additional privileges. FPPE may also be (in fact, are expected to be) triggered by a well functioning OPPE system. Finally, certain types of events in the clinician's practice may themselves trigger an FPPE. Healthcare organizations are given considerable latitude in constructing their FPPE processes and the triggers for FPPE, but again these must be administered consistently and fairly, using an organized structure and with a confidential but traceable process.

Organization for Administration of OPPE / FPPE: The Department of Anesthesiology at Vanderbilt University School of Medicine has three standing committees related to quality and involved with administration & operation of the OPPE / FPPE process:

- Quality and Performance Improvement/Patient Safety Oversight Committee (QAPI/PS Oversight)
- Peer Review Committee (PRC)
- Quality, Morbidity & Mortality, and Improvement Committee (QMMI)

The Chair of the Quality and Performance Improvement/Patient Safety Oversight Committee, who is also the Departmental Patient Safety Officer, is the point of input for all OPPE measurements, as well as many events that might trigger an FPPE. Importantly, the operational leadership of the department, who have control over clinical assignments, salary and reappointment, are not involved in administration or primary review of OPPE. The structure and relationships of these committees are illustrated below:

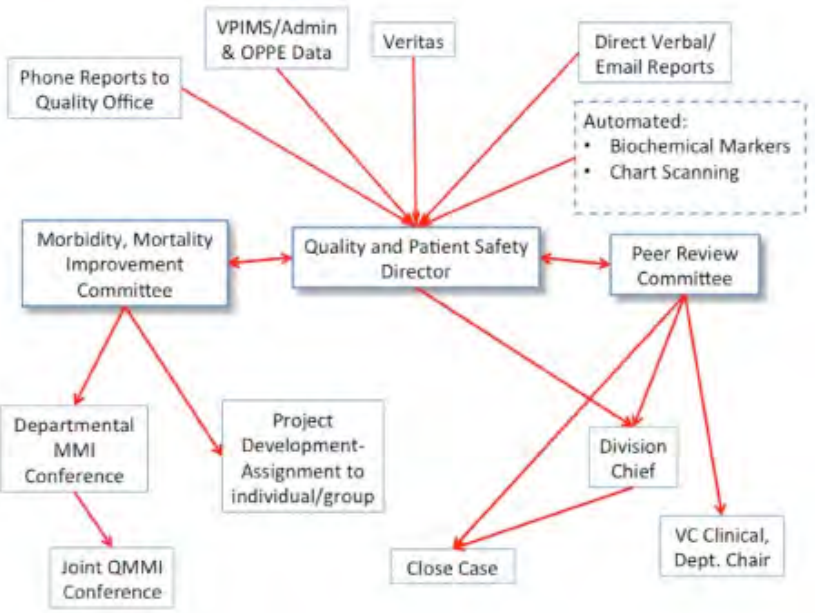


Figure 2: Structure of the Vanderbilt Quality & Safety Functions

The operational leadership of the department are not directly involved in the creation or initial administration of FPPE, though they may play a facilitating role.

FPPE and Operation of the FPPE Process: The Joint Commission gives health care organizations considerable latitude the construction and administration of FPPE. As described above, the FPPE serves at least 3 purposes, which inform the construction of the FPPE to be employed. FPPE are used for the initial evaluation supporting granting of privileges. An FPPE can be triggered by non-normative events or actions involving the evaluated individual. Finally, an FPPE can be triggered by the results of the OPPE process.

OPPE processes that depend on electronic capture of case information or administration of brief surveys yield copious data. Since the OPPE process is expected to generate some FPPEs if the process is working well, the data must be analyzed objectively to identify clinicians warranting an FPPE. This can be done by searching for outliers in objective data. However, when subjective responses are used, as in the 360° evaluation process, individual variation in the application of the rating scale obscures potential outliers. Baker (3) has shown that converting Likert scale data to Z-scores for each rater and then aggregating rater-specific Z-scores for the rated individuals allows distinctions to be made between individual rated subjects. A sample of such a distribution is shown below:

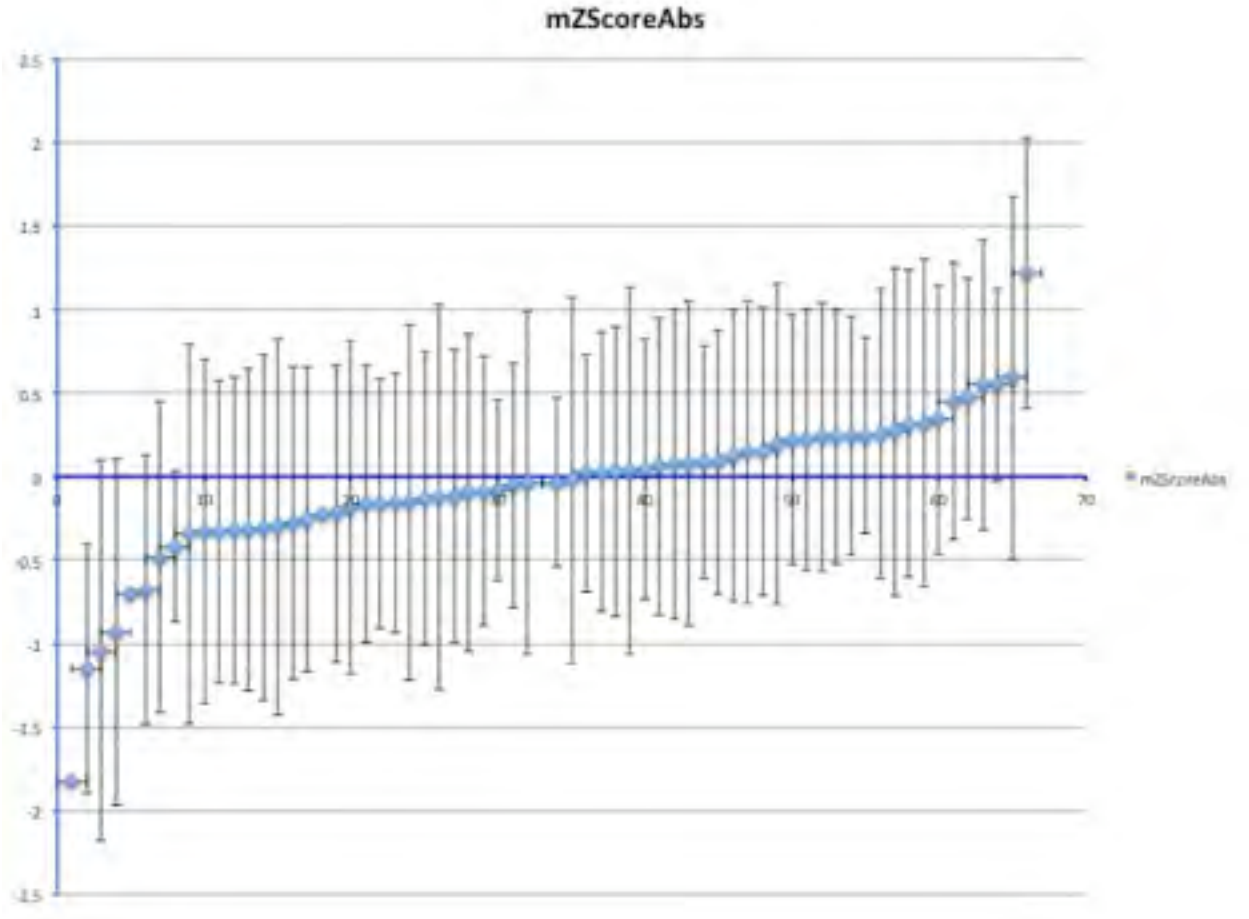


Figure 3: Rank ordering of rated individuals' performance, by mean of raters' Z-score of performance on a selected metric.

At Vanderbilt, each new member of the faculty has an FPPE as they join the faculty. This is constructed as a week-long proctoring experience with a senior clinician member of the department. This clinician observes the performance of the new faculty member, making a longitudinal qualitative assessment of whether the new faculty member is practicing within the norms expected of the overall faculty, with a goal of establishing group membership. This FPPE also includes coaching on the performance elements that comprise OPPE.

In many instances, FPPE is being conducted in response to specific problems with performance, and when this occurs, we try to construct the FPPE to be educational and to address the specific concern. To this end, we have also conducted a series of FPPE, tailored to the specific situation, as described below:

- A member of the faculty consistently neglected to complete anesthesia documentation (documentation completion rates and lag times are reported monthly). Since there was no specific educational component required, we with-held the individual's clinical productivity bonuses until performance improved and monitored monthly for 6 months.
- Inadequate technical skills: FPPE consisted of faculty proctored technical training with education.
- Inadequate team communication in the OR, implicated in adverse outcomes: FPPE consisted of sponsoring the individual (attendance required) for three rounds of Anesthesia Crisis Resource Management Training at a simulation center separate from Vanderbilt.

Our 360° evaluation component of OPPE has just been put into service, so we do not yet have data for analysis.

Discussion: In many practices, it is possible to employ data from enterprise-wide AIMS – which provides reliable and extensive documentation of clinical monitoring and physician practice patterns – to meet the JC OPPE requirement at essentially no cost. It is also possible to use such systems to confidentially and automatically administer 360° evaluation questions – again at essentially no cost. To date, we have deliberately avoided any metrics (such as reintubation rates, or unplanned ICU admissions) that might penalize practitioners in high-risk specialties. Moreover, we have avoided metric that would critically require

risk adjustment for case-mix. The purpose of OPPE and the initial FPPE is to demonstrate group membership. By focusing on objective data deriving from core functions of anesthesiology practice, as well as simple questions about practice, we were able to create a system that is broadly applicable to virtually all clinicians in the department with minimal added overhead.

In the future, we expect to replace and/or add additional metrics over time in order to ensure our ability to continually differentiate individual provider performance. These might include:

- Documentation of antibiotic re-dosing
- Re-documentation of medical direction
- Documentation of periodic patient positioning checks
- Perioperative temperature measurement & management

References:

1. Ehrenfeld, J. M., J. P. Henneman, et al. (2012). "Ongoing professional performance evaluation (OPPE) using automatically captured electronic anesthesia data." Jt Comm J Qual Patient Saf **38**(2): 73-80.
2. Ann G. Bailey, M.D., Lisa Crabtree, Zeno Pfau, Marc Caruana, C.R.N.A., Fred Spielman, M.D., David Zvara, M.D. (2011) "Ongoing Professional Practice Evaluations (OPPE); Meaningful Data From Electronic Evaluations" Anesthesiology A731,
3. Baker, K. (2011). "Determining resident clinical performance: getting beyond the noise." Anesthesiology **115**(4): 862-878.

AACPD
Concurrent Sessions

New CPD's Session
Moderator: Catherine M. Kuhn, M.D.

Job Description: What Your Mission/Charge Is
Jeffrey S. Berger, M.D., M.B.A.

Due Process and Correction Action
Catherine M. Kuhn, M.D.

Job Description: What Your Mission/Charge Is

Jeffrey S. Berger, M.D., M.B.A.

Notes: _____

New Program Director

DREAM JOB OR NIGHTMARE?

JEFFREY S. BERGER, MD, MBA
THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

Overview

- Development
- Attributes
- Roles
- Responsibilities
- Preparations
- Advice

- Disclaimer: content may not be relevant to all programs

Junior Faculty Development

- Academic promotion
- Educator
  - Accept opportunities (chores)
    - Mentor residents
    - Prepare resident lectures
    - Schedule-making
    - Committee work
    - Technology
    - Simulation creation
  - Receive excellent evaluations
  - Teaching awards

Development

- Clinician
  - Develop a niche
  - Create goals and objectives
  - Update the curriculum
  - Be a model faculty member
- Researcher
  - Conduct clinical research
  - Conduct educational research
    - Pilot new initiatives
- Advocate

Development

- Societies
  - Education Committee for clinical subspecialty
  - Society for Education in Anesthesia (SEA)
- Degrees
  - Certificate degree: research, teaching, leadership
  - Masters Degree: MEd, PhD, MBA, MPH
- Last-person-standing strategy

Development

- CHAIR:
  - I would like you to be the program director for our department. Do you accept?
- You:
  - A: Yes, thank you!
  - B: Thank you, what an incredible opportunity. Do you mind if I take some time to think it over and get back to you with some questions in a couple days when I've had a chance to consider this?
  - C: After listening to Jeff's lecture at the AACPD, not a chance!

Investigate

- Expectations?
- Current health of program?
  - Previous PD? Burnout?
  - Coordinator experience?
  - Set-up: Categorical vs. Advanced?
  - Current ACGME citations (cycle length)?
  - Program evaluations
    - Faculty?
    - Residents?
  - Recruitment statistics?
  - Board pass rate?

Investigate

- Support: time and resources?
  - Staff:
    - Administrators
    - Associate Program Directors
    - Webmaster
    - Other key faculty
  - Non-clinical time?
  - Call adjustment?
  - Meeting time: SEA, SAAA, ASA
  - Scheduling software

Investigate

- Committees?
- Annual events?
  - Recruitment
  - Research day
  - Social events
  - Graduation
- Budget
  - Funding: endowments, Medicare, other
  - Expenses
  - Previous year sample

Accept

- CHAIR:
  - Well?
- YOU:
  - Thank you so much. In order to do a great job with this opportunity, I would like the following…

Development

- Personal 5-10 year plan
  - Chairs like stability, particularly for leadership
- PD-Chair relationship
  - Consider values alignment
  - Prior to 2003, Chair was PD
  - 2007, SAAC/AAPD to SAAA
- Networking
  - Mentorship
  - Other PDs

5 Key Attributes

- Passionate
- Creative
- Open-minded
- Salesperson
- Resilient

Attributes

- *Characteristics of anesthesiology residency program directors 2011*
  - 33 – 74 years old (median 52 years)
  - 28% women
  - 67% senior academic rank (professor or associate)
  - 3.7 year median appointment duration

Long, TR, et al. JCA (210) 22, 583-586

Roles

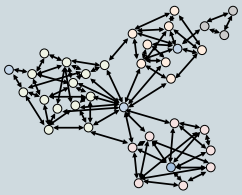
- Manager
- Scheduler
- Administrator
- Curriculum designer
  - Education Committee
  - Create an action plan
  - Demonstrate continuous improvement
  - Adapt to ACGME requirements
    - Core competencies
    - Milestones

Roles

- Credentialing specialist (residents & graduates)
- Auditor (retreats, internal reviews & site visits)
- GME exec committee
  - Conduct Internal Reviews for other departments
  - Be responsive to the requests of the DIO

Informal Networks

- Central connector
  - E-mail blasts
  - "Leadership" (Chair's ear)
- Boundary spanner
  - Other departments
  - Other institutions
- Information broker
  - Faculty complaints
  - Resident complaints
  - GME (annual review, requests)
  - ACGME (accreditation)
  - ABA (semi-annual reporting)
  - NBME (recruitment)



Disciplinarian

- Investigator
- Prosecutor
- Defense attorney
- Judge
- Jury (Clinical Competency Committee)
- Executioner
  - Core competency deficiencies: medical knowledge, professionalism
  - Misconduct

Disciplinarian

- Mediator
- Compliance officer
  - Faculty oversight
  - Evaluation completion
  - Duty hours violations
  - Case log monitoring
  - Social media
  - Substance abuse policy
  - Misconduct
  - Moonlighting

Advocate

- Cheerleader
- Parent, friend, trusted confidant
- Tutor
- Medical student advisor
  - Meetings
  - Letters of recommendation
  - Document reviewer
- Researcher
- Research liaison: students & residents
- Marketing director
  - Brand manager
  - Webmaster

Human Resources

- Social Director
  - Happy hours and events
  - Party planner (graduation)
  - Emcee (department events, graduation)
- Headhunter
- Alumni relations specialist
- Newsletter contributor
- Scouting Director
- Recruiter
- Interviewer
- Mentor to junior faculty

Clinician

- Excellent anesthesiologist
- Top teacher
- Hard worker

Responsibilities

- *The core program director must…*
  - 15-20% turnover rate
  - Anesthesiology Program Requirements
    - 7,542 words
    - 142 times "The Program/Program Director must…"
    - 40 times "not"
    - 40 times "should"
    - 42 times "requires(ed)"
  - Common Program Requirements
  - Must learn the program requirements

Sanford, TJ. JCA (2010) 22, 581-2

Beware of Burnout

- *Anesthesiology residency program director burnout*
  - Conclusions of questionnaire: 52% of anesthesiology program directors are at high risk for developing burnout syndrome!
    - Predictors of high burnout were
      - Compliance issues
      - Family support
      - Job satisfaction

De Oliveira, GS, et al. JCA (2011) 23, 176 - 182

Internship

- Approve rotations, directors
- Duty hours
- Rotation assignments
- Semiannual or Quarterly reports
- Other
  - Monthly meetings
  - Unique rotations

Education Program

- Administer and maintain environment
  - Space
  - Equipment
  - Meeting rooms
  - Computer support and medical information systems access
  - Adequate, gender-specific on-call facilities
- Comply with institutional policies

Education Program

- Ensure quality of education
  - Mandatory curriculum
    - Practice management
    - Geriatric anesthesia
    - Neuromonitoring
  - Involve faculty in lectures, supervision, etc
    - Education Committee
    - Clinical competency committee
  - Case exposure: monitor case logs and verify accuracy

Documentation

- ACGME: Accreditation Data System (ADS)
- Annual program evaluation
- Review program
  - Continuous program improvement
  - Annual retreat
    - Participants?
    - Agenda?
- Semi-annual reviews of performance and feedback
- Confirm graduation requirements
- Provide summative evaluation
- Annual Report to institutional GME

Duty Hours

- Implement policies and procedures, including moonlighting, to control duty hours
  - distribute, monitor and adjust
  - Back-up support plan
  - Scheduled napping, scheduling, and distribution of cases

Faculty

- Approve selection of faculty
- Approve local director at participating sites
- Sufficient faculty at each site
  - Ensure faculty are devoted to resident education commit sufficient time
  - Supervision should not vary with time of day or day of week (no more than 2 settings at a time)
- ABA certification and license required

Faculty

- Scholarship: environment of inquiry
  - Funding, publications, presentations, national committees
- Regular participation in journal clubs, didactics, rounds
- Teaching provided by faculty with documented subspecialty interest
- Faculty development available
- Evaluate program faculty and approve continued participation

Pitfalls

- Resident survey: misinterpretation of questions
- Case log deficiencies at graduation
- Transfer Note for residents that transfer into program
  - Verify previous training
  - Summative, competency-based evaluation from program
- NRMP match history
  - Make sure you don't offer interview to applicant with outstanding obligation to another program – it's your job to know

Core Competencies

- Imbue 6 core competencies into all documentation
  - Goals and objectives
  - Evaluation
  - Assessment
- Make sure your entire Department speaks the language of Core Competencies
  - You didn't have an M&M conference… you had a Practice-based Learning & Improvement conference where you discussed Patient Care and the Interpersonal & Communication errors that led to a breakdown in Systems-based Practice

Dealing with your Chair

- Discuss expectations
- Keep your chair informed
  - What issues does my chair like to be involved with?
  - What issues should I handle on my own
  - How to best communicate?
    - Email vs. Face-to-face
    - Formal report vs. informal discussion
- Request an annual program budget
- Cross your chair at your own risk!

Dealing with Faculty

- No longer most popular
  - You give them work
  - You don't seem to be "working"
- Identify "key" faculty (central connectors) for Committees
- No idling!!!
  - When you're in your office, your working!
- Communicate "why" frequently
- Simplify obligations (limit evaluations)
- Beware of incentives!
- Listen and follow-up
- Difficult faculty – document, work with Chair, don't alienate

Dealing with Residents

- Keep an open door!
- Respect
  - Be their biggest supporter in public
  - Demand excellence in private
- Delegate to surrogates:
  - Chief residents: call concerns, social
  - Coordinator: reminders
  - Associate PDs: curriculum updates, 360-eval collections
- Create an anonymous, intranet suggestion box
- Listen and follow-up

Dealing with GME, ACGME, NRMP and ABA

- Complete paperwork on-time and thoroughly
- Visit their Web sites often
- Your unique situation is generally not that interesting

On the horizon…

- Faculty survey
- Next Accreditation System (NAS)
  - ANNUAL GME review
- Milestones development/implementation
- Split Part I ABA Written Board Examination

Advice

- Make sure to secure enough non-clinical time
- Don't go at it alone
  - Confer with your Chair
  - Network
    - Program Directors
      - Try to attend the same society meetings each year
      - Other new PDs for empathy
      - Mentors for advice
    - Designated Institutional Official, the Dean of GME,
    - GME executive committee: other department PDs
  - Choose your team wisely
    - Consider an associate PD with experience in GME
    - Ask your most experienced faculty to Chair your Clinical Competency Committee

Advice

- Keep annual to-do list broken down by month
- Fix it, don't fake it
  - Consecutive reviews with an unresolved citation is poor form.
  - If you have a citation or a survey item that highlights a deficiency, fix it
  - For example, if your residents aren't getting enough of a certain type of case, since you can't hire the surgeon, send your residents somewhere to get the experience.

How do you measure success?

- Is it…
  - Title?
  - Personal promotion?
  - Financial remuneration?
  - Residency match?
  - Boards performance?
  - Job/fellowship placement?
  - Satisfaction on surveys?

How do you measure success?

- Or is it…
  - Getting invited to a resident's wedding or other life event?
  - A warm hug and sincere thank you at a graduation as you get introduced to your residents' parents
  - A call from a 2009 graduate – just to check in
- After 5 years, being a PD is still my dream job and I hope it is the same for you

Due Process and Correction Action

Catherine M. Kuhn, M.D.

I. How to avoid successfully recruiting a problem resident

II. Clear definition of expectations

III. Taxonomy of problems

IV. Diagnosis of the problem

V. Intervention

VI. Documentation

VII. Due process and legalities

I. How to avoid being successful in recruiting problem residents:

- assess insight of applicant into career choice
- define departmental/specialty goals
- identify traits important for those goals
- select candidates who represent these traits
- behavior directed interview (handout)

II. Clear definition (and dissemination) of expectations:

- Policies and procedures: institution and department
- Rotation goals and objectives: should include specifics
- Higher order (career goals, overarching principles/philosophy of residency)

III. Taxonomy of the problem resident:

Poor career choice

Cognitive Problem

- Knowledge Base
- Test-taking (written and oral)
- Learning disability

Affective Problem

- Work ethic
- Compassion
- Respect
- Altruism
- Impairment
  - Substances
  - Medical illness
  - Psychiatric illness

Psychomotor Problem

- Technical skill
- Stamina

Cognitive problems often have affective components, and affective problems usually cause problems in cognition. One problem usually predominates.

IV. Diagnosis of the problem:

What do you mean when you say you have a problem resident?

- Not performing related to some standard
- Not progressing

- Consider whether the problem is with performance, or with the standard Is there a standard, or are there multiple standards (Beware the hidden curriculum)
- If the standard isn't clear/consistent, it's hard to convince the resident that s/he has a problem.
- Faculty may not remember, or accept the standard.
- May have to restate expectations many times and in many settings.

DIAGNOSIS BEFORE TREATMENT: go from symptoms, to differential diagnosis, to diagnosis, then consider the treatment. Diagnosis is the hardest part.

Cognitive Problems:

- How does s/he study: how, when, where do they do it.
- Historical data: Med school grades, USMLE, written evaluations to elicit a pattern
- Study log for a week: have them complete: where, when how long, what books, bring in books/notes to see what they do with material.
- Test reading skills in textbook: Have them read a page and then summarize. (restate in their own words, which sentences contain facts versus elaboration, opinion)
- Test auditory comprehension: Have them sit in on a good lecture, write an outline of the talk during the lecture and then a summary.
- Thinking aloud: During procedures, have them talk about what they are considering or thinking about.

Affective Problems: The most common type (personal opinion)

- Collect data: define the problem behaviorally and objectively.
- Meet with resident: honest, heart-to-heart talk. Set a supportive tone. Your goal is to get the resident to accept there's a problem. Your intent is to help them "cure the disease". Third party important in some cases. Don't attempt impairment interventions without expert help.
- What are his/her goals?
  May have to change goals if they are happy with the goal but the goal is inadequate. Up the ante. Once goals are established, address the consequences of not meeting the goals in terms that they accept—get them to describe the consequences to you. Who are their role models? Often the most charismatic faculty unwittingly demonstrate behavior that is maladaptive—be careful of the hidden curriculum (what faculty behavior is rewarded in your department?)

V. INTERVENTION: Planning takes more time than execution

- Varies depending on the problem and the individual
- Consistent approach: demonstrates fairness to residents who may feel vulnerable when one of their peers is in trouble.
- Confidentiality: protect the resident's self-esteem
- Resources: GME office, hospital counsel, EAP, NCPHP, "older and wiser" program directors, ACGME, specialty board.

VI. DOCUMENTATION, DUE PROCESS AND LEGALITIES:

- There is no such thing as too much documentation.
- Importance of frequent feedback/evaluation
- “No good deed goes unpunished”—N. Ciompi
- Protect the resident, the program/department, and yourself

Resources:

1. The American Board of Anesthesiology Inc. Booklet of Information www.theABA.org
2. The Accreditation Council for Graduate Medical Education www.acgme.org
3. Kachalia A, Studdert DM. Professional liability issues in graduate medical education. JAMA 202: 1051-6, 2004.
4. Eckert JM and Mets B. The legal background for residency training: implications for education. In:Int Anes Clin, Lineberger CK, ed. Philadelphia, Lippincott, Williams and Wilkins, 2008, pp127-136.

SAMPLE ROUTINE CORRECTIVE ACTION DOCUMENT

Date

Dear Dr. X;

This note summarizes our discussion of ….Date…..

The Clinical Competency Committee met on …Date….. and discussed your performance over the past six months.

The committee determined that your performance during the past six months was overall unsatisfactory. Although the committee recognized your efforts toward improvement, including your efforts with a study plan, significant concerns were raised about the following:

- Continued deficits in knowledge base and application to clinical environment.
- Poor performance on the March 20XX intraining examination, especially considering the amount of time you are reporting for the study plan.
- Continued concern about your speed of processing with procedures and decision making.
- Concern of lack of fundamental understanding of the rationale for decision making
- Continued concern about your ability to develop progressive independent decision making, and overreliance on faculty.

The conclusion of the committee was that your overall performance level is more in keeping with a resident of twelve months' experience, rather than one at the end of the CA-2 year. On repeat rotations there is generally concern about the slow pace at which you process information, seeming as though it is your first rotation on the service. Faculty continue to feel that you require more supervision than expected for your level of training. There are concerns about the rationale and knowledge base underlying your clinical decisions. You have not achieved the degree of progressive independence expected for the CA-2 year, and faculty feel you are not ready for the independence required for the CA-3 year.

The committee decided that based on the lack of sufficient progress in the areas described above, you will receive an unsatisfactory Clinical Competence Certificate for the January-June 20XX period, and this will be reported to the American Board of Anesthesiology. Additionally, it was decided that you should not be promoted to the CA-3 year, but should remain at the CA-2 level for an additional six months, from July 1-December 30 20XX.

As part of this corrective action, you will:

- Take the AKT-24 examination with the rest of your residency class. Failure to achieve a score of at least 30th percentile will result in dismissal from the program. If you succeed in this test, it is expected that you will achieve at least 30th percentile on all subsequent standardized tests taken at the appropriate time intervals.
- Proceed with your current proposed schedule for the next academic year, which includes CA-2 rotations, and includes no CA-3 rotation expectations such as senior call until after January 20XXX.
- Continue to consult with Employee Occupational Health Services regarding fitness for work and ongoing medical needs.
- Continue your study plan of 15 hours per week, supervised by your advisor. You are responsible for setting up meetings at least twice a month with your advisor. You will continue to submit your study logs to me and your advisors every Monday.
- Meet with Dr. AB every other week to get written and verbal feedback from the faculty on your rotation to help you identify your strengths and areas of improvement.

- Meet with your advisors and me approximately at the midpoint of this evaluation, August 15, to receive feedback on your performance to date.
- Discuss with me and your advisors the advisability of a career coaching evaluation.

If there are other strategies you believe would be helpful to you which we should include in this plan, please let us know ASAP as we sincerely hope to help you succeed.

It is acknowledged that this scrutiny can be stressful, and you are reminded of the availability of PAS, a free confidential service for employees and their families. If you need assistance with your work schedule to make appointments for this or Employee Occupational Health, please let me know as soon as possible.

The Clinical Competency Committee will meet in December 20XX. At this meeting, if your performance has been satisfactory on all rotations, the faculty will decide to promote you to the CA-3 level, with the expectation that you will require at least twelve months of training at that level. This will extend the duration of your training until December …Date…...

If your clinical progress is deemed by the faculty as unsatisfactory, you will be informed that your contract will not be renewed, or you will be dismissed from the program.

If you wish to have this corrective action reviewed, please see the GME website , the materials provided to you at your institutional orientation, and the Corrective Actions Hearings documents. You have seven (7) days from the date of this letter to request a review from (DIO) in writing or via email.

Signed:

_____ _____

Resident Date

_____ _____

Residency Program Director Date

_____ _____

Resident Advisor Date

CC: Department Chair, DIO

AACPD
Concurrent Sessions

Experienced CPD's Session
Moderator: Joy L. Hawkins, M.D.

Establishing Educational Research in Your Department
Randall M. Schell, M.D., MACM

Faculty Development in Education
Manuel C. Pardo, Jr., M.D.

Avoiding Burnout in Your Position
Leila M. Pang, M.D.

Establishing Educational Research in Your Department

Randall M. Schell, M.D., MACM

Objective

1. Describe the unique opportunities associated with medical educational research
2. Identify key components to begin and maintain an educational research program in your department
3. Identify specific resources within and outside of your department to facilitate medical education research

I. Introduction

A broad definition of "medical education research" is any investigation related to the education of medical professionals. Some examples of topics in medical education research include: (1) teaching methods, (2) evaluation (student, teacher, course), (3) selection of candidates for training, (4) use of technology in education, (5) curriculum development, (6) faculty development, and (7) research methodology.

Medical education research is not as well established or understood as a form of scholarly activity like classic basic science or clinical research. Although some cite impediments to organizing, performing, and publishing educational research including; lack of funding and training (e.g. social science research methodology), the nature of qualitative research, difficulty with internal and external validity and generalizability of results, this presentation will instead focus on the exceptional opportunities (e.g. publishing unique aspects of your training program, outcomes research, collaboration with colleagues) and fun associated with medical educational research and some basic ideas for starting and growing an educational research project/program in your department.

II. Educational Research: The Early Stages of Development

1. Determine why you are interested in educational research

- Questions you want to answer, passionate about education, desire to collaborate with colleagues, desire to advance professionally by doing scholarly work.

2. Talk with others and get ideas from those who have been successful in performing educational research

- Obtain a mentor if possible.

3. Determine what you can accomplish "now"

- Narrative descriptions, editorials, letters, surveys, pre-experimental studies; Educational research cannot and should not always utilize controlled experimentation as the only method of preference. Examples:

  -Fragneto RY, DiLorenzo AN, Schell RM, Bowe EA. Evaluating Practice Based Learning Improvement: Efforts to Improve Acceptance of Portfolios. Journal of Graduate Medical Education December 2010, Vol. 2, No. 4, pp.638-643.

  -Schell RM, Bowe EA, Fragneto RY. Education in Anesthesiology should be Evidence-Based. Anesth Analg 2008; 106:1587-1588.

- What are you doing in your program that is unique, might be generalizable, and that could help others? Do you have a new curriculum, interesting teaching technique(s), innovative use of technology, or things you are doing that might be interesting to other educators. Example:

  -Rebel A, Hassan ZU, Boral L, Lin Y, Dilorenzo A, Schell RM. Initial Results of a Structured Rotation in Hematology and Transfusion Medicine for Anesthesiology Residents. Journal of Clinical Anesthesia 2011, Vol. 23, pp.469-474.

  -Schell RM, DiLorenzo A, Fragneto R, Bowe EA, Melguizo-Castro, Hessel E. Anesthesiology resident personality type correlates with faculty global assessment of resident performance. (In Press) Journal of Clinical Anesthesia. 2012.

  -DiLorenzo AN, Schell RM, Sardam S, Bowe EA, Dority JS. The Use of a Wiki to Enhance Anesthesiology Resident Education. Poster Presentation at Society of Education in Anesthesia Meeting. Pittsburgh, PA. June 2010.

  -Schell RM, Fragneto RY, Bowe EA, DiLorenzo A, Sardam S, Melguizo-Castro. Anesthesiology residents' readiness for self-directed learning does not correlate with performance on standardized examinations. Presented at ACGME Conference. Grapevine, Texas. March 2009.

  -Hassan Z, DiLorenzo A, Sloan P. Teaching clinical opioid pharmacology with the Human Patient Simulator. Journal of Opioid Management 2010;6(2):125-131

4. Don't get discouraged by initial lack of resources

- Faculty volunteering their time and resources results in the majority of education research.
- Frequently your "subject(s)" is your learners or the program and many educational studies will be given IRB exemptions or expedited reviews.

5. Focus on early successes and encourage other faculty/residents to join you

- Submit abstracts at meetings (i.e. SEA, IARS, ASA, ACGME, etc) and consider submitting your initial scholarly activities to meetings more likely to accept your work.
- All authors should attend meetings where abstracts presented to discuss results with others, develop new ideas, and form collaborations with colleagues.
- Encourage residents to consider an educational research project for meeting the ACGME requirement for scholarly activity.

6. Select target journals for publication

- Submit initial scholarly work where success in publication is more likely.
- Consider submitting to journals with emphasis on education (i.e., Journal of Graduate Medical Education, Medical Teacher, Teaching and Learning in Medicine, Medical Education, Simulation in HealthCare).

III. Educational Research: The Later Stages of Development

1. Consider obtaining formal training in medical education and research

- Education research relies heavily on social science research methodology. Most clinical faculty do not have the expertise to design educational research studies and will need to acquire these skills or collaborate with specialists in medical education research methodology and statistics
- Examples of advanced degrees include the Masters in Health Profession Education program at UIC and the Masters in Academic Medicine program at USC (see references for websites).

2. **Work with or hire an education specialist/research coordinator**
   - Help with research design, statistics, facilitate IRB process, etc.
3. **Develop databases and collect data for longitudinal studies**
   - Examples include data on residents (e.g. MBTI; personality profile), selection process scoring, and electronic archiving of evaluations.
4. **Develop collaborations with others**
   - Collaborations might include others within your department, within your institution, and with other institutions.
   - When larger sample sizes and increased generalizability of results desired, collaboration with other institutions becomes even more important.
5. **Begin to branch into more involved qualitative research and into quantitative research**
   - A consultant statistician becomes even more important at this stage.
6. **Look for funding for your research**
   - Apply for grants (e.g. FAER, Stemmler, SGEA)
7. **Select target journals for publication**
   - Consider higher impact journals
8. **Help teach and mentor others interested in educational research**
   - Consider forming a faculty development program in medical education research in your department/institution.

Select References:

Sullivan GM. Writing education studies for publication. Journal of Graduate Medical Education June 2012;133-137

Sullivan GM, Sargeant J. Qualities of qualitative research: Part I. Journal of Graduate Medical Education December 2011;449-452

Sargeant J. Qualitative research Part II: Participants, analysis, and quality assurance. Journal of Graduate Medical Education March 2012;1-3

Collins J. Medical education research: Challenges and opportunities. Radiology 2006;240:639-647

Advanced Training/Degrees (examples):

Masters in Health Professions Education (MHPE) at University of Illinois Chicago
http://chicago.medicine.uic.edu/departments___programs/departments/meded/

Masters in Academic Medicine (MACM) at University of Southern California
http://keck.usc.edu/Education/Division_of_Medical_Education/Master_of_Academic_Medicine.aspx

Master in Medical Education (MME) at University of Iowa
http://grad.admissions.uiowa.edu/academics/master-medical-education-mme

Masters in Education (MEd) at University of Cincinnati
http://www.cincinnatichildrens.org/education/clinical/graduate/grad/masters/default/

Faculty Development in Education

Manuel C. Pardo, Jr., M.D.

I. **Introduction**
   a. Faculty development definition
      i. Activities to renew or assist faculty in their roles as teachers, scholars, administrators, leaders
      ii. Manage change, develop strengths and skills
      iii. This presentation will focus on the education roles of faculty
   b. Goals of faculty development
      i. For junior/mid-level faculty: promote oneself based on education accomplishments
      ii. For senior faculty: promote career development of faculty you are mentoring
      iii. All faculty: increase mastery of different facets of their roles as an educator

II. **Roles of Medical Educator**
   a. Direct teaching
      i. Clinical teaching, lectures, small-group workshops, simulations, problem-based discussions
      ii. Documentation: teaching scores compared to mean; systematic peer review; teaching awards
   b. Curriculum development (Instructional design)
      i. Develop or substantially revise courses, clerkships, rotations; recognize unmet curricular need and bring new curricular element from idea to reality; includes appropriate evaluation approaches to assess impact
      ii. Documentation: clear goals, adequate preparation, appropriate teaching methods, evaluation of results, comparative ratings
   c. Educational Administration/Leadership
      i. Program directors, associate program directors, clerkship directors, rotation directors, committee members/leaders involved with planning or evaluation of education
      ii. Documentation: description of leadership activities, impact of the individual; 360 degree evaluation (e.g. promotion letters)
   d. Education Research
      i. Generation of new knowledge in a medical education area
      ii. Documentation: peer-reviewed publications/presentations; enduring materials used outside institution; peer-reviewed grant funding
   e. Advisor/Mentor
      i. Sought as formal advisors, career advisors, informal mentors, research and scholarly project collaborators
      ii. Documentation: individuals mentored, description of mentoring efforts, outcome of mentoring

III. **Types of Faculty Development**
   a. Dimensions of faculty development
      i. Individual versus group activities
      ii. Informal versus formal approaches
      iii. Sporadic versus regular
      iv. Faculty development community versus "workplace community"
         1. Acknowledges that many faculty development efforts do not take place in the work environment of the individual

IV. **Examples of faculty development**
   a. Individual, informal
      i. Reflection, observation, discussion with mentor
      ii. Example: discuss your resident teaching evaluations with program director
      iii. Example: look at online and/or journal-based resources <http://medschool.ucsf.edu/academy/faculty_development/external_sites.aspx>
   b. Individual, formal
      i. Peer coaching, online learning
      ii. Example: formal teaching observation program in place at medical school <http://medschool.ucsf.edu/academy/faculty_development/tip-top.aspx>
   c. Group, informal
      i. Workplace learning, communities of practice
      ii. Example: subspecialty group discussion of resident evaluations and goals of subspecialty rotation
      iii. Example: participation in medical school "education academy" meeting
      iv. Example: department-based faculty development workshop series
   d. Group, formal
      i. Workshops, seminars, longitudinal programs
      ii. National examples – anesthesia specific
         1. SEA Teaching Workshop and Annual Meetings
         2. SAAA Annual Meeting
         3. ASA Annual Meeting
      iii. National examples – other
         1. AAMC Medical Education Research Certificate <https://www.aamc.org/members/gea/merc/>
         2. Harvard Macy Institute <http://www.harvardmacy.org>
            a. Program for Educators in Health Professions
            b. Leading Innovations in Health Care & Education
            c. A Systems Approach to Assessment in Health Professions Education
         3. Masters of Education, Masters of Academic Medicine (see Dr. Schell's presentation)
      iv. Local examples
         1. Program director's leadership program at U-Florida Jacksonville (Haan et al. reference below)
         2. Institution sponsored education skills workshops <http://meded.ucsf.edu/radme/educational-skills-workshops>
         3. Teaching Scholars Programs <http://medschool.ucsf.edu/teachingscholars/>
            <http://www.meded.washington.edu/teaching-scholars>
            <http://www.uams.edu/teachingscholars/default.asp>

V. **Recommendations and practical advice**
   a. Mentor others in roles that are compatible with your strengths
   b. Decide on the education role(s) you would like to develop further

i. Look for faculty development opportunities for yourself
ii. Seek mentors for these areas

c. Make use of local resources first; see what is offered in your institution

d. Consider formal programs if they are consistent with your career goals

e. Know your institution's promotion criteria, and develop scholarly education activities consistent with these criteria

References

1. Castiglioni A, Aagaard E, Spencer A, Nicholson L, Karani R, Bates CK, Willett LL, Chheda SG. Succeeding as a Clinician Educator: Useful Tips and Resources. J Gen Intern Med. 2012 Jul 27. PubMed PMID: 22836953
2. Glassick CE. Boyer's expanded definitions of scholarship, the standards for assessing scholarship, and the elusiveness of the scholarship of teaching. Acad Med. 2000 Sep;75(9):877-80. PubMed PMID: 10995607
3. Haan CK, Zenni EA, West DT, Genuardi FJ. Graduate medical education leadership development curriculum for program directors. J Grad Med Educ. 2011 Jun;3(2):232-5. PubMed PMID: 22655147
4. McLean M, Cilliers F, Van Wyk JM. Faculty development: yesterday, today and tomorrow. Med Teach. 2008;30(6):555-84. Review. PubMed PMID: 18677659
5. O'Sullivan PS, Irby DM. Reframing research on faculty development. Acad Med. 2011 Apr;86(4):421-8. PubMed PMID: 21346505
6. Steinert Y. Faculty development: from workshops to communities of practice. Med Teach. 2010;32(5):425-8. PubMed PMID: 20423263
7. Steinert Y. Commentary: faculty development: the road less traveled. Acad Med. 2011 Apr;86(4):409-11. PubMed PMID: 21451270
8. Steinert Y, Mann K, Centeno A, Dolmans D, Spencer J, Gelula M, Prideaux D. A systematic review of faculty development initiatives designed to improve teaching effectiveness in medical education: BEME Guide No. 8. Med Teach. 2006 Sep;28(6):497-526. Review. PubMed PMID: 17074699

Avoiding Burnout in Your Position

Leila M. Pang, M.D.

Notes: _____

Avoiding Burnout as a Program Director

Leila Mei Pang, MD
Ngai-Jubilee Professor of Anesthesiology
College of Physicians & Surgeons of Columbia University
New York Presbyterian Hospital
New York, N. Y.

Columbia University Medical Center

Objectives

At the end of this session, the participants will

- Understand the elements that lead to burnout
- Appraise how these elements can stimulate rather than lead to burnout
- Discover how I have utilized potential stressful challenges to enhance a sense of personal accomplishment

What is burnout?

Wikipedia definition of burnout:

Psychological term for the experience of

- long-term exhaustion and
- diminished interest

Measurement of burnout has been best defined by Maslach and colleagues and is now a standard tool used in research

Maslach Burnout Inventory: Three dimensional description

- Emotional exhaustion – chronic state of physical and emotional depletion that results from continuous job and/or personal demands and **continuous stress**.
- Cynicism (general distrust of others motives or ambitions) or **depersonalization** (feeling of watching oneself with no feeling of control over the situation)
- Inefficacy or **sense of diminished personal accomplishment**

12 Phases of burnout – not necessarily sequential

1) Compulsion to prove oneself
2) Work even harder
3) Neglecting own needs
4) Displace conflict
5) Revise values to avoid conflict
6) Deny emerging problems
7) Withdraw
8) Change behavior
9) Depersonlize self
10) Inner emptiness
11) Depression
12) Burnout

I can understand how burnout may happen.

Continuous stress: such as having to monitor work hours, case logs, evaluation compliance, curriculum adjustments, prepare for site visits, meet new requirements by ACGME, JCAHO, etc. in the limited amount of time most of us have

Depersonalization: Things happen that we have little or no control over such as protracted illness by either residents or staff, residents leaving the program, call scheduled created by other services that your residents may be rotating on, patient work load, etc.

Sense of diminished personal accomplishment: Above tasks leaves little time to make improvements to the program or develop new programs

The antithesis of burnout as defined by Maslach and colleague

Engagement

- Energy
- Involvement
- Efficacy

With the new challenges (e.g., from the ACGME) how can you possibly not be involved or have a diminished sense of accomplishment?

Three challenge examples:

- "The resident must participate in one simulated experience each year"
  - At our institution, we do not have a simulation center which is fully operational
  - How does a program like mine fulfill this requirement?
- Milestone Project
  - How does the program define the milestones?
    - Should your program develop your own
    - Should the program use the basic definitions developed by the ACGME's expert panel and the specialty's working group
  - How does the program assess the acquisition of milestones for each of their residents?
- New Accreditation System (NAS) – what does this entail?

SIMULATION EXPERIENCE

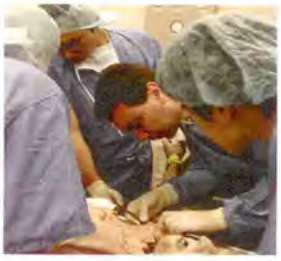
This is the only challenge I am going to address today

Patient Simulator Airway Workshop
Dr. Anthony Clapcich, Director

	Morning	Afternoon
Mon:	*Airway Anatomy*	*Pediatric Difficult Airways*
	Tools & Techniques	*Surgical & Invasive Airways*
	Adult Difficult Airways	
Wed:	*ICU Airways*	*Thoracic Cases*
	OB Airways	*Bronchoscopy*
Fri:	*Oral Board Exam*	*ENT Chief Clinic*

Other Simulation Experiences
2) TEE Simulation

3) Cadaver Workshop



At the end of the upper body cadaver session

4) Regional block and vascular access workshop of the lower body is held - for CA-1 – 3 residents who attend the Cadaver workshop

Columbia University
College of Physicians and Surgeons

Other Simulation Experiences

5) Full day ultrasound workshop preceded by an on-line course - for all CBY residents

6) Trauma simulation with Peds EM and Peds Surgical residents

Columbia University
College of Physicians and Surgeons

Inventory of simulation experiences

Class Year	Airway	TEE	Cadaver Workshop	Regional Workshop	Ultrasound Tutorial & Workshop	Peds Trauma
CBY					X	
CA-1	±	X	±	±		±
CA-2	X	±	X	X		±
CA-3	±		X	X		±

Columbia University
College of Physicians and Surgeons

AACPD
Concurrent Sessions

All CPD's Session
Moderator: Karen J. Souter, M.D.

Best Practices
Harendra Arora, M.B.,B.S.; Peter M. Fleischut, M.D.; Mojca Remskar Konia, M.D.

Milestones
Deborah J. Culley, M.D.

Comprehensive Simulation-Based Transfusion Medicine Curriculum

Mojca Remskar Konia, M.D.; Shanna M. Morgan, M.D.; Benjamin Rioux-Masse, M.D.

Description of Your Best Practice

In collaboration with transfusion medicine department, we developed a comprehensive simulation-based curriculum of transfusion medicine. The educational experience, which takes approximately 2.5 hours, consists of a pre-test, a lecture with power point presentation, a simulation scenario with check-list of appropriate learner actions, a debriefing with video-recording review, and a post-test. Five different simulation scenarios have been developed to facilitate education of any learner on the ward, the intensive care unit and the operating room. Acquired knowledge is measured with multiple choice question test. The educational activity is evaluated by the learners for its quality and relevance. Feedback is used to make improvements.

Why You Chose to Implement It (Did You Do a Needs Assessment Etc)

Recently published studies have indicated deficiencies in medical students and junior residents' knowledge of transfusion medicine (1, 2). During the needs assessment we determined the following:

1. Anesthesiology faculty member observed lack of understanding of transfusion medicine by learners.
2. Learners asked for transfusion medicine related educational activities.
3. Learners had low scores on pre-test.
4. Systematic follow up of massive transfusion protocol activations in the hospital indicated a need for education of all levels of operating room staff.
5. The surgery department indicated a desire for increased education in transfusion medicine for their incoming residents.

How you implemented it in your program

A single transfusion medicine simulation scenario was first tested on anesthesia residents and their feedback was solicited. We used resident feedback, test results and review of video-recording of the session to finalize the scenario. We then created additional four scenarios to allow different learners (medical students, interns, internal medicine, surgery, anesthesiology residents) to practice medical knowledge, skills and attitudes necessary for safe and appropriate transfusion of blood products in different clinical environments. Once the simulations were ready, we included them into a pre-existing yearly didactic curriculum of all anesthesia residents, all incoming surgery residents, all medical students rotating through the anesthesia department and students rotating through transfusion medicine department.

What strategies were employed to facilitate success?

We believe the following contributing factors to be important:

1. A thorough needs assessment
2. Collaboration of multiple specialties that are involved in transfusion medicine
3. Use of learner feedback
4. Actively evaluation of our results

Did you encounter any barriers?

Time limitations for learners and faculty.

What outcome measures did you use to evaluate its effectiveness?

We used the following outcomes:

1. Learner satisfaction
2. Expert review of session, lecture, check-list, and test review
3. Check-list of desired actions
4. Objective results on a multiple choice questions test
5. Learner evaluation form
6. Course evaluation form

How could this "best practice" be implemented by other programs?

In institutions with existing simulation laboratory, the session would be easy to implement. The curriculum is published in MedEdPORTAL and available to anyone for use (www.mededportal.org/publication/9207). The site includes all the materials, including the power point presentations, evaluation forms, check-lists, tests, and simulation scenario descriptions.

References:

1. O'Brein KL, Champeaux AL, Sundell ZE, et al. Transfusion medicine knowledge in postgraduate year 1 residents. Transfusion 2010; 50: 1649-1653.
2. Karp JK, Weston CM, King KE. Transfusion medicine in American undergraduate medical education. Transfusion 2011; 51: 2470-2479.

Novel Curriculum for PGY-1s: Academic Medicine Rotation

Harendra Arora, M.D.; Susan Martinelli, M.D.

Brief description: A 5-week non-clinical rotation was added into our clinical base year. Four domains were covered by experts in critical appraisal, quality improvement, professional development, and teaching. Faculty included anesthesiologists, health science librarians, IRB members, researchers, grant experts, legal staff, pediatricians, obstetricians, surgeons, and risk-managers. Instruction was delivered using small-group discussions, hands-on activities, didactic lectures, and self-directed learning modules. Curriculum components linked to all ACGME core competencies except direct patient care. Seminars covering healthcare policy, specialty advocacy, and leadership were also included in the course. Instructor led sessions totaled approximately 62 hours with additional time allotted daily for self-directed learning and research projects. With the aid of an assigned faculty mentor, the interns pursued research in one of two categories: quality improvement or evidence-based literature review. At the completion of the rotation, the entire department was invited to the graduation symposium where each intern delivered an oral presentation of their research. Of particular note, the interns developed interpersonal and communication skills by participating in high-level discussions and problem solving sessions in a small group format.

Reasons for implementation of the Academic medicine rotation: A survey of our interns prior to beginning this rotation revealed either "minimal" or "some" formal training in the areas of critical appraisal of the literature, process and quality improvement techniques, professional advocacy, and teaching. Inclusion of such a curriculum early during the residency may increase scholarly productivity.

Strategies: A physician from the School of Public Health and a senior Health Science Librarian were instrumental in the development and faculty selection of the critical appraisal component of the curriculum. Overall, we looked to other departments within and outside of our institution in order to find experts in each of the topics we covered. It was also imperative that this rotation be the sole focus of our ten interns during this time period.

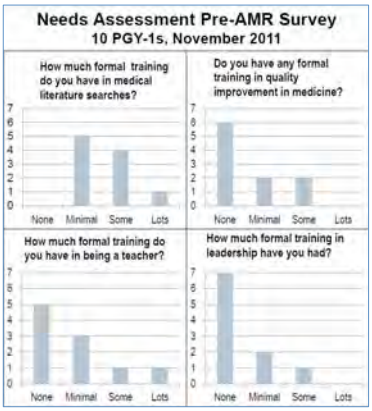
Barriers: We didn't encounter any major barriers during the implementation of this rotation.

Outcome measures: We confidentially surveyed all of our residents (interns through CA-3s) four months prior to the rotation and before the course content had been described. We will use the survey results as the program "baseline" for skill sets and confidence in the content areas of the rotation. We had the interns confidentially evaluate every session besides obtaining weekly feedback for course improvement. We also held an end of rotation wrap-up session and administered a post-rotation survey. Feedback for the course by the interns and the faculty session leaders was overwhelmingly positive.

How other programs can implement AMR?: As the program directors have control over the rotations that their interns do, it should be possible to remove all interns from clinical obligations for a 4-5 week period. In order to implement a rotation such as this, it is important to develop a team of experts, including faculty outside the department of anesthesia, to lead the various sessions. With the right personnel and motivated expert session leaders, we believe this course can be reproduced and have a large impact on training programs.

Novel Curriculum for PGY-1s: Academic Medicine Rotation

Harendra Arora, MD
Susan Martinelli, MD
University of North Carolina



Structure

- 5 week rotation
- No clinical commitment
- ≈62 hours instructor led sessions
- Daily self-directed learning
- Involved all core competencies except direct patient care
- Fits in ACGME, ABA CBY requirements

Institute for Healthcare Improvement: http://app.ihi.org/lms/onlinelearning.aspx

Course Faculty

- Experts within and outside of our department and institution:
  - Anesthesiologists
  - Health science librarians
  - IRB members
  - Researchers
  - Grant experts
  - Legal staff
  - Pediatricians
  - Obstetricians
  - Surgeons
  - Risk-managers
  - Members of the NC medical board

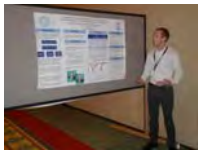
Critical Appraisal	Quality Improvement	Teaching	Professional Development
Asking a question and searching for answers	The science of quality improvement	Clinical teaching while you work	Personality inventory
Cross sectional studies	Prevention of surgical site infection	Simulation tools in anesthesia education	Medical malpractice liability reform
Cohort studies	Overview of risk management	Social media in medical education	Understanding anesthesia billing
HSL Department of Anesthesiology Library Resource Guide	National surgical quality databases	The RIME framework	Accountable care organization
Case control studies	Health literacy and anesthesia consent	Preparing effective PowerPoint presentations	North Carolina Medical Board
Limitations to EBM	TeamStepps	Designing a poster presentation	The NCSA
Searching for different study types	National anesthesia quality databases and incident reporting mechanisms	Optimizing problem based learning	Common problems with the IRB process
Applying statistics in medicine	Just culture and dealing with complications	Feedback in learning and teaching	Public speaking
Writing an abstract	Preparing an M&M conference	Educational research	Lifelong learning in medicine and MOCA
Systematic reviews and meta-analysis	Designing and using surveys		Persuasion and negotiation
What study type and when?			Planning your future as an anesthesiologist in a knowledge based environment
EBM and outcomes research			Leadership series: skills workshop
Randomized controlled clinical trials			Conflict resolution in medical practice
EBM: clinical applications sessions			The value of anesthesiologists outside of clinical care
Ref work and End Note			Walk through a malpractice case
Overview of research funding and grants			

Individual Research Project

- Evidence based review vs. QI
- Put to use the material from course
- Faculty mentor
- Graduation symposium
  - oral presentation

Worthwhile?

- Observations
  - Development of interpersonal and communication skills
  - Positive feedback
  - Submitting conference presentations



- How can you do it?
  - Connections in other departments
    - School of Public Health
    - Health Sciences Library
  - Intern time off rotations

Innovative Approach to Improving Quality and Patient Safety by Creating a Housestaff Quality Council©

Peter M. Fleischut, M.D., Susan Faggiani, Gregory Kerr, Eliot Lazar, Cynthia Lien, John Savarese

Description of the Best Practice:
The creation of a Housestaff Quality Council© is a grassroots, unique and innovative initiative that had not been employed in any teaching hospital.[1,2,3] Since the creation of this council in 2007, it has become a proactive contributor to changes in hospital processes and systems, designed to improve patient care and safety by creating a culture that promotes greater housestaff participation.

Why this Best Practice was Implemented:
Ten years after the Institute of Medicine report "To Err is Human: Building a Safer Health System," finding physicians who are willing to be actively involved in quality improvement projects remains a challenge.[4,5,6] Even more difficult, is engaging housestaff in quality and patient safety (QPS). As healthcare providers on the front-lines, housestaff are well poised to identify issues and actively participate in solutions that promote the delivery of quality care; yet, until now, housestaff have not been a part of a hospital's QPS processes.

With the emergence of high-reliability organizations, it is essential to engage housestaff as frontline providers in the institution's quality and patient safety processes.[7] Active housestaff participation can assist hospitals in meeting their quality and safety goals. Simultaneously, residencies can provide experience in improvement of patient care through practice-based learning and systems-based practice.[8]

How this Best Practice was Implemented?
A faculty member and 2 housestaff in the Department of Anesthesiology spearheaded the effort to involve housestaff in quality and patient safety processes. With the support of Hospital administration and the Division of Quality and Patient Safety, as well as participation of the QPS Administrator in Anesthesiology, they presented the concept of establishing a Housestaff Quality Council©.

Early in their deliberations, the HQC established its mission: a) to improve patient care and safety at the hospital by creating a culture that promotes greater housestaff participation, b) to create an innovative, hospital-wide, multi-modal communication process that provided two-way communication with hospital Administration and key clinical departments, including a standard and emergent communications pathway, and c) to conduct formal research on housestaff attitudes and behaviors, aimed at establishing and promoting "Best Practice."[3]

What Strategies Were Employed To Facilitate Success?
The HQC was initially aligned with the Office of GME but soon found that the more natural alignment was with the Division of (QPS). QPS goals are established each year by the division and the HQC sets goals aligned with those of the hospital.

Did You Encounter Any Barriers?
Sustainability and ongoing engagement have been the greatest challenges. The leadership must constantly consider ways to incentivize residents so that they remain involved with the Council and excite them to the point where they want to bring their colleagues into "the fold." Most importantly, there needs to be the constant reminder that indeed housestaff can make a difference in improving patient care and hence should be included in the quality improvement process.

What Outcome Measures Did You Use To Evaluate Its Effectiveness?
Three of the several important contributions the HQC has made to QPS improvements Include:

1. Medication Reconciliation
2. Use of the Electronic Medical Record to Improve Accuracy of Lab Ordering
3. A Patient Safety Awareness Campaign

How Could This "Best Practice" Be Implemented By Other Programs?
The Housestaff Quality Council© at New York-Presbyterian Hospital/Weill Cornell Medical College has served as a model to several other institutions in establishing similar organizations.

See attached manuscripts for additional information on HQC:

- Fleischut, P, Faggiani, SL, Evans, AS, Brenner, S, Liebowitz, R, Forese, L, Kerr, GE, Lazar, EJ. **The Effect of a Novel Housestaff Quality Council on Quality and Patient Safety.** *Joint Commission Journal on Quality and Patient Safety.* July 2012: 38 (7): 311-317The Role of Housestaff in Implementing Medication Reconciliation on Admission at an Academic Medical Center
- Fleischut P, Evans A, Nugent W, Faggiani S, Lazar E, Liebowitz R, Forese L, Kerr G: **Ten Years after the IOM Report: Engaging Residents in Quality and Patient Safety by Creating a Housestaff Quality Coucil©**. *American Journal of Medical Quality.* March-April 2011: 26 (2): 89-94
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- Evans A, Lazar E, Tiase V, Fleischut P, Bostwick S, Hripsak G, Liebowitz R, Forese L, Kerr G: **The Role of Housestaff in Implementing Medication Reconciliation on Admission at An Academic Medical Center.** *American Journal of Medical Quality*. January-February 2011: 26 (1): 39-42.

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"You are more likely to have an effect if you ask the right question—Is medical care safe?—rather than the question, Is medical care of high quality?, which is less likely to influence people's thinking."

—Kenneth I. Shine, MD (p. 293)

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The Effect of a Novel Housestaff Quality Council on Quality and Patient Safety

Innovation in Patient Safety and Quality at the Local Level

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From left: Adam S. Evans; Karen Scott, MD, MPH, Vice President, Quality and Patient Safety, New York-Presbyterian Hospital (NYP); Susan L. Faggiani; Eliot J. Lazar; Samantha Brenner; Peter M. Fleischut; Laura Kent, MD, Assistant Clinical Professor of Medicine and Psychiatry, Columbia University Medical Center; Aileen Alapan, MBA, Divisional Administrator for Quality and Patient Safety, NYP

Article-at-a-Glance

Background: In 2008 New York-Presbyterian Hospital (NYP)/Weill Cornell Medical Center, New York City, the largest not-for-profit, nonsectarian hospital in the United States, created and implemented a novel approach—the Housestaff Quality Council (HQC)—to engaging housestaff in quality and patient safety activities.

Methods: The HQC represented an innovative collaboration between the housestaff, the Department of Anesthesiology, the Division of Quality and Patient Safety, the Office of Graduate Medical Education, and senior leadership. As key managers of patient care, the housestaff sought to become involved in the quality and patient safety decision- and policy-making processes at the hospital. Its members were determined to decrease or minimize adverse events by facilitating multimodal communication, ensuring smart work flow, and measuring outcomes to determine best practices. The HQC, which also included frontline hospital staff or managers from areas such as nursing, pharmacy, and information technology, aligned its initiatives with those of the division of quality and patient safety and embarked on two projects—medication reconciliation and use of the electronic medical record. More than three years later, the resulting improvements have been sustained and three new projects—hand hygiene, central line–associated bloodstream infections, and patient handoffs—have been initiated.

Conclusions: The HQC model is highly replicable at other teaching institutions as a complementary approach to their other quality and patient safety initiatives. However, the ability to sustain positive momentum is dependent on the ability of residents to invest time and effort in the face of a demanding residency training schedule and focus on specialty-specific clinical and research activities.

Many innovative strategies have been implemented to improve quality and patient safety.[1–5] Clinical leaders, medical educators, and experts in quality and patient safety are faced with the challenge of committing precious organizational resources to determine which of these new innovations have the potential to deliver sustainable results. The vast number of quality and safety initiatives/interventions available today, and the increasing recognition of unintended consequences of some of these, further compounds this challenge.[6–13]

The Institute of Medicine (IOM) report *To Err Is Human* presents an imperative for reducing preventable medical errors.[14–17] In its follow-up report, *Crossing the Quality Chasm*, the IOM maps out a fundamental strategy that aligns accountability in quality of care with payment incentives by promoting evidence-based practice and the use of clinical information systems.[18,19] Subsequently, The Joint Commission established the National Patient Safety Goals (NPSGs) campaign, implemented in January 2003.[20–22] The NPSGs were then incorporated into the Joint Commission standards. These events, among others, catalyzed a redesign of the approach to quality and

patient safety by health care institutions in the United States, which required radical, innovative change.

Since 2003 The Joint Commission's NPSGs have focused performance improvement activities on achieving success with quality and patient safety issues, such as medication reconciliation and hand hygiene.[23–28] In response, hospitals throughout the United States have worked on developing processes and systems to address the NPSGs. An essential component in improving quality and safety is engagement of frontline clinicians. In teaching institutions, residents are a substantial segment of the clinical providers. More importantly, today's trainees are tomorrow's physician staff. Several academic centers have developed curricula for residents that address quality and patient safety with a focus on education, engagement of residents in quality and performance improvement, and enhanced professional development in this area.[29–38] Many of these efforts are recent, raising the question of sustainability, particularly in view of the fact that residents continually move through the health care system.

In 2007, at New York-Presbyterian Hospital (NYP)/Weill Cornell Medical Center (WCMC), New York City, we created and implemented a novel approach—the Housestaff Quality Council (HQC)—to engaging housestaff in quality and patient safety activities. The HQC facilitated rapid identification of improvement opportunities and selection of value-added enduring solutions.[39–44] At the time that the HQC was formed, a search did not identify any similar groups with the primary mission of engaging housestaff in quality and patient safety. Since its creation, the HQC has promoted significant quality improvements. In this article, we describe the creation and implementation of the HQC and present data suggesting that incremental quality improvement achieved through this process is sustainable.

Methods

Setting

The New York City–based NYP, at 2,409 beds, is the largest not-for-profit, nonsectarian hospital in the United States. It has nearly 2 million inpatient and outpatient visits a year, including 12,797 deliveries and 195,294 visits to its emergency departments. NYP's 6,144 affiliated physicians and 19,376 staff provide inpatient, ambulatory, and preventive care in all areas of medicine at five major centers: Weill Cornell Medical Center, Columbia University Medical Center, Morgan Stanley Children's Hospital, The Allen Hospital, and Westchester Division. NYP has academic affiliations with Weill Cornell Medical College and Columbia University College of Physicians and Surgeons.

Creation and Implementation of the Housestaff Quality Council

The HQC was conceived in November 2007 by a faculty advisor in the Department of Anesthesiology and was initially led by two anesthesiology residents with an interest in quality and patient safety. With the assistance of the quality and patient safety administrator of the department, in December 2007, the group received senior leadership's endorsement. An innovative collaboration was initiated between the housestaff, the Department of Anesthesiology, the Division of Quality and Patient Safety, the Office of Graduate Medical Education, and senior leadership to form the council, and the work of organizing the residents began.

Residents from various specialties were recruited to join the council, and by April 2008 the HQC started meeting monthly. The first objective of the council was to declare its goal: To improve patient care and safety at New York-Presbyterian Hospital by creating a culture that promotes greater housestaff participation. As key managers of patient care, the housestaff sought to become involved in the quality and patient safety decision- and policy-making processes at the hospital. Its members were determined to decrease or minimize adverse events by facilitating multimodal communication, ensuring smart work flow, and measuring outcomes to determine best practices.

During the next few months, the HQC expanded the membership of the council to include frontline hospital staff or managers from areas such as nursing, pharmacy, and information technology. Monthly presentations by various administrators to the HQC membership were soon replaced with housestaff-driven discussions about projects that were of interest to them. It became apparent that this interdisciplinary group, on the front line of patient care, was well poised to actively participate with senior leadership in solving some of the daily operational issues that perplexed hospital administration.

Involving housestaff in policy and decision making was considered a unique approach at the time, but this approach quickly evolved into a win-win situation for all parties as the HQC stakeholders became the biggest champions in addressing and resolving various issues at the bedside. By aligning the HQC goals with goals set forth by senior leadership, the HQC was recognized as a distinct, yet integral, part of the quality infrastructure.

Figure 1 (page 313) shows the HQC integration into the Division of Quality and Patient Safety in the NYP table of organization. The 2012 quality and patient safety goals for NYP are shown in Figure 2 (page 314). Early on, it became apparent that the core components of alignment and integra-

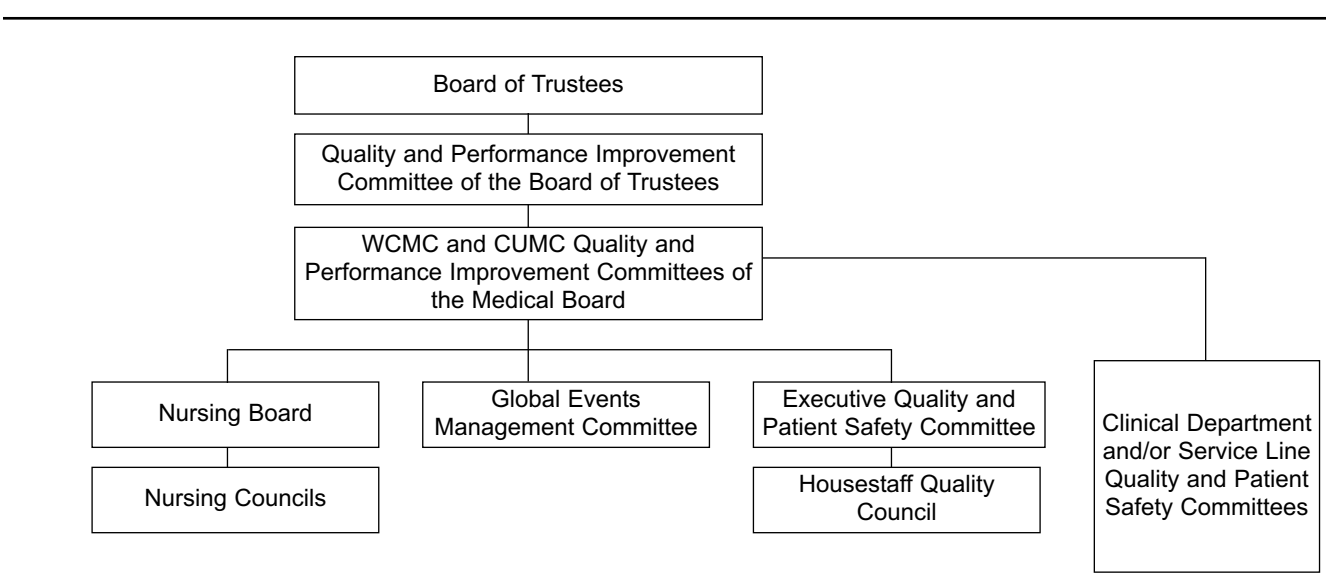

Figure 1. *The figure shows the integration of the Housestaff Quality Council (HQC) into the Division of Quality and Patient Safety table of organization at New York-Presbyterian Hospital (NYP), Weill Cornell Medical Center (WCMC), and Columbia University Medical Center (CUMC).*

tion with hospital administration were essential to the effectiveness of the HQC. In collaboration with the Division of Quality and Patient Safety, the HQC aligned its initiatives with the division and embarked on several projects. Their initial efforts yielded impressive results, and now, more than three years later, these improvements have been sustained.

Improvement Projects

Two early improvement projects overseen by the HQC—medication reconciliation and use of the electronic medical record (EMR)—as well as three new projects (hand hygiene, central line–associated bloodstream infections [CLABSIs], and patient handoffs) are now summarized.

Medication Reconciliation

In August 2008 the hospital identified an opportunity for improvement in medication reconciliation as identified by a Joint Commission NPSG. This issue was presented to the HQC and the council discussed various solutions. Because the hospital already had a computerized provider order entry (CPOE) system in place, the HQC was able to work collaboratively with the divisions of information technology (IT) and nursing to create a "hard stop" in the CPOE if medication reconciliation was not completed within the first 12 hours after admission to the hospital.[42] Because the HQC representatives were engaged in creating the solution to the problem, they were instrumental in communicating the IT changes to the housestaff and educating them using various modalities. At the time of implementation, HQC representatives, working with senior management and clinical leadership, facilitated and staffed the implementation of the IT system changes. This "forcing function," which was initiated on September 30, 2008, was so effective that compliance with medication reconciliation increased to > 90% within two months. This improvement was sustained when remeasured at six months.[42] Senior leadership viewed these results as evidence of an effective vehicle for further quality and patient safety improvement. As shown in Figure 3 (page 315), the hard stop in the CPOE has continued to facilitate compliance with medication reconciliation on admission, with compliance results sustained at > 90% from 2009 through 2011. Involving housestaff in designing the solution to medication reconciliation created the buy-in that would have been difficult to attain if driven by hospital administration alone. Yet medication reconciliation continues to be a challenge for many institutions, requiring continual attention to maintain compliance.[45]

Quality Improvement Through Use of the Electronic Medical Record

In November 2008, in partnership with the pathology and nursing departments, the HQC again took on a project centered on the EMR. NYP had a fully functional EMR and auto-

2012 New York-Presbyterian Hospital (NYP) Quality and Patient Safety Goals

Figure 2. *The 2012 NYP quality and patient safety (QPS) goals are shown.*

mated laboratory system, yet paper requisitions were still being used at surprisingly high levels. The goal of this project was to ensure that all laboratory tests were ordered through the EMR to decrease laboratory ordering errors, ensure correct patient identification and blood tube selection, reduce duplicate orders, and effectively track laboratory specimens to improve results turnaround time. The HQC worked collaboratively with faculty and resident staff from the two departments to conduct a pilot project in a selected critical care unit. In March 2009, after the pilot showed a significant reduction in the use of paper orders, the project was expanded to all critical care units during a seven-month period. Once again, because the HQC was engaged in the problem and the solution, its representatives were able to communicate and educate the housestaff, facilitating and sustaining the improvement. During the next eight months, after orienting staff to procedures to be followed and providing them with the necessary technical support, compliance with electronic ordering of laboratory tests improved by 70% over baseline levels. These results also continue to be sustained years later.

Hand Hygiene Campaign

In March 2012 the HQC initiated a collaborative Hand Hygiene Campaign to address Joint Commission NPSG.07.01.01 ("Comply with either the current Centers for Disease Control and Prevention [CDC] hand hygiene guidelines or the current World Health Organization [WHO] hand hygiene guidelines")[20] with the objective of achieving even higher rates of housestaff compliance. NYP consistently has overall hand hygiene rates of ≥ 90%, but data suggest opportunities to improve hand hygiene rates among physician groups. The HQC is currently using various analytic methods to examine current housestaff work flow to determine how hand hygiene practices can be improved.

Central Line–Associated Bloodstream Infections

In April 2012 the HQC also created a subcommittee to examine CLABSIs (NPSG.07.04.01, "Implement evidence-based practices to prevent central line–associated bloodstream infections. Note: This requirement covers short- and long-term central venous catheters and peripherally inserted central catheter [PICC] lines.")[20] The goal of this project is to ensure that there is standardized education for consistency in insertion and maintenance of central lines; to ensure patient safety and thereby prevent complications, including infections; and to standardize the supplies that are used for improved efficiency. The HQC provides a venue for housestaff from various specialties to discuss the elements of a uniform central line supply kit, and the HQC is working with hospital operations leadership to revise current supplies.

Effective Patient Handoffs

Patient handoffs, as cited by a Joint Commission NPSG in effect through 2009,* and since then by a standard,†[46] are being addressed through use of the EMR. A new, comprehensive "Hand Off" tab is included in a recent upgrade of the EMR to facilitate communication among physicians about important clinical information. In March 2012 representatives from the HQC started working with IT representatives to refine the work flow and ensure that key information is prepopulated into the Hand Off tab and readily available to all care providers.

* NPSG.02.05.11: "The hospital implements a standardized approach to hand-off commuications, including an opportunity to ask and respond to questons." The Joint Commission. *2009 Comprehensive Accreditation Manual for Hospitals: The Official Handbook.* Oak Brook, IL: Joint Commission Resources, 2008.

† Element of Performance 2 ("The hospital's process for hand-off communications provides for the opportunity for discussion between the giver and receiver of patient information") for Standard PC.02.02.01 ("The hospital coordinates the patient's care, treatment, and services based on the patient's needs").

Medication Reconciliation Compliance on Admission at All New York-Presbyterian Hospital (NYP) Sites, 2009–2011

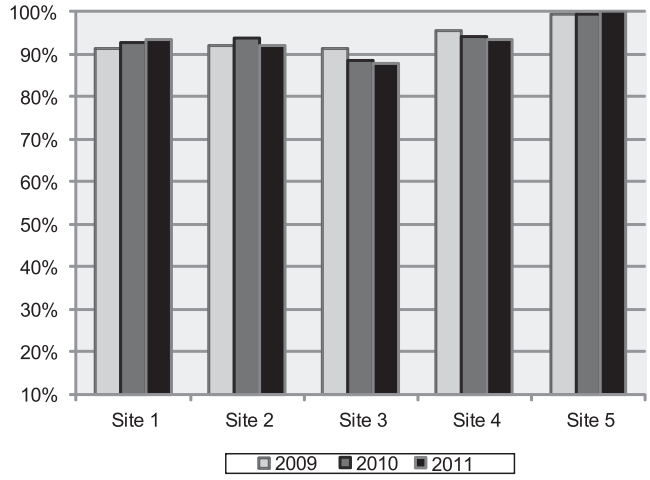

Figure 3. *The hard stop in the computerized provider order entry system has continued to facilitate compliance with medication reconciliation on admission, with compliance results sustained at > 90% from 2009 through 2011.*

Discussion

The HQC was successful in some of its first projects, and these results appear to be sustainable. However, a number of issues, representing challenges and lessons learned, have been associated with the HQC. First, project champions have helped the council to accomplish many of its goals. Senior leadership respects the thoughts and ideas of the HQC and seeks its opinions when initiating new plans or revising hospital processes and procedures. This mutually beneficial relationship has assisted hospital administration to accomplish its goals while supporting the HQC in contributing to the quality and patient safety improvements at the institution.

Second, although these projects were successful because of interdisciplinary collaboration and departmental and institutional support, the ability to sustain positive momentum is dependent on the ability of personnel to invest time and effort. The nature of contemporary graduate medical education provides additional challenges to successful institutional improvement initiatives. The housestaff have a number of obligate activities, such as rounds and conferences, in addition to their patient care obligations. Adherence to resident work-hour rules and rotations at varying clinical sites constrain the housestaff's ability to meaningfully participate in ongoing improvement initiatives. The success that the HQC has enjoyed reflects the hard work of the resident representatives on the council and the administrative support that has been provided to them at the departmental and institutional level, maximizing the time they spend on any project. Having senior leadership assist the council with the creation of agenda and action plans has increased the council's efficiency. Ultimately this has led to less demand on the housestaff, enabling them to focus on various key initiatives as opposed to managing the details of too many projects. In addition, selecting appropriate projects that are relevant to as many housestaff as possible is essential to keeping the housestaff engaged in the HQC.

Still, the time commitment needed for a resident to devote to the HQC cannot be underestimated, particularly in view of a demanding residency training schedule and its concomitant responsibilities. However, if we are to train health care leaders of the future, such endeavors must be an increasing component of resident education and training. The Accreditation Council for Graduate Medical Education (ACGME) has requirements to educate residents in the core competencies of medical knowledge, patient care, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice.[47,48] We believe that a resident's active participation in the HQC fulfills the competencies of practice-based learning and improvement and systems-based practice. Creating an interest in quality and patient safety and mentoring, coaching, and nurturing housestaff to become future leaders in health care is challenging because the primary goal of the housestaff is to engage in clinical and research activities related to their respective specialties. Housestaff are held to the responsibilities of their clinical departments, and, at various times throughout the year, assignments such as rotations outside the institution or ICUs may constrain a resident's time to actively participate in the council's initiatives. As such, can a case be made for devoting a portion of residency work hours to the proceedings of the council? This may be a controversial topic, particularly with the high degree of involvement of residents in direct patient care, but nonetheless, a topic that should be considered by program directors and clinical chairs.[49]

If participation in council-led initiatives were made an institutional priority, benefits would accrue in three ways, as follows:

1. Residency training programs would achieve the ACGME core competencies.

2. Hospital quality and patient safety goals and objectives would be achieved with the active participation of the frontline care providers—the housestaff.

3. Housestaff education would be enhanced and expanded to include interdisciplinary project management, health care

administration, outcomes analyses and management, resource utilization, and cost efficiency—qualities needed in the future leaders in health care.

As a complication to the time demands of meetings, early on the HQC became a highly desired informational platform for many departments in the hospital that required a forum to communicate a policy or procedure change. This placed the HQC leadership in the position of having to contemplate restricting the meeting agenda to avoid losing precious discussion time at monthly meetings. Drawing on advice and support from faculty advisors from the academic departments, as well as the chief medical officer for quality and patient safety, who is a member of senior hospital administration, the HQC leadership was able to address this problem. Monthly planning calls served as a venue for reinforcing the need to keep the agenda focused on the HQC rather than a series of presentations by hospital departments. Accordingly, we allowed the agenda to include up to two 5-minute presentations (which could be provided by housestaff or the hospital), with 20 minutes of discussion per presentation.

Second, as the HQC participants embarked on their projects, the HQC encountered barriers that required midcourse corrections. For example, with the medication reconciliation project, the HQC had not anticipated the need to provide technical assistance to the housestaff on the "go live" date. In response, the HQC quickly mobilized representatives to staff a call center so residents on duty had a central location from which to respond to questions. The EMR project addressing computerized ordering of laboratory tests uncovered a need for technical and hardware maintenance—a nonanticipated need. The departments of pathology and information technology took the lead to ensure that the infrastructure was modified to provide the necessary tools to support the project. Additional housestaff feedback helped identify other necessary modifications in the process, which facilitated the success of the project.

Finally, as the HQC begins new projects, there is an ongoing challenge to reevaluate and maintain its sustainability to ensure its prolonged growth and development. In July 2009, representing the beginning of the second year of the council, the HQC leadership rotated. By using the model of a chair, a vice chair, and a small number of officers, an annual succession plan was established. Despite the change of leadership each year, the primary mission of actively engaging housestaff in quality and patient safety is not compromised. It is crucial that hospital leadership continue to guide the council. Since the HQC's assimilation into the culture of NYP, its representatives are consistently invited to participate in and lend their ideas and support to quality improvement efforts when new projects are initiated at the hospital.

Summary

The concept of actively engaging residents in quality and patient safety by the creation of a novel HQC has repeatedly demonstrated sustainable results. As the HQC evolves, so will its performance. We believe that the HQC model is highly replicable at other teaching institutions as a complementary approach to their other quality and patient safety initiatives. J

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Ten Years After the IOM Report: Engaging Residents in Quality and Patient Safety by Creating a House Staff Quality Council

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Abstract

Ten years after the 1999 Institute of Medicine report, it is clear that despite significant progress, much remains to be done to improve quality and patient safety (QPS). Recognizing the critical role of postgraduate trainees, an innovative approach was developed at New York-Presbyterian Hospital, Weill Cornell Medical Center to engage residents in QPS by creating a Housestaff Quality Council (HQC). HQC leaders and representatives from each clinical department communicate and partner regularly with hospital administration and other key departments to address interdisciplinary quality improvement (QI). In support of the mission to improve patient care and safety, QI initiatives included attaining greater than 90% compliance with medication reconciliation and reduction in the use of paper laboratory orders by more than 70%. A patient safety awareness campaign is expected to evolve into a transparent environment where house staff can openly discuss patient safety issues to improve the quality of care.

Keywords

Housestaff Quality Council, patient safety, quality improvement, residents

House Staff Involvement in Quality Improvement (QI)

The Institute of Medicine (IOM) report, *To Err Is Human: Building a Safer Health System*, published in November 1999, concluded that 44 000 to 98 000 people die annually as a result of errors in inpatient hospital treatment.[1] This publication served as a call to action on the issue of medical errors in the health care industry. Although substantial progress has been made, experts believe that significant work remains.[2] To decrease medical errors and provide safer quality care, the health care industry recognizes the need to create high reliability organizations that reduce system failures and respond effectively when failures do occur.[3] At the center of this concept is teamwork, an essential component of high-reliability organizations.[4]

Despite progress in health care toward enhancing teamwork and addressing medical errors, house staff generally have not been engaged in the QI process. Since the IOM report, the Accreditation Council on Graduate Medical Education (ACGME) has required major academic teaching centers to include systems-based practice as a core competency in educational programs for house staff.[5] The ACGME requires trainees to advocate for quality patient care and optimal patient care systems, to work in interprofessional teams to enhance patient safety, to improve patient care quality, to participate in identifying system errors, and to implement potential systems solutions.

Engaging house staff has been an ongoing challenge for academic health centers, as Nash and Goldfarb recently described in their editorial "Point With Pride, View With Alarm, End With Hope: Quality and Safety Measurement and Improvement Is Maturing."[6-13]

The literature demonstrates the efforts that have been made to engage medical students and postgraduate trainees

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early in their education in the ACGME Core Competencies and IOM Aims for Improvement. This has been achieved at the departmental level by the creation of clinical microsystems that support integration of these values in interdisciplinary patient care and daily work flow.[14] Morbidity and Mortality conferences have also been used to apply a systematic analysis of the core competencies, applying them to discussion of a clinical case with a goal of achieving improved patient care.[15] A matrix tool, used at Vanderbilt University Medical Center to facilitate daily assessment of patients using the competencies, has identified areas where improvements are needed.[16] This model has also been used at the medical student level to encourage proactive leadership in the area of QI.[17] House calls have also been valuable in exposing the house staff to ACGME Core Competencies.[18] These efforts have been critical to the successful implementation of the ACGME and IOM values in several institutions.

In 2008, New York-Presbyterian Hospital (NYP), Weill Cornell Medical College, in New York created a Housestaff Quality Council (HQC) to begin the process of engaging house staff in quality and patient safety (QPS). Since its inception, the HQC has received recognition for the involvement of house staff in QPS initiatives. This article describes the HQC infrastructure and accomplishments.[19-21]

How the Housestaff Quality Council Was Started

There are numerous reports of documented QI initiatives across medical centers in the United States.[22-24] However, a review of the literature failed to identify any QPS publications regarding targeted house staff involvement in the policy and decision-making process. At NYP, the faculty and hospital administration acknowledged the importance of house staff to successfully implement patient care improvements, ACGME Core Competencies, and the IOM Aims for Improvement, but when adverse events occurred, house staff were engaged to a limited extent in the development of corrective action plans. House staff rarely participated in root cause analyses. If QPS were to improve, a paradigm shift was needed to address improved leadership and communication between the hospital and house staff.[25-28]

A faculty member and 2 house staff in the Department of Anesthesiology at NYP, Weill Cornell Medical College, spearheaded an effort to involve house staff in QPS processes. With the support of hospital administration and the Division of Quality and Patient Safety as well as the participation of the QPS administrator in the Department of Anesthesiology, they presented the concept of establishing an HQC. The residents assumed leadership of the council as cochairs and contacted all the clinical departments in the hospital to identify other house staff who were interested in QPS.

Early in deliberations, the newly formed HQC established its mission: (*a*) to improve patient care and safety at the hospital by creating a culture that promotes greater house staff participation; (*b*) to create an innovative, hospital-wide, multimodal communication process that provides 2-way communication with hospital administration and key clinical departments, including a standard and an emergent communications pathway, and (*c*) to conduct formal research on house staff attitudes and behaviors, aimed at establishing and promoting "best practice."[29]

"Nuts and Bolts" of the Housestaff Quality Council: Infrastructure

The HQC met for the first time in April 2008 and has met monthly since then. Initially, meetings included presentations from various hospital leaders to discuss QPS initiatives that were of interest to the house staff. The meetings rapidly evolved into HQC-directed discussions of preventable medical errors and systems changes that could improve daily operations and work flow in patient care. Examples of noteworthy initiatives and interventions include modifying the electronic medical record to streamline computerized physician order entry (CPOE), standardizing intravenous medication dosing, developing mechanisms for early diagnosis and prevention of *Clostridium difficile*, and developing processes to facilitate medication reconciliation and the administration of pneumococcal and influenza vaccines.

To ensure sustainability each academic year, the HQC developed rules and regulations governing the leadership, qualifications, and responsibilities of members; succession and reappointment processes; subcommittee structure; and administrative support. The Rules and Regulations were ratified by the HQC in April 2009, and the first election of new officers was held in June 2009.

Administrative support of the council is provided by a faculty advisor, a departmental QPS administrator, and a QPS operations manager who support various administrative and strategic activities for the council. Combined, these efforts constitute approximately 1 full-time employee. This administrative group and the HQC chairman and vice chairman meet regularly to discuss council initiatives and plan the monthly HQC meeting agenda.

The chairman of the HQC also serves as the resident QPS officer for NYP and, along with the HQC vice chairman, meets weekly with the hospital's chief QPS officer and regularly attends the institution's weekly QPS officers' forum. QPS initiatives are discussed at these meetings, and the HQC chairman and vice chairman ensure that key

information is brought back to the HQC representatives at monthly meetings for discussion and dissemination to the entire house staff.

Communication

One of the first goals of the HQC was to create a robust, multimodal, bidirectional communication process between house staff and the HQC. The council sought to creatively develop new ways to communicate with the entire house staff while simultaneously addressing routine and emergent quality and safety issues.[30,31]

The communications plan was launched in late 2008, utilizing an external communications consultant, with weekly meetings to brainstorm improvements and create viable short- and long-term solutions. During this period, it became apparent that one of the major impediments to effective communication was the inability to quickly determine the importance or relevance of messages. Prior to development of the HQC, there had often been a mismatch between message content and the communication vehicle used. Multiple sources of information conflicted, at times, and the rationale for policy changes was often unclear. Traditional, unidirectional, top-down communication was deemed to be suboptimal.

The HQC formed a communications subcommittee that uses a robust communications matrix that aids in the prioritization of messages (Figure 1). Every message sent to house staff is evaluated on 2 scales: urgency and consequence. Urgency conveys how quickly the message must be disseminated. Consequence relates to the overall importance of the message or process change. Following this matrix, the means of communication (media) are then matched on similar scales, such that messages to house staff are delivered via an appropriate medium. Media methods include grand rounds presentations, chief resident communications, e-mail messages, newsletters, posters, α-numeric paging, and Infonet announcements. Furthermore, wherever possible, the messages include data in support of the process change and evidence that house staff are involved in the process improvement (buy-in); messages are sent directly from the HQC.

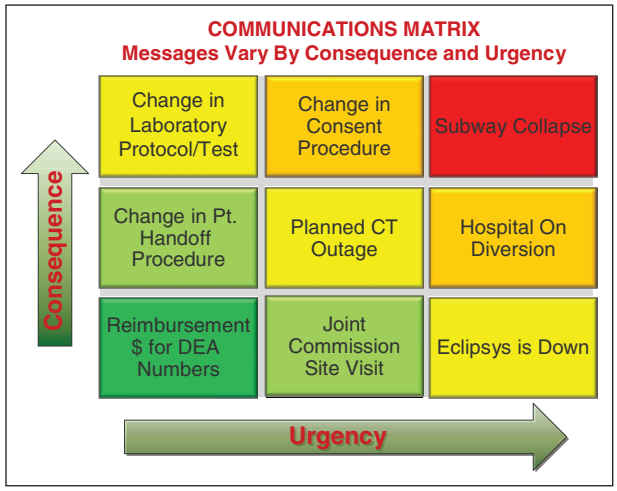

Figure 1. Example of the communications matrix
Abbreviations: Pt, patient; CT, computed tomography; DEA, Drug Enforcement Agency

Patient Safety Awareness Campaign

To become a more effective, reliable organization, the HQC established a goal of not only reducing medical errors but also raising awareness of errors and sentinel events. At a welcoming reception held for house staff at the beginning of the academic year, a patient safety awareness campaign was launched to encourage transparency in reporting medical errors and to promote vigilance in identifying possible flaws in hospital processes and systems. At one of the monthly HQC meetings, the chairman and vice chairman led the HQC representatives in a brainstorming session to identify the most common medical errors that they witnessed throughout their training. These errors were prioritized and adapted into fictional scenarios that the HQC deemed universal, multifactorial, and serious or potentially serious. To increase the impact of the campaign, residents volunteered to put their photographs on posters describing these adverse patient events. These recognizable faces demonstrated how medical errors can occur and provided authenticity to each scenario. The posters were displayed in prominent locations at the HQC reception, which was attended by more than 100 house staff as well as many other members of the hospital and medical college community. Areas highlighted included the following:

- Deep vein thrombosis prophylaxis
- Potency of hydromorphone (dilaudid) versus morphine sulfate
- Retained central line guidewires
- Electronic order entry
- Antibiotic administration in sepsis
- Insulin management
- Lab ordering
- Checking labs prior to central line placement
- Not seeking help

The goal of this initiative was to make the spectrum of medical errors as real and authentic as possible, demonstrate transparency, and thereby reduce errors.[30] Although concurrent QPS initiatives may influence a reduction in medical errors, it is expected that by raising awareness, the

house staff will become more cognizant of medical errors, and this "Hawthorne effect" will reduce the occurrence of specific medical errors.[32]

Quality and Safety Initiatives

Since the inception of the HQC almost 2 years ago, several successful initiatives have been driven by the HQC or greatly enhanced as a result of HQC participation. These initiatives included medication reconciliation, timely vaccine ordering, conversion of paper to electronic lab ordering, development of a standardized tracheostomy checklist, standardized intravenous medication dosing across all intensive care units (ICUs), proper collection and submission of tissue samples, and reduction of *C difficile*. Many of these initiatives were initiated by the HQC, whereas others were already hospital projects, so it is difficult to attribute 100% success of some of these initiatives to the HQC alone. However, without the support and participation of the HQC, these projects would not have gained the traction needed to be successful.

The first initiative of the council was to create a system that would increase compliance with medication reconciliation. A 2008 National Patient Safety Goal of The Joint Commission included medication reconciliation at the point of admission, transfer, or discharge from the hospital.

Working collaboratively with the hospital's Information Technology (IT) and Nursing Divisions, the HQC recommended a "hard stop" in the electronic CPOE system that would require a resident to complete medication reconciliation before orders could be entered into the system. On the "go live" date, HQC representatives manned a command center to ensure that medication reconciliation was completed on every inpatient. As a result of these efforts, compliance increased by 55% within 45 days.[33,34]

The medication reconciliation project was so successful that a similar process was created for compliance with timely vaccine ordering. As a result, more than 90% of eligible patients now receive appropriate vaccines in a timely manner.

The HQC currently has a project under way that focuses on reducing the more than 700 000 paper requisitions for lab tests, with a goal of having all lab tests ordered through the CPOE system. In conjunction with the Department of Pathology and the Nursing Division, this project was piloted in the cardiothoracic ICU in February 2009. Physicians were oriented to the benefits of ordering lab tests electronically, IT provided technical support to ensure that label printers functioned properly, and after 1 month, a 70% reduction in paper lab orders was realized. This approach will be extended throughout the institution.

As the HQC has matured, the representatives have become increasingly involved in QPS awareness, and as a result, several basic projects have led to improvements that have simplified and standardized patient care processes. These initiatives include the creation of a tracheostomy checklist for standardized management of patients with a tracheostomy and standardized intravenous medication orders for patients across all ICUs. Individual residents have also been the impetus for significant QPS initiatives routed through the HQC. For example, one resident created a hospital-wide communication on the proper collection and submission of tissue specimens for deep-wound cultures and demonstrated collection techniques at one of the HQC monthly meetings.

Barriers

If residents are to have an impact on the creation of policies that influence patient care, they must be given the opportunity to provide input. Whenever culture change of this magnitude is being sought, hospital leadership must actively endorse and encourage such input. Therefore, a coherent and powerful case must be devised and presented by those who are interested in making this culture change to the leadership of the institution.

Changing the behavior of large numbers of house officers is a substantial undertaking. It is especially difficult when residents in each department work in their respective departmental silos and do not demonstrate overt interest in changing the way they manage patients because they believe they are doing it as well as possible. Frequently, it is instilled into the psyche of many residents that they are better than their peers in other departments. Therefore, these virtual walls that have been created over time must be brought down.

These walls can be broken down by reaching out to key individuals in the various departments and making a strong argument for the need for such a council. One of the initiatives that piqued house staff interest was the creation of the patient safety awareness campaign. When residents from various specialties banded together to identify the most common medical errors made by house staff and then put their faces on posters describing those errors, they not only broke through departmental barriers but also created a project that gave them ownership.

The experience at NYP has demonstrated that the presence and expression of passion by the advocates for such an initiative is a critical factor to its success. If passion and urgency are not there, potential "recruits" will have a difficult time engaging.

Ultimately, sustainability and ongoing engagement can be the greatest challenge. The leadership must constantly consider ways to incentivize residents to stay involved

with the council as well as excite them to the point that they want to bring their colleagues into "the fold." Incentives may include receptions, meals, contests, publications, recognition, and expressions of gratitude. In addition, an annual stipend is planned for the HQC leadership, which is expected to provide an extra incentive to take on the work of the council. Most important, there must be the constant reminder that house staff can indeed make a difference in improving patient care and hence should be included in the QI process.

Future Goals

The primary goal of the HQC is to promote an environment that encourages house staff involvement in QPS. This goal requires a shift in culture and behavior and can best be achieved through robust communications, IT support designed to standardize and streamline documentation of clinical care, and an open dialogue with hospital administration. The NYP HQC will continue to utilize the communications matrix and a multimodal communication process to provide a 2-way dialogue with administration and key personnel in an effort to disseminate information back and forth between house staff and these communicators. The patient safety awareness campaign is expected to evolve into a transparent environment in which house staff will feel that they can openly discuss patient safety issues to improve the quality of care. Because house staff are on the front lines of utilizing the electronic medical record, the hospital plans to continue to involve the HQC in decision making and engage them in the IT policies of the hospital. Finally, the HQC will continue to be involved in the recognition and reduction of hospital-acquired infections.

Focus on these key areas will contribute to an overall improvement in patient safety and quality by engaged house staff. This engagement will ultimately further a change in culture that will create the physician champions of the future.

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An Anesthesiology Department Leads Culture Change at a Hospital System Level to Improve Quality and Patient Safety

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KEYWORDS

• Housestaff quality council • Culture change
• Quality and patient safety • Quality improvement

When one does a Google search for "housestaff culture," one is referred to many sites dealing with the culture of the White House staff and even more on how residents should obtain, handle, and evaluate bacterial cultures. According to the Accreditation Council on Graduate Medical Education (ACGME), medical housestaff—residents and

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fellows—make up one-seventh of all active physicians in the United States at any given point in time.[1] Despite their central role in the health workforce, few people have looked at the cultural changes associated with these postgraduate trainees who are intimately involved and embedded in our nation's health care system. Yet one cannot overestimate the importance of the culture of physician housestaff (residents and fellows) and the impact that it has on the delivery of patient care. The fact that there are 109,000 residents and fellows out of a total of slightly more than 700,000 physicians in the United States demonstrates the significant role of the housestaff.[1,2] Thus, the residents' knowledge base, clinical skills, attitudes, goals, and behavior, ie, the housestaff culture, greatly affect our nation's health care order.

The past decade has seen the emergence of the Joint Commission National Patient Safety Goals, the Centers for Medicare and Medicaid Services (CMS) Quality Program, the Leapfrog Group, Reasonably Preventable Conditions, and various quality initiatives such as the 2004 Institute for Healthcare Improvement's 100,000 Lives campaign to avoid unnecessary deaths (deaths deemed to be avoidable in hospital settings). When one attends seminars or conferences dealing with the issues, it is rare to see housestaff present to become involved in discussions around the best way to address these goals or to communicate the message. Given that residents provide a significant percentage of patient care at academic institutions, their involvement would seem to be of great importance. It appears that another cultural transformation is in order.

It is unusual for hospitals with residency programs to have formal systems in place where ongoing communication between key stakeholders in the hospital work regularly with housestaff to generate policies and procedures that have the goals of optimizing patient care and safety. Members of the Department of Anesthesiology at New York-Presbyterian Hospital, Weill Cornell Medical Center recognized this shortcoming and the need for culture change by proposing a systematic approach to involvement of housestaff in quality and patient safety (QPS) matters in a more meaningful way.

The chair of the Department of Anesthesiology at New York-Presbyterian Hospital (NYP), Weill Cornell Medical Center has supported and actively encouraged members of the department to pursue their particular interests. Indeed, leadership like this fosters creativity, ingenuity, and productivity. Because of this, many members of the faculty and staff in the department are intimately involved in the affairs of the hospital. Many, either directly or indirectly, oversee clinical care of patients in the operating rooms, the postoperative anesthesia care units, the pain management clinic, and some of the intensive care units. Many of them chair some of the most influential clinical committees in the hospital.

Over the years, it became clear to many of the faculty and staff that a key partner in patient care, the resident, was rarely present at clinical committee meetings with the ability to give input on important issues. As members of the department tried to understand how best to engage the housestaff into quality improvement efforts, it became clear that housestaff had to be equally involved in the planning process. There was a strong belief that an environment where housestaff felt empowered would result in a culture where housestaff would be motivated to deliver optimal patient care. It was felt that this cultural transformation could be accomplished by engaging housestaff in the generation of policies and decisions that involved patient care and safety, thereby empowering residents to provide the best patient care possible.

In 2008, members of the Department of Anesthesiology at New York-Presbyterian Hospital, Weill Cornell Medical College presented the concept of a GME-focused effort in quality and patient safety. The centerpiece for this initiative and the highlight of the vision was the creation of the Housestaff Quality Council (HQC). The HQC is

composed of resident representatives of all the clinical departments in the institution who assumed the role of facilitators of the culture change.

There have been huge cultural shifts with regard to the housestaff experience over the past 50 years. In the 1970s, housestaff activism compelled hospitals to improve working conditions as well as improve compensation. In the 1980s, housestaff in New York State started to work shorter hours owing to legislation passed by the New York State legislature. In 2003, the Patient and Physician Safety Act was passed by Congress to address patient safety and resident work hours, as well as sleep deprivation. Not only do housestaff get paid more and work fewer hours, they now feel empowered to ensure that the work hour regulations get enforced. Improved patient care delivery will be the result of empowering the housestaff in ways that incite them to enhance the care they deliver.

CREATION OF THE HOUSESTAFF QUALITY COUNCIL BY THE DEPARTMENT OF ANESTHESIOLOGY

Hospital Background

NYP is the largest hospital in New York and one of the most comprehensive university hospitals in the country, with leading specialists in every field of medicine. It is one medical center with several campuses, affiliated with 2 highly regarded, Ivy League medical schools: Weill Cornell Medical College of Cornell University and Columbia University College of Physicians and Surgeons.

This 2298-bed hospital provides state-of-the-art inpatient, ambulatory, and preventive care in all areas of medicine. The hospital includes several facilities: NYP-Weill Cornell Center, NYP-Columbia Presbyterian Center, The Allen Hospital, Morgan Stanley Children's Hospital of New York-Presbyterian, and NYP Hospital/Westchester Division.

Preliminary Discussions

In 2008, the medical director of the Cardiothoracic Intensive Care Unit (CT-ICU), an anesthesiologist, approached two CA-1 residents in anesthesiology to discuss the creation of a quality improvement project in the CT-ICU. The residents had a particular interest in QPS matters stemming from medical school days and were eager to make a contribution. While discussing this project and its potential merits, it became apparent to the CT-ICU medical director that housestaff in anesthesiology, as well as other clinical departments, had minimal input in strategic planning or daily operations at the hospital when adverse events occurred or problems were identified. They were caring for patients in their own silos, generally not engaged in QPS issues, either at the hospital or departmental level. Simultaneously, it was noted that at hospital operational meetings and conferences, the "preachers were preaching to the choir," ie, hospital leadership was addressing issues to those already aware of them whereas those who were not aware, the housestaff, were not present to participate in these discussions. The housestaff as front-line caregivers were not at the table participating in these discussions about QPS and for any change to occur, a drastic cultural shakeup was needed.[3,4]

This preliminary discussion quickly shifted to the need for housestaff involvement in QPS matters and policy decision making, with an alteration in the traditional role of the housestaff in their relationship with hospital leadership. As a result, the CT-ICU medical director suggested that the residents explore the development of a group to engage residents in the hospital's quality and patient safety activities.[3,4]

To frame this project, the residents approached the QPS administrator in the Department of Anesthesiology to learn about some of the current QPS projects and concerns in the department. Early on, they determined that some of the departmental concerns were likely similar to those in other clinical departments. Speaking with resident colleagues in other departments, the residents in anesthesiology thought that there was enough interest to proceed with conducting a research study aimed at improving patient care and safety by promoting housestaff participation in policy and decision making. With the urging of the CT-ICU medical director, and from these preliminary discussions, the HQC was born.

Presentation to Senior Hospital Leadership

To begin the process of creating the HQC, the residents needed buy-in and approval from senior leadership at the hospital. They needed to convince senior leadership that if their ideas could be heard in a formalized manner, the housestaff could play a key role in making improvements in the daily operations of the hospital. If the culture at the hospital was to change, formal 2-way communication needed to be established.[3]

Working with the CT-ICU medical director and the departmental QPS administrator, the residents developed a presentation and invited the chief medical officer, the vice president of medical affairs/designated institutional official, the chief QPS officer, and vice presidents of quality and patient safety to meet with them. The presentation focused on several components:

- *The Current Milieu*: As key partners in patient care, and frequently involved in sentinel events, the housestaff were not routinely included in discussions and decision making regarding policy changes, inadvertently creating an “us” versus “them” environment. In an environment of public reporting, it seemed essential to involve housestaff in moving the needle to improved processes and outcomes.
- *The Mission*: To improve patient care and patient safety at NYP by creating a culture that promotes greater housestaff participation.
- The Proposal:
  1. “Buy-in” through involvement in policy making
  2. Dissemination of knowledge to peers
  3. Enforcement of best practices and policies
  4. Development of relationships
  5. Communication of key changes
  6. Measurement of how we are doing.

The presentation was received enthusiastically and the senior leadership group endorsed the proposal.[4]

Tracking the Change in Culture

Cultural change is difficult to assess. How do you evaluate the effect of what you have done and whether your actions have resulted in a major influence on an organization’s culture? In an environment where the hospital was continually initiating changes to improve quality and patient safety, how could the introduction of the HQC and their involvement in quality and patient safety be assessed?

As the members of the Department of Anesthesiology started the HQC, the founding members wanted to establish a baseline of housestaff attitude and assess the culture toward quality and patient safety. Partnering with Dr Bryan Sexton, formerly of Johns Hopkins University and currently at Duke University, an attitudinal survey was used to

assess housestaff attitude and culture. In the past, this survey had been distributed throughout the country to assess hospital-based culture.

Institutional review board approval was obtained and the survey was distributed to the entire housestaff in September 2008. Since the initial distribution, the survey has been repeated in 9-month intervals over the past 3 years, and has been slightly modified to include measurement of interdepartmental communication. The most recent version of the survey is shown in **Fig. 1**.

The initial survey showed that the housestaff were neutral in their view of QPS and demonstrated that they were not engaged in QPS at the hospital, as seen in the sample of survey questions shown in **Table 1**.[5]

These data suggested that improvement could be made in quality and patient safety by engaging housestaff in the policy and decision-making processes of the hospital.

IRB Protocol #0807009889

New York Presbyterian Hospital-Weill Cornell Medical College Safety Attitudes Survey

My participation in this minimal-risk survey study is entirely voluntary. During the course of this study, the research team of the Weill Cornell Medical College (WCMC) will be collecting information that they may share with New York Presbyterian Hospital-Weill Cornell Medical College administration, study monitors who check the accuracy of the information, and individuals who put all the study information together in report form. No identifying information will be collected. I understand that I may refuse to answer any (or all) of the questions at this or any other time. By answering the questions, I am providing authorization for the research team to use and share this information at any time. If I do not want to authorize the use and disclosure of this information, I may choose not to answer these questions and my status and the relationship with WCMC will not be affected by it. There is no expiration date for the use of this information as stated in this authorization. This process will be repeated every eight months until August of 2011.

Department: _____ **Training Level: PGY-**___ **Gender:** Male / Female

Did you complete this survey in 2009? Yes / No / Don't Know

Are you a member of the Housestaff Quality Council? Yes / No / Don't Know

Please choose your responses using the scale below:

1	2	3	4	5	X
Disagree Strongly	**Disagree Slightly**	**Neutral**	**Agree Slightly**	**Agree Strongly**	**Not Applicable**

1.	It is difficult to speak up if I perceive a problem with patient care.	1	2	3	4	5	X
2.	I have the support I need from other personnel to care for patients.	1	2	3	4	5	X
3.	It is easy for personnel here to ask questions when there is something that they do not understand.	1	2	3	4	5	X
4.	The physicians and nurses here work together as a well-coordinated team.	1	2	3	4	5	X
5.	I would feel safe being treated here as a patient.	1	2	3	4	5	X
6.	The Housestaff Quality Council has improved patient safety	1	2	3	4	5	X
7.	I know the proper channels to direct questions regarding patient safety in the hospital.	1	2	3	4	5	X
8.	It is difficult to discuss errors that occur in my daily work.	1	2	3	4	5	X
9.	I am encouraged by my colleagues to report any patient safety concerns I may have.	1	2	3	4	5	X
10.	The culture in the hospital makes it easy to learn from the errors of others.	1	2	3	4	5	X
11.	My suggestions about safety would be acted upon if I expressed them to management.	1	2	3	4	5	X
12.	I am aware of the Housestaff Quality Council.	Yes				No	
13.	This is a good place to work.	1	2	3	4	5	X
14.	Hospital administration supports my daily efforts.	1	2	3	4	5	X
15.	I am aware of the work the Housestaff Quality Council does.	1	2	3	4	5	X
16.	The levels of staffing in my clinical area are sufficient to handle the number of patients.	1	2	3	4	5	X
17.	I am provided with timely information about events in the hospital that might affect my work.	1	2	3	4	5	X
18.	Trainees in my discipline are adequately supervised.	1	2	3	4	5	X
19.	The Housestaff Quality Council communicates well with the housestaff.	1	2	3	4	5	X
20.	I experience good collaboration with attending physicians in my clinical area.	1	2	3	4	5	X
21.	I experience good collaboration with pharmacists in my clinical area.	1	2	3	4	5	X
22.	Communication breakdowns that lead to delays in delivery of care are common.	1	2	3	4	5	X
23.	Communication between housestaff and the hospital regarding patient safety policies is good.	1	2	3	4	5	X
24.	I am provided with timely information by the Housestaff Quality Council about events in the hospital that might affect my work.	1	2	3	4	5	X
25.	My level of knowledge with regards to the dosing of Dilaudid (hydromorphone) has increased over the past year.	1	2	3	4	5	X

I enjoy the quality of teamwork and cooperation/communication with housestaff from: (use the same rating scale as above)

Anesthesiology	1 2 3 4 5 X	Ob/Gyn	1 2 3 4 5 X	Phys Med&Rehab	1 2 3 4 5 X
Dermatology	1 2 3 4 5 X	Ophthalmology	1 2 3 4 5 X	Psychiatry	1 2 3 4 5 X
Emergency Med	1 2 3 4 5 X	Orthopedic Surgery	1 2 3 4 5 X	Rad Oncology	1 2 3 4 5 X
Medicine	1 2 3 4 5 X	Otolaryngology	1 2 3 4 5 X	Radiology	1 2 3 4 5 X
Nephrology	1 2 3 4 5 X	Pathology	1 2 3 4 5 X	Surgery	1 2 3 4 5 X
Neurology	1 2 3 4 5 X	Pediatrics	1 2 3 4 5 X	Urology	1 2 3 4 5 X
Neurosurgery	1 2 3 4 5 X	Plastic Surgery	1 2 3 4 5 X		

Additional Comments to the HQC: _____

Thank you for completing the survey – your time and participation are greatly appreciated.

Disclaimer: This survey is derived from the University of Texas at Austin Copyright 2004 Safety Attitudes in Your Unit and has been modified to address the needs of the NYPH-WCMC.

Fig. 1. New York-Presbyterian-Weill Cornell Medical College Safety Attitude Survey.

Table 1
Initial safety attitude survey results

Survey Question	Score
It is difficult to speak up if I perceive a problem with patient care.	2.5
It is difficult to discuss errors that occur in my daily work.	2.6
Communication breakdowns that lead to delays in delivery of care are common.	3.0

Scale: 1 = Strongly Disagree; 5 = Strongly Agree.

This survey has also served as a tool to assess the affect of the HQC since its inception. However, it is recognized that the creation of the HQC alone may not be the sole reason for these results; concurrent hospital QPS initiatives may have also influenced the results.

Strategic Plan and Recruitment

With the endorsement of senior leadership to proceed with the formation of the HQC, the residents wrote a letter to each of the clinical department chairmen and program directors, requesting 2 members of the housestaff from each department to join the HQC. Once the housestaff were appointed to the HCQ, the residents put together informational packets that included the presentation to senior leadership, a copy of The Joint Commission National Patient Safety Goals, a communications plan, and a directory of HQC representatives. The first HQC meeting was scheduled, only 5 months after the initial presentation.[4]

First Meeting and Agenda Creation

The first meeting of the HQC took place in April 2008, co-chaired by the residents in anesthesiology. Initially the meetings were focused on a few ideas that would make a difference in quality and safety outcomes. *HOT TOPICS* were discussed, feedback was provided, and various clinical departments were invited to make presentations to the HQC. Through this early format, the HQC representatives developed a list of initiatives that they thought would be most beneficial to improvements in patient care and daily workflow.

The first major QPS initiative that the HQC addressed was immediately following a survey by The Joint Commission. The hospital had received a Requirement for Improvement (RFI) in the area of medication reconciliation and had only 45 days to address its deficiency in compliance. The HQC responded to this need by suggesting that a “hard stop” be placed in the admission order set of the Computerized Provider Order Entry (CPOE) if the medication reconciliation was not performed within the first 12 hours of admission.

Over time, the HQC meetings evolved from passive presentations on QPS initiatives by various departments to HQC-driven discussions of how care can be improved through active participation by the HQC.

Administrative Support

From the outset, the Department of Anesthesiology was instrumental in providing the leadership and administrative support to the HQC and continues to do so today. In addition, the support from the medical school and hospital has been profound, though complex.

The medical director of the CT-ICU serves as the faculty advisor to the HQC and the QPS administrator serves as the QPS liaison. One of the anesthesiology residents who

started the HQC was encouraged to focus on the HQC initiatives during his 6-month research elective.

The HQC has received financial support from the senior vice president and chief QPS officer of the Division of Quality and Patient Safety, senior administration, and through grants from the New York-Weill Cornell Center Alumni Council (CAC).

Because of the complexities of the administrative support and relationships, the HQC chair and vice chair meet regularly with senior leadership and the QPS officers to ensure they are well informed about various QPS initiatives at the hospital. One of the challenges is to provide administrative time to the HQC leadership for this purpose. The clinical department chairs have been overwhelmingly supportive of the HQC and with their assistance, they do their best to help the HQC leaders meet these goals while maintaining resident work hour compliance.

Communications

The key to changing culture in any organization is communications among all those involved in the process. The initial conversation between the Department of Anesthesiology and hospital leadership was the first step in this communication process and even more important was the communication between the hospital leadership and the housestaff. If the culture was to change, an effective communication process was needed.

To address the goal of developing a robust, 2-way communications system, the HQC formed a communications subcommittee and identified some of the barriers to effective communications, including the inability for housestaff to identify the importance or relevance of a message.

The HQC engaged Synecticsworld, a company known for its innovative, systematic approach to problem solving, and with their guidance during 4 separate sessions with key members of the HQC, a communications matrix (**Fig. 2**) was established. The

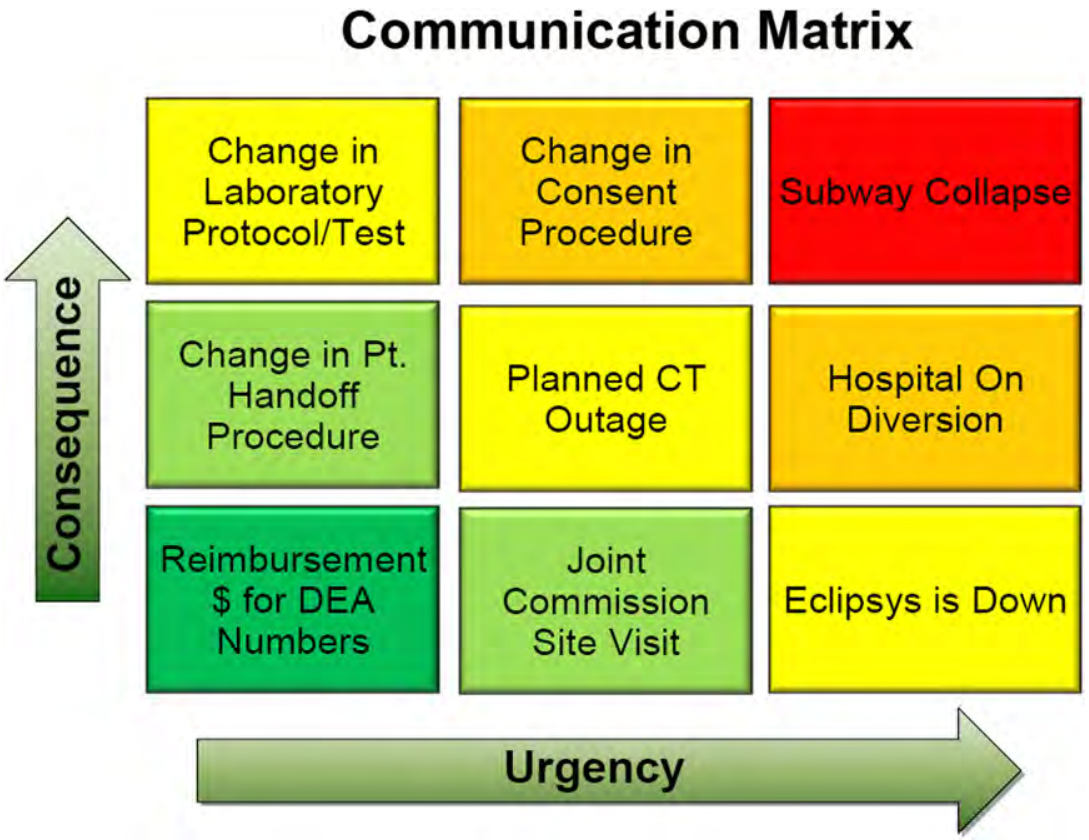

Fig. 2. HQC communications matrix.

matrix is used to prioritize a message as to urgency and consequence and the means of communication is selected based on that priority.[4,6] Some of the methods of communication include e-mail messages, newsletters, posters, alpha-numeric paging, Grand Rounds presentations, and Infonet announcements. In addition, whenever possible, messages are sent directly by the HQC to improve "buy-in."

The HQC also developed a Web site (**Fig. 3**), which is part of the hospital Infonet, dedicated to communications for and about the HQC. They publish a quarterly newsletter, *Clinical Updates*, to summarize the results of recent accomplishments by the HQC.

Resident Quality and Patient Safety Officer

In an effort to recognize the important role of the HQC chair, the chief QPS officer created the role of resident QPS officer in 2009. This position has given the HQC chair an opportunity to learn about the QPS issues at the hospital, to bring these issues back to the HQC in a more enlightened way, and has facilitated alignment with strategic goals between the HQC and the hospital's QPS agenda. Working collaboratively with the other QPS officers at the hospital, the resident QPS officer has helped strengthen the relationship between the HQC and hospital leadership and key clinical and support departments.

Organizational Structure

To ensure a sustainable and functioning organization, the HQC turned its attention to creating formal rules and regulations. A subcommittee was formed to address this topic and the first rules and regulations were ratified by the HQC in May 2009.

The rules and regulations codify the mission and vision of the organization, the composition of the HQC, the responsibilities of the chair and vice chair, the qualifications of the members and their responsibilities, the reappointment process, succession planning, financial authority, and administrative support.

The HQC reports through the hospital's Division of Quality and Patient Safety (**Fig. 4**). The HQC provides periodic reports to the hospital's Medical Board and Board of Trustees Quality and Performance Improvement Committee and is represented on several Medical Board committees, including the QPS Executive Committee, IT Prioritization Committee, Sedation and Analgesia Committee, Perioperative Services Steering Committee, and Surgical Site Infection Committee.

HQC Quality Focus Areas/Alignment with NYP

Each year, quality focus areas are selected by the Division of Quality and Patient Safety with collaboration and approval of hospital leadership. To achieve these goals, it is important for the hospital to foster culture change at the institution and they have emphasized their motto "We Put Patients First" to accomplish this objective.

The hospital has experienced great success with a reduction in central line–associated blood stream infections (CLABSIs), hand hygiene compliance, and other QPS initiatives because of on-going efforts at communications and marketing of its goal: to create a culture of optimal quality and patient safety. At the same time, the HQC has partnered with the hospital in creating synergy with the quality focus areas.

In 2009, the HQC focused its strategic goals to align with those of the hospital. The strategic goals (**Fig. 5**) for the year included medication safety, communications, infection prevention and control, efficiency and patient flow, and surgical and procedural safety. To align with these goals, the HQC established a focus on hydromorphone and morphine sulfate, the communications matrix, compliance with influenza vaccine administration, paperless laboratory orders, and a tracheostomy care checklist.

Fig. 3. HQC Infonet Web site.

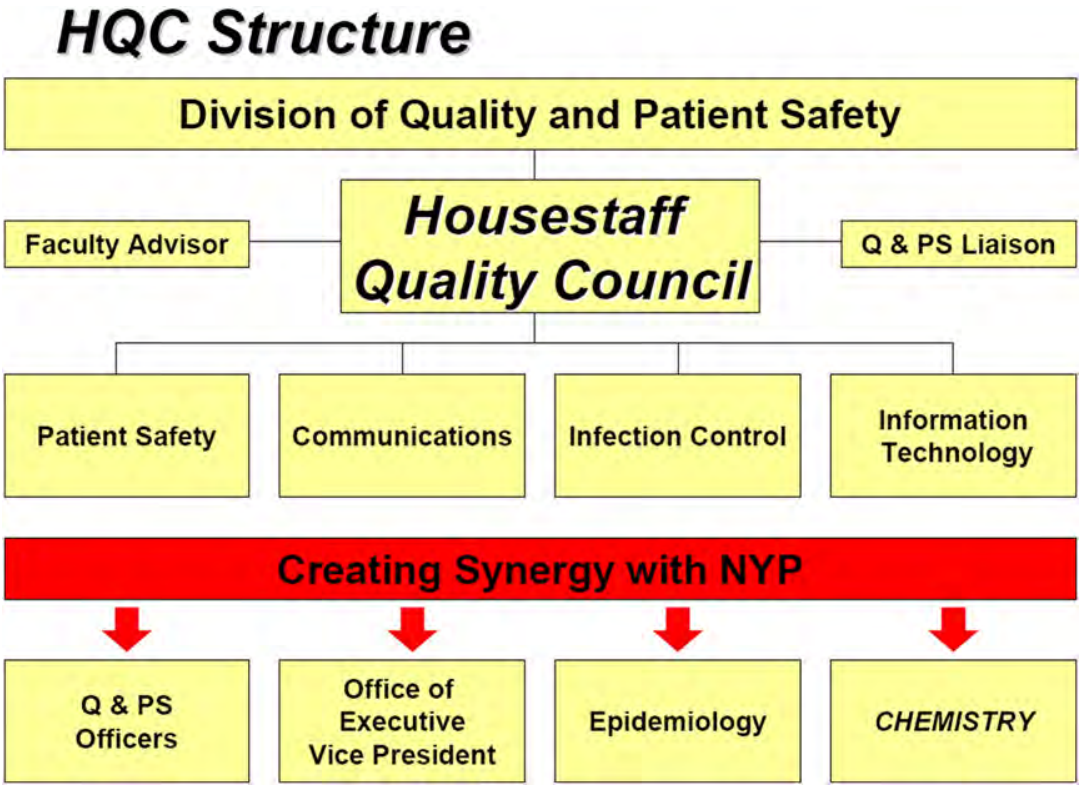

Fig. 4. HQC organizational structure.

Sustainability and Succession Planning

The HQC has continued to develop and grow since it began in 2008. The founding members of the HQC have a vested interest in ensuring that the work of the HQC continues and the ratification of the HQC rules and regulations supports this goal.

In May 2009, in accordance with the rules and regulations, the first election of a vice chair was held and a surgery resident was appointed to the leadership of the HQC for

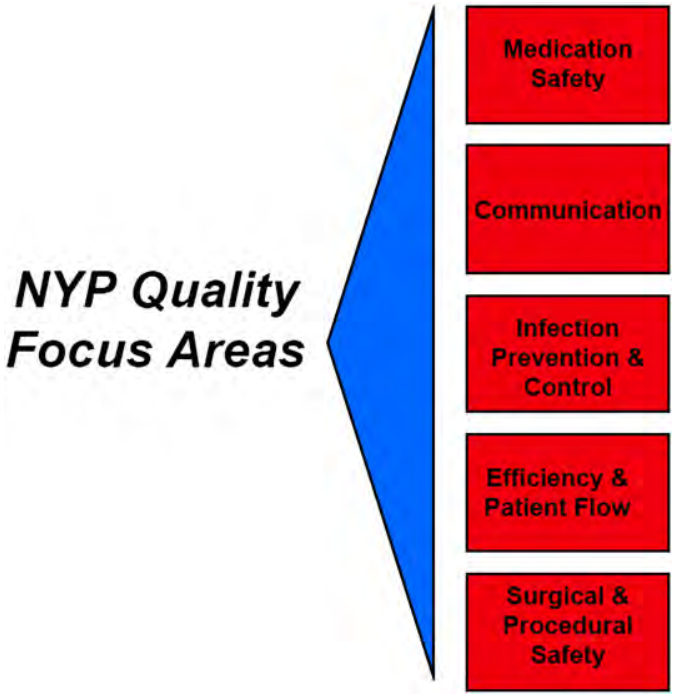

Fig. 5. HQC/NYP quality focus areas.

a 2-year period, first as vice chair, and then as chair for the second year. A second election was held in May 2010 and an internal medicine resident was elected as the 2010–2011 vice chair. With leadership passing outside of the Department of Anesthesiology, the HQC will be sustained by residents from other specialties in medicine.

Replicability

The success of the HQC at NYP has garnered recognition and interest from many other institutions throughout the country and the concept of the HQC has been replicated at other medical centers. In addition, the HQC has been invited to make presentations at the Harvard Quality Colloquium, the ACGME, the American Association of Medical Colleges (AAMC), the David Rogers Health Policy Colloquium, the Duke Physician Leadership in Quality and Patient Safety, the New York State Department of Health, and the American Medical Student Association (AMSA).

RESULTS

How has the HQC improved quality and patient safety? By forging a bi-directional communication pathway with senior leadership and key clinical and administrative departments, thereby developing a systematic approach to identifying QPS issues where housestaff participation will affect outcomes. This approach includes (1) identifying QPS issues, (2) collecting data, (3) analyzing data, (4) implementing process/system changes, and (5) monitoring the effectiveness of the changes.

Over the past 3 years, the HQC has made several important contributions to QPS improvements, some of which are highlighted as follows:

1. Medication Reconciliation: As previously mentioned, this Joint Commission National Patient Safety Goal requirement was championed by a group of HQC members after receiving an RFI during a Joint Commission accreditation site visit. With 45 days to develop a corrective action plan, the HQC recommended placing hard stops in the electronic medical record admission order set and worked collaboratively with Nursing and Information Technology to accomplish this. Once this force function was placed in the CPOE system, compliance increased to 90% or greater, which was sustained when re-measured at 6 months (**Fig. 6**).[7] This initiative was successful because it engaged all housestaff in the policy and decision-making process and raised awareness of the need for immediate compliance. In

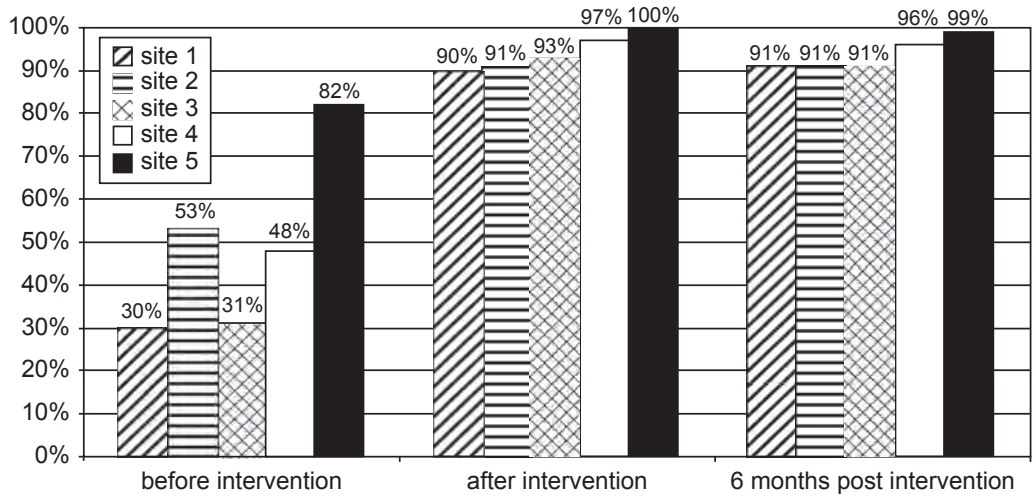

Fig. 6. Medication reconciliation pre- and post-intervention rates.

addition, since this was a housestaff-driven solution, the housestaff became the communicators and enforcers of complying with medication reconciliation.

2. Changing Physician Behavior, through close collaboration with the hospital's QPS officers, has afforded the HQC an opportunity to recommend substantive changes in the processes and systems that enhance patient safety. As an example of this, the HQC focused on hydromorphone-related respiratory depression. Hydromorphone is 7 times more potent than morphine and reduced hydromorphone doses can achieve the same analgesic effect as morphine. The HQC sought to limit dose ranges for hydromorphone. One of the National Quality Forum (NQF) Never Events, defined as an inexcusable outcome in a health care setting, is death or disability associated with a medication error.[8] This initiative was accomplished by placing a constraint or force function in the hospital's CPOE system, whereby the prescribing dose range was limited. A 50% reduction in higher doses was realized in just 1 month of the CPOE change (**Fig. 7**). Pain scores, medical event reporting, and naloxone usage is being analyzed to show evidence of effectiveness
3. Use of the Electronic Medical Record to Improve Accuracy of Lab Ordering was initiated with a goal of having all lab tests ordered through the CPOE system to decrease lab ordering errors; ensure correct patient identification, blood tube selection, and labeling; reduce duplicate orders; effectively track missing lab specimens; and most importantly, reduce the results turnaround time back to housestaff. This collaborative project was conducted with Nursing and the Department of Pathology. After orienting physicians to the benefits of electronic ordering of lab tests, and providing the necessary technical support, a 75% decrease from baseline was realized in all ICUs over a 7-month period (**Fig. 8**).
4. A Patient Safety Awareness Campaign was launched in July 2009 to encourage transparency in reporting medical errors and to promote vigilance in identifying possible flaws in hospital processes and systems. Areas highlighted included deep vein thrombosis prophylaxis, potency of hydromorphone (Dilaudid) versus morphine sulfate, retained central line guidewires, electronic order entry, antibiotic

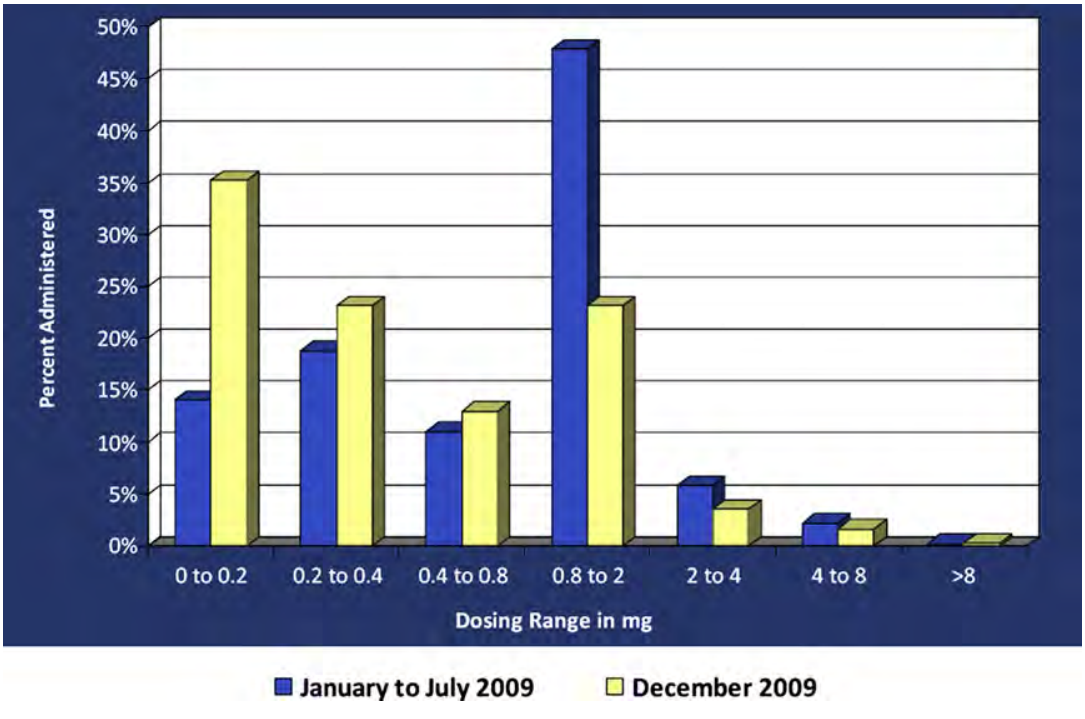

Fig. 7. Changes in hydromorphone prescribing.

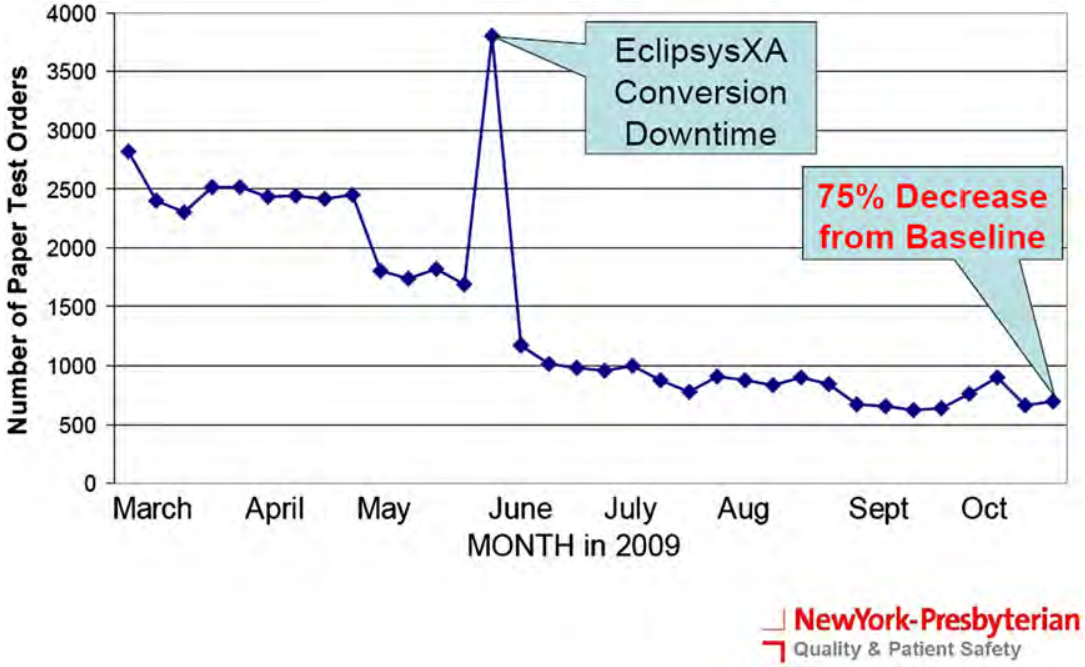

Fig. 8. Paperless laboratory project.

administration in sepsis, insulin management, excessive lab ordering, checking labs before central line placement, and not seeking help.[4,9]

Additional initiatives have been undertaken by the HQC including development of a standardized tracheostomy care checklist, improvement in vaccination rates in eligible patients, proper collection and submission of tissue samples, creation of an opiate conversion card, and an emergency code lab order set.

SUMMARY

In 2005, the American Society of Anesthesiology (ASA) published a report "Task Force on Future Paradigms of Anesthesia Practice," which asserted that the field of anesthesiology was uniquely positioned to be a clinical and administrative leader in tertiary care hospitals.[10] At the 2006 American Society of Anesthesiologists (ASA) Annual Meeting, Mark A. Warner, MD, built on this concept when delivering the 44th Annual Rovenstine keynote lecture. Dr Warner suggested that for anesthesiologists to embrace their changing role in health care systems, residency programs must improve the preparation of trainees in health care administration so they are prepared to explore opportunities to advance various aspects of health care.[11]

Simultaneously, many other national organizations were focusing on how to engage housestaff in quality and patient safety to improve the current quality of care delivered. Specifically, the ACGME, the Alliance for Independent Academic Medical Centers (AIAMC), the AAMC, and the Lucian Leape Institute, released white papers, launched initiatives, and/or held national conferences in the past 5 years focused on this concept.[12–15]

Conceived and initiated by the Department of Anesthesiology at NYP Hospital, Weill Cornell Medical Center, the HQC illustrates one model that both engages housestaff in QPS while simultaneously creating future leaders in this area. Although the HQC and department have garnered a good deal of recognition over the 3-year period since its inception, they still face barriers to success. These include (1) defining the optimal means of communication that will involve housestaff in new policies and procedures,

(2) creating a balance between transparency in reporting measured safety and quality indicators and hospital confidentiality, (3) measuring a culture change despite perception of its success, and (4) creating protected time for housestaff to perform administrative duties while recognizing the primary goal of residency education and clinical experience.

The field of anesthesiology has a long tradition of quality improvement and patient safety. In 1985, it became the first medical specialty to create a separate foundation, the Anesthesia Patient Safety Foundation (APSF), specifically focused on improving patient safety and reducing morbidity caused by anesthesia administration. In 2009, the ASA launched the Anesthesia Quality Institute (AQI), a national registry developed to collect data for the assessment and improvement of anesthesia care. The ultimate goal of the AQI is (1) to serve as a resource to anesthesiologists to obtain patient safety and quality management data and (2) to help anesthesiologists meet regulatory requirements designed to improve patient care.[16]

Given the longstanding commitment to improving and fostering innovation in patient safety, anesthesiologists are well poised to involve housestaff in these initiatives, thereby providing an opportunity to initiate a system-wide culture change and nurture future leaders in this area.

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Perspective: **Call to Action: It Is Time for Academic Institutions to Appoint a Resident Quality and Patient Safety Officer**

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Abstract

In meeting the Accreditation Council for Graduate Medical Education (ACGME) core competency requirements, teaching hospitals often find it challenging to ensure effective involvement of housestaff in the area of quality and patient safety (QPS). Because housestaff are the frontline providers of care to patients, and medical errors occasionally occur based on their actions, it is essential for health care organizations to engage them in QPS processes.

In early 2008 a Housestaff Quality Council (HQC) was established at New York–Presbyterian Hospital, Weill Cornell Medical Center, to improve QPS by engaging housestaff in policy and decision-making processes and to promote greater housestaff participation in QPS initiatives. It was quickly realized that the success of the HQC was highly contingent on alignment with the institution's overall QPS agenda. To this end, the position of resident QPS officer was created to strengthen the relationship between the hospital's strategic goals and the HQC. The authors describe the success of the resident QPS officers at their institution and observe that by appointing and supporting resident QPS officers, hospitals will be better able to meet their quality and safety goals, residency programs will be able to fulfill their required ACGME core competencies, and the overall quality and safety of patient care can be improved. Simultaneously, the creation of this position will help to create a new cadre of physician leaders needed to further the goals of QPS in health care.

In 1999, the Institute of Medicine's seminal report, *To Err Is Human: Building a Safer Health System*,[1] illustrated the need to examine patient safety practices and create processes and systems that addressed improvements. Since that time, the Accreditation Council for Graduate Medical Education (ACGME) has required teaching institutions to promote systems-based practice as a core competency.[2] At the heart of these mandates is the need to improve safety in patient care and involve *all* members of the health care team in accomplishing this goal, especially young physicians working in high-reliability organizations.[3,4] This essay was written (1) to urge leaders of teaching hospitals to engage housestaff in their quality and patient safety (QPS) processes and (2) to describe a way to foster such engagement and present how it has succeeded at our institution.

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Background

Teaching hospitals are challenged to provide formal training to postgraduate trainees in the area of QPS. Typically, QPS is not a dominant theme in medical school curricula; if physicians are to become QPS leaders in the future, it is incumbent on their postgraduate mentors and supervisors to provide education and guidance on this topic.[5,6]

There is a related need in teaching hospitals, because quality initiatives seldom include residents.[7] A systematic review of the literature from 1990 to 2008 found evidence of only 28 articles describing residents' engagement in quality improvement (QI).[7] That review categorized residents' involvement in various QI initiatives, including improvements in residents' clinical performance, interdisciplinary QI teams, and curricula innovations in quality management.[7] Some of the barriers to residents' participation in QI initiatives described by Patow et al[7] include lack of time, low attendance, crowded curriculum, away rotations, limited data collection capabilities, presumption that residents have little interest in QI, skepticism, and program expense. Although all residency programs need to attest to the fact that their graduates are sufficiently trained in systems-based practice and practice-based learning, resident QI projects are rarely aligned with organizational strategic goals. Because housestaff are the frontline providers of care to patients, and medical errors frequently occur based on their actions, it is essential for health care organizations to engage residents in QPS initiatives. In addition, identifying resident leaders to facilitate communication with other housestaff is a crucial component of improving QPS.

Moreover, given the importance of engaging physicians in QPS in the current national health care discussion, new paradigms of policy and decision-making infrastructure are warranted to educate the next generation of physicians.

The Resident QPS Officer Position and Its Importance

In early 2008, the Housestaff Quality Council (HQC) was established at New York–Presbyterian Hospital, Weill Cornell Medical Center, to improve QPS by engaging housestaff in policy and decision-making processes, to promote greater housestaff participation in QPS initiatives, and to improve communications among housestaff, hospital leadership and governance, and key clinical departments.[8]

The HQC, led by a resident QPS officer, has identified and addressed various systems-based QPS issues. The council's approach to problem solving includes (1) identifying QPS issues, (2) collecting data, (3) analyzing data, (4) implementing process/system changes, and (5) monitoring the effectiveness of the changes. The council consists of approximately 35 residents from each clinical department in the hospital. In addition to the resident representatives, the HQC, which meets every month, consists of representatives from the pharmacy, nurses, physician assistants, information technology staff, QPS officers, and the hospital administration. The chief QPS officer and faculty advisor serve in an advisory capacity to the HQC.

The council is led by a chair and vice chair, who are both current residents. In addition, the council chair is designated as the resident QPS officer for the institution for a period of one year. HQC elections are held annually to select a vice chair, who succeeds the chair at the beginning of the academic year. Vice chair candidates are approved by their respective residency program directors to place their names in nomination before the elections. The creation of this council fulfills one of the commitments to safe and high-quality care by providing the infrastructure needed for effective communication among key stakeholders, namely, the Division of Quality and Patient Safety, the Office of Graduate Medical Education, and the housestaff.[9]

In his or her capacity as resident QPS officer, the council chair communicates the hospital-wide QPS goals and leads the HQC in its quality and performance improvement initiatives. The council's activities have included initiatives such as improving medication reconciliation, developing an institution-wide multimodal communications matrix for dissemination of standard and emergent information to residents, and recommending medication dosing modifications in the computerized provider order entry system.[8,10–12] The HQC's role also provides an effective conduit for housestaff to discuss adverse events, participate in root cause analyses, and propose practical solutions to problems.

For the HQC to achieve its goals, it was essential to not only have institutional support but to be part of the established infrastructure of the Division of Quality and Patient Safety; aligning with that division facilitated engagement of the HQC and the housestaff in the policy and decision-making processes of the hospital. One of the main reasons that the resident QPS officer position was created was to strengthen the relationship between the hospital's strategic QPS goals and the HQC.

The resident QPS officer serves as the institutional lead to engage housestaff in QPS activities. He or she represents housestaff on hospital QPS projects throughout the institution and meets on a weekly basis with the chief QPS officer for the institution, as well as other institutional QPS officers. This serves to ensure that residents are truly part of the health care quality and safety team for the organization. The resident QPS officer can serve as a resource in the development of QPS educational programs but is not charged with education of housestaff in QPS matters. An HQC is an ideal way to support a resident QPS officer, but even in an institution without an HQC, such a position can still be created. To support a resident QPS officer without an HQC, the institution must have some venue to engage housestaff in the policy and decision-making processes, such as a housestaff GME council or a chief residents council. These types of councils can provide a forum where housestaff can convene to discuss pertinent QPS initiatives.

The resident QPS officer is fully integrated into the organizational quality and safety program. He or she is an integral member of the institution's annual QPS goal-setting process and participates in quarterly assessments on progress. Serious adverse events are discussed with the resident QPS officer, who transmits "lessons learned" to the housestaff through the HQC and related communication vehicles such as newsletters, e-mails, and discussions at monthly meetings. The resident QPS officer also presents biannual reports to the quality committee of the medical board and the board of trustees. Whereas the particular committees and forums in which the resident QPS officer participates are specific to each institution, the concept can be broadly generalized to any teaching hospital.

Given the benefits of having a resident QPS officer, institutions must ask themselves: Who is the ideal candidate to serve in such a significant administrative role? What incentives can we offer, given the already demanding schedule of a clinical residency? In our experience, the ideal candidate for this position is someone with prior exposure to QPS issues, an interest in QPS, and leadership ability. Also, the incentives for assuming such responsibility are numerous. This position can dramatically further a resident's education in QPS by providing firsthand knowledge of the complexity of health care organizations, health care systems, and the medical college, significantly adding to a resident's professional experience. In addition, being the resident QPS officer can serve as a valuable stepping stone for the creation of a future leader in patient safety and for someone looking to gain increased experience in health care administration. Finally, the former resident QPS officers have realized that having this position and leading the HQC have made a significant contribution to improving the quality of care at the institution.

Once the HQC was established, there were no barriers to creating the position of resident QPS officer, particularly because it aligned so successfully with the existing administrative structure of the Division of Quality and Patient Safety. The resident QPS officers have experienced some difficulty in maintaining the time commitment necessary to participate in the administrative aspects of QPS initiatives. It is important to separate the HQC administrative responsibilities and assign them to support staff so that the resident QPS officer can direct his or her time appropriately. Often, this requires 5 to 10 hours of additional time per week beyond the hours of the clinical residency, and these are included in work hours calculations.

To date, the housestaff perceive the resident QPS officer's position as beneficial to achieving the HQC goals because it links the residents with the hospital administration and helps the housestaff have a voice in institutional change.

What the Institution Must Do

Because the role of the resident QPS officer is critical to facilitating communications with the HQC and

housestaff at large, he or she can succeed only if the organization understands, recognizes, and respects his or her roles and responsibilities as resident QPS officer. Building the appropriate infrastructure and an annual stipend from the hospital are ways to support the resident QPS officer.

In addition, to successfully implement the resident QPS officer position, an institution must also be focused on QPS and provide a milieu to nurture the development of the resident QPS officer in his or her role. Giving adequate administrative support to the HQC initiatives and activities and the resident QPS officer is also crucial to the success of the council and the individual leading it. At our institution, the HQC activities are supported by a QPS liaison, who also serves as the QPS administrator in a clinical department and assists the HQC chair and vice chair with the administration of the council. In addition to administrative support, there must be a strong commitment from an individual's clinical department chair and program director to assist the resident QPS officer in attending weekly meetings with the institution's QPS team.

Once the barriers and obstacles are addressed, the bidirectional communication between the resident QPS officer representing the HQC and the QPS division and senior hospital leadership becomes more successful and effective, facilitating the work of the council in its performance improvement activities.

In Summary

With the imperative for teaching hospitals to function as high-reliability organizations, it is essential to engage housestaff as frontline providers in the institution's QPS processes. A resident QPS officer can serve as an important catalyst in this process. As a result, hospitals will be better able to meet their quality and safety goals, residency programs will be able to fulfill their required ACGME core competencies, and the overall quality and safety of patient care can be improved. Simultaneously, the creation of this position will help to create a new cadre of physician leaders needed to further the goals of QPS in health care.

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The Role of Housestaff in Implementing Medication Reconciliation on Admission at an Academic Medical Center

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Abstract

Since 2006, the Joint Commission has required all hospitals to have a process in place for medication reconciliation (MR). Although it has been shown that MR decreases medical errors, achieving compliance has proven difficult for many health care institutions. This article describes a housestaff-championed intervention of a "hard stop" for on-admission MR orders that led to a statistically significant increase in compliance that was sustained at 6 months after intervention. Academic medical centers, which comprise large numbers of housestaff, can improve compliance with on-admission MR by engaging housestaff in the development of solutions and in communication to their peers, leading to sustained results.

Keywords

medication reconciliation, housestaff, academic medical center, electronic solution

Since January 2006, The Joint Commission has required hospitals to have policies and procedures that support the process of medication reconciliation (MR). MR is defined as the process of "accurately and completely reconcile[ing] medications across the continuum of care."[1] In practice, it involves compiling a list of the patient's medications from before the hospital admission, comparing those medications to what is prescribed at admission, reconciling those medications with each transfer of care while in the hospital, and finally, communicating this information at discharge to the patient and to the next provider of care. All current medications, including alternative and nonprescription medications, are included in the MR process.

Although seemingly straightforward, it is quite challenging to implement MR at large academic medical centers, which have substantial numbers of housestaff, faculty, and nursing and other support personnel, without disrupting clinical flow. Complicating factors include the lack of standardized processes to perform MR, requiring each hospital to develop its own unique plans and measures of effectiveness; lack of a consistent electronic health record across the continuum of care; and considerable resource requirements for already strained health care organizations.[2]

A review of case reports from several academic institutions that use paper-based systems has yielded mixed results. Bartick and Baron[3] involved housestaff in the design of a paper-based MR form and demonstrated a 43% reduction in adverse drug events in the first period after the worksheet was implemented.[3] However, one institution described the paper-based MR process as unsuccessful because the housestaff saw the MR document as

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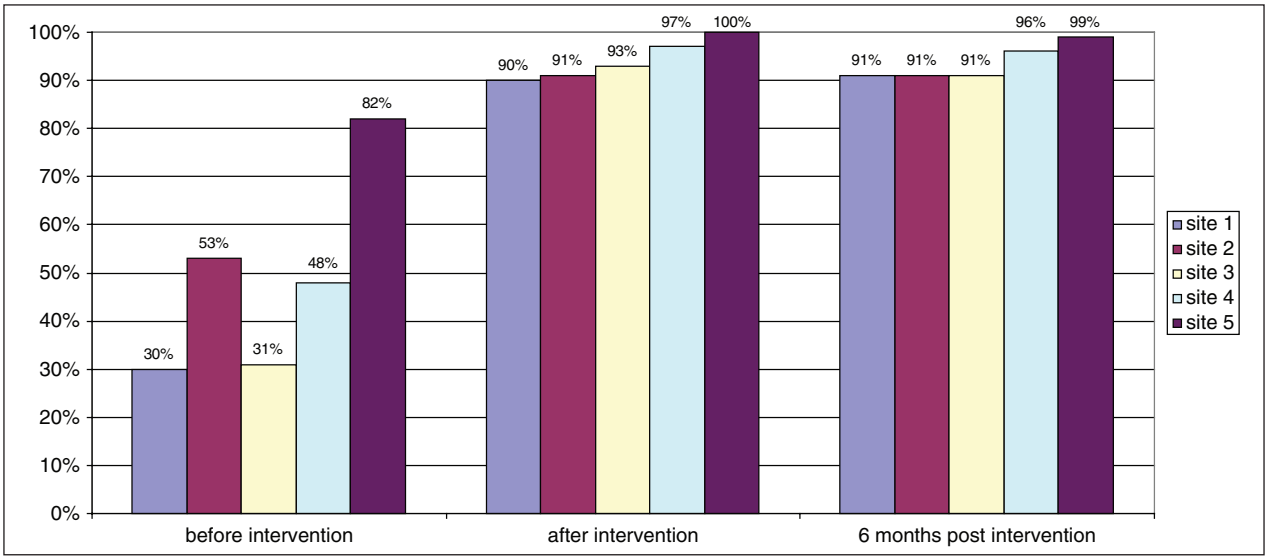

Figure 1. Postintervention rates before, after, and at 6 months of on-admission medication reconciliation

"yet another form to complete."[4] Surprisingly, when that same institution transitioned to an electronic health record, the rate of MR across a variety of patient care units was only 10% to 65%. It was not until 6 months later, when a forcing function was implemented to prevent further patient orders after 12 hours unless MR was completed, that compliance greater than 90% was consistently achieved, although it never reached 100%.

In September 2008, New York Presbyterian Hospital (NYPH) revisited its approach to MR, having achieved partial success up until that point. Using an intervention that engages housestaff in the process, obtains their buy-in, and encourages them to take active ownership of the problem, the hospital was able to achieve greater than 97% compliance within 2 months. This article serves as a case study for other large academic medical centers confronting the challenges of MR.

Methods

Setting

The NYPH is a large academic medical center comprising 5 clinical sites, including 2 campuses with more than 2200 beds. It also has the distinction of being affiliated with 2 Ivy League medical schools: Weill Medical College of Cornell University and Columbia University College of Physicians and Surgeons. The institution's size, affiliations, and merged cultures have created a dynamic institution. However, these factors have also created challenges that include the standardization of a huge electronic patient information system. Currently, the enterprise-wide electronic medical record (EMR) includes computerized physician order entry, physician and nursing documentation, and quality/benchmarking metrics. The EMR is a vendor-based system from Eclipsys.

Medication Reconciliation Electronic Solution History

Because of the difficulty of implementing a paper-based system in 2006, an organization-wide multidisciplinary Medication Reconciliation Steering Group was formed in 2007 and charged with creating a strategy that would help NYPH comply with the Joint Commission requirement for MR. In September of 2007, one teaching campus implemented a new EMR, and the newly created MR order was integrated into the training for the new system. The other campus continued to use paper documentation, which was designed with virtually no housestaff input. In retrospect, the housestaff were not well informed about the connection between MR and the Joint Commission. Many months after evaluating the level of MR compliance on both campuses, it was deemed to be less than optimal. (Figure 1, sites 2 and 4).

Recognizing the problem as well as the need to ensure a quick remedy, the organization decided to focus on the frontline providers (primarily the house staff) for their input.

Housestaff Quality Council/Communication

In 2007, NYPH implemented an initiative with a goal of engaging housestaff in decision- and policy-making processes related to quality and patient safety at site 4. This initiative resulted in the development of a novel

Housestaff Quality Council (HQC). Each department was invited to nominate a resident, from any training year, to be a representative to the HQC. The HQC meets on a monthly basis; HQC members are integrally involved in policy development and communicate with their resident colleagues. Hospital administrators and physician leadership view the HQC as an important forum to discuss opportunities to improve patient care and a vehicle by which to disseminate information, resulting in a strong collaborative effort.

Table 1. χ^2 Analysis of On-admission Medication Reconciliation Order Submissions Before, After, and at 6 Months Postintervention

	Compliant	Not Compliant	χ^2
Before	3364	4484	
After	6780	552	4205
Six months after	7368	591	0.178

Medication Reconciliation: The Solution

A paper MR record had already been instituted in 2006. Although significant efforts had already been taken to attain a high compliance rate in the institution, the desired goals had not been achieved. Recognizing the lack of success with the paper MR and the challenges to be faced, institution administration met with the HQC to determine which MR process would be most effective. The HQC, other housestaff, information technology specialists, and hospital administration met frequently to analyze the situation, propose alternative solutions, and then select the one deemed most acceptable. In early September 2008, the group agreed on a decision support model in the form of reminders as well as an eventual "hard stop." A hard stop is an alert in an EMR that does not allow one to proceed with orders or documentation until the required task is performed—in this case, MR. A "soft stop" is a reminder that begins at 6 hours after admission and continues until 18 hours after admission. Providers may still enter orders during the soft stop period. A hard stop occurs at 18 hours after admission, at which time the provider cannot write another order until MR has been completed. To get past the hard stop, the provider must submit an order for MR admission. This requires the provider to compare both the home medication list and the currently ordered medications. The MR admission order contains an attestation statement within it; once submitted, the provider has attested to the fact that the reconciliation on admission has been performed.

Creating a decision support alert is usually not enough to ensure the appropriate entry of orders (only alerts on orders). In fact, before such an alert is placed, it is imperative that the frontline user be made aware of its existence. If not aware, the user may (1) find a way to ignore and bypass the alert, (2) feel resentful of an alert that was included in the system without prior notification, (3) have no understanding of the importance of the alert, and (4) ignore the chart when the alert "pops up" and pass it on to the next person who accesses the patient's EMR. None of these sequelae contribute to a friendly atmosphere; they certainly do not allow the frontline user to feel a part of the decision-making process but rather give rise to the feeling that rules are being imposed.

Because of the aforementioned concerns, it was crucial to reach out to frontline users as rapidly as possible to address any impediments to the implementation of the hard stop. Recognizing the importance of immediately communicating this change to frontline users, the HQC used a multimodal communications process to disseminate the news to housestaff. This multimodal communications approach was guided by a communications plan previously drafted by the council with the aid of a communications consultant—Synectics, Inc. It is a plan that takes into account the degree of urgency and the consequential weight of the news or information being shared. The HQC departmental representatives returned to their respective departments and informed their colleagues of the new changes. In some cases, information technology assistants aided in the presentation to the departments. The HQC also disseminated hospital-wide communication via e-mail messages sent to all housestaff. Although infrequently used, an immediately effective tool to reach the housestaff was an alphanumeric text message via the hospital paging system at the time the hard stop was initiated. All housestaff who were carrying their pagers were immediately notified of the creation of the hard stop, the reason behind it, and the importance of complying with MR.

On September 30, 2008, this alert was initiated throughout the institution. The immediate response was significant improvement in on-admission MR attestation with compliance. On the whole, the housestaff were very receptive to the new modifications in the MR process, largely because collaboration between hospital administration and the HQC allowed them to design the force function rather than have it be mandated to them.

Two months after the proposed changes, the organization achieved a level of compliance that was 90% or greater across all institutions and was sustained for longer than 6 months (Figure 1). The status of before and after intervention was found to be highly significant: $\chi^2(2, n = 15\ 180) = 4205$; $P < .01$ (Table 1). Although there is no statistically significant change from "after to 6 months,"

the data illustrate a sustained positive statistical improvement from baseline (Figure 1).

Compliance with MR is measured at 24 hours after admission. Even though there is a force function, there is still the potential for noncompliance. If no one enters the chart for a certain number of hours, the alert does not appear despite being at the key limit time. For example, if a patient is admitted at 8 AM, the hard stop would go into effect at 2 AM the following morning if MR was not performed. If an order was not placed in the patient's chart until after 8 AM the next day, it would be counted as noncompliance with MR.

Discussion

The Joint Commission created the MR mandate to ensure that patients would receive appropriate medications on admission and throughout the continuum of their care in the hospital. Although physicians historically believe that the MR process was, for the most part, being done for patients, in fact, no formal mandate existed enforcing physicians (or physician extenders) to verify that the appropriate medications were being administered throughout the continuum of the patient stay. Given that medication errors account for increasing health care costs, it makes sense that health care providers prescribe appropriate medications for a patient and that they, therefore, be mandated to verify the appropriateness of the medications they prescribed.

Measuring the degree of actual compliance is difficult, particularly with paper-based systems. With EMR documentation and computerized order entry, an institution can (1) insert a decision support alert in the form of a hard stop, (2) easily track compliance, and (3) perform MR more easily.

Early engagement is crucial for housestaff to "buy in" to changes that may otherwise feel forced and imposed on them. In corporate America, changing the culture of an institution requires the involvement of leadership as well as those who are, though not necessarily the official leadership of the institution, the so-called change makers. These change makers can reach out to colleagues for input and ideas to inform an institution about how it can quickly implement best practice. Ultimately, everyone involved agrees to move the new policy or concept in the agreed-on direction. Because the number of residents at an academic hospital can range from a handful to many hundreds at large institutions, it would be virtually impossible to have all housestaff involved in discussions about policy changes or developments. However, departmental resident representatives can. By involving housestaff leaders (ie, the change makers) who have the desire and the skill to lead and by using housestaff representatives from all departments, as in the HQC, change can be effected much more collaboratively and, hence, effectively and efficiently.

As more health care institutions increase their usage of EMRs, there will be an opportunity to incorporate policies to improve safety more readily in the daily clinical work flow. Although there are different modes of MR (ie, paper-based approach vs electronic approach) and different providers (ie, pharmacists, nurses, attending physicians) who are primarily responsible for MR, the results presented in this article can be generalized to institutions that have purchased or are considering purchasing vendor-based EMRs and that rely primarily on housestaff for MR. We acknowledge that we address only compliance at admission. Current processes are under way to detect the accuracy of MR at admission as well as to assess compliance and accuracy during transfer and at discharge. In addition, future efforts will examine the interrater reliability regarding how housestaff perform MR.

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Milestones

Deborah J. Culley, M.D.

Notes: _____

AACPD
Concurrent Sessions

Panel: Enhancing Your Residency Program
Moderator: Robert M. Craft, M.D.

Incorporating a Global Health Rotation
L. Jane Easdown, M.D.

Developing a "Resident as Teacher" Rotation
Jeffrey S. Berger, M.D., M.B.A.

Using the Cloud and the Internet to Enhance Your Residency Program
Larry Chu, M.D., M.S. (BCHM), M.S.

Incorporating a Global Health Rotation

L. Jane Easdown, M.D.

In 2006 the Department of Anesthesiology added a fourth component to the academic three legged stool - Service. It was agreed that we were in a position to develop international rotations and other experiences for our trainees and faculty members. It seemed the right thing to do. This presentation will discuss the VIA experience and lessons learned in creating a global experience for our residents and fellows.

There is considerable interest in global health, and over 25% of US medical students have been involved in international medicine. (1,2) Many applying for anesthesiology residencies have an active interest in global health and are seeking programs with this sort of opportunity. The value of these activities includes exposure to diverse patient populations and healthcare systems. Although many trainees go with the wish to provide service or education for altruistic goals, most feel that their experience was equally if not more valuable for their own education. Residents return with an appreciation of health disparity and a change in attitude towards public health, cross-cultural communication and serving the disadvantaged. The lessons learned overseas benefit current patients in respect to resource management and professionalism. (3)

Vanderbilt International Anesthesia was created in 2006 to support and coordinate the department's international activities under the direction of Dr. Mark Newton. (4) It is a non-profit charitable foundation supported by private donations, as well as other sponsoring organizations. A fun event is the annual rodeo and silent auction held every Fall with all proceeds benefitting VIA. Dr. Newton is a pediatric anesthesiologist and a Clinical Associate Professor at Vanderbilt. He works ten weeks per year at Monroe Carrel Jr. Children's Hospital at Vanderbilt and spends the remainder of the year in East Africa, working at Kijabe Hospital, near Nairobi, Kenya. He has lived in Kenya since 1997, developing anesthesia services through physician and non-physician anesthesia education at the Kijabe Hospital, as well as in surrounding countries. Dr. Newton is a member of the ASA Global Health Initiative and has recently been awarded the 2012 AMA Nathan Davis International Award in Medicine for his humanitarian work. (5) The success of the VIA program can largely be attributed to the presence of an on-site faculty member, Dr. Newton, who has lived for many years in the culture, speaks the local language, and is able to mentor residents and fellows as they train in this challenging but fulfilling healthcare setting.

VIA has supported global anesthesia activities not only in Kenya but also in Guatemala, Haiti and Tanzania. Most residents and fellows have journeyed to Kenya, but others have worked with other healthcare organizations, such as Health Volunteers Overseas. Health Volunteers Overseas (HVO) has a partnership with the Society for Education in Anesthesiology (SEA) to provide scholarships for deserving trainees who then teach overseas. Two of our residents have received scholarships through SEA-HVO to teach in Tanzania. Our pediatric faculty and fellows travel to Guatemala, and VIA has also supported faculty trips to Vietnam and Haiti.

The international rotation in Kenya took several years to implement. In the beginning our residency program applied to the ABA for residency credit for each resident who participated in an international service mission. When Dr. Newton joined our department, the departmental leadership collaborated with him to develop a recurring international anesthesia experience under his supervision. Initially our Program Director, Dr. John Algren, submitted this curriculum to the ACGME Anesthesiology Residency Review Committee (RRC) for approval as an educational innovation. However, the RRC recommended that it be organized as an elective rotation, tentatively approving it pending final documentation. This was accomplished in May 2011, with execution of a program letter of agreement (PLA) between Vanderbilt University Medical Center and Kijabe Hospital. The capacity for reliable and consistent supervision of residents was essential for approval of this international elective experience. The international rotation follows a full ACGME curriculum, and residents must comply with all ACGME requirements, including case documentation and duty hour compliance.

Since the inception of VIA, 5-6 residents have elected each year to travel to Kenya to learn and teach while providing clinical anesthesia care. In the 2011-2012 year, a total of 10 anesthesia residents and fellows spent a month each at Kijabe Hospital. Residents find this experience to be both maturing and humbling. Under Dr. Newton's supervision, they instruct and mentor Kenyan nurse anesthesia students, providing anesthesia care for routine cases - as well as complex vascular and neurosurgical cases - all performed with basic anesthetics and monitoring. They are introduced to Halothane and anesthesia techniques still used in developing countries with limited resources, such as "draw-over" anesthesia machines. They also work in the six-bed ICU, where they learn to manage high acuity patients without the benefit of invasive monitors or sophisticated lab support. They find they must make hard decisions concerning resource management. Flexibility and adaptability are fundamental to their success. Upon returning home last year Dr. Alli Greening commented "This was my first experience supervising and my first experience in another country. Every day I went to work wondering how I could make a positive difference…."

In addition to providing clinical care and guidance in the operating room and ICU, residents teach Kenyan nurse anesthesia students in the classroom. Each resident must plan to teach at least four topics including regional anesthesia. They also act as "external board examiners" and grade papers and tests. Two of our residents determined to teach Advanced Cardiac Life Support to one group and had to start with showing them the first ECG many had seen. How amazing it was for them to hear later that one of their students proved to be the only person who knew how to successfully use a defibrillator at a local 1500 bed community hospital! There is a direct relationship between these residents and increased level of healthcare in Africa. The Kenyan CRNAs trained at Kijabe are often the sole anesthesia providers for their local hospitals. Occasionally residents also have the opportunity to work alongside anesthesia residents from the Nairobi residency program. These experiences provide a foundation for friendship among developing anesthesia leaders who will support international anesthesia development in the future. Dr. Justin Wright stated: "Every day was a thrill to go to work. It was so refreshing to practice medicine where everyone has the same goal- to look after the patient. It reaffirmed what I went into medicine to do and what I want to do with my life as a physician. I have my batteries charged."

To prepare for the rotation, residents follow a detailed curriculum manual, prepared by the program with contributions from the Institute for Global Health and GME Office. This manual provides information about the Kenyan people, culture, and common diseases they will encounter. It also provides extensive information about the requirements and logistics of travel and medical practice in another country, including the following: required immunizations; application for a Kenyan medical license; purchase of personal medical insurance (which is inexpensive and purchased locally); VISA; travel arrangements; health insurance; etc. Expenses for travel, accommodations, immunizations, medical license and insurance are covered through VIA. Vanderbilt University Medical Center continues to provide residents' salaries during their international experience, even though they are ineligible for CMS funding. Residents also bring donated supplies to the hospital in Kenya, demonstrating that small donations of items routinely discarded in the US can support education and be life-saving in Africa.

Security for those travelling abroad is critical. Last year a trip of three residents was delayed due to some uncertainty with safety in the Nairobi area. We are fortunate to have the help of the Vanderbilt Institute for Global Health to monitor safety in areas where Vanderbilt sanctioned trips are planned. Also, having faculty on site, to make day-by-day decisions "in-country," adds a level of safety which should not be overlooked. Furthermore, the Vanderbilt Institute for Global Health tracks all trainees on international rotations and provides medical evacuation insurance (ISOS) to enable prompt repatriation of trainees in the event of a serious injury or illness.

Plans for the future of VIA include more sites, including one in the western hemisphere which will enable shorter rotations and less costly travel. Our new faculty member, Dr. Kelly McQueen, Chair of the ASA Global Health Initiative, will work with DR. Newton to develop research projects in Kijabe and other areas of East Africa. Many local areas in Africa and other locations would benefit from a long-term association with a committed residency program. According to Dr. Newton an ideal relationship would be" a deep partnership between departments in America and academic physicians in Africa, with a plan for bilateral exchange of trainees. A commitment which lasts 5-7 years is necessary for real capacity building in the areas of need and relationship building takes time as well as finances."

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Notes:

ART Program

Anesthesiology Residents as Teachers

Jeffrey S. Berger, MD, MBA
Associate Professor
The George Washington University

Disclosures

(Does anyone know an organization that is actually willing to fund educational studies?)

- The contents of the ART Program are due to be published in the Journal of Graduate Medical Education's (JGME) December volume, 2012
- Department funding for time of leadership team and materials
- University funding for Standardized Students and Patients via Clinical Learning & Simulation Skills (CLASS) Center

Introduction

Training model
Participants
Requirements
Outline

Sessions
Theory
Details
Supplemental Materials

Training Model

- Goal: dispersion of Residents-as-Teachers curriculum throughout institution
- Train-the-trainers
  - Senior educators
  - Junior educators (Anesthesiology Faculty)
  - Anesthesiology faculty receive 1 hour training
  - Anesthesiology faculty create specialty specific cases
  - Timeline
    - Year 1: Senior Educators lead, Juniors observe
    - Year 2: Junior lead, Seniors observe
    - Year 3: Juniors alone with Senior visits

Participants

- Demographics
  - 8 residents
  - PGY2 residents (CA-1 class)
  - 2nd or 3rd month of anesthesiology training
- Rationale
  - Availability
  - Open to learning
  - Medical student supervision expectations
    - 2 week anesthesiology requirement for 180 students
    - 4 week anesthesiology AI for roughly 25

Requirements

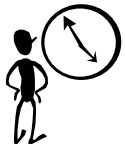
- Administration
  - Schedule lecture time, rooms
  - Reserve rooms
  - Create session packets
  - Schedule standardized students and patients

Requirements

- Facilities
  - Conference room
  - Simulator lab for "teaching a skill"
  - Standardized patient exam rooms for residents
  - Optional: video capabilities for review

Requirements

- Time
  - Introduction 1 hr
  - Each workshop (6) lasts 1 hours
  - Wrap-up 1 hr
  - Total time: 8 hours



Outline

- Introduction
- 6 Workshops
  - Orienting a new learner
  - Giving feedback
  - Teaching around a case
  - Teaching at the bedside
  - Teaching a skill
  - Giving a mini-lecture
- Wrap-up

Sessions

- Generally 2 workshops per session
  - 2 hours total per session,
  - 4 sessions for residents-as-teachers program
- Session format
  - Introduction
    - Discussion: adult learning principles
    - Pre-test: self evaluation

Theory

- Adult learning
  - Knowles Principles (The Adult Learner, 1998)

1	Need to Know	Feels the need to address own knowledge deficits
2	Self-Concept	Feels responsible for own decisions (self directed)
3	Past Experience	Has experiences, biases, and sense of self

Theory

4	Readiness to Learn	Needs to time learning with task or development
5	Orientation to Learning	Learns more effectively in real life context
6	Motivation	Feels internal pressure more than external

Sessions

- Workshops
  - Review previous workshop
  - Interactive, large group discussion
  - Presentation of 3-P's checklist:
    - Prepare,
    - Perform,
    - Practice
  - Role play +/- standardized students
  - Large group wrap-up
  - Supplemental materials distributed

Sessions

- Wrap-up:
  - Summary discussion: skills application
  - Post-test: self-evaluation
  - Workshop evaluation

Supplemental Materials

- 3-P model cards
- Teaching theory articles
- Evaluation
  - Program
  - Self
- Video demonstration
- Role play cases

Details: 3P Model

	Workshop	Adult Learning Principle
Prepare	Make goals of exercise clear	Establish clear goals & objectives
	Explore relevance to learner needs & past experience	Teach to learner's needs and encourage integration of past experiences
Perform	Present overview of skill	Calibrate teaching to learner's needs
	Break skill into smallest part	
	Change tactics to fit learning style	

Details: 3P Model

	Workshop	Adult Learning Principle
Process	Ask for self assessment	Adjust feedback to learner's needs
	Offer feedback positive/corrective	
	Summarize teaching points	
	Ask learner to summarize take home points	Encourage application of learning to real life
	Provide resources for further learning	Encourage independent learning

Details: 3P Model

	Workshop	Adult Learning Principle
Overall	Treat learner with respect	Create safe environment to take risks
	Encourage participation	Elicit participation of learner

Results

2009-2011

- Self reported improvement in 13 of 14 teaching domains ($P < 0.05$)
- Workshops were rated highly
- Medical student evaluation of residents averaged 4.9/5.0 (previously 4.7)
- 30% increase in medical students choosing anesthesiology at GW
- Increase in residents choosing academic careers (faculty at teaching institution & fellowship) vs. private practice

Notes:

AACPD
Concurrent Sessions

Panel: Challenges Facing Your Residency Program
Moderator: Theodore J. Sanford, Jr., M.D.

Healthcare Reform and Funding for GME
Theodore J. Sanford, Jr., M.D.

SBP: Education Your Residents About the Survey and NAS
Robert M. Craft, M.D.

How To Cope With the 2 Part ABA Written Exam
Catherine M. Kuhn, M.D.

Healthcare Reform and Funding for GME

Theodore J. Sanford, Jr., M.D.

Notes:

Health Care Reform and Funding for GME

Theodore J. Sanford Jr. MD
Program Director
University of Michigan

No Disclosures

- Board of Directors for OPDA
- OPDA Representative to ACGME Committee on Review Committees

Premises

- The are huge pressures both from Federal Government and Congress and States to cut back on GME funding.
- Loss of GME funding will impact on your residencies!
- GME funding is "low hanging fruit"

Challenges for PDs

- Understand GME funding
- Competing Agendas
- Competing Proposed Solutions
- Bottom Line

GME Funding

- Dept of Health and Human Services
  - Thru Centers for Medicare and Medicaid Services
  - Single Largest funding source to **help** fund GME
  - $9.5 Billion in Medicare
  - $2.0 Billion in Medicaid
- There are other sources both public and private.
  - 40 states paid #3.78 Billion thru Medicaid in 2009 mostly derived from matching federal payments.
  - Private insurers- e.g. BCBS in Michigan

Graduate Medical Education (GME) Funding from CMSS

- Direct Medical Education expenses- **DME**
  - Intended to cover salaries, benefits, administrative costs, overhead, malpractice, faculty teaching time
  - Hospital-specific per-resident amount (PRA) based on costs to educate residents in 1983
    - PRA adjusted for inflation but not work hours reform, competencies, oversight rules
  - Hospitals' DME reimbursement = (# of residents*) x (PRA**) x (% of hospital's business attributable to Medicare)

*Capped at 1997 numbers of residents
** Large variations between hospitals

Graduate Medical Education (GME) Funding CMSS

- Indirect Medical Education Expenses-**IME**
  - Factored in as an adjustment to Medicare billings:
    - Varies based on resident/bed ratio, capped at 5.5% add on
    - Example: If usual Medicare DRG is $10000, we may get $10550
  - Intended to cover:
    - Sicker patients
    - More complex patients
    - More advanced diagnostic and therapeutic modalities
    - Longer lengths of stay and additional testing

GME Funding

- IME > DME for most hospitals treating adult patients*
- 2010-
  - DME was $3 billion
  - IME was $ 6.5 billion
    - But MedPAC estimates this may be $10 billion!
      - This group advises Congress
- Estimates are that current funding just about covers costs

What are the Issues

- Is the nation training enough doctors..
  - Of the types that are needed?
- Is federal support for GME too costly?
- Should federal dollars be directed to funding other types of health care providers?
- Should federal dollars be tied to achieving certain outcomes---- (read) Next Accreditation System!

Costs of GME

- 115,000 physicians in residency programs
  - $100,000/resident/year
    - $500,000 total
- 1997- Balanced Budget Act- capped residency slots

Controlling the Costs

- 2010 National Committee on Fiscal Responsibility and Reform (Simpson-Bowles)
  - Recommendation 3.3.5: "Reduce excess payments to hospitals for medical education"
  - There's a sense that someone other than CMS / taxpayers (profession, hospitals, other insurers) should be funding training
  - Proposal: Fix DME at 120% of salary and cut IME to 2.2% = $6 billion a year saved
  - Not adopted by Congress-

Controlling the Costs

- 2011 Obama administration proposed cutting Funding to Children's Hospitals by 50%!
- Congress has not acted on this.. Yet
- The problem is that the 'deficit commissions' are making decisions to reduce the deficit/ debt

Impact of GME cuts

- Some hospitals will fold their residencies
- Those that do not:
  - Most will have to find alternative ways to fund resident education
  - Many will make cuts:
    - Administration
    - Teaching supplements
    - Benefits
    - Numbers of residents?

Competing Agendas

- Government (state and federal) wants to cut funds
  - But wants to increase Primary Care support at the cost of decreasing advanced training positions.
  - More doctors-16 new med schools this year
  - No additional training slots
- Multiple public agencies and medical organizations advocate for reform in GME funding that includes
  - More training slots!
  - Eliminate the SGR
  - Eliminate the Sequestration that will occur on January 1, 2013

Impact of Sequestration on January 1, 2013

- Balanced Budget Act of 2011- 2% sequester
  - $10.7 billion in 2013
  - $16.4 billion in 2021
  - Will not reduce benefits to enrollees
    - Accomplished by reducing payments for health care services!
  - Estimated loss of 496,000 jobs
    - Workers directly employed (RESIDENTS!!!) as well as the support jobs
    - Up to 766,00 fewer jobs by 2021

Impact of GME cuts (cont.)

- Fewer residents means fewer man-hours available for inpatient care
  - Hospitals will need to hire more extenders or shift rotations from elective/outpatient to inpatient
- Will ACGME change the rules for training?
- Will the Government bend to pressure from 62 professional societies (AMA etc) and 48 state medical associations to change Medicare and the whole GME funding system? NJ, AK missing

Competing Agendas

- There is going to be in-fighting between the specialty training groups and primary care
  - But we must recognize the diversity of practices and work within it.
- There is a call for redistribution of physicians by additional funding only for rural training
- Public pressure to assure that we are providing a competent work force and one that deserves the $$$$$ spent

Bottom Line

- The Next Accreditation System from ACGME is going to try to address the public demands
  - Accountability for our product
- We need to make sure that the public knows the value of GME training
- Identify additional sources for GME funding
- Develop Innovative ways to distribute GME funds
- Collect meaningful data that demonstrates the state and regional workforce needs.
- Advocate, advocate, advocate to preserve current funding
- Be creative and flexible- may need to change practice models.

Pathways to advocacy

- Call your Representative and/or Senators and ask to speak to the staffer for health care or education
- Make it clear that you are a physician, caring for patients on Medicare, and that you support preserving funding for Graduate Medical Education
- Personalized letters with stories about patients are the best
- It's important to acknowledge the reality that everyone is going to have to pitch in

Take Home

- The Golden Rule- right now CMS is king
- Change will happen- but what and when
- GME slots are at big-time risk
  - Up to you to demonstrate their value
- Advocacy from residents is crucial-
  - Michigan example

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SBP: Education Your Residents About the Survey and NAS

Robert M. Craft, M.D.

I. Annual Electronic Communication with the RRC in the NAS
   a. Resident Survey
   b. Faculty Survey
   c. Case logs
   d. Milestones evaluation
   e. Recruitment and retention (ADS)
   f. Written Exam and Board certification rates
   g. Duty Hours/Learning Environment (CLER)
   h. Scholarly activity report

II. Potential Conflicts Toward a Valid Survey
   a. Resident and faculty understanding of program requirements
   b. Resident and faculty understanding of survey question

III. Audience Response Questions

IV. Resolution of Conflict
   a. "Internal" or "Mock" survey – continual improvement tool between ACGME surveys
   b. Review of question format of past surveys
   c. Review of program requirements.

Enhancing Your Residency Program

Upon completion of this learning activity, participants should be able to:

1. Identify several methods to enhance a residency program past the fulfillment of program requirements
2. Translate the methods presented to the structure of their particular institution
3. Evaluate the potential manpower and financial cost verses the benefit for their program
4. Design an appropriate enhancement
5. Implement an appropriate enhancement

Educating Your Residents about the Survey and NAS

Upon completion of this learning activity, participants should be able to:

1. Identify the components of the annual electronic communication with the RRC in the NAS
2. Describe the potential conflicts toward a valid resident/faculty survey
3. Formulate a plan for reconciliation of this conflict through education of faculty and residents in the program requirements

Educating Your Residents about the Survey and NAS

Robert M. Craft, MD
Professor and Vice-Chair
Residency Program Director
University of Tennessee COM, Knoxville

Goals and Objectives

- Identify the components of the annual electronic communication with the RRC in the NAS
- Describe the potential conflicts toward a valid resident/faculty survey
- Formulate a plan for reconciliation of this conflict through education of faculty and residents

Annual Communication with the RRC in the NAS

- Recruitment and retention (ADS)
- Written Exam and Board certification rates
- Duty Hours/Learning Environment (CLER)
- Scholarly activity report

Annual Communication with the RRC in the NAS

- Resident Survey
- Faculty Survey
- Case logs
- Milestones evaluation

Potential Conflicts Toward a Valid Survey

- Resident understanding of purpose and importance of survey
- Resident and faculty understanding of survey questions
- Resident and faculty understanding of program requirements

Audience Response Questions

- Do you review the purpose and/or importance of the Annual Survey prior to the administration of the Survey?
  - 1) Yes
  - 2) No

Audience Response Questions

- Do you review survey questions from previous years prior to the administration of the survey?
  - 1) Yes
  - 2) No

Audience Response Questions

- Have you administered an “internal” or “mock” survey in the interval between ACGME annual surveys?
  - 1) Yes
  - 2) No

Audience Response Questions

- Do you review the results of the Annual Survey as part of your Annual program Review?
  - 1) Yes
  - 2) No

Audience Response Questions

- Have you reviewed the Program requirements with your residents and/or faculty?
  - 1) Yes
  - 2) No

Resolution of Conflict for a Valid Survey

- Review results of previous survey as part of the Annual program review –
  - This allows for an open forum to discuss whether a non-compliant response is due to misunderstanding the question or an actual issue that should be addressed through the process of annual review and improvement

Resolution of Conflict for a Valid Survey

- Consider “internal” or “mock” survey in the interval between ACGME surveys, particularly if significant or persistent non-compliant responses –
  - This serves as a continual improvement tool for “real” issues, as well as allowing for further education regarding question format and intent

Resolution of Conflict for a Valid Survey

- Consider review of program requirements on an annual basis with residents and faculty –
  - Ensure that faculty and residents understand requirements as well as your program's response to each – they are everyone's requirements, not just yours!

Resolution of Conflict for a Valid Survey

- Consider reviewing intent and importance of Annual Survey with residents immediately prior to administration –
  - Reminding them that this is really a "virtual site visit" and that honest answers are expected to reflect the actual experience of the program

Other NAS Components

- Case Logs –
  - In addition to semi-annual review with each resident, consider monthly review of activity and comparison with EMR entries

Other NAS Components

- Duty Hours –
  - Consider monthly review for accuracy and education, as well as continual improvement and "early warning" of problem rotations

Summary

- NAS increases importance of accurate electronic representation of program
- Surveys pose potential conflicts toward a valid response
- Education of residents and faculty on program requirements and survey increases accuracy and provides method for self-improvement

Notes:

AASPD
Concurrent Sessions

Innovative Programming
Moderator: Robert N. Sladen, M.B.Ch.B., F.C.C.M.

The Critical Care Experience
Christopher E. Swide, M.D.

The Pain Proposal
Gary J. Brenner, M.D., Ph.D.

Advanced Curriculum Pediatric Anesthesia Training
Scott G. Walker, M.D.

The Apgar Scholars Program
Margaret Wood, M.B., Ch.B.

Notes: _____

Notes: _____

Notes: _____

The Apgar Scholars Program

Margaret Wood, M.B., Ch.B.

The Department of Anesthesiology at Columbia wanted to develop a new training track for future academic faculty in addition to providing excellent clinical training for residents either entering private practice or becoming cutting edge "master clinicians" within an academic medical center. Our goal was to attract a subset of medical students who knew at the outset that they wanted to remain in academic medicine and to enter either clinical subspecialty or research fellowships following residency. To that end, in November 2002 we instituted the Virginia Apgar Scholars Program. Medical students commit to either a two year clinical or research fellowship program following residency - they have to designate whether they wish to be a clinical or basic science scholar. Basic Science and Research Scholars have the opportunity to enter our NIH T32 program. Virginia Apgar Scholars become lifelong members of the Virginia Apgar Society, are on the committee to select the Virginia Apgar Annual Lecturer, and receive a $15,000 annual supplement during their CA1, CA2, CA3, and fellowship years.

The Virginia Apgar Society we hope will become a vehicle to provide career support during training and early faculty development, but later as a society composed of Virginia Apgar Scholars and an honorary President (currently Dr. Margaret Wood) they will interact and support each other and become a "community" that fosters a culture of academic scholarship and leadership. Currently, there are 27 scholars. We wished to address both the day to day needs and long term career goals of physician-scientist trainees, not all of whom are MD PhD graduates. We formed the program in response to recognition that there was concern of a decline in physician-scientists in Anesthesiology following the manpower/ residency recruitment issues of the 1990s that related to our specialty. We wished to provide a departmental forum for trainees to meet and interact with each other as a group and provide their own peer mentoring, discuss their research, identify senior mentors either from within the department or without, and plan their future career options and goals well before graduating from the core program so that they "jumpstart" their fellowship programs: hence the Scholars Program is one of career/leadership development, mentoring and "community" building.

In addition to the day to day mentoring that occurs within the department, we hold an annual Virginia Apgar Day, with an invited lecturer, and symposium that discusses various topical aspects of research and career development. In addition, the Virginia Apgar Lecturer provides career advice to the Scholars. Finally, the Virginia Apgar Scholars provide an "applicant pool" for the Department's NIH T32 Training Grant.

We believe that the program has been successful in terms of grant funding, publications and national award recognition. Other departments have followed our lead (there are now more than 10 similar programs in other institutions).

AASPD
Concurrent Sessions

Update 2012: The New RRC Program Requirements
Moderator: Robert N. Sladen, M.B.Ch.B., F.C.C.M.

Milestones Update
Linda J. Mason, M.D.

RRC Update
Margaret Wood, M.B., Ch.B.

Notes:

New Kid on the Block: Hopes and Aspirations for the Newly Accredited Obstetric Anesthesiology Fellowship
Robert R. Gaiser, M.D.

How Do We Match Up? (Part 1)

- **NRMP Representative**
  Mona M. Signer, M.P.H.
- **San Francisco Match**
  Jack Shanewise, M.D.

New Kid on the Block: Hopes and Aspirations for the Newly Accredited Obstetric Anesthesiology Fellowship

Robert R. Gaiser, M.D.

Objectives:

1. Understand what is the OB fellowship
2. Review the differences between this fellowship and current fellowships
3. Review the current applicant pool and what is necessary for success
4. Understand challenges for the new fellowship

New Kid on the Block: Hopes and Aspirations for the Newly Accredited OB Fellowship

ROBERT GAISER, M.D
PROFESSOR OF ANESTHESIOLOGY AND CRITICAL CARE
HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA
CORE PROGRAM DIRECTOR

I have no financial disclosure

Learning Objectives

- Understand what is the OB fellowship
- Review the d… …lowship and current fello…
- Review the c… …what is necessary for…
- Understand … …owship

OB Anesthesia: Accredited on Oct 1, 2011

- One year fellowship
- Subspecialty of anesthesiology devoted to the comprehensive anesthetic management of women during pregnancy and the puerperium

Program Requirements for GME in Obstetric Anesthesiology

What's Different in Program Requirements?

- Faculty
  - Faculty certified in adult CCM must be available for consultation and collaborative management of peripartum women with critical care needs
- Program Director
  - 20% to the fellowship
  - 50% to the anesthetic care of obstetric women

Program Requirements for GME in Obstetric Anesthesiology

What's Different in Program Requirements?

- Policies and procedures governing the labor and delivery unit, obstetric operating rooms and PACU, including the potential effects of societal, institutional, and governmental factors
- Principles and ethics of research in pregnant women
- Research funding
  - Applicable funding agencies
  - Components of a research budget
  - Funding procurement mechanisms

Program Requirements for GME in Obstetric Anesthesiology

Obstetric Anesthesia Fellowship Curriculum

- 7 months operating room and labor and delivery clinical activity
- 2 week rotation on MFM
- 2 week rotation in neonatology
- 3 months research
  - Fellows should be involved in a scholarly project which leads to
    - Presentation at national meeting
    - Publication

Program Requirements for GME in Obstetric Anesthesiology

Where Did OB Drop the Ball?

- Pediatric Anesthesiology
  - Fellows should become experienced in teaching principles of pediatric anesthesiology to other resident physicians, medical students, and other health care professionals

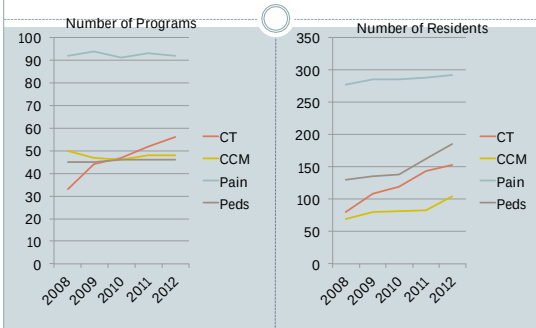
Program Requirements for GME in Pediatric Anesthesiology

Where Did OB Drop the Ball?

- Adult Cardiothoracic Anesthesiology
  - The division of responsibilities between the residents and fellows must be clearly delineated. The presence of a CT fellow must NOT be permitted to compromise the clinical experience and number of cases available to the residents in a core program in anesthesiology

Program Requirements for GME in Pediatric Anesthesiology

Growth in Programs



ACGME Data Resource Book, 2011-2012

Accreditation Status

Program	Number of Programs	Full Accred	Initial Accred	Probation	Future Withdraw
CT	56	43	12	1	0
CCM	48	42	6	0	0
Pain	92	83	7	1	1
Peds	46	45	1	0	0

ACGME Data Resource Book, 2011-2012

Program Director – A lot of Work

- Programs with at Least One Program Director Change
  - Core – 132 (11.3%)
  - CT – 56 (0.2%)
  - CCM – 48 (18.7%)
  - Pain – 92 (16.3%)
  - Peds – 46 (15.2%)

ACGME Data Resource Book 2011-2012

Who Will Be the OB Fellow?

- Most likely obtained anesthesia residency through match (2010)
  - 79.7% filled through match
  - 1.8% unmatched
  - 2.3% withdrawn
  - 16.2% never in match
  - Reasons for not being in match
    - Osteopathic
    - International medical grad

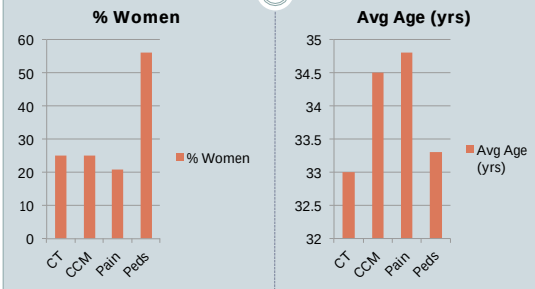
Jolly P. Academic Medicine 2012;87:586

Who Will Be the OB Fellow

Program	Total Residents	Canad Med School	IMG	Osteopath Med School	US Med School
CT	153	1%	10%	10%	79%
CCM	104	2%	21%	6%	71%
Pain	292	1%	22%	12%	66%
Peds	185	2%	10%	6%	83%

ACGME Data Resource Book, 2011-2012

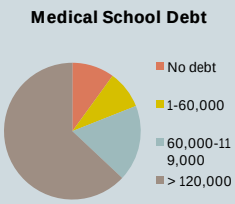
Who Will Be the OB Fellow?



ACGME Data Resource Book, 2011-2012

The OB Fellow Will Be Poor!

- 49 residency or fellowship programs in Anesthesia participated
- Of the 2386 residents, 537 completed
  - 10% no debt
  - 43% > $150,000



Steiner JW. Anesth Analg 115;115:170

Debt Does Not Influence Choice to Pursue Fellowship

- (1 = not likely at all, 5 = very likely)
- How likely are you to pursue a fellowship?
  - 0-29,999– 3.7
  - 30-89,999 – 3.9
  - 90-119,999 – 3.4
  - 120-149,999 – 3.6
  - >150,000 – 3.5

Steiner JW. Anesth Analg 2012;115:170

Debt Does Influence Career Choice

- (1 = not likely at all; 5 = very likely)
- How likely are you to pursue a career in

	0-30 x 10(3)	30-90 x 10(3)	90 x 120 10(3)	120 – 150 x 10(3)	> 150 x 10(3)
Acad	3.3	3.3	3.0	2.8	2.9
Res	2.4	2.5	2.3	2.1	2.1
Priv Pract	4.0	3.7	4.2	4.1	4.2

Steiner JW. Anesth Analg 2012;115:170

Debt Correlates with Desire to Moonlight

- The greater the debt, the greater the desire to moonlight
- OB Anesthesiology Fellowship has most protected research time
- Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program
- Time spent by fellows in Internal and External Moonlighting must be counted towards the 80-hour Maximum Weekly hour limit

Steiner JW. Anesth Analg 2012;115:170

Speaking of Moonlighting

- Challenges Confronting the OB Anesthesiology PD
- Duty Hours – limited to 80 hours per week, averaged over a four-week period
- What do residents do when not working or sleeping?
  - Survey to residents in pediatrics, internal medicine, and surgery residents
  - 16 institutions participated with 634 responses
    - Internet use – most common
    - Watch TV – second most common
    - Bottom three
      - Read professional journals
      - Read for leisure
      - See a movie

Baldwin DC. Academic Medicine 2012;87:395

Other Challenges for the OB PD

- ACGME Survey
- A response rate > 70% for programs with 4 or more residents; a response rate of 100% for programs with less than 4 residents
- Programs with fewer than 4 residents will NOT see aggregate reports to maintain resident anonymity

Resident/Fellow Survey - What Programs Need to Know

How Accurate is the Survey

- Single surgical department administered ACGME survey and in-house GME survey
- 25 residents completed both
- Difference in response:
  - Faculty spent sufficient time teaching (48% vs 85%)
  - Emphasis on education vs service obligations (73% vs 96%)
  - Interference of other learners (81% vs 25%)

Fahy BN. J Surg 2010;67:387

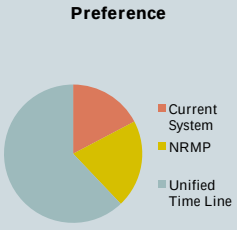
How Do Fellows Decide Upon a Program?

- Frequency that each factor was ranked most important
  - Family, significant other, personal – 29.7%
  - Prestige of program – 26.0%
  - Location – 20.6%
  - Competitiveness of subspecialty – 14.5%
  - Other – 9.1%

Bernacki KD. Am J Clin Pathol 2012;137:543

When Should Positions Be Offered?

- Survey by 366 pathology residents
- Current System, NRMP, or Unified time line



Bernacki KD. Am J Clin Pathol 2012;137:543

Why Keep Things As IS?

- Flexibility relating to personal factors such as spouse employment and home ownership
- Personal decision instead of computer algorithm with contractual obligation
- Putting in time should be rewarded
- Inability to have couples match with other specialties
- Time and money

Bernacki KD. Am J Clin Pathol 2012;137:543

Why Use the NRMP?

- Fairness
- The ability to enforce a set of rules
- The opportunity for applicants to evaluate more programs
- Removal of
  - Pressure
  - Unpredictability
  - Confusion
  - Chaos

Bernacki KD. Am J Clin Pathol 2012;137:543

What Will the OB Fellow Do Upon Graduation?

- Of course, the fellow will have a final summative evaluation which
  - Documents the fellow's performance during the final period of education
  - Verifies that the fellow has demonstrated sufficient competence to enter practice without direct supervision

Program Requirements for GME in Obstetric Anesthesiology

What Will the OB Fellow Do Upon Graduation?

- Electronic survey sent to chairs of US anesthesiology training programs
- Response rate of 60% (72 of 121)
- Average number of open positions: 3.3
- Most common subspecialty need:
  - Generalist, peds, CCM, cardiac pain

Subspec	2008 (%)	2010 (%)
Generalist	31	28
Pediatric	21	23
Cardiac	12	12
CCM	11	15
Regional	6	6
Pain	6	9
Ambul	4	0
Obstet	4	3
Neuro	4	3

Open Faculty Positions by Specialty

Kheterpal S. Anesth Analg 2011;112:1480

Success as an OB PD (Really any PD)

- 1. Equity
- 2. Justice
- 3. Communication and Interpersonal Relations
- 4. Role Modeling
- 5. Work Ethic
- 6. Balancing Work and Personal Life
- 7. Empathy
- 8. Interest in Trainees and Younger Colleagues
- 9. Organization and Prioritation
- 10. Administrative Skills

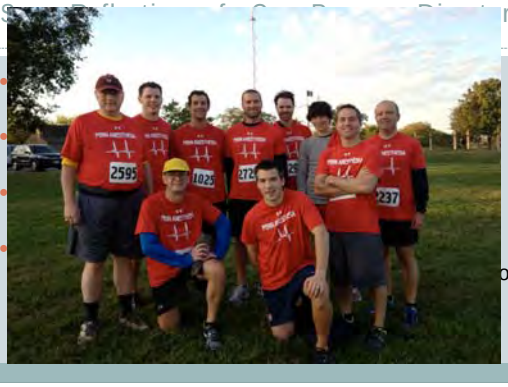
Alpert JS. Am J Med 2010;123:1071

Success as a PD

- The most important thing is MOJO (that positive spirit toward one's present endeavor
  - Identity
  - Achievement
  - Reputation
  - Acceptance

Nussmeier NA. J Cardio Vasc Anesth 2011;25:759

[illegible]r



How Do We Match Up? (Part 1): NRMP Representative

Mona M. Signer, M.P.H.

Notes: _____

A Match for Anesthesiology Fellowships

NRMP
National Resident Matching Program

November 2, 2012

Mona M. Signer
Executive Director

NRMP Matching Programs

Main Residency Match

- 38,000 applicants
- 4,400 programs
- 26,800 PGY-1 and PGY-2 positions

Specialties Matching Service

- 24 fellowship matches
- 47 subspecialties
  - 7,000 positions
  - 9,000 applicants

NRMP

Benefits of a Match

- Allows applicants and programs to consider all options before making decisions
- Creates an impartial venue for matching programs' and applicants' preferences
- Establishes a uniform date for appointments to GME programs
- Produces a "stable marriage"

NRMP

Why Should Program Directors Want a Match?

It's the right thing to do for applicants:

- Professionalizes recruitment process
- Eliminates undue pressure on trainees to select a program before all interviews are complete
- Allows "late bloomer" decisions
- Reduces "career change" dropouts

NRMP

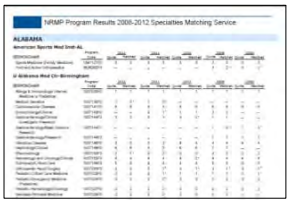
Why Should Program Directors Want a Match?

It levels the playing field among programs:

- Programs can interview more applicants
- Eliminates undue pressure on programs
  - To select applicants before all interviews are complete
  - To make appointments earlier and earlier each year

It produces convenient, useful specialty-specific data

NRMP



NRMP

Specialties Matching Service
Participation Criteria

Programs must meet <u>one</u> of the following criteria:

- Accredited by the ACGME
- Affiliated with an ACGME-accredited program in the core discipline
- Lead to specialty certification or oversight by an ABMS-recognized certifying board

NRMP IO (ACGME DIO) must assume oversight

NRMP

Fellowship Sponsor Agreement
Annual Commitment

- At least 75% of programs with available positions will be registered in the Match
- These programs will actively participate by submitting rank order lists of applicants
- At least 75% of the available positions within the subspecialty will be in the Match

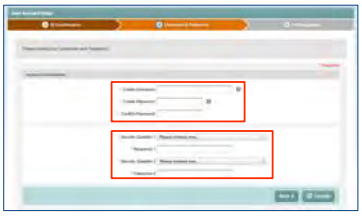
NRMP

NRMP

Logging in to the R3 system

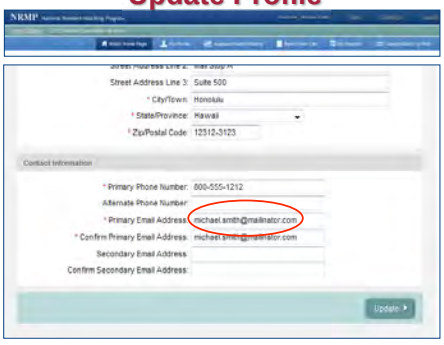
NRMP

Logging in to the R3 system



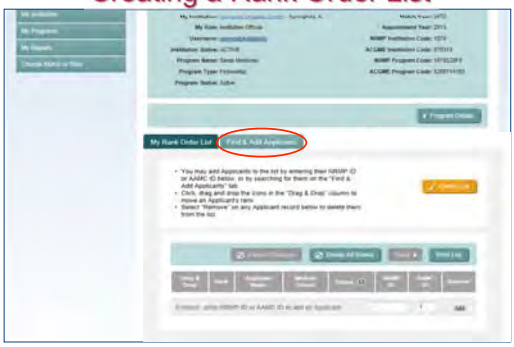
NRMP

Update Profile



NRMP

Creating a Rank Order List



NRMP

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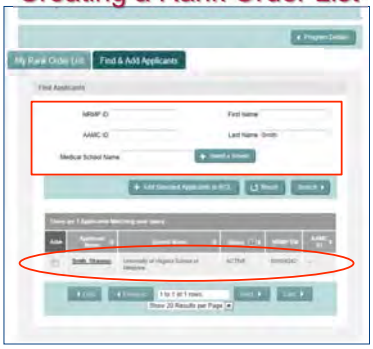
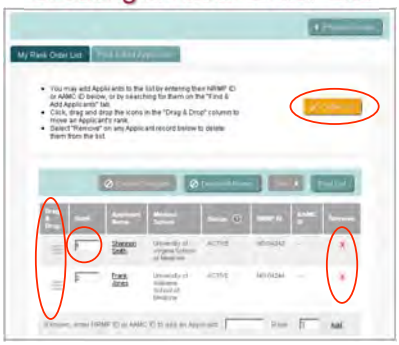


NRMP

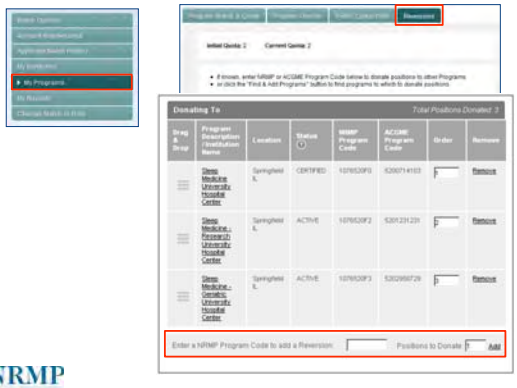
Creating a Rank Order List



NRMP

Certifying a Rank Order List

NRMP



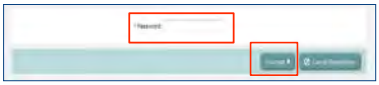
NRMP

Match Day!

- Confidential Roster of Matched Applicants
- Match Results by Ranked Applicant
- List of Unfilled Programs
- List of Unmatched Applicants
- Match Results Statistics
- Match Outcome for All Programs

NRMP

The Match Participation Agreement



NRMP

The Match Commitment

Section 5.1:

"The listing of an applicant by a program on its certified rank order list or of a program by an applicant on the applicant's certified rank order list establishes a binding commitment to offer or to accept an appointment if a match results and to begin training on the date specified in the contract.

Failure to honor this commitment by either party participating in a match will be a breach of this Agreement and may result in penalties to the breaching program or applicant……."

In limited circumstances, the NRMP may grant a waiver of the match commitment.

NRMP

Match Waivers

Applicants:

- Hardship
- Change of specialty: must be requested by January 15
- Completion of residency postponed

Programs:

- Loss of funding
- Loss of accreditation
- Hardship

Waivers must be requested from, and can be granted only by, the NRMP.

NRMP

Violation Investigations

Report potential violation to Executive Director

Information gathered by NRMP

Preliminary report reviewed by all parties

Case reviewed by Violations Committee

Review Panel Report to violator

Violator can arbitrate; pending action noted in ***R3*** system

Final Report distributed

NRMP

Violations by Applicants

- Final Report sent to medical school, ABMS, ECFMG, FSMB
- Applicant barred from positions in Match-participating institutions for 1year
- Applicant identified as a match violator in ***R3*** system and barred from future matches for 1 - 3 years or permanently
- Violation summary in Applicant Match History

NRMP

Applicant Match History

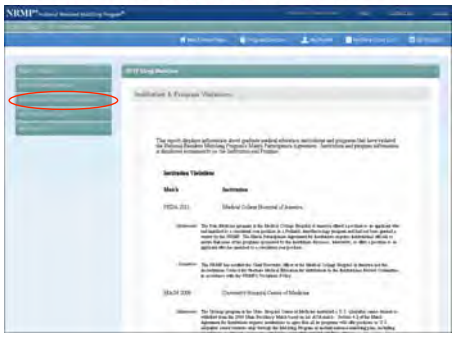
NRMP

Violations by Programs

- Final Report sent to NRMP IO, ACGME/RC, and program director organization
- Program identified as a match violator in R3 system and barred from future matches for 1 - 3 years or permanently
- Violation summary in Institution/Program Report

NRMP

Institution/Program Violations



NRMP

Roadmap to a Match
2014 Appointments

Now: **Match sponsor surveys program directors to reach 75%**

- ✓ Will the program participate in the Match?
- ✓ How many first-year positions in program?
- ✓ How many first-year positions in the Match?
- ✓ Which tracks will program use & number of positions?

Sponsor returns 75% Agreement & Web Site description

NRMP

Roadmap to a Match
2014 Appointments

March 2013: **Sponsor submits participating program information**

- ✓ Program director contact information
- ✓ Program tracks
- ✓ Number of positions per track

April 2013: **NRMP preloads *R3* system**

Early May: **Program directors receive log in information**

May 8, 2013: **Match opens for registration**

NRMP

Roadmap to a Match
2014 Appointments

July 31, 2013: **Ranking opens**

September 4, 2013: **Quota change deadline**

September 18, 2013: **Ranking deadline**

October 2, 2013: **Match Day!**

July 1, 2014: **Training begins**

NRMP

Match Fees

Programs

$175 institution fee

$30 per program track

$30 per matched applicant

Applicants

$50 registration fee

$15/partner couple fee

NRMP

National Resident Matching Program

www.nrmp.org

support@nrmp.org

202-400-2233

866-653-NRMP

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How Do We Match Up? (Part 1): San Francisco Match

Jack Shanewise, M.D.

Adult Cardiothoracic Anesthesiology (ACTA) fellowship programs and applicants have been struggling for a number of years to deal with problems created by lack of coordination of the application, interview, offer, and acceptance processes. For the applicants these have been mainly dealing with different timelines for different programs and being asked to make decisions about offers before being able to complete all their interviews. The programs have had problems with applicants holding onto offers only to be turned down late in the game. Efforts in the past to deal with these problems have included an informal agreement not to force applicants to decide on offers before a certain date (e.g. July 31 or June 30) and a more structured but still informal agreement among programs to simultaneously make offers good for one week at a given date and time (e.g. 3 pm June 6). These attempts have been to large degree successful in gaining the participation of most programs, but have not eliminated the annual scramble and confusion at the end of the application process. The process has to include exceptions to accommodate special situations in which programs and applicants need to make agreements earlier than usual. These exceptions are internal candidates, candidates looking for commitments more than one year long (e.g. doing ACTA and CCM fellowships at the same institution), couples situations, international applicants, and applicants with military commitments. There has been a growing feeling and much discussion among the ACTA program directors that the best solution to all these problems may be to have a match assign the applicants to the programs. Accordingly, Mark Stafford-Smith, as chair of the SCA ACTA PD Committee, investigated the options available to accomplish this. There are a number of businesses that offer matching services to post graduate medical training programs, and the one identified as most suitable to the ACTA situation was San Francisco Matching Programs—SF Match.

SF Match has been coordinating the process distribution and review of applicants for post graduate medical education programs since 1977 and has processed over 50,000 applications. Currently it has three residency matches and 18 fellowship matches. SF Match offered the ACTA programs flexibility in the match date and the ability to accommodate the needed exceptions. The SCA and SF Match recently reached an agreement that there will be a match this spring for the 2014-2015 ACTA fellowship year. Participating programs will register with SF match for a fixed fee (~$150- $325 depending on when they sign up) and applicants will register for a fee of $50 no matter how many programs they rank. Programs and applicants will submit their rank lists in the late spring, and the match will occur one or two weeks after that. The exceptions will be handled by programs and applicants agreeing to rank each other high enough to assure matching, and each program will submit their exceptions for review prior to the match to help avoid errors. A substantial majority (>85%) of ACTA fellowship positions are verbally committed to be in this match, and we will know soon how many programs actually sign up. We will be waiting with anticipation to see what effect this important development has on the upcoming ACTA application season.

General *Sessions*

General Session 1: Developing a Quality Program in a Department of Anesthesiology: Two Approaches

Moderator: Berend Mets, M.B., Ch.B., Ph.D., FRCA, FFA(SA)

Approach 1
John Allyn, M.D.

Approach 2
Richard P. Dutton, M.D., M.B.A.

Approach 1

John Allyn, M.D.

Notes: _____

Approach 2

Richard P. Dutton, M.D., M.B.A.

Objectives

1. Recognize important steps in organizing an anesthesia department quality management program
2. Understand the difference between top-down QM and bottom-up QM
3. Learn the advantages of participation in the National Anesthesia Clinical Outcomes Registry

Quality of Care in Anesthesia Departments

The government has a question for you. The Joint Commission has the same question. Also your hospital Quality Manager. Your group administrator may have asked it before, in private. And it may have woken you up in the middle of the night. The question is:

How do you know you're providing good care?

In ages past the answer was paraphrased from Justice Potter Stewart: "I don't know what quality is, but I know it when I see it." The problem is that nowadays we do know what quality is. At least some people think so. They work for the government. Or the Joint Commission. Or the American Board of Anesthesiology. And they're the ones who are asking you the question. And they are expecting an answer.

If you're the Chair of a University Anesthesiology Department then you know this already and you've taken steps to comply. You have designated a Quality Management Officer (QMO) for your group, to gather the data you need, to analyze it, and to produce the reports that the hospital (and other stakeholders) are asking for. You collect outcome information from your group's practice, including business metrics and patient-centered quality and safety outcomes, and you put this data to work. You've established a robust process for reviewing individual events, and for learning from them. In short, you've already done all the things that are spelled out in the AQI document: "Quality Management in Your Practice." But it's attached anyway, in case you want to share it with your graduating residents.

The purpose of this talk is to discuss how you can work with the Anesthesia Quality Institute to take your QM program to the next level. The AQI was chartered in 2009 as a related organization of ASA. AQI's purpose is to foster quality management in anesthesiology nationwide, and the specific task is creation of the National Anesthesia Clinical Outcomes Registry (NACOR). This is a very large database, designed to collect clinical information and outcomes from every case, every day, in the United States. NACOR is populated electronically from participating practices, through data pipes constructed to take advantage of existing digital data. This may include billing records (which every group has), intraoperative process data (from Anesthesia Information Management Systems), hospital electronic record information, and quality management software. **Participation in NACOR is open to every anesthesia practice in the country – there is no minimum requirement for 'wiredness.'** Participation costs $500 per supervising provider in the group per year, but is discounted to $0 for ASA members. AQI participation is **FREE** to groups and departments with 100% ASA membership.

AQI Participating Practices have continual access to the NACOR Reports Server, which displays the data they have submitted (neatly packaged, if we do say so ourselves), along with national and peer-group benchmarks. We provide our participants with the ability to 'drill down' in their own data to the facility or provider level, and to filter the comparative benchmarks based on practice type. The goal is to provide participating practices with the tools they need to assess and improve both business efficiency and clinical outcomes. As a side benefit, there are reports and formats compatible with reporting requirements for the Joint Commission's mandated OPPE and FPPE programs (Ongoing and Focused Professional Practice Evaluation), and other hospital-based initiatives.

Establishing the basic infrastructure for NACOR was the focus of AQI's first year of operations. The decision was made to house AQI within ASA Headquarters in Chicago, and to host NACOR within ASA's information technology umbrella. This allowed a quick start and rapid accumulation of data. As of November 1, 2012, approximately 1000 practices have expressed interest in NACOR, 210 have completed data sharing contracts, and 130 are submitting clinical data from every case, every day.

AQI participants include both community and academic practices and range in size from 3 to more than 180 anesthesiologists. Data in NACOR now comes from 11,000 providers, 1300 facilities, and more than 7,000,000 cases. The AQI receives data from thirty-five different healthcare IT platforms (billing software, AIMS, quality management programs, and hospital electronic records) and is working with IT vendors to expand this portfolio. In 2013, AQI will capture data on 15-20% of the anesthetics performed in the US.

Data in NACOR is growing in depth as well as breadth. All cases include a minimum data set of patient age, sex and ASA status; preoperative ICD9 codes; surgical and anesthetic CPT codes; date and duration of surgery; facility and provider details; and anesthesia type. Approximately 25% of cases are now transmitted from AIMS, and include structured data on anesthesia procedures, monitors, medication doses, fluids, vital signs and preoperative patient evaluation. An overlapping 25% of data is reported from practices that include short-term clinical outcomes from digital quality management programs. These include both safety outcomes – based on the Registry Dataset of the ASA Committee on Performance and Outcome Measures – and practice management outcomes such as resource utilization and efficient patient flow. Increasing penetration of AIMS and EHRs in general will lead to a steady increase in the data available in NACOR. AQI is working with MPOG and various subspecialty societies to create and promulgate standard formats for this information.

The AQI issued its first report "Anesthesia in the United States" in 2010, summarizing data culled from public and ASA sources regarding the profession and its activities. This document has been updated twice; the 2012 version is available on the AQI website and at no cost to AQI participants. The AQI provides aggregated national data to ASA leadership. The AQI website—www.aqihq.org—includes educational resources for anesthesia department quality management, including recommendations for technology vendors, a video show on how to use QM data in your practice and several documents which define anesthesia outcomes of interest. Going forward, these educational products will be based on the needs identified in AQI's registries, and will be produced in collaboration with ASA.

In October 2011 the AQI launched the Anesthesia Incident Reporting System, a second registry which focuses on collection and analysis of serious adverse events, near misses and interesting cases. Any provider, anywhere, can enter cases into AIRS: www.aqiairs.org. Cases in AIRS are reviewed and categorized by a panel of experts, seeking common factors and occurrences that impact on anesthesia quality. One exceptional case each month is abstracted for an educational presentation in the *ASA Newsletter*, in the hope that many can learn from the experience of one. Several academic practices have expressed interest in uploading cases directly from their own incident-capture systems to AQI, and we are working to accommodate this. AQI also offers the AIRS software as a "front-end" for practices that wish to use its taxonomy for internal incident capture.

The AQI has created a steadily expanding data repository that will yield numerous academic projects in the years to come. Data in NACOR and AIRS is available to researchers at AQI participating institutions at minimal cost.

Collaborating scientists must have IRB permission to access the data, and must complete a project-specific Data Use Agreement with AQI. (Contact r.dutton@asahq.org for further information.) In 2013, AQI will combine with the Foundation for Anesthesia Education and Research (FAER) to offer a Mentored Research Training Grant for a young investigator who wishes to pursue a career in health delivery research. More information on this opportunity is available at www.FAER.org.

Quality Management in Your Practice

The goal of quality management (QM) is to improve efficiency and outcomes. An entire industry has arisen devoted to making this simple concept complex, and to frustrating hard-working anesthesiologists by obscuring common sense with jargon. The purpose of this document is to provide very basic instructions for creating an anesthesiology QM program. The program will help your group directly, and will make it easier to meet your hospital's needs for QM data, along with Joint Commission requirements for Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE), and ABA requirements for Maintenance of Certification in Anesthesiology (MOCA).

A detailed review of the history, theory and practice of QM can be found in the Manual for Anesthesia Department Organization and Management (MADOM), written by the ASA Committee for Quality Management and Departmental Administration. For those just starting out, here is a simple 8-step plan:

Step One: Designate a physician in your group to lead QM efforts. Successful QM programs depend on a physician champion. This individual should recruit others (a committee) to help with data analysis and peer review, and should engage with QM personnel in the facilities you serve. The facility has similar QM obligations to your practice, and may have resources (such as dedicated QM nurses) who can help gather data.

Step Two: Establish a list of indicators for your practice. An indicator is any variable that tells you something about your practice, ranging from how many patients die in the OR to how long it takes the hospital to replace a light bulb in the women's locker room. Indicators tell you something about your structure (e.g. how many practitioners, how many ORs), your process (e.g. how many patients get perioperative antibiotics), or your outcomes (e.g. how many patients die) Measuring indicators will enable you to engage in the "quality cycle," which is simple and intuitive:

- Measure what you do
- Make improvements
- Measure again

Appended is the AQI recommended list of indicators. This is only a starting point, and should be adjusted based on what data is most important to your practice.

Step Three: Gather data and enter it in a database. There are commercial products available to assist with this process, but many groups have developed their own electronic tools. The ASA provides samples in the MADOM chapter, and the AQI provides recommendations and referrals on its website. The purpose of your database is to facilitate analysis and reporting.

Step Four: Report overall data to your group and to local stakeholders (such as hospital administration). Three concepts are worth noting. First, some data should be reported as *rates*: occurrences per opportunities (post-dural puncture headaches per total spinals and epidurals attempted). Second, data should be presented over time (monthly or quarterly), and gains value when *trends* can be observed. Third and finally, some data – especially outcomes – are strongly biased by external factors, and should be *risk adjusted* prior to presentation or *benchmarked* to data gathered under similar conditions. As an example of all three concepts, anesthetic mortality in a trauma center (the *rate* of deaths per anesthetic) is presented quarterly (*trended* over time) and either *adjusted* for the patients' severity of injury or *benchmarked* to mortality from other trauma centers.

Step Five: Review unusual events. Many complications of anesthesia are rare, and thus not suitable for numeric assessment until numbers get very large. These events should be individually reviewed and discussed by the QM Physician and Committee. Discussion should focus on what happened and how to prevent it from happening again. The discussion should be documented: Keep notes! When a cluster of events occurs, one response is a 'focused review' by a small group of experts, focused on identifying common systematic factors and potential solutions. This, too, should be documented.

Step Six: Make improvements. Sometimes quality can be improved by presentation of data or discussion of cases (i.e. provider education). This is true for many rare but serious events, and is the basis for the traditional "Morbidity and Mortality" conference. It can also be a mechanism for leveraging peer pressure, such as public reporting of compliance with documentation standards. In general, though, most QM activity should be kept 'within the family' and at the level of the practice rather than individual providers. This is because most QM "opportunities" arise from problems with the system rather than with individuals.

Judicious search of the anesthesia literature and the ASA website can reveal guidelines, recommendations and advice for addressing QM issues. Many such documents are listed and summarized in the MADOM.

Step Seven: Re-measure, and automate the process. QM becomes easier over time, because trends in accumulating data make it easier to discern true problems from random variation. Increasing experience increases physician confidence in the process, and the openness and utility of event review. One goal of the QM Physician is to embed the process of measurement and reporting in the fabric of the practice in such a way that data capture and analysis become as automatic to your group as monitoring a patient's vital signs and changing the anesthetic depth.

Step Eight: Participate in the AQI. Contribution of data to the National Anesthesia Clinical Outcomes Registry (NACOR) entitles a practice to receive regular benchmarking reports, making it easier to identify areas of good and bad performance. AQI membership is open to any anesthesiology practice in the US. NACOR is populated by continuous passive collection of digitized information from participating groups, ranging from simple billing system information to sophisticated electronic hospital records. In addition to aggregated national data and peer-group benchmarking, participation in the AQI is intended to provide ASA members, practice groups, and healthcare facilities with an easy and effective means to meet regulatory requirements for QM and practice assessment. Information on joining the AQI is available at www.aqihq.org.

AQI Recommended Indicators (Updated for 2012)

These are the things you should report:

Business Indicators

- Cases done
  - By surgical service
  - By anesthesia type
  - By ASA class
  - By location
- Number of providers
  - By type (Physician, Resident, CRNA, AA, etc.)
  - By subspecialty training or group
- Total minutes billed
  - By surgical service
- Top ten cases done, and average duration

Process Indicators

- On-time starting percentage of first cases
  - By service / facility
- Cancellation rate
  - By cause and preventability
- PQRS measure compliance
  - Prophylactic antibiotic administration
  - Adherence to central line bundle
  - Normothermia in the PACU
- Documentation compliance (% of cases with completed QM records)
  - By location / service / provider
- Number of patient complaints

Clinical Outcome Indicators

- Number of cases completed uneventfully
- Number of each critical event occurring (by location/service):

-Death
-Cardiac arrest
-Perioperative MI
-Anaphylaxis
-Malignant hyperthermia
-Transfusion reaction
-New stroke
-Visual loss
-Incorrect surgical site
-Incorrect patient
-Medication error
-Unplanned admission
-Unplanned ICU admission
-Intraoperative awareness
-Unplanned difficult airway
-Unplanned reintubation
-Dental trauma
-Perioperative aspiration
-Vascular access complication
-Pneumothorax
-Infection after regional anesthesia
-Epidural hematoma
-High spinal
-Postdural puncture headache
-Local anesthetic toxicity
-Peripheral neurologic deficit

Patient Experience Indicators

- Overall patient satisfaction
    - By Service/facility/patient type
- Rate of postoperative nausea and vomiting
- Adequacy of pain management in the PACU
- Patient complaints
    - By Service/facility/patient type

Consensus definitions of critical events can be found on the AQI website: www.aqihq.org under the tab for "Resources." Look for the document titled "CPOM Registry Data Set." These definitions were developed by the ASA Committee on Performance and Outcome Measurement.

Data to Collect

To assemble the indicators listed above, an anesthesia practice QM program will need to electronically capture the following relatively short list of raw data:

- For each case done:
    - Location (facility)
    - CPT code(s)
    - surgeon
    - anesthesia provider(s)
    - date
    - time (or duration)
    - anesthesia type (general, regional, sedation, combination, etc)
    - ASA class
    - PQRS compliance (yes/no/not applicable for each of three variables)
    - Occurrence of a listed complication (yes/no, and which one)
    - Patient survey data (satisfaction, PONV, pain questions)
- Documentation completed, including QM form (yes/no)
- Number of patient complaints received (obtain this from the facility and the surgeons as well as from your own office mail)

Alliance with the facility QM personnel can help to gather patient satisfaction and complaint data, as well as complications occurring beyond the immediate perioperative period. A number of software programs have been developed to facilitate capturing these data elements, analyzing them, and reporting the indicators listed above. Some of these resources are available in MADOM, while a list of other (proprietary) solutions can be obtained from the AQI website.

General *Sessions*

General Session 2: Succession Planning, Healthcare Reform, Digital Era

Moderator: Berend Mets, M.B., Ch.B., Ph.D., FRCA, FFA(SA)

Succession Planning

- **Choosing and Mentoring a Prospective Chair**
  Raymond C. Roy, M.D., Ph.D.
- **Choosing and Mentoring a Prospective Program Director**
  Robert R. Gaiser, M.D.

Trends in Compliance Enforcement and Academia: Lessons Learned from Recent OIG, RAC, and CMS Contractor Audits
Stanley W. Stead, M.D., M.B.A.

Innovation and Transition to a Digital Era in Anesthesiology
David L. Reich, M.D.

Succession Planning: Choosing and Mentoring a Prospective Chair

Raymond C. Roy, M.D., Ph.D.

QUESTIONS

These three questions are those that Kaplan poses in reference one.

1. Have you picked one or more prospective chair candidates (potential successors)?
2. Are you coaching your prospective chair candidates and giving them challenging assignments?
3. Have you become a decision-making bottleneck?

ANSWERS

1. Have you picked one or more prospective chair candidates (potential successors)?

   The answer should be "yes." The individuals, the department, and the dean should know who they are in case you are temporarily disabled.

2. Are you coaching your prospective chair candidates and giving them challenging assignments?

   The answer should be "yes." If you are not, then you are practicing poor time management, becoming vulnerable to burnout, and less likely to retain your best people. Delegation is an important part of any succession plan.

3. Have you become a decision-making bottleneck?

   The most likely answer will be "no" but it is less likely to be the true answer because we are all slow to recognize this problem in ourselves and in our department. The most common cause of this problem is micromanagement from inadequate delegation of responsibility and authority.

OBJECTIVES

1. To present succession plans as important components of personal career and retirement planning.
2. To discuss how succession planning can be a tool in the prevention and treatment of burnout.
3. To demonstrate how chair absences from their departments for vacations and meetings provide opportunities for mentoring.

INTRODUCTION (Brief CV)

Raymond C. Roy, M.D., Ph.D., earned his B.Sc. (Chemistry) from the University of Pennsylvania (1966), his Ph.D. (Inorganic Chemistry) from Duke University (1971), and his M.D. from Tulane University (1974). He received his anesthesia training at the Hospital of the University of Pennsylvania (1976-78). He served as anesthesia chair at the Medical University of South Carolina (1992-6), University of Virginia (1996-8), and Wake Forest University (1998-2008), director (1993-2005) and president (2003-4) of the American Board of Anesthesiology, chair of the ABA/ASA Joint Council on In-Training Examinations (1998-2002), trustee of North Carolina Baptist Hospital (2005-8), and president of Wake Forest University Physicians (2007-9). He is currently professor of anesthesiology at the Wake Forest University School of Medicine and a guest editor of *Anesthesia & Analgesia*.

SYLLABUS

Notification of Survey. This presentation will be part of a Wake Forest School of Medicine Institutional Review Board approved survey of succession planning by current anesthesia department chairs. The co-investigators are Joseph R. Tobin, MD, FAAP, FCCM, Professor and Chair, Department of Anesthesiology, Wake Forest School of Medicine, and Timothy T. Houle, PhD, Associate Professor of Anesthesiology and Neurology, Wake Forest School of Medicine, Statistical Editor, Anesthesiology. Five questions will be presented for answering anonymously and confidentially by the anesthesia chairs in the audience prior to the actual presentation. The answer sheets will be inserted into envelopes, sealed and collected during the presentation for analysis at a later date in a submission to either *Anesthesiology* or *Academic Medicine*. **The content in these five questions**, which will be revealed during the talk, absent analysis of the actual answers, **will form the basis of this formal presentation**.

Credentials - Why Listen to Me? I am not Ron Miller (UCSF) or Alex Evers (Wash U), but I am a decent role model. I have been well mentored; have had a reasonably successful tenure as chair at three different academic institutions, and mentored eight faculty members who went on to become anesthesia chairs. Two mentors during my residency at the Hospital of University of Pennsylvania deserve mention: Frank Murphy, the equivalent of anesthesia residency program director, talked to me on multiple occasions on the formation of a career plan; and Ted Eger, as a visiting professor, was the first person to get me to articulate that I was interested in becoming the chair of an academic anesthesia department. Two mentors during my faculty years at Bowman Gray (now Wake Forest) deserve mention: Tom Irving, the chair who hired me, sought me out for innumerable informal one-on-one leadership discussions during his tenure; and Frank James, the chair who delegated specific administrative tasks to me and appointed me as the first vice chair for the department, scheduled regular formal one-on-one leadership discussions with me. My first dean, Layton McCurdy, became a close friend, colleague, and advisor. Finally, I have employed personal executive coaches when I thought I was getting off track or encountering significant difficulty addressing major problems (budget, manpower plan, specific personnel issues). I made it a practice early in my tenure at each of the three academic institutions where I served as chair to identify to the dean a faculty member who could serve as an effective acting chair should I become disabled. Rightly or wrongly I claim some credit for identifying, mentoring, and providing strong recommendations for the following eight chairs of anesthesiology:

1. Medical University of South Carolina (1992-96)
   a. Joanne M. Conroy – appointed vice chair; succeeded me as chair; now serves as Chief Medical Officer for the AAMC
   b. Scott T. Reeves – recruited to MUSC to head cardiac ICU; current chair
2. University of Virginia (1996-8)
   a. Roger Johns – appointed vice chair; became chair at Johns Hopkins
   b. George Rich – kitchen cabinet; current chair
3. Wake Forest School of Medicine (1998-2008)
   a. John Butterworth –kitchen cabinet, associate dean for research, section head cardiac; became chair at Indiana; current chair at Virginia Commonwealth University
   b. Richard Prielipp – section head (critical care); became chair at Minnesota
   c. Joseph Tobin – section head (pediatric anesthesia and pediatric critical care), kitchen cabinet; current chair
   d. David Zvara – section head (cardiac); became chair at Ohio State; current chair at UNC

Finally I am currently happily working in preplanned "phased retirement" that I describe as one of the most professionally satisfying periods in my life.

Question One - Career and Life Plan. According to Kaplan (1) and Lexa (3), becoming a department chair should be part of a broader plan for your life. "When you're challenging and testing people, you delegate to them more often, which frees you to focus on the most critical strategic matters facing the business. This will make you more successful and a more attractive candidate for **your own future promotion** (1)." Your next position may in fact be a "second term" as chair at the same institution with a revitalized strategic plan. "…**you should start your tenure [as chair] by planning and working with the end in mind**…. I advise leaders to start preparing at least 5 years ahead of their expected dates of retirement (3)." If after you step down as chair you plan to stay in the department, you must reconcile your view as to what your role will be with the view of the current chair (your boss) to become a good former chair.

Question Two – Why Identify and Mentor? There are selfish, professional, and legacy reasons to identify and mentor prospective chair candidates. The selfish reasons are to reduce your work stresses by delegating to improve your own time management to provide more personal development and family time, to maintain focus on the departmental and institutional strategic plan, and to sustain passion and enthusiasm to prevent burnout. The job requirements (creating a leadership pipeline) relate to retention of good faculty, improving department performance, and providing security to your faculty members in case of your disability. The legacy requirement works both in your department (protecting what you have built and allow others to build on it) and for the profession when someone you mentor becomes chair elsewhere. "Asking one person to shoulder all of the leadership tasks is a poor way to run an organization (3)" "If you aren't identifying potential successors, you are probably not delegating as extensively as you should (1)."

Questions Three and Four – Specific Times to Mentor. Once you have identified individuals and delegated responsibilities (with or without a title) it is important informally and formally to schedule mentoring time. "…your subordinates want to be coached and developed in a truthful and direct manner. They want to get feedback while there is still an opportunity to act on it; if you've waited until the year-end review, it's often too late (1)." Trips away from the medical center, whether they be short (3-4 days) or long (2 week vacations), provide perfect opportunities to demonstrate confidence in those to whom you have delegated responsibilities. Meeting with them before your travels, identifying them and their responsibilities to the department and to the dean before you go, and debriefing them when you return are important mentoring moments.

Question Five – Formal Succession Plan. None of us is likely to dictate our successor. But you do not want your department to be a motor vehicle accident, heart attack, or stroke away from a crisis. "It is sufficient to identify possible successors without actually telling them you've done so – as long as this identification causes you to manage them differently. In particular, you will want to delegate more of your major responsibilities to these professionals (1)." But a more formal succession plan protects your department in case of an emergency and designates who the acting or interim leadership will be and also looks to a successful future. "…it is encouraging to see that both senior and emerging leaders are interested in making a difference to their divisional groups by doing succession planning and leadership development (4)." Finally Engells (5) suggests that that the succession planning document could be an active (periodically updated throughout the year) document called the turn over folder.

Five Specific Suggestions.

1. Create a personal career and retirement plan now.
2. Identify a prospective chair within your department and let dean know who he or she is.
3. Delegate more, coach more , and if uncoachable, replace. Use trips away from medical center as positive mentoring opportunities.
4. Develop a formal succession plan.
5. Utilize a professional executive coach to help implement 1-4 rather than do a lot of reading on leadership.

Annotated References:

1. Kaplan RS. What to ask the person in the mirror. *Harv Bus Rev* 2007 Jan; 85(1): 86-95

   The best nine pages of advice of how personally and privately to evaluate your current "midterm" performance as a leader that I have ever read. Succession planning is a tool to prevent or treat burnout, and maintain focus and enthusiasm.

2. De Oliveira GS, Jr., Ahmad S, Stock MC, et al. High incidence of burnout in academic chairpersons of anesthesiology. Should we be taking better care of our leaders? *Anesthesiology* 2011; 114:181-93

   This is the most current research on anesthesia chair burnout. The most commonly cited stressor is faculty retention. Delegation may improve retention and decrease burnout.

3. Lexa FJ. Succession leadership. *J Am Coll Radiol* 2011; 8:281-2

   This is a nice two-page "how to do it" manual.

4. Craighead PS, Anderson R, Sargent R. Developing leadership within an academic medical department in Canada: A road map for increasing leadership span. *Healthc* Q 2011; 14:80-4

   This is an excellent example of how succession planning stabilized a potential leadership "perfect storm" in the medicine department at the University of Calgary in 2009-10. An expert coach guided the effort.

5. Engells T. Turn over folders: a proven tool in succession management planning. *J Healthc Prot Manage* 2011; 27(1):36-42

   This practical article describes how a current chair could create an active document, the turn over folder, to allow an acting chair to function effectively should that chair become incapacitated.

6. Scemama PH, Hull JW. Developing leaders in anesthesiology. A practical framework. *Anesthesiology* 2012; 117:651-6

This article makes a strong argument for collaborative "first among equals" leadership.

Succession Planning: Choosing and Mentoring a Prospective Chair

2012 SAAA Annual Meeting
General Session 2 – 9:30-9:45 a.m.
San Francisco, CA

Raymond C. Roy, M.D., Ph.D.
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Wake Forest School of Medicine
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Who am I to Lecture You?

- I am not Ron Miller or Alex Evers!
- Anesthesiology chair x 3
  - 1978-92 - Wake Forest (Bowman Gray) faculty member
  - Medical University of South Carolina
    - 1992-96 – 15 faculty members
  - University of Virginia
    - 1996-98 – 30 faculty members
  - Wake Forest University
    - 1998-2008 – 60 faculty members
    - 2007-10 – President: WFU Physicians; hospital board
    - 2010 - present - phased retirement (75% time)

Well-Mentored

- U Penn (residency)
  - Attending: Frank Murphy; VP - Ted Eger
- Wake Forest (Bowman Gray)
  - Chairs: Tom Irving, Frank James
- MUSC
  - Dean: Layton McCurdy
  - Executive coach
- Wake Forest
  - Dean: Dick Dean
  - Executive coach

Mentored Future Chairs

- MUSC: Joanne Conroy – MUSC
- MUSC: Gary Haynes – St. Louis
- MUSC: Scott Reeves – MUSC
- UVA: Roger Johns – Johns Hopkins
- UVA: George Rich – UVA
- WFU: John Butterworth – Indiana → VCU
- WFU: Rich Prielipp – Minnesota
- WFU: David Zvara – Ohio State →UNC Chapel Hill
- WFU: Joe Tobin – WFU

INSTRUCTIONS

IRB-Approved Questionnaire

- Please provide the demographic information.
- If you are a chair, for each question select all answers that apply to you.
- If you are a program director, for each question select all answers you think your chair will select (no collusion please!).

Question 1

How does being chair of anesthesiology fit into your career and life plan?

Question 2

What is your view of the importance of identifying and mentoring a prospective chair?

Question 3

Before coming to this SAAA meeting, what did you do with regard to your departmental leadership?

Question 4

Before going on two week vacation, what do you do with regard to your departmental leadership?

Question 5

What would happen in your department if during this SAAA meeting you were in a serious accident or suffered a stroke or myocardial infarction?

Question 1: How does being chair fit into your career and life plan?

- Becoming chair should be part of a broader plan for your life [Kaplan, Lexa]
- "…You should start your tenure [as chair] by planning and working with the end in mind."
  - Lexa FJ. Succession leadership. *J Am Coll Radiol* 2011; 8:281-2
- Your next position could be a "second term" as chair with a revitalized strategic plan

Question 2: What is your view of the importance of identifying and mentoring a prospective chair?

- "Asking one person to shoulder all of the leadership tasks is a poor way to run an organization."
  - Lexa FJ. Succession leadership. *J Am Coll Radiol* 2011; 8:281-2
- "If you aren't identifying potential successors, you are probably not delegating as extensively as you should."
  - Kaplan RS. What to ask the person in the mirror. *Harv Bus Rev* 2007 Jan; 85: 86-95
- Mentoring = Delegating
  - ↑ or maintain enthusiasm, ↑focus, ↑faculty retention, ↑legacy, ↑personal development time, ↑family time
  - ↓ stress, ↓burn-out

Question 3: Before coming to this SAAA meeting, what did you do with regard to your departmental leadership?

- You may be criticized for being away from your department.
- Turn (-) into (+). Opportunity to:
  - Identify faculty members with leadership potential
  - Demonstrate that you have confidence in individuals to whom you have delegated responsibility

Question 4: Before going on two week vacation, what do you do with regard to your departmental leadership?

- Better mentoring opportunity than short time away from department to:
  - Meet with key individuals and discuss current issues, review strategic plan, review delegated responsibilities
  - Demonstrate trust and confidence
  - Nurture feeling that you are "first among equals"
  - Enjoy a well-deserved break from the action

Question 5: What would happen in your department if during this SAAA meeting you were in a serious accident or suffered a CVA or MI?

- You do not want your department to be an MVA, CVA, or MI away from a crisis!
- Help the dean help your department by identifying prospective chairs
- Consider developing a formal succession plan as part of the department's strategic plan

Six Specific Suggestions

1. Create personal career and retirement plan now
2. Delegate more, replace if uncoachable
3. Based on #2, identify prospective chair(s), let dean know who he/she/they are.
4. Use trips away to identify leaders to others and serve as mentoring opportunities
5. Develop a formal succession plan
6. Consider a professional executive coach for 1-5
   - Six annotated references: reading time < 1 hr
   - If compelled to read more, try Frank Herbert's *Dune*

Notes:

And So I Face the Final Curtain – Choosing and Mentoring a Prospective Program Director

Robert Gaiser, M.D., M.S.Ed.
Professor of Anesthesiology and Critical Care
Hospital of the University of Pennsylvania
Program Director

I have no financial disclosure

Learning Objectives

- Review the role of the program director
- Identify reasons why there may be a change in program director
- Develop a plan to mentor the new program director
- Design a means for the smooth transition

Who is the Program Director?

- The one physician designated with authority and accountability for the operation of the residency or fellow-ship program

ACGME Glossary of Terms, June 28, 2011

Who is the Program Director?

- ACGME Program Requirements for GME in Anesthesiology
  - "PD must" – 142 times
  - "not" – 44 times
  - "should" – 40 times
  - "required" – 42 times
  - "ensure" -17 times
  - "document" – 18 times
  - " submit" – 9 times
  - "approve" – 13 times
  - "substantial" – 3 times

Sanford TJ. J Clin Anesth 2010;22:581

Program Director Requirements

- Requisite specialty expertise and documented educational/administrative experience acceptable to RRC
- Current certification
- Current medical licensure
- Significant academic achievements in anesthesiology, such as publications, development of educational programs, or conduct of research

ACGME Program Requirements for GME in Anesthesiology

Who is the Program Director?

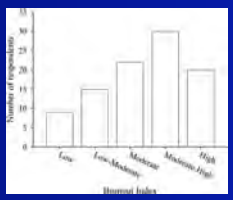
- Most likely male gender
- Most likely older (median 52 years)
- Median appointment duration (3.7 years)

Specialty	Programs	Residents	Female Res (%)	Female PD (%)
Anesth	132	5322	37.5	29
EM	153	4922	40.3	19
Surg	246	7661	35	11
Int Med	379	22,292	44.8	24

Long TR. J Women's Health 2011;20:1867
Long TR. J Clin Anesth 2010;22:583

PD is also likely to be burned out

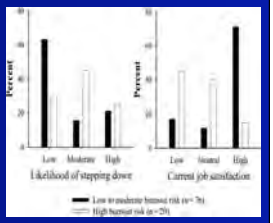
- Burnout is a work-related psychological syndrome
- Survey sent to 132 PD
- Response rate – 76%
  - 20 PD – high burnout
  - 30 PD – moderate high



De Oliveira GS Jr. J Clin Anesth 2011;23:176

Burnout Leads to Departure

- 43% reported dissatisfaction between balance between personal and professional life
- 29 of 55 who had been PD for > 5 yrs had decreased job satisfaction
- 22% had likelihood of stepping down



De Oliveira GS Jr. J Clin Anesth 2011;23:176

Yet, We are still better than Internal Medicine

- Survey to 391 IM PD
- 70% response rate
- Independent Predictors of Satisfaction
  - Annual take-home pay
  - No of FTE administrative support
  - # of months on consulting service

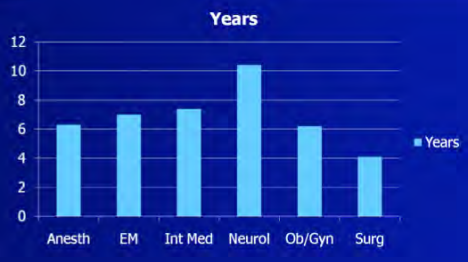
Hinchley KT. Am J Med 2009;122:197

Be Prepared for Change

- The PD should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability
- Anesthesiology in 2011-12
  - 11.4% programs with New Directors
  - 11.4% with distinct changes
  - Lower than EM, Int Med, Fam Med, Surg
  - Higher than Peds

ACGME Data Resource Book, 2011-2012

Mean Length in Years of Past PD



ACGME Data Resource Book, 2011-2012

New PD – How Much Time

Specialty	Avg Hrs/Wk	Hrs Admin	Hrs Clin	Hrs Research	Hrs Teaching
Anesth	53.8	19.9	25.4	3.3	5.2
EM	46.1	18.7	16.7	3.8	5.3
Fam Med	39.9	20.8	13	1.7	4.4
Int Med	45.8	22.6	11.9	2.9	8.3
Neurol	43.4	15.4	16.9	5.6	5.5
Ob/Gyn	45.1	20	17.4	2.6	5.1
Surg	59.7	20	27.9	4.4	7.4

ACGME Data Resource Book, 2011-2012

End of PD – End of Life

- Universal
- Influenced by availability of medical treatment
- End if highly individual and is influenced by unique combination of several factors
- Advance Care Planning
- Continuity of Care

Waldrop DP. Treatment at the End of Life 2008

Things I Would Recommend

- Recommend that the New PD be an Associate or Full Professor
  - Pre-PD
    - Peer Reviewed Publications – 22
    - Chapters - 29
  - Post-PD
    - Peer Reviewed Publications – 10
    - Chapters – 16

Things I Would Recommend

- My Biggest Fear

I Don't Want to Jump the Shark

Remind Yourself of the Benefits

- Watching a resident become a master clinician
- Receiving an appreciative note from a patient describing the resident's role in their care
- Learning that a resident had a manuscript accepted
- Hearing that a resident will become a new mother or father
- Learning about a resident's first job
- Receiving good news in the match
- Witnessing high quality care
- Allowing a resident to learn from a mistake

A New Program Director is Inevitable

- Be prepared
- Choose your successor
- Mentor and include them
- Provide the guidelines
- Be realistic
- Be supportive
- Allow enough time for smooth transition

A Successful Transition

- And now the end is near
- And so I face the final curtain
- My friend, I'll say it clear
- I'll state my case, of which I'm certain
- I've lived a life that's full
- I travelled each and every highway
- And more, much more than this, I did it my way
- Yes, there were times, I'm sure you knew
- When I bit off more than I could chew
- But through it all when there was doubt
- I ate it up and spit it out
- I faced it all and I stood tall and did it my way
- The record shows I took the blows AND

DID IT MY WAY!!!

Trends in Compliance Enforcement and Academia: Lessons Learned from Recent OIG, RAC, and CMS Contractor Audits

Stanley W. Stead, M.D., M.B.A.

Notes:

TRENDS IN COMPLIANCE ENFORCEMENT AND ACADEMIA:

LESSONS LEARNED FROM RECENT OIG, RAC AND CMS CONTRACTOR AUDITS

Stanley W. Stead, M.D., M.B.A.
President, Stead Health Group, Inc.
Section Chair, ASA Section on Professional Practice
AMA Relative Value Update Committee
AMA CPT Assistant Editorial Panel
Professor of Anesthesiology and Pain Medicine, UC Davis

1

DISCLOSURES

- I serve as a health care economic consultant to a variety of entities including: physician practices, hospitals, health systems, universities, states and the US government.
- I am a major stockholder in my company, Stead Health Group, Inc.
- This presentation does not contain information or services for which I could derive a financial benefit.

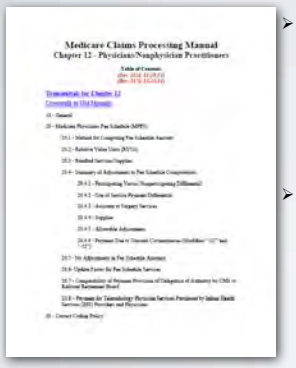
2

OVERVIEW

- Review the Medicare regulations regarding anesthesia and pain medicine
- Understand the how the HHS OIG is reviewing your claims and using the false claims act
- Strategies for meeting both clinical and documentation needs
- Legal protections afforded state institutions from the False Claims Act
- Establishing a defensive strategy to minimize exposure

3

MEDICARE PAYMENTS FOR ANESTHESIA SERVICES


Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

- Statutory
  - Omnibus Budget Reconciliation Act (OBRA) of 1989 (Pub. L. 101-239). . Section 1848(b)(2)(B) of OBRA established Anesthesia Base + Time Methodology
  - OBRA 1990, (Pub. L. 101-508)
- Regulatory
  - Medicare - Medicare Carrier Manual, Chapter 12
    - Sections 50 (Payment), 100 (Teaching), 140 (CRNA Payment)
  - Medicaid - guided by state

4

WHY RISKS ARE SO GREAT

- Fed gov't has increased enforcement
  - And funding for enforcement
- Powerful incentive for whistleblowers
  - 15-30% of proceeds (or settlement)
  - Median relator share: $123,885
- Can simply call Medicare or OIG
- Computer screens & post-payment audits

Recovery Audit Contractor (RAC)

Program Safeguard Contractor (PSC)

Medicare Integrety Contractor (MIC)

Zone Program Integrity Contractor (ZPIC)

Private Payor Audits

5

THERE'S MONEY IN ENFORCEMENT!

- OIG recovers $17 for each $1 invested in enforcement activities
- False Claims Recoveries:
  - $3 billion/yr (FY 2011) ($8.7B since 2009)
  - Whistleblowers accounted for $2.8B
- "[H]ealth care accounted for the lion's share . . . $2.4 billion (80%)

http://oig.hhs.gov/reports-and-publications/oas/cms.asp

6

CMS FFS RAC RESULTS

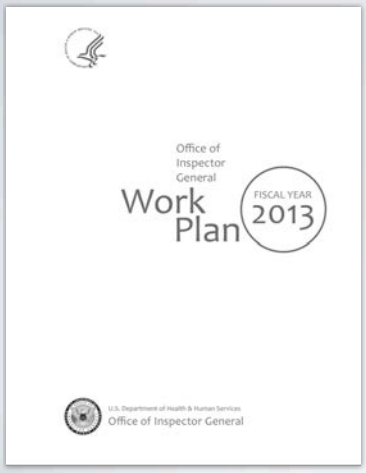
CMS

Medicare Fee-for-Service Recovery Audit Program
May 2012

	Recovery Audit National Program				
	FY 2010 Oct 2009-Sept 2010	FY 2011 Oct 2010 - Sept	FY 2012 1st Qtr Oct 2011 - Dec 2011	FY 2012 2nd Qtr Jan 2012 - Mar 2012	Total National Program
Overpayments Collected	$75.4M	$797.4M	$397.8M	$588.4M	$1.86B
Underpayments Returned	$16.9M	$141.9M	$24.9M	$61.5M	$245.2M
Total Corrections	$92.3M	$939.3M	$422.7M	$649.9M	$2.1B

7

OIG WORK PLAN - 2013



- Imaging Services - Payments for Practice Expense
- Noncompliance with Assignment Rules and Excessive Billing
- Error Rate of Incident-To Services
- Use of Modifiers for Global Surgery Period
- **Anesthesia Services**

https://oig.hhs.gov

8

OIG WORK PLAN - 2013

Anesthesia Services —Payments for Personally Performed Services (New)

We will review Medicare Part B claims for personally performed anesthesia services to determine whether they were supported in accordance with Medicare requirements. We will also determine whether Medicare payments for anesthesiologist services reported on a claim with the "AA" service code modifier met Medicare requirements. Physicians report the appropriate anesthesia modifier to denote whether the service was personally performed or medically directed. (CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, ch.12, § 50) The service code "AA" modifier is used for anesthesia services personally performed by an anesthesiologist, and the "QK" modifier is used for medical direction of two, three, or four concurrent anesthesia procedures by an anesthesiologist. The QK modifier limits payment at 50 percent of the Medicare-allowed amount for personally performed services claimed with the AA modifier. Payments to any service provider are precluded unless the provider has furnished the information necessary to determine the amounts due. (Social Security Act, §1833(e).)
(OAS; W-00-13-35706; various reviews; expected issue date: FY 2013; new start)

HHS OIG Work Plan | FY 2013 pg. 21

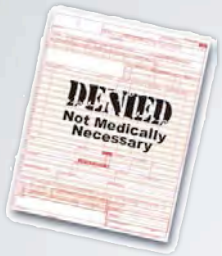
9

DANGER ZONE

CODING	DOCUMENTATION	MUE
• Creative Coding • Unbundling • Upcoding • Billing for services not rendered • Improper modifiers	• Local Coverage Determinations (LCDs) • National Coverage Determinations (NCDs) • Insurer Policies and Procedures • Inadequate documentation of services rendered • ICD-9 (ICD-10) diagnosis codes • E&M Documentation • Procedural Documentation • Imaging	• CCI Edits • Multiple procedures • Combinations of procedures • Services provided on the same day

10

MEDICAL NECESSITY



- The Medicare Act contains a definition of medical necessity which is an express condition of payment, and explicitly links each Medicare payment to the requirement that the particular item or service be reasonable and necessary.
- Submission of every claim form to Medicare means that all health care providers implicitly certify compliance with the Medicare Act's medical necessity definition, and that they are only seeking payment for services that are reasonable and necessary.

11

FALSE CLAIMS ACT

- The False Claims Act (FCA) (31 U.S.C. §§3729-3733) is a federal statute that imposes penalties on entities that improperly bill the government. In the health care arena, this means knowingly submitting false claims to the Medicare or Medicaid programs for reimbursement.
- Examples of false claims include:
  - Upcoding
  - Misrepresenting the services that were rendered
  - Submitting claims for services that were not performed
  - Unbundling
  - Submitting claims for unreasonable costs.

12

FALSE CLAIMS ACT

- In order to encourage individuals with the knowledge of wrongdoing to come forward, the FCA allows those individuals, called "relators," to file a civil suit, a qui tam action, against the wrongdoer in the name of the government. See 31 U.S.C. §3730(b). In return for reporting the wrongdoing and for being a party to the suit, the relator receives between 15% and 30% of the award. 31 U.S.C. §3730(d)(1)&(2).
- Unfortunately, this monetary incentive, which often equals millions of dollars, could give rise to abuse and may result in claims that are aptly termed "parasitic."

13

FALSE CLAIM ACT (FCA) MAY NOT BE APPLICABLE TO STATE INSTITUTIONS

- State agencies are not "persons" subject to FCA liability
- The University is a state agency and thus not a "person," and therefore may not be sued under the FCA
- The "University Associates" are typically business units of the states
- The "defendants" are therefore not "persons" and may not be sued under the FCA
- The University may vigorously contest the applicability of the FCA and potential FCA liability in this case

14

REVIEW OF THE GOVERNMENT AUDIT PROTOCOLS

- Audit period: Typically selected over a period of years
- Dates of service selected via multiple criteria
  - Judgmentally selected by OAS
  - Selected based on relator documents by DOJ
- Dates of service actually audited may be arbitrary
- Request for all relevant records - open ended

15

BILLING COMPLIANCE: AVOIDING "FRAUD & ABUSE"

Billing Requirements and Billing Compliance

"I will not encounter billing compliance problems so long as you provide good patient care and are not out to cheat the system."

WRONG!

You do not need to intend to cheat the system to incur substantial financial liability for bills you (or others) submit for your services, especially if the patient was a Medicare, Medicaid or other federal program beneficiary.

16

SANCTIONS

- False Claims: triple damages + $11,000 per claim
- Improper submitted claim for $790: $13,370 ($11,000+3*$790)
- 100 claims ($13,370*100) = $1,370,000 each year.

The government does not have to establish specific intent to defraud and it is no defense that the Group provided other reimbursable services or that it did not have actual knowledge that the claims were false.

17

CRIMINAL FALSE CLAIMS LAWS

- Prohibit knowingly & willfully making false statement in claim to gov't, or
- Submitting false & fictitious claims
  - Knowledge of falsity not required
  - "Willful blindness"/deliberate ignorance sufficient for liability

18

CALCULATING TIME

- Continuous, actual presence
- Starts: when begin to prepare patient for anesthesia
  - Pre-op exam time is not anesthesia time
  - When does time start when doing other, separately paid services ?
    - Post-op pain epidural
- Ends: when patient may be safely transferred for post-op care

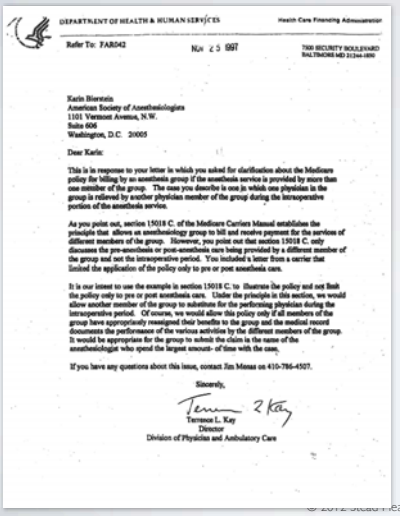
19

ANESTHESIOLOGY RISK FACTORS

- Personally Performed
- Teaching Anesthesiologists
- Medical Direction
- Time
- Group Billing Practices
- PreOp Evaluation
- PostOp Documentation
- Handoffs and Breaks
- Pain Management
- Imaging
- E&M Documentation

20

BILLING GROUP PRACTICES



DEPARTMENT OF HEALTH & HUMAN SERVICES — Health Care Financing Administration

Refer To: FAR042 — NOV 25 1997 — 7500 SECURITY BOULEVARD BALTIMORE MD 21244-1850

Karin Bierstein
American Society of Anesthesiologists
1101 Vermont Avenue, N.W.
Suite 606
Washington, D.C. 20005

Dear Karin:

This is in response to your letter in which you asked for clarification about the Medicare policy for billing by an anesthesia group if the anesthesia service is provided by more than one member of the group. The case you describe is one in which one physician in the group is relieved by another physician member of the group during the intraoperative portion of the anesthesia service.

As you point out, section 15018 C. of the Medicare Carriers Manual establishes the principle that allows an anesthesiology group to bill and receive payment for the services of different members of the group. However, you point out that section 15018 C. only discusses the pre-anesthesia or post-anesthesia care being provided by a different member of the group and not the intraoperative period. You included a letter from a carrier that limited the application of the policy only to pre or post anesthesia care.

It is our intent to use the example in section 15018 C. to illustrate the policy and not limit the policy only to pre or post anesthesia care. Under the principle in this section, we would allow another member of the group to substitute for the performing physician during the intraoperative period. Of course, we would allow this policy only if all members of the group have appropriately reassigned their benefits to the group and the medical record documents the performance of the various activities by the different members of the group. It would be appropriate for the group to submit the claim in the name of the anesthesiologist who spend the largest amount- of time with the case.

If you have any questions about this issue, contact Jim Menas on 410-786-4507.

Sincerely,

Terrence L. Kay
Director
Division of Physician and Ambulatory Care

- "It is our intent to use the example in section 15018C to illustrate the policy' and not to limit the policy only to pre or post anesthesia care. Under the principle. in this section, we would allow another member of the group to substitute for the performing physician during the intraoperative period. Of course, we would allow this policy only if all members of the group have appropriately reassigned their benefits to the group and the medical record documents the performance of the various activities by the different members of the group. It would be appropriate for the group to submit the claim in the name of the anesthesiologist who spend the largest amount of time with the case."

Letter from Terry Kay, Nov 25, 1997

21

MEDICAL DIRECTION AND TEACHING

- When Medical Direction is performed by more than one physician, each Teaching Physician must personally document his or her presence during specific services and the specific services he or she performed. Additionally, both must personally document their immediate availability during the portion of the case during which they provided medical direction. The documentation must clearly show when the transfer occurred and that all the elements of medical direction were met and by which anesthesiologist.
- When more than one anesthesiologist is involved in a medically directed case, the charge is submitted under the name of the anesthesiologist who spent the most time on the case. When cases are billed under the Anesthesia Teaching Physician rules, they are billed under the name of the anesthesiologist who started the case.

MCM, Ch 12, Section 100

22

MEDICAL DIRECTION (CONT.)

- Physician must participate only in the most demanding procedures of the anesthesia plan, including, if applicable, induction and emergence.
- Physician must document in the medical record that he or she performed:
  - the pre-anesthetic examination and evaluation
  - provided indicated post-anesthesia care
  - were present during some portion of the anesthesia monitoring
  - were present during the most demanding procedures, including induction and emergence, where indicated.

MCM, Ch 12, Section 50C

23

MEDICAL DIRECTION (CONT.)

- Physician can medically direct two, three, or four concurrent procedures involving qualified individuals, all of whom could be CRNAs, AAs, interns, residents or combinations of these individuals.
- For services furnished on or after January 1, 2010, the medical direction rules do not apply to a single resident case that is concurrent to another anesthesia case paid under the medical direction rules or to two concurrent anesthesia cases involving residents.

MCM, Ch 12, Section 50C

24

MEDICAL DIRECTION (CONT.)

- If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service.
- However, the medical record must indicate that the services were furnished by physicians and identify the physicians who furnished them.

MCM, Ch 12, Section 50C

25

MEDICAL DIRECTION (CONT).

- However, if the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature. Carriers may not make payment under the fee schedule.

MCM, Ch 12, Section 50C

26

MEDICAL SUPERVISION

- The Part B Contractor may allow only three base units per procedure when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedures. An additional time unit may be recognized if the physician can document he or she was present at induction

MCM, Ch 12, Section 50C

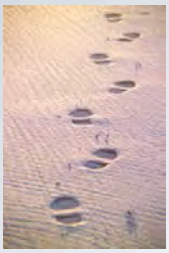
27

FAILED MEDICAL DIRECTION

- Failed Medical Direction occurs when any portion of the Medicare rules of Medical Direction is not provided or documented or when a non-allowed activity is performed during medical direction.
  - If a Certified Registered Nurse Anesthetist (CRNA) is involved in a failed medical direction case, STATE LAW MAY permit billing under a CRNA's name with the –QZ modifier and payment at 100% allowable
  - No anesthesiologists fees should be billed for failed medical direction cases

28

7 STEPS AND 6 EXCEPTIONS



1. Perform preanesthetic exam
2. Prescribe anesthetic plan
3. Personally participate in most demanding parts of the procedure
4. Ensure performance by qualified anesthetist
5. Monitor at frequent intervals
6. Remain physically present/available for immediate diagnosis
7. Provide indicated post-anesthetic care

6 Exceptions

1. Addressing an emergency of short duration in the immediate area
2. Administering a labor epidural
3. Periodic (not continuous) monitoring of an obstetric patient
4. Receiving patients entering the operating suite for the next surgery
5. Checking or discharging patients in the recovery room
6. Handling scheduling matters.

Medicare Claims Processing Manual, Chapter 12 Physicians/Non-physician Practitioners, p120-122.

29

"ROUTINE" EXCEPTIONS?

- Even if carrier says you can do other things, you still must meet medical direction requirements:
  - Participate in most demanding portions
  - Monitor at frequent intervals
  - Must remain immediately available
- Can't routinely rely on exceptions
  - "We do not expect that a physician who is directing the administration of anesthesia to four surgical patients would be involved routinely in furnishing any additional services to other patients. . . .
  - Carriers will review hospital records to ensure that such circumstances do not occur frequently [and] are of short duration . . . ."

30

MEDICAL DIRECTION RISKS

- Why is medical direction a risk area?
  - Rules are detailed
  - Not always intuitive
    - Particularly w/advances in technology
  - Must document all 7 steps
    - Lack of documentation can lead to inability to explain what services actually were provided
  - Biggest area of risk:
    - Not meeting all seven steps of medical direction

31

MEDICAL DIRECTION AMBIGUITIES

- What is "short" duration?
  - Need for common definition
- "Receiving" patients for next surgery
  - Doesn't permit preanesthetic exam (unless CRNA w/you)
- How far away can you be and still be immediately available?
  - Again, need common definition

32

MEDICAL DIRECTION: OTHER SERVICES

- Example of services that cannot be personally performed while medically directing:
  - Pain blocks
  - Easy target for OIG investigators & RACs: Are medically directing physicians doing pain blocks? Are they doing TEE's?

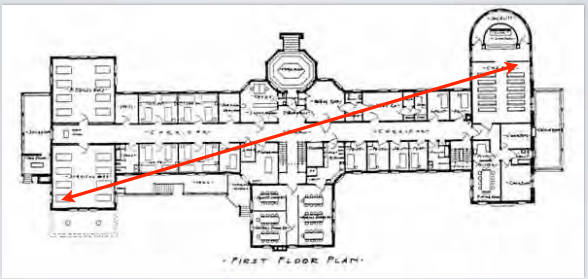
33

IMMEDIATELY AVAILABLE

- Concept of "immediately available may seem obvious, but specifics are undefined
- "Physically present and available for immediate diagnosis and treatment of emergencies" 42 C.F.R. 415.110
- No specifics about proximity
- "The CMS is not defining availability in terms of geographic location vis-à-vis the operating room" Claims Processing Manual, Ch. 12, Section 100.1.2(A)(Surgery)
- 2011 OPPS Final Rule- "physically present…but without reference to any physical boundary."

34

IMMEDIATELY AVAILABLE



- Anesthetizing locations
  - Main OR suite, Labor & delivery
  - Other areas -- e.g., MRI, EP, ambulatory surgery
- Must remain physically present & immediately available
  - Even for permitted exceptions

35

IMMEDIATELY AVAILABLE AMBIGUITIES

- Additional areas to be defined:
  - When does emergence occur?
    - A process, not a single point
  - How frequently must you monitor cases for "frequent" monitoring?
    - Single time frame won't apply to all cases
  - How what locations are considered physically present: time and distance

36

BREAKS FOR COLLEAGUES

- Medically directing physician cannot provide a "break" for a CRNA
  - Would be personal performance
  - Can't medically direct & personally perform at the same time
- Have same category of provider relieve
- CRNA can't substitute for physician
  - Personally performed case: requires physician's presence throughout case
  - Medically directed case: only a physician can medically direct

37

INTRAOPERATIVE HANDOFF

- Medicare -- Medically Directed procedure
  - Anesthesiologists within a group practice may substitute for each other
  - Medical record must identify who provided which services
  - Bill in name of physician with most time on case Billing risk: failure to document
  - Change in medically directing physician AND
  - The time of the handoff
  - Or change in CRNA

38

HANDOFF DOCUMENTATION

- Consider developing a standard template for handoffs
  - AHRQ - MATCH (Managing at Transitions and Clinical Handoffs)
  - ACS - Standards for Surgical Handoffs

39

DOCUMENTING TIME

- Document time of preop block (or line placement)
  - Document: start & stop of preop block time
    - Separate from anesthesia time
    - Important, if audited
    - If not documented, OAS assumes fraud
  - No need to deduct time if lines placed intraoperatively

40

QUALIFIED PROVIDERS & TIME

- Time stops if "qualified individual" not w/patient
- "Qualified individual" who can be medically directed:
  - AAs & CRNAs (& SRNAs)
  - Residents, interns
- Not a "Qualified individual"
  - Holding area/circulating nurse
  - Medical student

41

DISCONTINUOUS TIME

- Can aggregate discontinuous segments of anesthesia time
  - E.g., delays in starting surgery; regional cases
- Anesthesia time & monitoring w/in each block of time must be continuous
- Must document start & end times of any separate segments of anesthesia time
- Consider impact of discontinuous time on
  - Concurrencies – number of cases being "medically directed"
  - CRNA
    - Does CRNA appear as working on more than one case at the same time?

42

FREQUENCY DISTRIBUTION OF MINUTES

Evidence of Rounding to 5 minute interval on End Time

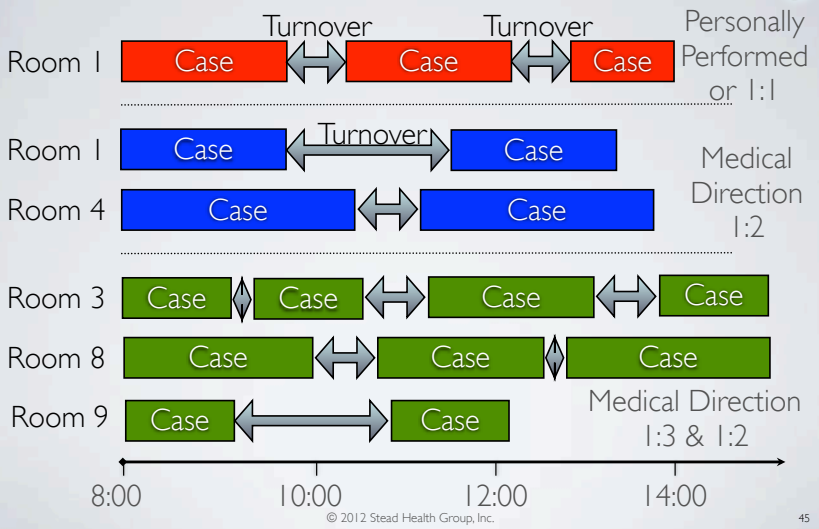
43

DEFINITION OF CONCURRENCY

- Concurrency is defined with regard to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap each other.
- Concurrency is not dependent on each of the cases involving a Medicare patient. For example, if an anesthesiologist directs three concurrent procedures, two of which involve non-Medicare patients and the remaining a Medicare patient, this represents three concurrent cases

44

CONCURRENCY EXAMPLES



45

CALCULATING CONCURRENCIES

- Time measured in minutes
  - Overlap of one minute = concurrency
  - Personally performed case, resident or CRNA services:
    - No overlapping times
  - Medically directed case: Up to 4 concurrent cases permitted
- In case of intraoperative handoff, must calculate concurrencies for each medically directing anesthesiologist
  - Cannot use concurrencies for only one of the anesthesiologists
    - E.g., the one with the most time on the case

46

DAILY COMPUTERIZED CONCURRENCY REPORT

Concurrency by Attending

```
PAGE  1                                  CONCURRENCY REPORT                                    09/22/12 03:49:52 PM
                                         File X  Batch BATCH0  Doctor/Group:
                                CASE
 DATE    C  ANES.TIME     CRNA (if any)   DR   FL BATCH  FC     ACCOUNT #     PATIENT NAME  HC CPT       DESCRIPTION

     *** Axxxxxxxx,C (UNIQUE DR ID: 401..) ***

10-10-03 2  0720 to 1100  544 Lxx,RES      401  X  BATCH0 07*    1496582       MXXXXX,KXXXX     00902-P1  ANESTH ANORECTA
                          >>> 401 HEM 1511597      0741 to 1102  (File X, Batch BATCH0)     00918-P2
10-10-03 2  0741 to 1102  534 Hxx,RES      401  X  BATCH0 07*    1511597       HXXXXXX,PXXXX    00918-P2  ANESTH STONE RE
                          >>> 401 MEL 1496582      0720 to 1100  (File X, Batch BATCH0)     00902-P1
10-10-03 1  1248 to 1455  544 Lxx,RES      401  X  BATCH0 07*    1515525       Axxxxxxxxx,Mx    00790-P2  ANESTH SURG UPP

01-09-04 2  0702 to 0920  543 Kxxxxxx,RES  401  X  BATCH0 07*    1519832       Hxxxxxxxx,Exxx   00740-QXP3ANESTH UPPER GI
                          >>> 401 ALV 1805502      0725 to 1312  (File X, Batch BATCH0)     00160-P2
01-09-04 2  0725 to 1312  976 Txxxx,CRNA   401  X  BATCH0 07*    1805502       Axxxx,MXXXXXX    00160-P2  ANESTH NOSE/SIN
                          >>> 401 HAT 1519832      0702 to 0920  (File X, Batch BATCH0)     00740-QXP3
                          >>> 401 MIR 1656111      0935 to 1145  (File X, Batch BATCH0)     00914-P2
01-09-04 2  0935 to 1145  543 Kxxxxxx,RES  401  X  BATCH0 07*    1656111       MXXXXXX,MXXXX    00914-P2  ANESTH REMOVAL
                          >>> 401 ALV 1805502      0725 to 1312  (File X, Batch BATCH0)     00160-P2
01-09-04 2  1320 to 1650  976 Txxxx,CRNA   401  X  BATCH0 07*    1805564       BXXXX,EXXXX      00160-P3  ANESTH NOSE/SIN
                          >>> 401 MAY 1313650      1425 to 1525  (File X, Batch BATCH0)     00910-P3
01-09-04 2  1425 to 1525  543 Kxxxxxx,RES  401  X  BATCH0 07*    1313650       MXXXXXXX,NXXX    00910-P3  ANESTH BLADDER
                          >>> 401 BUS 1805564      1320 to 1650  (File X, Batch BATCH0)     00160-P3
```


47

CONCURRENCY MAPS FOR EACH DAY

48

STRATEGIES: MULTIPLE RESPONSIBILITIES

- Don't personally perform if medically directing
  - Hand off cases to a colleague
- Watch if Case 2 starts during Case 1
  - CRNAs can't be in 2 cases at once
- Don't shave time for back-to-back cases
  - Appearance of manufactured, not actual, time
  - Inconsistency with hospital times?

49

PERSONAL PERFORMANCE

- If personally performing, anesthesiologist is fully occupied
  - Cannot have responsibility for other cases
    - E.g., labor epidural
  - Cannot leave room
    - E.g., present during bypass
- If personally performing: Can't bill for more than one patient at a time
  - Cannot be in "continuous actual presence" for more than one patient at a time

50

MEDICAL NECESSITY

- Medicare (& other payors) only pay for services that are medically necessary
  - Problem areas:
    - MAC
    - Anesthesia for GI procedures
    - Anesthesia for EP procedures
    - Anesthesia for pain procedures
    - Multiple post-op pain procedures

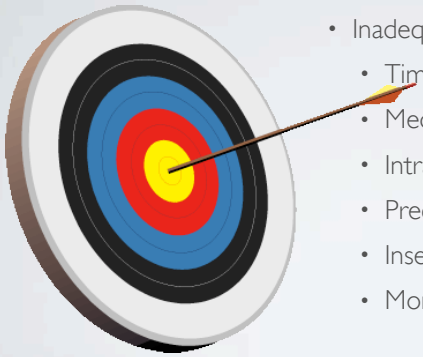
51

DOCUMENTATION

- Documentation must legible
  - Auditors will not ask for explanation
  - Auditors will not decipher illegible documentation
- Illegible documentation is as problematic as no documentation Clear, legible evidence of the services provided
  - Important for billing
  - Important for protection against professional liability
- Narrative always better than
  - Check boxes
  - Initials

52

COMMON DOCUMENTATION ERRORS



- Inadequate documentation of:
  - Time
  - Medical direction
  - Intraoperative handoffs
  - Precise procedure performed
  - Insertion of invasive monitoring lines
  - Monitoring of labor epidurals

53

DOCUMENTING LABOR EPIDURALS

- Documentation:
  - What services provided?
  - Who provided them?
  - Times of monitoring?
- Who
  - Performed the preop?
  - Inserted the epidural?
  - Monitored?
  - Removed catheter?
- When did monitoring occur? For how long?

54

POST-OP PAIN DOCUMENTATION

- Surgeon's request
  - Preferably, have surgeon document
- Epidural/block primarily for post-op pain
  - Anesthesia for surgical procedure not dependent upon efficacy of regional technique
- Time for pain service not included in anesthesia time

55

OAS/OIG CLAIMS ANALYSIS

Analysis of Medicare Claims and Error Rates/Dollars

Error Type	Description	Monetary Adjustment
1	"AA" modifier used instead of "QK" modifier.	50% allowed
2	Overlapping surgeries in different buildings.	Unallowable
3	Overlapping surgeries in same building, different floor.	Unallowable
4	Overlapping surgeries in same operating suite.	Unallowable
5	Miscellaneous: No post-op record, missing initials, etc.	Unallowable

- Spanned 6-10 Years
- Based upon a sample of 20 days within those 10 years
- < 400 Medicare and Medicaid services
- Inexperienced OAS team (no anesthesia experience)
- Non-random sample (relator driven)

56

OAS/OIG SAMPLING METHODS

- No Statistical Sampling
- Judgmental Sampling - sample based on who they think would be appropriate to study. Introduces self-selection bias, making it unlikely that the sample will accurately represent the broader population.
- Validity of the estimates of the parameters is unknown.

57

CRITICAL DATA

- Patient Identification
  - MRN, Name
- Case
  - Procedure, Anesthesia Start and Stop Times
  - Providers: attending, resident, nurse anesthetist
  - Type of Anesthesia, Room number
  - Factors effecting Medical Direction/Supervision
- Claim
  - CPT, Providers, Time, Modifiers, Units billed

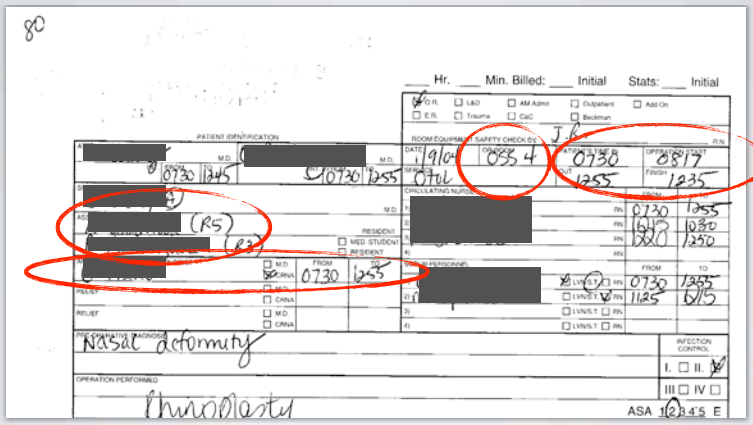
58

SOURCE DOCUMENTS

- OR LOG
- CMS 1500 Form(s) or alternately Account Detail Data
- Remittance Information
- Operating Room Record
- Anesthesia Pre-Anesthetic Assessment
- Anesthesia Record
  - Post Anesthesia Care Unit
  - PACU Admission Orders
  - Operative Report
  - Interdisciplinary Notes

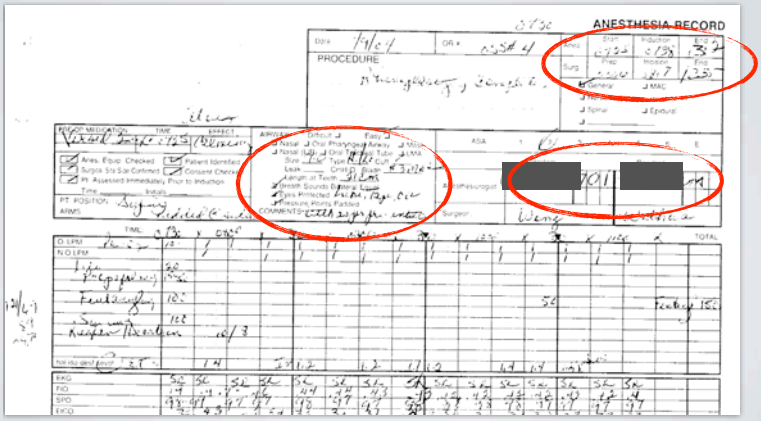
59

OR RECORD



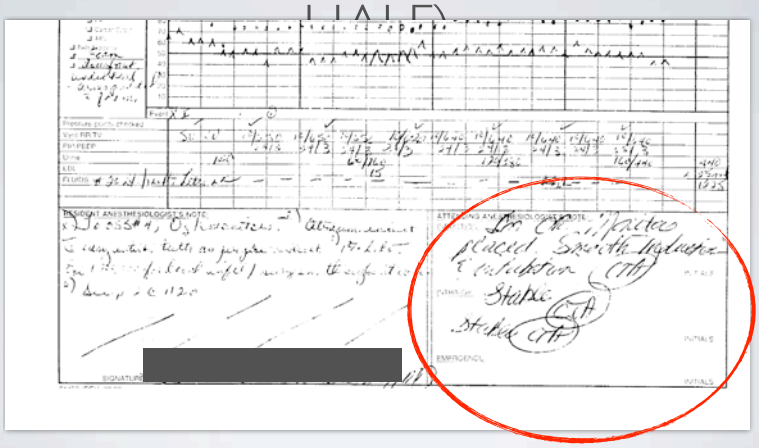
60

ANESTHESIA RECORD (UPPER HALF)



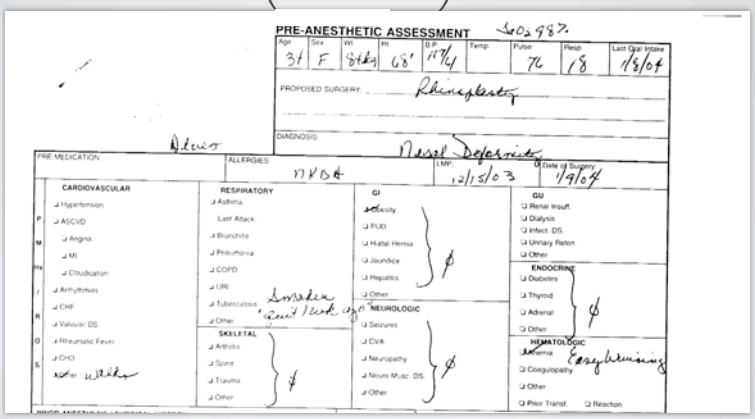
61

ANESTHESIA RECORD (LOWER HALF)



62

ANESTHESIA PRE/POST OP (UPPER)



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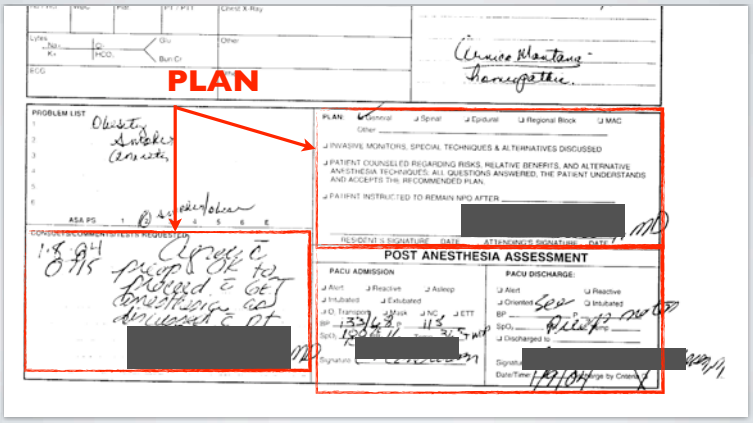
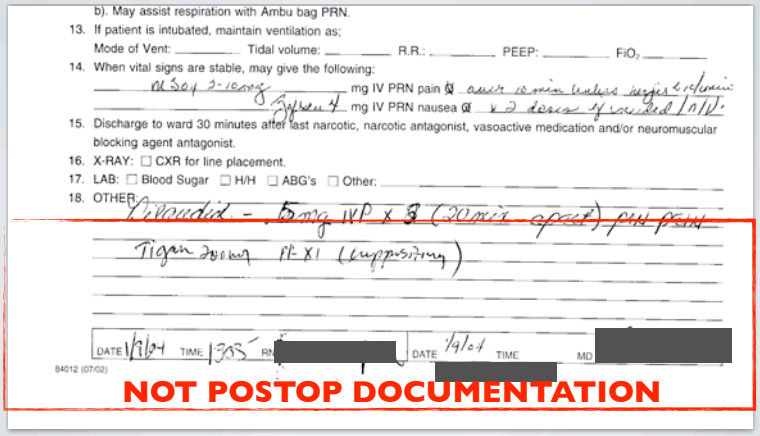
ANESTHESIA PRE/POST OP (LOWER)



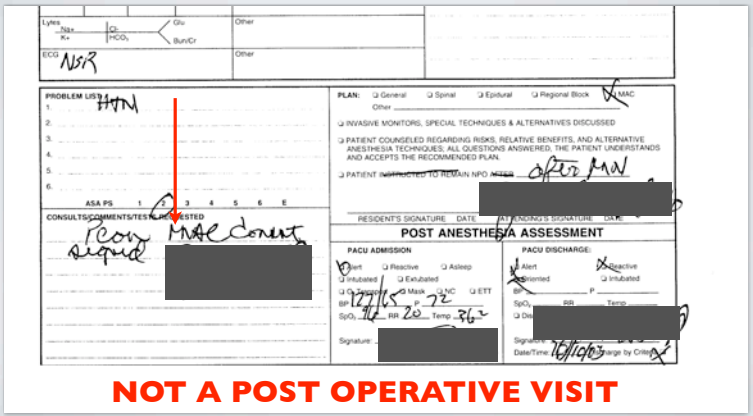
64

POST OP NOTES – PACU ORDERS



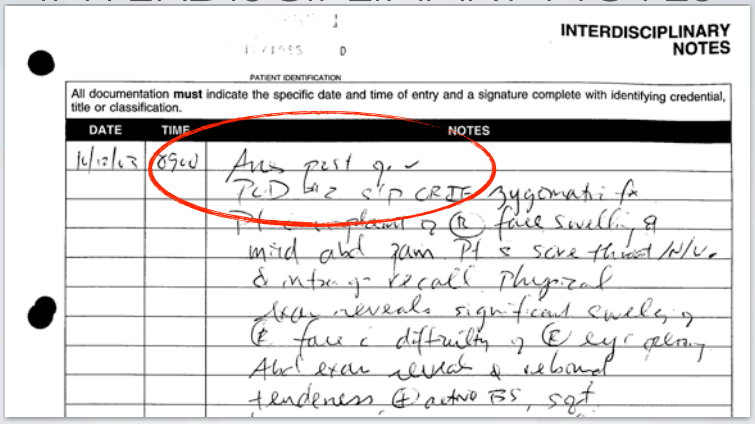
65

CASE 1735668 – PACU NOTE, COMPLETED BY BXXX



66

POST OP NOTES - INTERDISCIPLINARY NOTES



INTERDISCIPLINARY NOTES

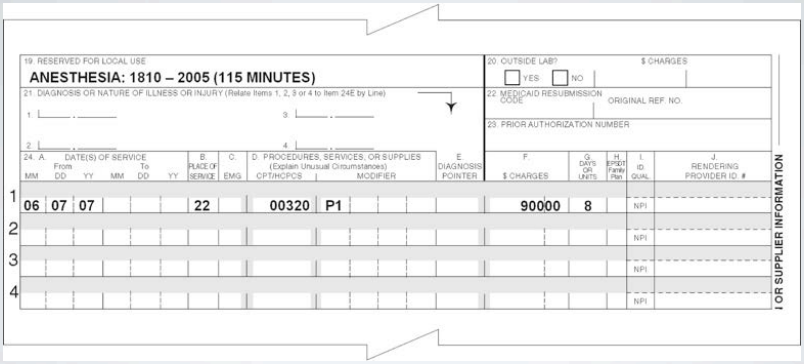
PATIENT IDENTIFICATION

All documentation **must** indicate the specific date and time of entry and a signature complete with identifying credential, title or classification.

DATE	TIME	NOTES
10/12/13	0900	Ans post q. ✓ PCD to s/p ORIF zygomatic fx Pt c/o pain 9 (R) face swelling 9 mid abd pain. Pt c severe thirst N/V, & intx q- recall. Physical exam reveals significant swelling (R) face c difficulty (E) eye opening Abd exam revealed rebound tenderness (+) active BS, sgt.

67

CMS 1500 FORM IS PART OF YOUR DOCUMENTATION



19. RESERVED FOR LOCAL USE

ANESTHESIA: 1810 – 2005 (115 MINUTES)

20. OUTSIDE LAB? ☐ YES ☐ NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 06 07 07		22		00320	P1		90000	8		NPI	
2										NPI	
3										NPI	
4										NPI	

I. OR SUPPLIER INFORMATION

68

REVIEW OF OAS ANESTHESIA AUDIT

- Case information extracted for each case
- Daily list of providers, rooms
- Time Mapping of all cases 3 ways:
  - Case by Anesthesiologist and Room
  - Case by 2nd Provider and Room
  - Case by Room and 2nd Provider
- Verification of room number, times and providers
- Concurrency mapping each case to determine appropriate modifier

69

AUDIT REVIEW CHALLENGES

- Missing components of patient record
- Poorly imaged copies
- Paper-based records with legibility issues
- Contradictory information
- Providers with very similar or same names (eg, RES Yeh, RES Yuh,)
- Same numbering system for rooms across multiple locations (LR 3, L&D 3, OSS3, Rm 3)
- Academic Anesthesia is a GROUP PRACTICE. Anesthesia attending physicians cover for each other.

70

OAS MEDICARE REVIEW 10/10/03

Analysis of Medicare Claims and Error Rates/Dollars

CLAIMS DATA											OIG DETERMINATION							
Date of Service	Physician Name	NPI	Patient Name	CAN	HCPCS	Modifier 1	Modifier 2	Claimed Amount	Allowed Amount	Paid Amount	Error Type	OIG Allowed Amount	Error Questioned Amount 1	2	3	4	5	Notes
10/10/03		WA67118A		19014929	00145	QY		1,261.00	194.58	147.66	4					147.66		OSS 01/OSS 02 overlap
10/10/03		WA67118A		48140403	00142	QK	QS	660.00	74.37	59.50	4					59.50		OSS 01/OSS 03 overlap.
10/10/03		WG40563C		76225323	00810	QK	GC	900.00	86.91	69.53	4					69.53		OR 04/OR 05 overlap
10/10/03		WA67118A		44141470	00142	QY	QS	900.00	65.41	52.33	4					52.33		OSS 01/OSS 02 overlap.
10/10/03		WA75813A		54394106	00790	QK	GC	1,920.00	284.05	227.22	4					227.22		OR 07/OR 08 overlap.
10/10/03		WG74994A		48419296	01844	QK	QS	1,080.00	155.01	124.01	5						124.01	Overlapping surgeries in same room
10/10/03		WA67118A		55900872	00800	QK	QS	720.00	86.91	69.53	4					69.53		OSS 01/OSS 02 overlap.
10/10/03		WA80365A		54266228	00170	QK	GC	720.00	104.83	83.86	2,4			83.86				OSS 04/OR 05 different building overlap. OSS 03/OSS 04 overlap.
10/10/03		WA80365A		55560062	00914	QK	GC	960.00	137.09	109.67	2			109.67				OSS 04/OR 05 different building overlap.
10/10/03		WA67118A		61221295	00400	QK	QS	480.00	67.20	53.76	4					53.76		OSS 01/OSS 02 overlap.
10/10/03		WA41371B		63165758	00914	AA	GC	900.00	265.22	212.18		212.18						
10/10/03		WA67118A		71428291	01610	QK	GC	1,080.00	154.11	123.29	4					123.29		OSS 01/OSS 02/OSS 03 overlap. Nguyen provided relief. OSS 01/OSS 02 overlap.
10/10/03		WG40563C		71466353	00320	QK	GC	1,080.00	156.80	125.44	4					125.44		OR 04/OR 05 overlap.

71

OAS MEDICARE REVIEW 10/10/03

Analysis of Medicare Claims and Error Rates/Dollars

CLAIMS DATA							
Date of Service	Physician Name	NPI	Patient Name	CAN	HCPCS	Modifier 1	Notes
10/10/03		WA6711BA		119014929	00145	QY	OSS 01/OSS 02 overlap.
10/10/03		WA6711BA		148140403	00142	QK	OSS 01/OSS 03 overlap.
10/10/03		WG40563C		176225323	00810	QK	OR 04/OR 05 overlap.
10/10/03		WA8711BA		244141470	00142	QY	OSS 01/OSS 02 overlap.
10/10/03		WA75813A		254394106	00790	QK	OR 07/OR 08 overlap.
10/10/03		WG74994A		548419296	01844	QK	Overlapping surgeries in same room.
10/10/03		WA87118A		550900872	00800	QK	OSS 01/OSS 02 overlap.
10/10/03		WA80365A		554266228	00170	QK	OSS 04/OR 05 different building overlap. 03/OSS 04 overlap.
10/10/03		WA80365A		555960062	00914	QK	OSS 04/OR 05 different building overlap.
10/10/03		WA6711BA		561221295	00400	QK	OSS 01/OSS 02 overlap.
10/10/03		WA41371B		563165758	00914	AA	
10/10/03		WA67118A		571428291	01610	QK	OSS 01/OSS 02/OSS 03 overlap. Nguyen provided relief. OSS 01/OSS 02 overlap.
10/10/03		WG40563C		571466353	00320	QK	OR 04/OR 05 overlap.

- States that there are case "Overlaps"
- Found an overall 70% error rate

72

CASES: ANESTHESIOLOGIST AND ROOM

No Overlaps Observed

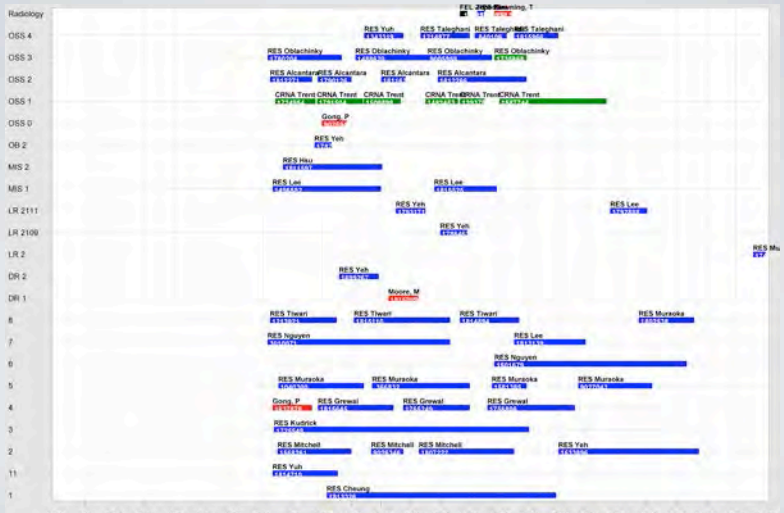
73

CONCURRENCY: ANESTHESIOLOGIST AND ROOM

- NO OVERLAPS
- 1:2 UNTIL 14:50
- Case 1812266 in OSS #2
  - OR record says OSS #2 , Anes record OSS #3; Attending N relieved Attending B at 1530
- Case in1735668 in OSS #3
  - Started by Attending G, relieved by Attending B after15:30, who provided the majority of the care, and therefore case was billed in his name.

74

CASES: ROOM AND 2ND PROVIDER



75

CASES: 2ND PROVIDER AND ROOM

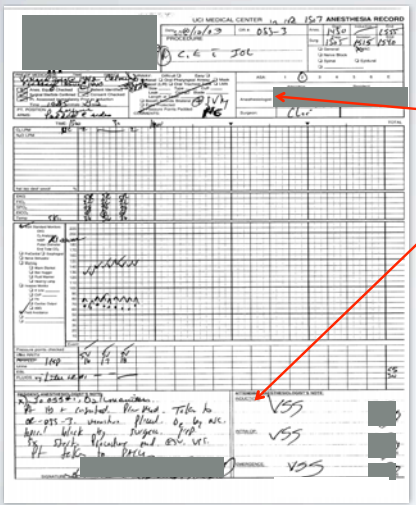
76

CONCURRENCY OF ANESTHESIOLOGIST AND ROOM

Case transitioned to Attending On Call

77

CASE 1735668



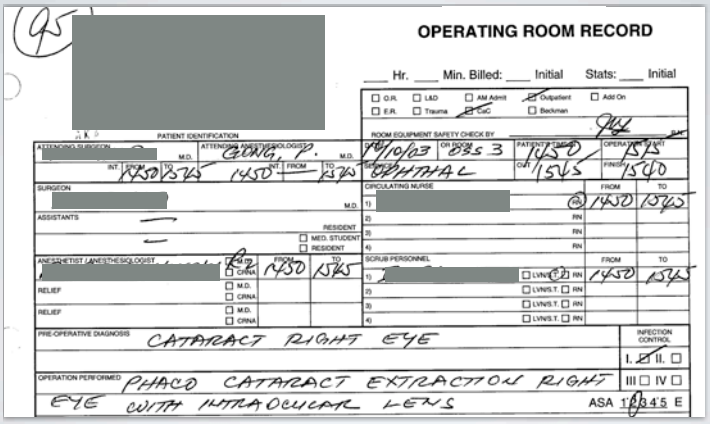
Started by GXXXX

Assumed by BXXXXX

- No Handoff documentation
- Poor Documentation on Steps of Medical Direction
- Attending and Times in Conflict with Nursing Notes

78

CASE 1735668 – NURSING NOTES, STARTED BY GXXX



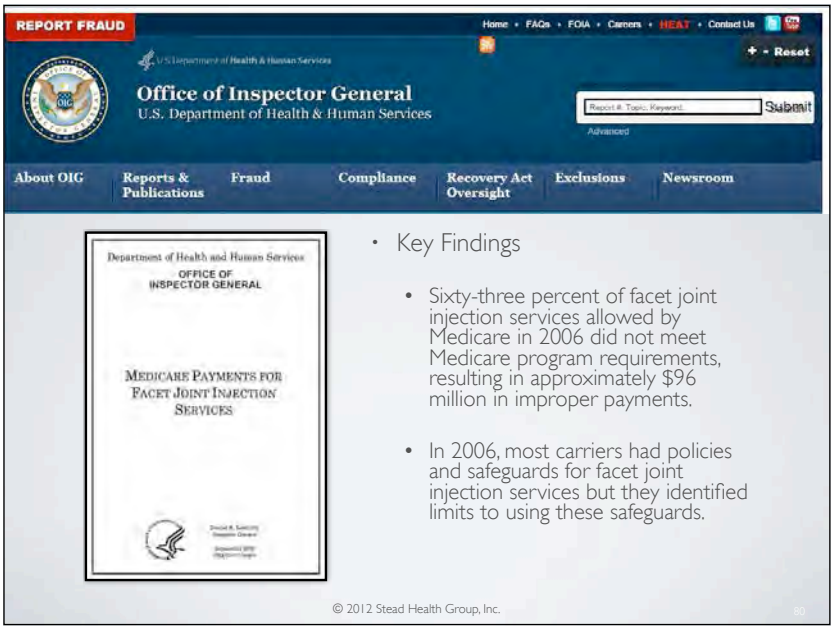
OPERATING ROOM RECORD

PRE-OPERATIVE DIAGNOSIS: CATARACT RIGHT EYE

OPERATION PERFORMED: PHACO CATARACT EXTRACTION RIGHT EYE WITH INTRAOCULAR LENS

ASA 1 2 3 4 5 E

79



- Key Findings
  - Sixty-three percent of facet joint injection services allowed by Medicare in 2006 did not meet Medicare program requirements, resulting in approximately $96 million in improper payments.
  - In 2006, most carriers had policies and safeguards for facet joint injection services but they identified limits to using these safeguards.

80

FACET: SUMMARY OF FINDINGS

State	# Claims Reviewed	# Services Allowed in Full	# Services Denied in Full	Error Rate	Due to Failure to Submit Documentation
AK	93	14	208	95%	19%
AZ	237	91	515	84%	42%
ID	168	94	307	79%	21%
MT	97	30	175	84%	32%
ND	39	8	66	91%	25%
OR	318	99	588	86%	20%
SD	108	66	118	61%	13%
UT	168	102	282	70%	30%
WA	338	136	513 (2 reduced)	80%	27%
WY	64	28	84	70%	22%

Error Rate = $ Billed in Error/$ All Claims Reviewed

81

AUDIT TAKEAWAYS: ENFORCEMENT FOCUS

- Medical Direction - need to document ALL SEVEN STEPS
  - Time: Start/Stop/Handoff times
    - Everyone is tracked: Attendings, Residents and CRNAs
  - Immediately available - physically present
  - Handoffs and Breaks
  - Post Operative Visit
- Overlaps: Pain blocks and anesthetic administration overlaps
- Documentation - poor documentation resulted in high error rate
- Extensive "forensic" chart review reduced error rate to < 5%.
- Pain Management - Acute and Chronic

82

CONCLUSIONS

- Develop an anesthesia-specific compliance plan addressing:
  - Documentation by clinicians (and who is responsible)
  - Time (and which times are to be used: Nursing/Anesthesia)
  - Handoffs
  - Permissible activities during Medical Direction
  - Immediately available (distance and time)
  - Plan for an audit to happen
- Conduct a "gap" analysis of your vulnerabilities
- Conduct a practice audit under a "privileged and confidential" protection and act upon it

83

84

Notes:

Innovation and Transition to a Digital Era in Anesthesiology

David L. Reich, M.D.
Professor and Chair of Anesthesiology
Mount Sinai School of Medicine
New York, NY

Disclosures

- Past support from Casmed
- Research support from Covidien

"Publicity is justly commended as a remedy for social and industrial diseases. Sunlight is said to be the best of disinfectants; electric light the most efficient policeman."

Louis Brandeis: Other People's Money, and How the Bankers Use It (1914)

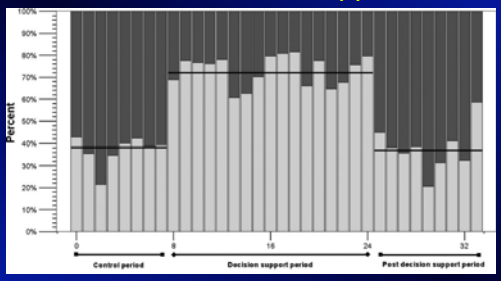
National Imperatives

Value Based Purchasing

- 1% withhold of Medicare hospital payments
- Return of portion or all of withhold, depending upon quality metrics
  - Outcome measures
  - SCIP
  - HCAHPS, including pain management

Preoperative Assessment

PONV Decision Support



Kooij FO et al: Anesth Analg 2008;106:893-8

Intraoperative Quality Indicators

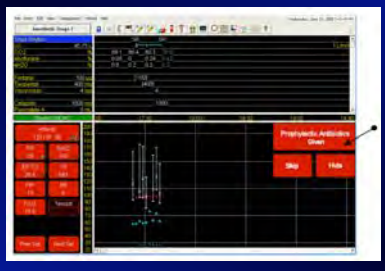
SCIP Adherence Infection Effect

	Nonadherent		Adherent		OR (95% CI)
	N	Infection Rate	N	Infection Rate	
S-INF-Core: all 3 original	44417	1.15%	154963	0.53%	0.86 (0.74-1.01)
S-INF: Full Set	59356	1.42%	158304	0.68%	0.85 (0.76-0.95)

Stulberg et al: JAMA 2010;303:2479-85

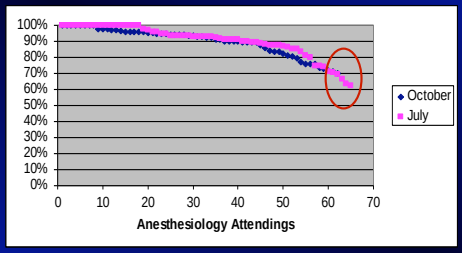
Antibiotics

Antibiotic Compliance Reminder



Wax et al: Anesth Analg 2007;104:1462-6

Antibiotic Compliance Reminder



Wax et al: Anesth Analg 2007;104:1462-6

An Anesthesia Information System Designed to Provide Physician-Specific Feedback Improves Timely Administration of Prophylactic Antibiotics

Michael O'Reilly, MD, MS*
Akke Nesl Talmon, PhD, RN†
Shamm VanRiper, MS, RN‡
Sachin Kheterpal, MD*
Richard Burney, MD§

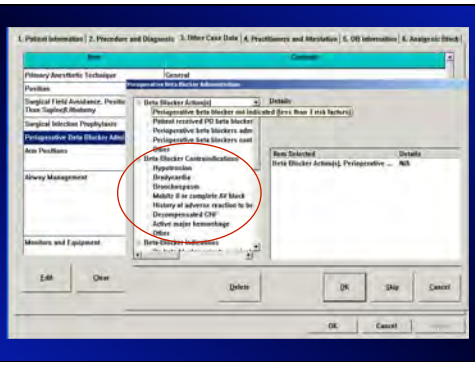
Surgical site infections are a frequent cause of morbidity and mortality and add significantly to the cost of care. One component of the national Surgical Infection Prevention (SIP) program is to ensure timely administration of prophylactic antibiotics, a key tactic to reduce postoperative infection. Our anesthesia department decided to assume the responsibility for timing and administration of antibiotic prophylaxis and we initiated a multimodal approach to remind the anesthesiologist to administer the prophylactic antibiotics. We used our anesthesia clinical information system to implement practice guidelines for timely antibiotic administration and to generate reports from the database to provide specific feedback to individual care providers with the goal of ensuring that patients receive antibiotic prophylaxis within 1 h of incision. Before the initiation of this project, 60% of eligible patients received antibiotics within 60 min of the incision. After the program began, there was a steady increase in compliance to 97%. 1 yr later, Provider-specific feedback increases compliance with practice guidelines related to timely administration of prophylactic antibiotics. Anesthesia information systems hold promise for implementing and monitoring new practice guidelines and the anesthesiologist may play a key role in influencing surgical outcomes by ensuring appropriate therapy that may not be directly related to anesthesia care.

Anesth Analg 2006;103:828–32

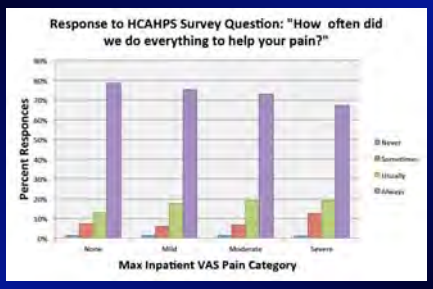
Physician Quality Reporting System (PQRS)

- Eligible professionals who successfully report a designated set of quality measures on claims may earn a bonus payment, subject to a cap, of 1.5% of total allowed charges for covered Medicare physician fee schedule services.
- Three elements in 2010:
  - Hypothermia prevention
  - Antibiotic timeliness
  - Central line insertion sterility checklist
- 0.5% revenue gain

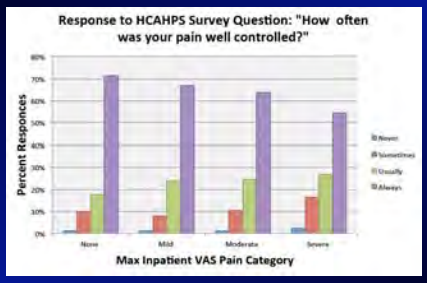
Beta Blockade



Pain Management



Am J Med Qual. 2012 Sep 25 [Epub]



Am J Med Qual. 2012 Sep 25 [Epub]

Predicting Inpatient Pain Severity

	Odds Ratio	Lower 95% CI	Upper 95% CI
Age (per 10yrs) for female	0.825	0.802	0.848
Age (per 10yrs) for male	0.769	0.746	0.793
LOS >7 days (vs. LOS=1)	7.259	6.495	8.113
LOS 3-7 days (vs. LOS=1)	4.336	3.934	4.779
LOS 1-3 days (vs. LOS=1)	2.476	2.254	2.721
African American vs. White	1.113	1.016	1.219
Latino vs. White	1.104	1.013	1.204
Asian vs. White	0.797	0.674	0.942
Other CNS drug vs. no CNS drug	1.247	1.142	1.363
Antidepressant vs. no CNS drug	1.226	1.110	1.354
Anxiolytic vs. no CNS drug	1.216	1.130	1.309

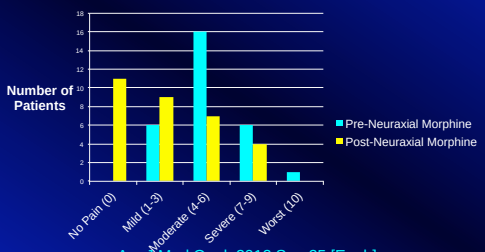
Am J Med Qual. 2012 Sep 25 [Epub]

Predicting Inpatient Pain Severity

(Odds Ratio vs. Medicine)	Odds Ratio	Lower 95% CI	Upper 95% CI
Orthopedics	7.676	6.345	9.285
Transplant Institute	5.705	2.914	11.168
Surgery	3.711	3.364	4.093
Dentistry	2.883	1.431	5.807
Neurosurgery	2.805	2.343	3.357
Rehabilitation	2.801	2.378	3.298
Urology	2.062	1.705	2.493
Radiology (Interventional)	1.932	1.272	2.936
Otolaryngology	1.440	1.147	1.809
Cardiothoracic Surgery	1.164	1.011	1.340
Gynecology	0.841	0.720	0.982
Neurology	0.727	0.584	0.905
Psychiatry	0.273	0.230	0.325

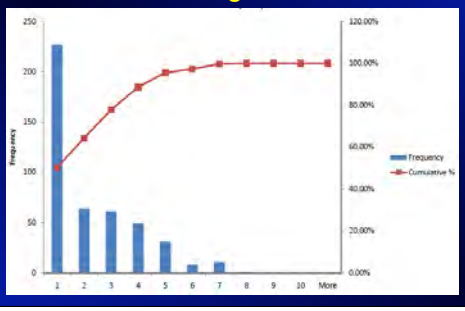
Am J Med Qual. 2012 Sep 25 [Epub]

Orthopedic Nursing Unit

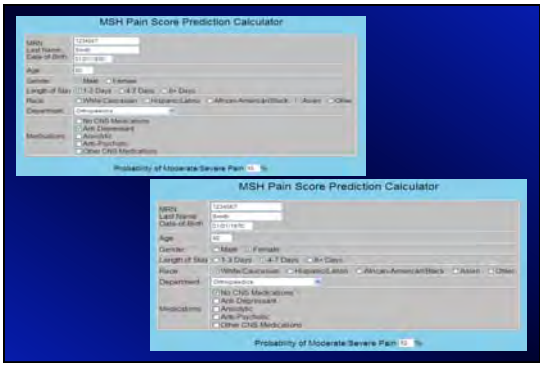


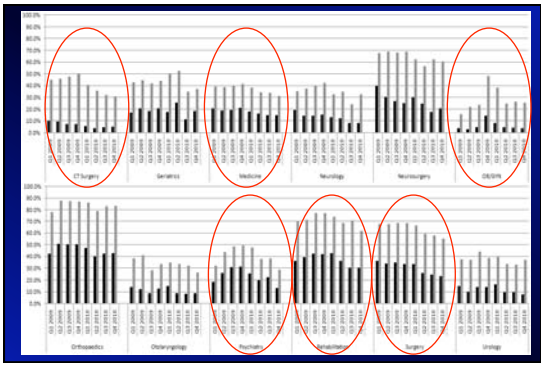
Am J Med Qual. 2012 Sep 25 [Epub]

PACU Discharge Pain Scores



Pain Buster Rounds



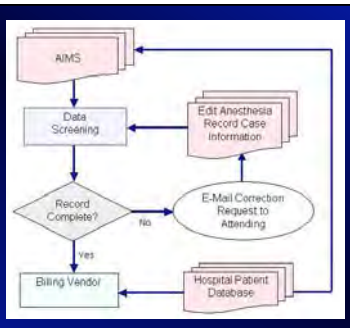


Administrative Use of AIMS

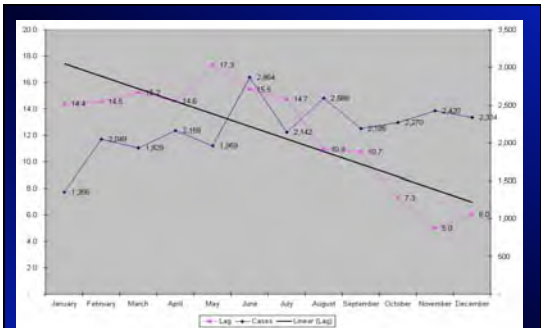
Providing Value to the Hospital

Hospital Quality Reports

- Returns to OR
  - Second operation within same hospitalization
- Anastomotic leak
- Surgical operation log
- PACU statistics and pain at discharge
- 48 hour post-anesthesia mortality
- Postop complications (standard CMS list)
- CLABS prevention program compliance
- Central line education report
- OR utilization reports



Anesthesiology 2006;105:179-86



Anesthesiology 2006;105:179-86

A Mission-Based Productivity Compensation Model for an Academic Anesthesiology Department

David L. Reich, MD
Maria Galan, MBA
Marina Krol, PhD
Carol A. Bodian, Dr PH
Ronald A. Kahn, MD

INTRODUCTION: We replaced a purely fixed-salary academic physician compensation model with a mission-based productivity model with the goal of improving attending anesthesiologist productivity.

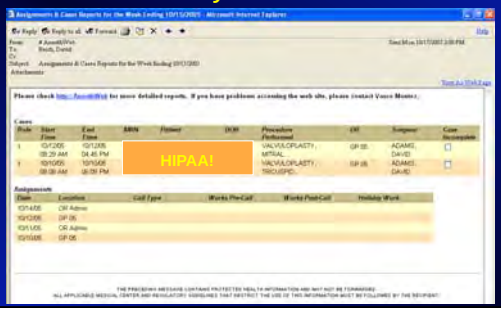
METHODS: The base salary system was stratified according to rank and clinical experience. The supplemental pay structure was linked to electronic patient records and a scheduling database to award points for clinical activity, educational research, and administrative points systems were constructed in parallel. We analyzed monthly American Society of Anesthesiologist (ASA) unit data for operating room activity and physician compensation from 2000 through mid-2007, including the 1-yr implementation period (July 2004–June 2005) for the new model.

RESULTS: Comparing 2005–2006 with 2000–2004, quarterly ASA units increased by 14% ($P < 0.0001$) and quarterly ASA units per full-time equivalent increased by 31% ($P < 0.0001$), while quarterly ASA units per anesthetizing location decreased by 10% ($P = 0.046$). Compared with a baseline year (2001), Instructor and Assistant Professor faculty compensation increased more than Associate Professor and Professor faculty ($P < 0.001$) in both pre- and postimplementation periods. There were larger compensation increases for the postimplementation period compared with preimplementation across faculty rank groupings ($P < 0.0001$). Academic and educational output was stable.

DISCUSSION: Implementing a productivity-based faculty compensation model in an academic department was associated with increased mean supplemental pay with relatively fewer faculty. ASA units per month and ASA units per operating room full-time equivalent increased, and these metrics are the most likely drivers of the increased compensation. This occurred despite a slight decrease in clinical productivity as measured by ASA units per anesthetizing location. Academic and educational output was stable.

Anesth Analg 2008;107:1981-8

Weekly Feedback



Billing Module from AIMS

Table 4. Missing Data Report Elements

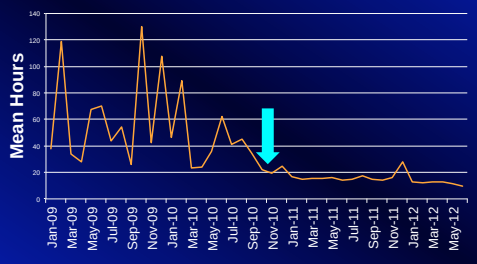
1. Service date
2. Internal case ID
3. Case number
4. Medical record number
5. Patient name
6. Patient date of birth
7. Attending anesthesiologist 1
8. Attending anesthesiologist 1 e-signature
9. Attestation comments
10. Attending anesthesiologist 2
11. Relief date/time 1
12. Attending anesthesiologist 2 e-signature
13. Attending anesthesiologist 3
14. Attending anesthesiologist 3 e-signature
15. Relief date/time 2
16. CRNA 1 e-signature
17. CRNA 2 e-signature
18. ASA classification
19. Performed procedure
20. Primary anesthetic technique
21. Preoperative diagnosis
22. Postoperative diagnosis
23. Surgeon
24. Anesthesia start time
25. Anesthesia end time

Anesthesiology
2006;105:179-86

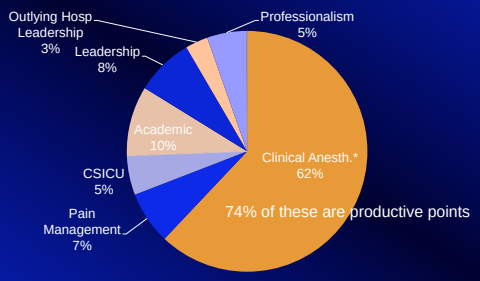
Daily Clinical Productivity

Case Number	Start Time	End Time	Points	Concurrency Adjustment	PostOp Note Lateness	Call Related	Completeness	Final Points
						Cardiac 1	N/A	450
						Worked Pre-Call	N/A	450
1	9:28	10:34	195	0.97	1		1	190
2	20:00	23:24	310	N/A after 1800	1		1	310
3	9:00	10:43	255	0.97	1		1	248
4	17:45	18:00	27	0.97	1		1	27
4	18:00	21:28	378	N/A after 1800	1		1	378
5	11:10	15:25	420	0.97	1		1	409
6	15:50	18:00	206	0.97	0.9		1	181
6	18:00	20:15	214	N/A after 1800	0.9		1	193
							Total	2836

Postoperative Note Latency



2013 Points Budget: 27.8m points



Comparison of the Pre- and Post-Implementation Periods

	MEDIAN		p-value
	Pre-Implementation	Post-Implementation	
Average Monthly ASA Units	43,563	49,594	.0001
Average Monthly ASA Units per OR FTE	601	790	<.0001
Average Monthly ASA Units per Location	1268	1147	.046

Anesth Analg 2008;107:1981-8

Mean Faculty Salary Ratios by Rank Grouping c/w 2001

Rank Grouping	Pre-Implementation (2003-2004)	Post-Implementation (2006-2007)[&]
Instructors and Assistant Professors*	1.12	1.57
Associate and Full Professors	1.01	1.35

*Higher mean salary increase for Instructors/Assistant Professors compared with Associate and Full Professors across periods ($p<0.001$)
[&]Higher mean salary increase for post-implementation period compared with pre-implementation across rank groupings ($p<.0001$).

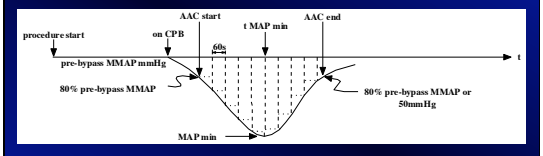
Anesth Analg 2008;107:1981-8

Administrative

- ACGME report automatic generation
- EPIC interface
- Tracking system
  - OR Control Desk, Family Waiting Room, Assessment Area, PACU's, Bed assignment unit, Cardiac White Board, Event Notification
- Scheduling system
  - Daily assignments
  - Night and weekend calls
  - Time off
  - Web displays and reports
- Personnel system

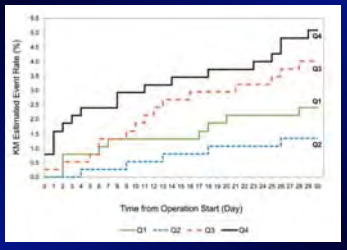
Research

Onset of CPB Hypotension



Levin MA et al: Circulation 2009 Oct 12 [Epub]

BP Excursions and Mortality

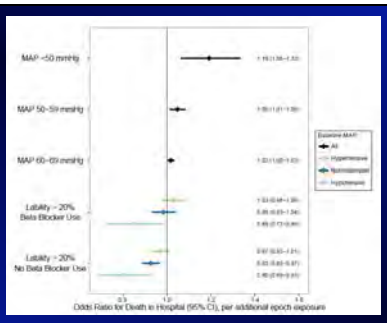


Anesth Analg 2011;113:19–30

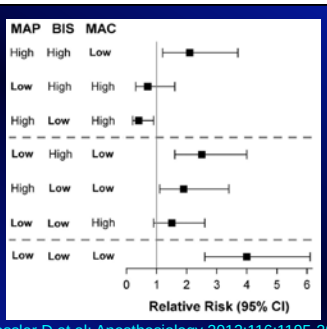
Independent Predictors of Hospital Mortality

Variable	Odds Ratio	P-value
ASA 3-5	47.4 [6.4-349]	0.002
Propofol Induction	0.24 [0.12-0.48]	<0.0001
Fentanyl Dosage	--	0.83
Post-Induct Hypotension	2.3 [0.95-5.5]	0.066

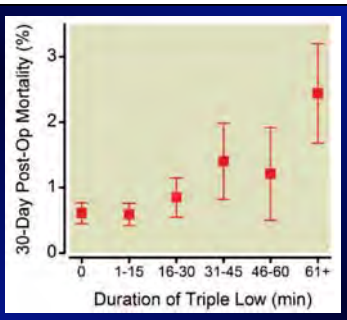
Anesth Analg 2005;10:622-8



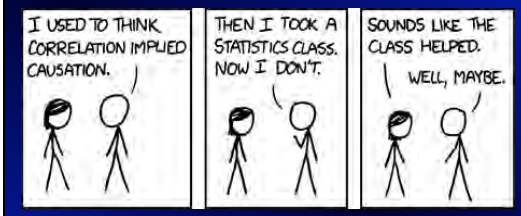
Unpublished Data



Sessler D et al: Anesthesiology 2012;116:1195-203



Sessler D et al: Anesthesiology 2012;116:1195-203

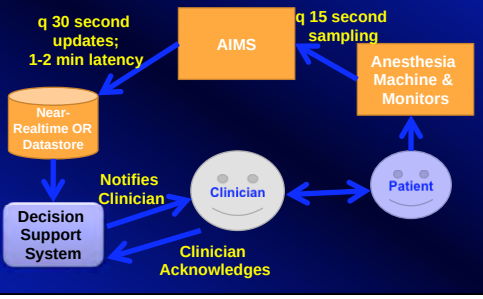


http://xkcd.com/552

Hemodynamics, Anesthetic Depth and Mortality

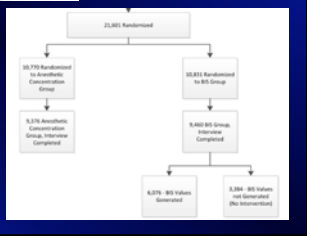
- Association does not prove causation
- Why should a brief period of hypotension or deep anesthesia be associated with hospital mortality?
  - Acute organ injury?
  - Anesthetic "stress test" is a marker for patients with more severe underlying illness?
    - Cancer patients (debilitated) have exaggerated responses to "standard" anesthetic doses

Clinician/DSS Feedback Loop



Prevention of Intraoperative Awareness with Explicit Recall in an Unselected Surgical Population

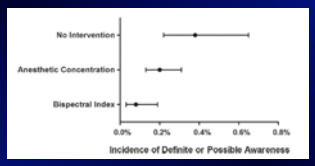
A Randomized Comparative Effectiveness Trial



Anesthesiology 2012; 117:717–25

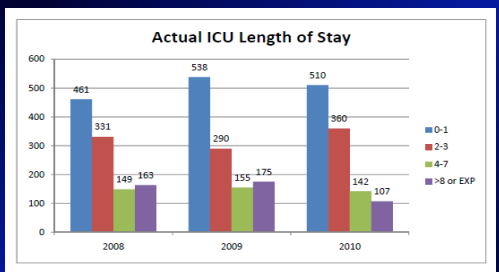
Prevention of Intraoperative Awareness with Explicit Recall in an Unselected Surgical Population

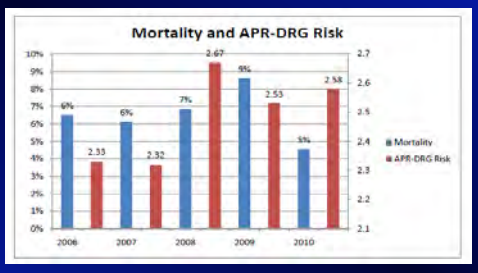
A Randomized Comparative Effectiveness Trial

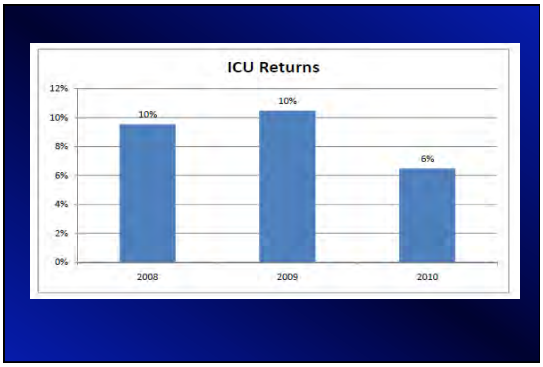


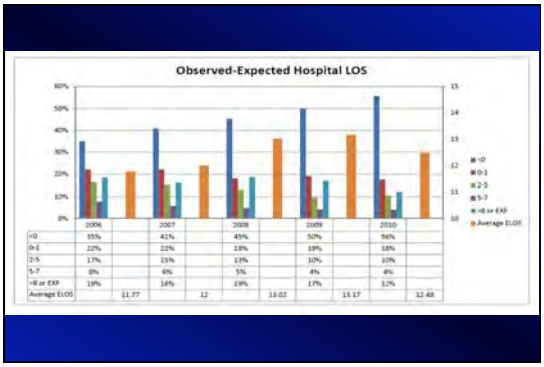
Anesthesiology 2012; 117:717–25

Intensive Care Unit Quality

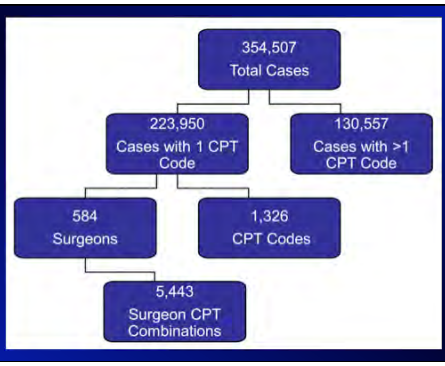


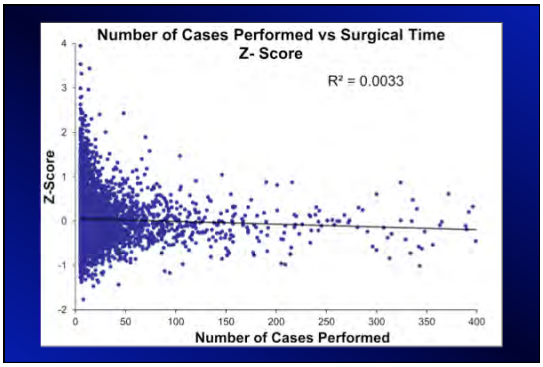


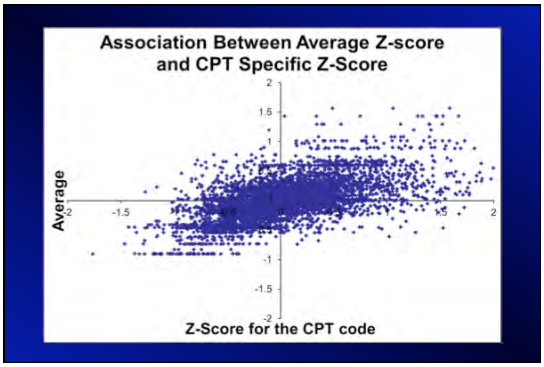




Surgeon Efficiency







Summary and Discussion

- Report generation needs: OR operations, quality, PQRS, custom reports
- Managing people with data
  - Linking quality with compensation
- Managing all of the missions of the Department

General Sessions

General Session 3: Milestones Update and Questions

Moderator: Catherine M. Kuhn, M.D.

Neal H. Cohen, M.D., M.P.H., M.S.; Lorraine C. Lewis, Ed.D., R.D.; Billy Hart

Milestones Update and Questions

Neal H. Cohen, M.D., M.P.H., M.S.; Lorraine C. Lewis, Ed.D., R.D.; Billy Hart

Notes: _____

Milestones and the Next Accreditation System What You Need to Know

Neal H. Cohen, M.D., M.P.H., M.S.
Vice Dean, School of Medicine
Professor of Anesthesia
University of California, San Francisco

Lorraine C. Lewis Ed.D., R.D.
Executive Director, RRC for Anesthesiology
ACGME

Billy Hart
Senior Accreditation Administrator, RRC for Anesthesiology
ACGME

Objectives

1. Describe the transition to a New Accreditation System (NAS) and its impact on program reviews.
2. Describe how milestones have been developed to assess resident performance.
3. Define how milestones will be integrated into the NAS and its relationship to other data elements that will be reviewed by ACGME and RRC.
4. Describe the timeline for implementing milestones.
5. Clarify how programs can utilize milestones as part of the internal review of resident progression and prepare for the transition to the NAS.

Disclosures

Neal Cohen
- Vice Dean, School of Medicine
- Professor of Anesthesia, University of California, San Francisco
- Former Chairperson, Anesthesiology RRC
- No conflicts of interest to report

Lorraine Lewis
- Executive Director, Anesthesiology RRC
- No conflicts of interest to report

Billy Hart
- Senior Accreditation Administrator, Anesthesiology RRC
- No conflicts of interest to report

Some slides adapted from *The Next Accreditation System*: TJ Nasca, CEO, ACGME; *AHME Presentation*: L Ling, SVP, Hospital Accreditation & T Brigham, SVP, Chief of Staff

The "Next Accreditation System" in a Nutshell

- *Continuous* Accreditation Model – updated annually
  - Based on annual dashboard that includes data submitted, other data requested, and program trends
- Scheduled Site Visits replaced by 10 year Self Study Visit
- No more PIF!
- Standards (Program Requirements) revised every 10 years, organized by Core Processes
  - Detailed processes
  - Outcomes

NAS - Annual Data Collected and Reviewed *Focus on Existing Data*

1. Annual ADS Update - Streamlined
   1. Program Attrition
   2. Program Characteristics – Structure and Resources
   3. Scholarly Activity – Not full faculty CV's
2. Board Pass Rate – Rolling Average
3. Clinical Experience – Case Logs
4. Resident Survey
5. Faculty Survey – Core Faculty
6. Semi-Annual Resident Evaluation and Feedback
   1. Milestones
   2. Clinical Competency Committee Assessments
7. Institutional (Sponsor) Site Visit (CLER)

ACGME Milestones Project *Objectives*

- Create a single set of learning and performance expectations for resident achievement *in each competency domain* for use by all residency programs within the specialty, the Review Committee and the certification board
- Provide residents with an explicit, clear description of what is expected of them at each level of training to enable self-assessment and facilitate their ability to seek learning opportunities
- Enhance opportunities for early identification of under-performers so that appropriate action can be taken
- Enable creation of a national database and comparison of program performance against specialty norms

What is a Milestone?

- Specific behaviors, attributes or outcomes to be acquired by a resident at a *particular point* during residency training
- *Distinct, observable* set of behaviors which *support the achievement of one or more of the six competencies* for an individual learner
- Represents a "notable accomplishment"
- Provides a method for *assessing* resident learning and performance over time and *against a benchmark*

How Have Milestones Been Developed?

- Defined by a group of experts in GME in Anesthesiology
  - RRC members
  - Program Directors
  - Resident
- Final draft being pilot tested
- Final version of the Milestones will be posted on ACGME web site in December 2012
- Work on subspecialty milestones will begin in July 2013
  - Greater focus on medical knowledge and patient care skills

Milestones Evaluation

- Initial implementation will provide experience with this new approach to assessing resident progression
  - Programs will have opportunity to determine best assessment tools, share best practices
  - Faculty and Clinical Competency Committees need experience in using Milestones
- After a full complement of residents has gone through a cycle of assessment using Milestones, a working group will be likely be convened to evaluate and potentially modify the narratives.

How Will the RRC Use Milestones?

- RRC will use data about Milestones as *one source* of information in assessing program performance
- RRC will only use de-identified aggregate Milestone data
- Focus will be on data *trends over several years*
- Milestone data will be used as *one measure of resident outcomes* that can be integrated with other sources of data
  - Board scores
  - Attrition
  - Faculty and resident survey results

Some Common Questions

- Can a resident graduate if s/he does not achieve every milestone?
  - The decision whether a resident is prepared to graduate from a residency program has not changed.
  - The program director determines if a resident is able to practice independently. The Milestones provide a framework and tools that should aid the program director in making that determination.

Some Common Questions

- What happens to cycle length in NAS?
  - Since NAS is a continuous accreditation model with annual data collection and review by the RRC, site visits will occur if the annual data submission suggests a potential problem.
  - Each program will have a scheduled 10-year self-study site visit, and new programs will have a site visit.

Some Common Questions

- How will the RRC use the Resident Survey in NAS?
  - RRC use of the Resident Survey emphasizes the themes or domains of the survey (comprehensive analysis), not individual questions.
  - The RRC reviews the trend of feedback for a program over time and evaluates an individual program based on performance across all AN residency programs (identifying outliers).

Resident Survey Domains

- Duty hours
- Faculty
- Educational Content
- Evaluations
- Resources
- Patient safety*
- Teamwork*

* New for 2012

NAS
Emphasis on Quality and Patient Safety

- Integrate quality and patient safety into your program and your program into quality
- Be certain that real "quality activities" are occurring at your institution, and that residents are actively involved
- Quality and patient safety should be evaluated as part of all competencies, but are specifically described as outcomes of:
  - Practice-based learning
  - System-based practice
- Quality and safety need to have the same priority as patient care experience and research

TO DO list

- Define and identify core faculty
- Organize reporting of faculty scholarly activity
- Learn about milestones
- Review processes within your clinical competency committee
- Train faculty on the use of milestones
- Integrate quality/safety into GME

The Rest of the TO DO List

- Look at some of the data indicators that will be used in NAS and ask yourself
  - Will our current resident evaluations allow us to make judgments on milestones?
  - Do any of the data we have available now identify areas in need of improvement?
  - Do we have reliable and efficient ways to collect the data that will be required as part of the NAS?

Anesthesiology RRC Transition to NAS

- Anesthesiology is Phase 2
- Begin transition process July 1, 2013
  - Programs will be notified of new site visit dates in Spring 2013
- NAS begins July 1, 2014

Anesthesiology Transition to NAS Site Visit Dates

- All site visits scheduled to take place prior to July 1, 2013 will occur as scheduled.
- Site visits scheduled after July 1, 2013 will be assigned a self-study date based on current cycle length.
  - Programs with a 1 to 2 year cycle length will be site visited under the old system between July 1, 2013 and June 30, 2014
  - Self-study site visits for fellowships will occur at the same time as their associated core.

Anesthesiology Transition to NAS Program Requirements

- Categorization, restructuring and revision of program requirements to meet NAS guidelines

Core : Statements that define structure, resource or process elements essential to every graduate medical educational program.

Detail : Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement.

Outcome : Statements that specify expected measurable or observable attributes (knowledge, skills, attitudes) of residents or fellows at key stages of their graduate medical education.

Program Requirements

- Revised and re-categorized program requirements
  - Adult Cardiothoracic Anesthesiology
  - Pediatric Anesthesiology
  - Critical Care Anesthesiology
- Re-categorized program requirements
  - Obstetric Anesthesiology
- Available for public comment Spring 2013

Program Requirements

- Anesthesiology residency programs
  - Re-categorized with focused revisions
  - Available for public comment Spring 2013
  - ALSO requesting comment on major revisions of residency program requirements
- Stay tuned to ACGME *E-Communication*

Anesthesiology Transition to NAS Reporting Milestone Data

- Milestone data will be reported twice a year
  - First milestone data will be reported around December 2014
  - Next submission will be around June 2015

Some Other Common Questions

- What is the faculty survey and when will it be administered?
  - The faculty survey will be sent to core faculty only, since they are most knowledgeable about the program.
  - The survey will use similar domains as the resident survey and be sent at the same time as the resident survey.\
  - Administration is planned for Winter/Spring 2014

Some Other Common Questions

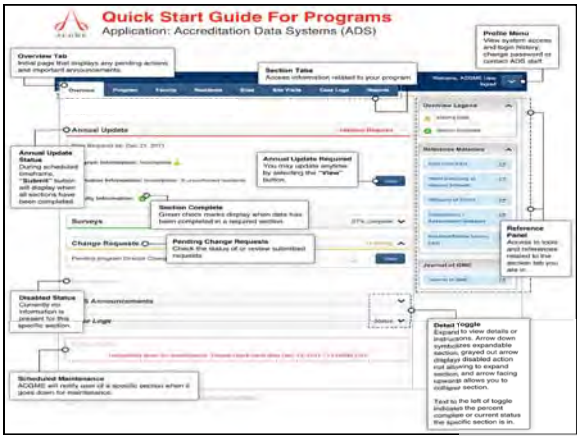
- When will we hear from the RRC in NAS?
  - Annual data will be available for RRC review in late Fall for meetings early in the year
  - You will receive notice of the results of the RRC's annual review of data early in the year
    - Anesthesiology first review in NAS will occur early in 2016

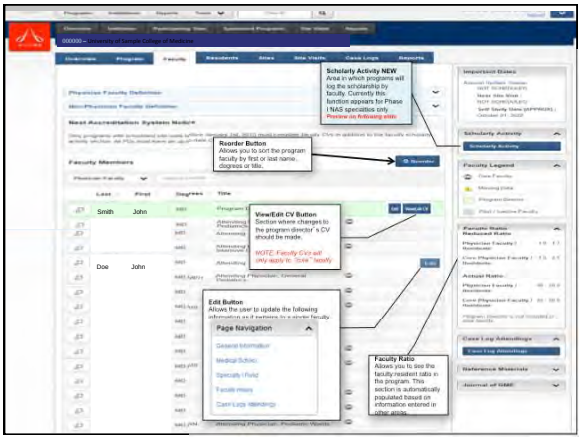
Some Other Common Questions

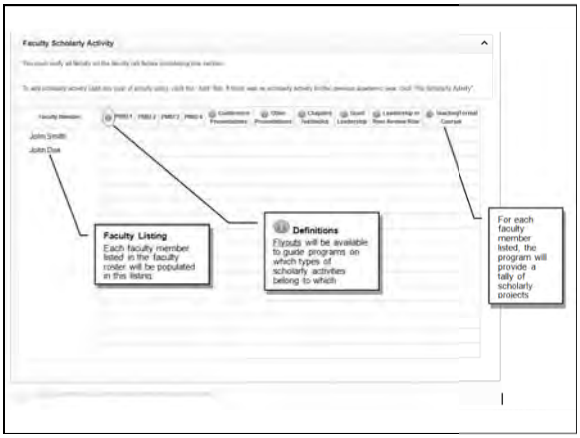
- What happens to Internal Review in NAS?
  - Internal reviews are no longer required as of July 2013; however, if programs and institutions find them useful, they can be continued.
  - Under NAS, Internal Reviews won't be done for accreditation but instead can be used as a tool for program improvement

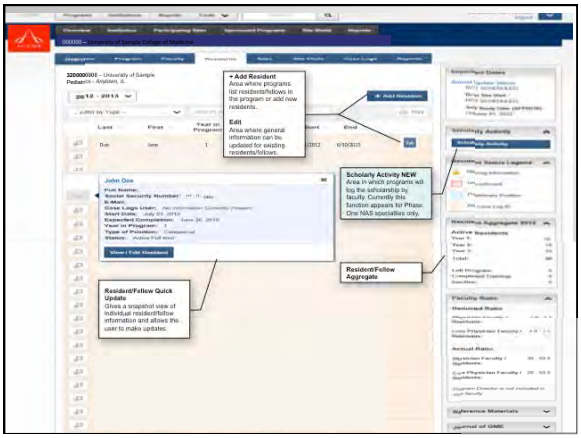
Some Other Common Questions

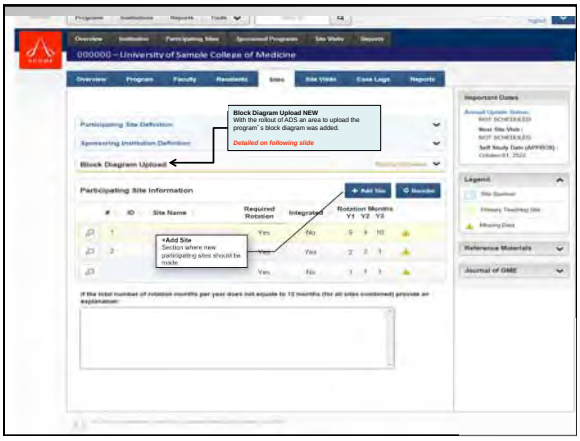
- Can innovative program requests still be submitted?
- What should I do if I want to submit a request for an innovation?
  - Contact me, Lori Lewis
  - llewis@acgme.org; 312-755-5043

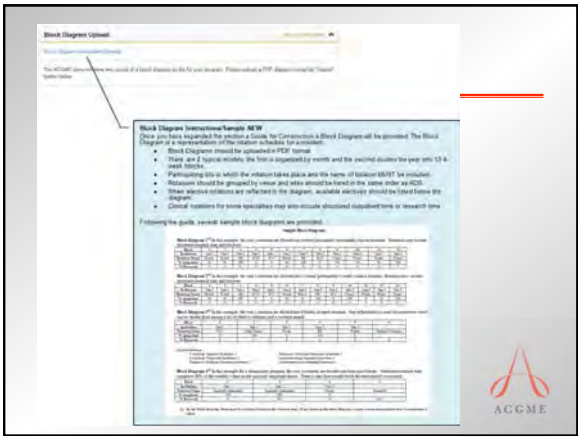

Quick Start Guide For Programs
Application: Accreditation Data Systems (ADS)
Overview Tab
Profile Menu
Section Table
Annual Update
Annual Update Status
Annual Update Required
Section Complete
Surveys
Change Requests
Pending Change Requests
Reference Panel
Disabled Status
Announcements
Detail Toggle
Scheduled Maintenance

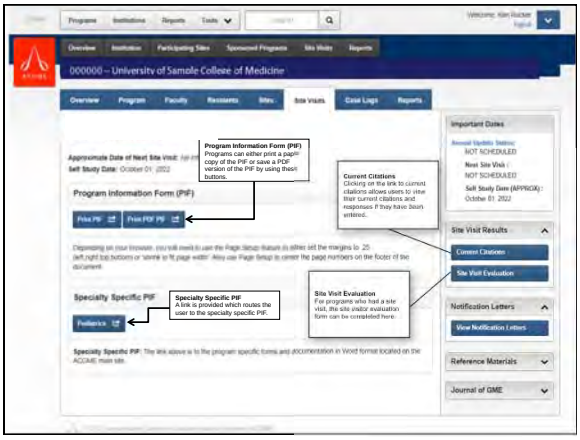

Scholarly Activity NEW
Reorder Button
Faculty Members
View/Edit CV Button
Edit Button
Page Navigation
Faculty Ratio

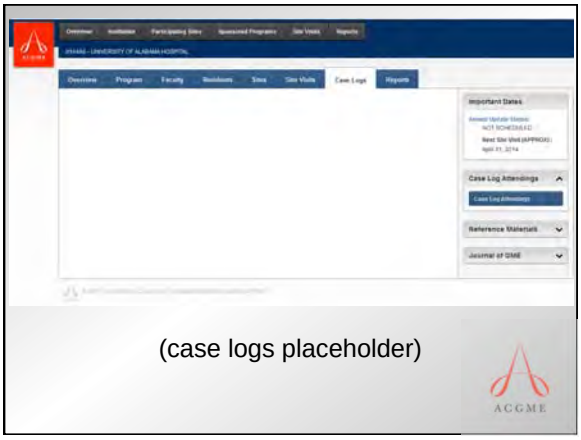

Faculty Scholarly Activity
Faculty Listing
Each faculty member listed in the faculty roster will be populated in this listing.
Definitions
Flyouts will be available to guide programs on which types of scholarly activities belong to which.
For each faculty member listed, the program will provide a tally of scholarly projects.

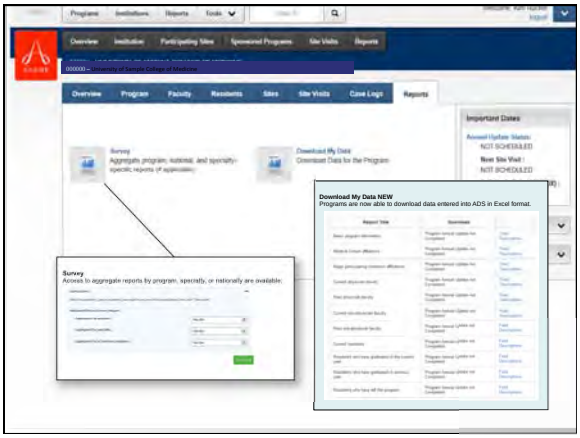

+ Add Resident
Edit
Scholarly Activity NEW
Resident/Fellow Aggregate
Resident/Fellow Quick Update


000000 – University of Sample College of Medicine
Block Diagram Upload NEW
Detailed on following slide
Participating Site Information
+Add Site


Block Diagram Upload
Block Diagram Instructions/Sample NEW
ACGME







ADS Representative

Raquel Eng

312.755.7118

reng@acgme.org

ACGME

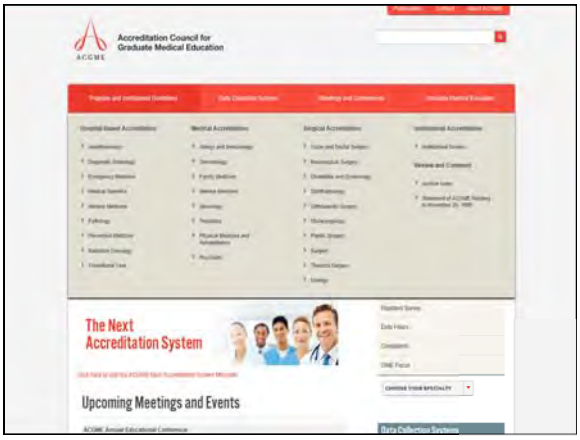
Program Resources

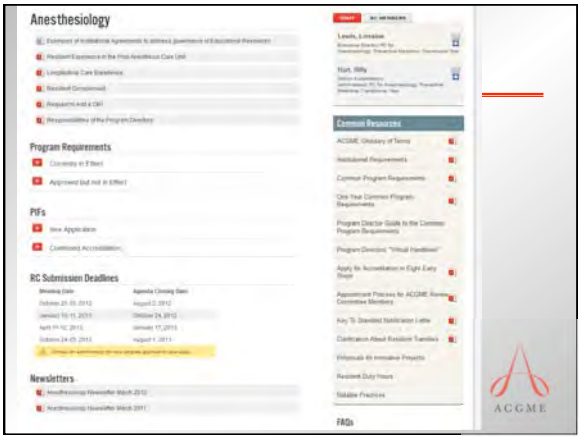
www.acgme.org

Weekly e-Communication

- ACGME Policies & Procedures
- Competencies/Outcomes Project
- List of accredited programs
- Accreditation Data System (ADS)
- Duty Hours Information/Affiliation Agreements/NAS FAQs
- General information on site visit process and your site visitor
- Notable Practices
- Anesthesiology Webpage
  - Resident complement increase policy
  - Program Requirements and PIFs
  - Archive of RRC Updates/Newsletters
  - Anesthesiology FAQs
  - Staff contact information

ACGME


Accreditation Council for Graduate Medical Education
The Next Accreditation System
Upcoming Meetings and Events


Anesthesiology
Program Requirements
PIFs
RC Submission Deadlines
Newsletters
Common Resources
FAQs
ACGME


Accreditation Council for Graduate Medical Education
Announcements
Quick Links
The Next Accreditation System
Upcoming Meetings and Events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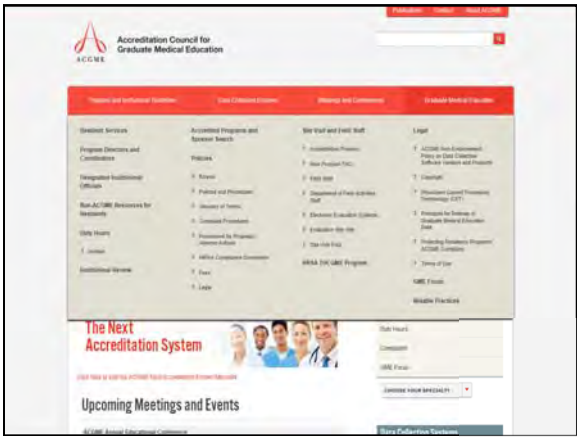
The Next Accreditation System
Upcoming Meetings and Events


Accreditation Council for Graduate Medical Education
The Next Accreditation System
Upcoming Meetings and Events


The Next Accreditation System
ACGME
Recent News
Perspectives on the Next Accreditation System

Questions

General *Sessions*

General Session 4: Updates

Moderator: Berend Mets, M.B., Ch.B., Ph.D., FRCA, FFA(SA)

ACGME Update
Thomas J. Nasca, M.D., M.A.C.P.

RRC Updates
Margaret Wood, M.D., Ch.B.

Notes:

General *Sessions*

General Session 5: Updates

Moderator: Jane C.K. Fitch, M.D.

ASA Update
Jane C.K. Fitch, M.D.

Update from SAAA Directors to ASA
Steven J. Barker, Ph.D., M.D.; Zeev Kain, M.D., M.B.A.

ABA Update
J. Jeffrey Andrews, M.D.

ITE Update
Cynthia Lien, M.D.

Notes: