2011
Annual Meeting

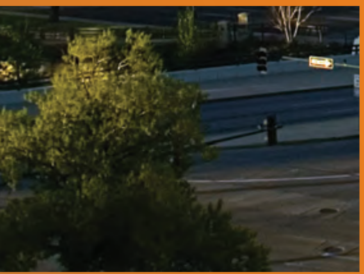
November 4 - 6, 2011

Grand Hyatt Denver

Denver, Colorado

American Society of Anesthesiologists

Jointly sponsored by the American Society of Anesthesiologists (ASA).



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- AACPD Members
  - *(Alphbetical by last name)*
  - *(Alphbetical by institution)*
- AASPD Members
  - *(Alphbetical by last name)*
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Program Schedule
- Presentations
- Friday
  - • AACPD
  - • AAAC
  - • AASPD
- Saturday
- Sunday

Program Information

Jointly sponsored by:

and

Registration Information

The registration fee for the SAAA 2011 Annual Meeting includes the course syllabus, all educational presentations, a continental breakfast, coffee breaks and Saturday reception. Registrations that are either faxed, mailed, or made via the website to the SAAA office must be received by October 1s. After October 1st, only late registration fees will be applied.

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.

About This Meeting

Topics for this meeting were selected by various methods. Suggestions for topics were derived from evaluations of the 2010 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.

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 *14.75 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.

The objectives of this meeting are:

- To provide new and current regulatory and management information to Chairman, Program Directors and Subspecialty Program Directors.
- To inform Participants about the current and future state of departmental and healthcare financing.
- To inform participants of future trends in anesthesiology training.
- To inform participants about evaluation and dealing with 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. Speakers are required to openly disclose and limitations of data and/or any discussion of any offlabel, experimental, or investigational uses of drugs or devices in their presentations.

Special Needs

The Society of Academic Anesthesia Associations 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 recieve service.

Faculty Information

Jeffrey L. Apfelbaum, M.D.
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ACGME
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Faculty Disclosures

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

Faculty	**Disclosure**	**Notes**
Steven J. Barker, Ph.D., M.D.	4, 5	Masimo Inc.
Robert M. Craft , M.D.	6	Haemascope
Ronald G. Pearl, M.D., Ph.D.	7	VasoNova, Merck
	6	Altor Bioscience, Bristol-Meyers Squibb
Warren S. Sandberg, M.D., Ph.D.	8	Masimo
	6	MedSleuth
Kevin K. Tremper, Ph.D., M.D.	3	GE Healthcare
John A. Ulatowski, M.D., Ph.D.	5	Sphere Medical
Margaret Wood, M.B.Ch.B.		ACGME RRC Committee Member

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

Jeffrey L. Apfelbaum, M.D.
Gary J. Brenner, M.D., Ph.D.
David L. Brown, M.D.
John F. Butterworth, IV, M.D.
Randall M. Clark, M.D.
Jerry A. Cohen, M.D.
Neal H. Cohen, M.D., M.P.H., M.S.
Joanne M. Conroy, M.D.
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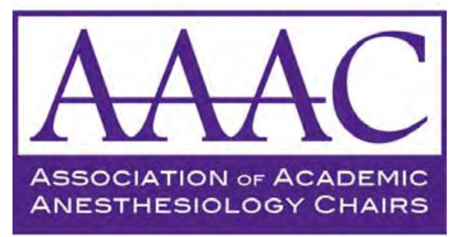

APPLICATION AAAC MEMBERSHIP FOR 2012
Departmental Dues Amount: $675

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) or AASPD if you are a Subspecialty Program Director (AASPD form).

Please make check payable to:
Society of Academic Anesthesiology Associations (SAAA)
Application and Applicable Payment is requested by March 31, 2012.

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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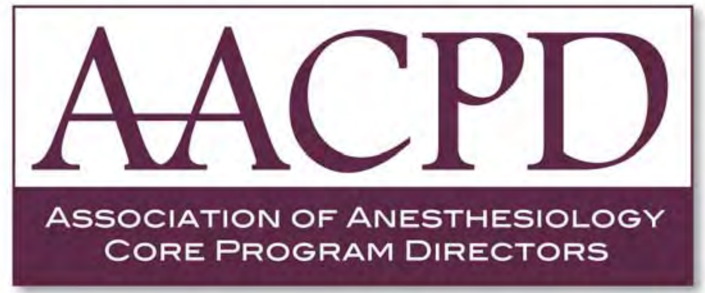

APPLICATION FOR AACPD MEMBERSHIP FOR 2012

Departmental Dues Amount: $675

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:

Society of Academic Anesthesiology Associations (SAAA)

Application and Applicable Payment is requested by March 31, 2012.

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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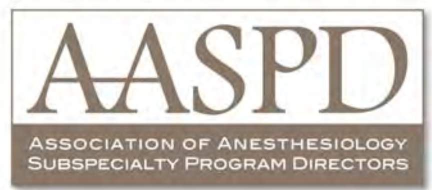

APPLICATION FOR AASPD MEMBERSHIP FOR 2012

Please complete the following contact information:

Name: ____

ACGME Approved Subspecialty Program – MUST be completed

- ☐ Pain Medicine
- ☐ Adult Cardiothoracic Anesthesiology
- ☐ Critical Care Medicine
- ☐ Pediatric Anesthesiology
- ☐ Obstetric Anesthesia

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: $675

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

Application and Payment (if required) is received by March 31, 2012.

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 AASPD if you are an 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 $200.

Name: ____

Address: ____

City: ____________________________ State: ________ ZIP Code: ______________

Telephone: __________________________ Fax: ______________________________

□ Check (*Make check payable to SAAA)* □ VISA □ MasterCard □ American Express

Credit Card No.: ______________________ Exp. Date: __________ CVV Number: ______

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Bailin, Michael T.	Baystate Med Ctr
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Marsh, H. Michael	Wayne State Univ
Martin, Robert D.	Loma Linda Univ
Maze, Mervyn	Univ of California, San Fran
McDonald, John S.	LA Cty Harbor, UCLA Med Ctr
McGoldrick, Kathryn E.	New York Med Coll, Westchester
McKay, Robert	Univ of Kansas Med Ctr Wichita
Mets, Berend	Penn State Milton S Hershey
Moore, Peter G.	Univ California Med Ctr- Davis
Mychaskiw, George	Drexel Univ Coll of Med
Narr, Brad J.	Mayo Sch of Grad Med Edu
Nearman, Howard S.	Univ Hosp Cleveland-Case Wstrn
Neuman, George	St. Vincent’s Hosp & Med Ctr
Newman, Mark	Duke Univ Med Ctr
O’Leary, Colleen E.	SUNY Upstate Med Univ
Pablo, Carmelita S.	Univ of Arkansas for Med Sci
Pearce, Robert A.	Univ Wisconsin Med Sch
Pearl, Ronald G.	Stanford Univ Med Ctr
Pesso, Raymond M.	Nassau Univ Med Ctr
Pollock, Julia E.	Virginia Mason Med Ctr
Presson, Robert G.	Indiana Univ Sch of Med
Prielipp, Richard C.	Univ of Minnesota
Prough, Donald S.	Univ of Texas Med Branch Hosp
Rao, Ashok S.	Louisiana St Univ Hth Sci Ctr
Reeves, Scott	Med Univ of South Carolina
Reeves-Viets, Joseph L.	Univ of Missouri Columbia Hosp
Reich, David L.	Mount Sinai Sch of Med

Rich, George F.	Univ Virginia Health System
Robelen, Gary T.	St Elizabeth's Med Ctr
Roberts, Kevin W.	Albany Medical Center
Rock, Peter	Univ of Maryland Sch of Med
Rosinia, Frank A.	Tulane Univ Sch of Med
Sandberg, Warren S.	Vanderbilt Univ Med Ctr
Santos, Alan C.	St Luke's Roosevelt Hospital
Savarese, John J.	New York Pres-Weill Cornell
Schapiro, Howard M.	Fletcher Allen Health Care
Schianodicola, Joseph	New York Methodist Hosp
Schubert, Armin	Ochsner Clinic Foundation
Schwartz, David E.	Univ of Illinois Chicago
Schwinn, Debra A.	Univ of Washington Med Ctr
Segal, Scott	Tufts-New England Med Ctr
Sidhu, Tejbir S.	MetroHealth-Case Wstrn Res
Simon, Brett A.	Beth Israel Deaconess Med Ctr
Spackman, Thomas	Mayo Clinic Florida
Stock, M. Christine	NW Univ Feinberg Sch of Med
Suresh, Maya S.	Baylor College of Medicine
Szpisjak, Dale F.	National Capital Consortium
Tobin, Joseph	Wake Forest Univ Sch of Med
Todd, Michael M.	Univ of Iowa Hosp & Clinics
Tremper, Kevin K.	Univ of Michigan Health System
Troianos, Christopher A.	Western Pennsylvania Hosp
Tuman, Kenneth J.	Rush Univ Med Ctr
Ulatowski, John A.	Johns Hopkins Hosp
Vacanti, Charles A.	Brigham & Women's Hosp
Voronov, Gennadiy	John H. Stroger Jr., Hospital
Ward, Denham S.	Strong Mem Hosp, Univ of Roch
Warltier, David	Med College of Wisconsin
Wasnick, John D.	Texas Tech Univ Lubbock
Wender, Ronald	Cedars-Sinai Medical Center
Whitten, Charles W.	Univ Texas Southwestern Med Ct
Wiener-Kronish, Jeanine P.	Massachusetts General Hospital
Williams, John P.	Univ of Pittsburgh Med Ctr
Wills, John	Univ of New Mexico Sch of Med
Winikoff, Stephen P.	St Joseph's Regional Med Ctr
Wood, Margaret	New York Pres Hosp, Columbia
Zanella, John	Univ of Tennessee, Memphis
Zvara, David A.	Univ of North Carolina Hosp

AAAC Members by Institution

AAAC Member	Institution
Roberts, Kevin W.	Albany Medical Center
Delphin, Ellise S.	Albert Einstein/Montefiore
Suresh, Maya S.	Baylor College of Medicine
Bailin, Michael T.	Baystate Med Ctr
Simon, Brett A.	Beth Israel Deaconess Med Ctr
Lewis, Keith P.	Boston Univ Med Ctr
Vacanti, Charles A.	Brigham & Women's Hosp
Abadir, Adel R.	Brookdale Univ Hosp
Wender, Ronald	Cedars-Sinai Medical Center
Brown, David L.	Cleveland Clinic Foundation
Goldberg, Michael	Cooper Hospital
Dodds, Thomas M.	Dartmouth Hitchcock Med Ctr
Kapur, Patricia A.	David Geffen Sch of Med UCLA
Mychaskiw, George	Drexel Univ Coll of Med
Newman, Mark	Duke Univ Med Ctr
Hill, Laureen L.	Emory Univ Sch of Med
Schapiro, Howard M.	Fletcher Allen Health Care
Berrigan, Michael	George Washington Univ Program
Kim, Young D.	Georgetown Univ Hosp
Hickey, Paul R.	Harvard Med Sch Childrens Hosp
Brown, Morris	Henry Ford Health System
Fleisher, Lee A.	Hosp of Univ of Pennsylvania
Presson, Robert G.	Indiana Univ Sch of Med
Voronov, Gennadiy	John H. Stroger Jr., Hospital
Ulatowski, John A.	Johns Hopkins Hosp
McDonald, John S.	LA Cty Harbor, UCLA Med Ctr
Martin, Robert D.	Loma Linda Univ
Kaye, Alan D.	Louisiana St
Rao, Ashok S.	Louisiana St Univ Hth Sci Ctr
Jellish, W. Scott	Loyola Univ Med Ctr
Konstadt, Steven N.	Maimonides Med Ctr
Allyn, John	Maine Med Ctr
Wiener-Kronish, Jeanine P.	Massachusetts General Hospital
Cole, Daniel J.	Mayo Clinic Arizona
Spackman, Thomas	Mayo Clinic Florida
Narr, Brad J.	Mayo Sch of Grad Med Edu
Warltier, David	Med College of Wisconsin
Reeves, Scott	Med Univ of South Carolina
Head, C. Alvin	Medical College of Georgia
Sidhu, Tejbir S.	MetroHealth-Case Wstrn Res
Reich, David L.	Mount Sinai Sch of Med
Pesso, Raymond M.	Nassau Univ Med Ctr
Szpisjak, Dale F.	National Capital Consortium

Bastien, John L.	Naval Med Ctr Portsmouth
Gullahorn, Gregory M.	Naval Med Ctr-San Diego
McGoldrick, Kathryn E.	New York Med Coll, Westchester
Schianodicola, Joseph	New York Methodist Hosp
Wood, Margaret	New York Pres Hosp, Columbia
Savarese, John J.	New York Pres-Weill Cornell
Blanck, Thomas J.J.	New York Univ Med Ctr
Stock, M. Christine	NW Univ Feinberg Sch of Med
Schubert, Armin	Ochsner Clinic Foundation
Harter, Ronald L.	Ohio State Univ Hosp
Kirsch, Jeffrey R.	Oregon Health & Science Univ
Mets, Berend	Penn State Milton S Hershey
Tuman, Kenneth J.	Rush Univ Med Ctr
Bittenbinder, Timothy M.	Scott & White Memorial Hosp
Robelen, Gary T.	St Elizabeth's Med Ctr
Winikoff, Stephen P.	St Joseph's Regional Med Ctr
Santos, Alan C.	St Luke's Roosevelt Hospital
Dorian, Robert S.	St. Barnabas Med Ctr
Haynes, Gary	St. Louis Univ Sch of Med
Neuman, George	St. Vincent's Hosp & Med Ctr
Pearl, Ronald G.	Stanford Univ Med Ctr
Ward, Denham S.	Strong Mem Hosp, Univ of Roch
Lema, Mark J.	SUNY at Buffalo
Glass, Peter S.	Suny at Stony Brook
Cottrell, James E.	Suny Downstate Med Ctr
O'Leary, Colleen E.	SUNY Upstate Med Univ
Barnette, Rodger E.	Temple Univ Hosp
Badr, Ahmed E.	Texas Tech Univ El Paso
Wasnick, John D.	Texas Tech Univ Lubbock
Grunwald, Zvi	Thomas Jefferson Univ Hosp
Segal, Scott	Tufts-New England Med Ctr
Rosinia, Frank A.	Tulane Univ Sch of Med
Davidson, Melissa L.	UMDNJ New Jersey Med Sch
Hunter, Christine	UMDNJ-Robert W Johnson Med Sch
Moore, Peter G.	Univ California Med Ctr- Davis
Hurford, William E.	Univ Cincinnati Med Ctr
Nearman, Howard S.	Univ Hosp Cleveland-Case Wstrn
Bowe, Edwin A.	Univ Kentucky Chandler Med Ctr
Fibuch, Eugene E.	Univ Missouri Kansas CIty
Ellis, Sheila J.	Univ Nebraska Med Ctr
Jones, Keith A.	Univ of Alabama at Birmingham
Barker, Steven J.	Univ of Arizona
Pablo, Carmelita S.	Univ of Arkansas for Med Sci
Kain, Zeev N.	Univ of California, Irvine
Manecke, Gerard R.	Univ of California, San Diego
Maze, Mervyn	Univ of California, San Fran
Apfelbaum, Jeffrey L.	Univ of Chicago Hosp
Henthorn, Thomas	Univ of Colorado, Denver

Gross, Jeffrey B.	Univ of Connecticut Health Ctr
Enneking, F. Kayser	Univ of Florida Med Ctr
Schwartz, David E.	Univ of Illinois Chicago
Todd, Michael M.	Univ of Iowa Hosp & Clinics
Kindscher, James D.	Univ of Kansas Med Ctr - K.C.
McKay, Robert	Univ of Kansas Med Ctr Wichita
Rock, Peter	Univ of Maryland Sch of Med
Heard, Stephen O.	Univ of Massachusetts Med Sch
Lubarsky, David A.	Univ of Miami Sch of Med
Tremper, Kevin K.	Univ of Michigan Health System
Prielipp, Richard C.	Univ of Minnesota
Allingham, Thomas A.	Univ of Mississippi Med Ctr
Reeves-Viets, Joseph L.	Univ of Missouri Columbia Hosp
Wills, John	Univ of New Mexico Sch of Med
Zvara, David A.	Univ of North Carolina Hosp
Williams, John P.	Univ of Pittsburgh Med Ctr
Lumb, Philip	Univ of Southern California
Epps, Jerry L.	Univ of Tennessee- Knoxville
Zanella, John	Univ of Tennessee, Memphis
Prough, Donald S.	Univ of Texas Med Branch Hosp
Hagberg, Carin A.	Univ of Texas Med Sch, Houston
Marco, Alan P.	Univ of Toledo Coll of Med
Schwinn, Debra A.	Univ of Washington Med Ctr
Fitch, Jane C.K.	Univ Oklahoma Hth Sci Ctr
Andrews, John Jeffrey	Univ Texas Hth Sci Ctr San An
Whitten, Charles W.	Univ Texas Southwestern Med Ct
Cahalan, Michael	Univ Utah Med Ctr
Rich, George F.	Univ Virginia Health System
Pearce, Robert A.	Univ Wisconsin Med Sch
Marrero, Miguel A.	University of Puerto Rico
Sandberg, Warren S.	Vanderbilt Univ Med Ctr
Arancibia, Carlos U.	Virginia Commonwealth Univ
Pollock, Julia E.	Virginia Mason Med Ctr
Tobin, Joseph	Wake Forest Univ Sch of Med
Evers, Alex S.	Washington Univ St. Louis
Marsh, H. Michael	Wayne State Univ
Driver, Richard P.	West Virginia Univ Sch of Med
Troianos, Christopher A.	Western Pennsylvania Hosp
Grant, James D.	William Beaumont Hospital
Hines, Roberta L.	Yale New Haven Med Ctr

Membership Lists

AACPD Members by Name

AACPD Member	Institution
Ahmed, Mohammed I.	Tufts-New England Med Ctr
Alarcon, William H.	Henry Ford Health System
Algren, John T.	Vanderbilt Univ Med Ctr
Alleyne, Audrey	Medical College of Georgia
Arica, Koray	Suny Downstate Med Ctr
Aronsohn, Judith L.	Brookdale Univ Hosp
Atwater, Benjamin I.	Univ of California, San Diego
Azocar, Ruben	Boston Univ Med Ctr
Baker, Keith H.	Massachusetts General Hospital
Beckman, William A.	Naval Med Ctr Portsmouth
Berger, Jeffrey S.	George Washington Univ Program
Black, Susan	Univ of Alabama at Birmingham
Calimaran, Arthur L.	Univ of Mississippi Med Ctr
Cary, Christopher W.	Maine Med Ctr
Chetty, Pramod K.	Univ Oklahoma Hth Sci Ctr
Chidiac, Elie J.	Wayne State Univ
Cirella, Vincent N.	UMDNJ-Robert W Johnson Med Sch
Clark, Laura L.	Univ of Louisville Hosp
Connors, Dean F.	St. Louis Univ Sch of Med
Cox, Thomas	Washington Univ St. Louis
Craft, Robert M.	Univ of Tennessee- Knoxville
Davidson, Melissa L.	UMDNJ New Jersey Med Sch
De Ruyter, Marie L.	Mayo Clinic Florida
Derdemezi, Jeanette	LA Cty Harbor, UCLA Med Ctr
Driver, Richard P.	West Virginia Univ Sch of Med
Duduch, Eleanor	Univ of Massachusetts Med Sch
Dunn, Steven M.	Baystate Med Ctr
Ebert, Thomas J.	Med College of Wisconsin
Eckert, Jill M.	Penn State Milton S Hershey
Euliano, Tammy Y.	Univ of Florida Med Ctr
Fibuch, Eugene E.	Univ Missouri Kansas City
Finegold, Helene	Western Pennsylvania Hosp
Freese, Kenneth J.	Nassau Univ Med Ctr
Gadsden, Jeff C.	St Luke's Roosevelt Hospital
Gaiser, Robert R.	Hosp of Univ of Pennsylvania
Gaitan, Brantley	Mayo Clinic Arizona
Gallagher, Christopher J.	SUNY at Stony Brook
Giesecke, Noel Martin	Univ Texas Southwestern Med Ct
Green, Michael S.	Drexel Univ Coll of Med
Hall, John K.	Texas Tech Univ Lubbock
Hawkins, Joy L.	Univ of Colorado, Denver
Helman, James D.	Virginia Mason Med Ctr
Hernandez, Michael R.	Univ of Chicago Hosp

Herron, Edwin W.	Louisiana St Univ Hth Sci Ctr
Jacobsen, Wayne K.	Univ of Arizona
Jaffar, Muhammad	univ of Arkansas for Med Sci
Karan, Suzanne B.	Strong Mem Hosp, Univ of Roch
Kaye, Alan D.	Louisiana St Univ New Orleans
Khorasani, Arjang	Advocate Illinois Masonic
Knox, S. Lynn	Univ of Texas Med Branch Hosp
Konia, Mojca R.	Univ of Minnesota
Kranner, Paul	Univ Wisconsin Med Sch
Kuhn, Catherine M.	Duke Univ Med Ctr
Landa, Seth E.	St Joseph’s Regional Med Ctr
Landrum, Alice L.	Univ of Missouri Columbia Hosp
Lawrence, John	Univ Cincinnati Med Ctr
Lekowski, Robert W.	Brigham & Women’s Hosp
Lema, Mark J.	SUNY at Buffalo
Levine, Adam I.	Mount Sinai Sch of Med
Lewis, Michael C.	Univ of Miami Sch of Med
Long, Timothy R.	Mayo Sch of Grad Med Edu
Lopez, Carlos J.	SUNY Upstate Med Univ
Lujan, Eugenio	Naval Med Ctr-San Diego
Macario, Alex	Stanford Univ Med Ctr
Maloney, Lisabeth L.	Dartmouth Hitchcock Med Ctr
Marasigan, Brian	Univ of Texas Med Sch, Houston
Marco, Alan P.	Univ of Toledo Coll of Med
Mayer, David C.	Univ of North Carolina Hosp
McAllister, Russell K.	Scott & White Memorial Hosp
McEvoy, Matthew D.	Med Univ of South Carolina
McIlvaine, William	Texas Tech Univ El Paso
McNulty, Stephen E.	Thomas Jefferson Univ Hosp
Metro, David G.	Univ of Pittsburgh Med Ctr
Mitchell, John D.	Beth Israel Deaconess Med Ctr
Murray, Amy M.	Loyola Univ Med Ctr
Nagle, Pamela C.	Wake Forest Univ Sch of Med
Nagy, Christopher J.	SAUSHEL
Nakata, David A.	Indiana Univ Sch of Med
Nasr, Ned F.	John H. Stroger Jr., Hospital
Nemergut, Edward C.	Univ Virginia Health System
Njoku, Mary J.	Univ of Maryland Sch of Med
Norcia, Matthew P.	Univ Hosp Cleveland-Case Wstrn
Ogden, L. Lazarre	Univ Utah Med Ctr
Pang, Leila Mei	New York Pres Hosp, Columbia
Pardo, Manuel	Univ of California, San Fran
Patel, Rajesh V.	Univ of Southern California
Philpot, Thomas E.	Emory Univ Sch of Med
Pitera, Richard	St. Barnabas Med Ctr
Primeaux, Paul J.	Tulane Univ Sch of Med
Rogers, James N.	Univ Texas Hth Sci Ctr San An
Roth, Andrew H.	Ohio State Univ Hosp

Sandison, Michael R.	Albany Medical Center
Sanford, Theodore	Univ of Michigan Health System
Savarese, John J.	New York Pres-Weill Cornell
Schartel, Scott A.	Temple Univ Hosp
Schell, Randall M.	Univ Kentucky Chandler Med Ctr
Scher, Corey	Albert Einstein/Montefiore
Schwartz, Jeffrey J.	Yale New Haven Med Ctr
Schwengel, Deborah A.	Johns Hopkins Hosp
Shapiro, Jay H.	Virginia Commonwealth Univ
Shulman, Mark S.	St Elizabeth's Med Ctr
Simonson, Jean A.	Univ Nebraska Med Ctr
Singh, Amrik	Univ California Med Ctr- Davis
Soto, Roy G.	William Beaumont Hospital
Souter, Karen J.	Univ of Washington Med Ctr
Stedman, Robin B.	Ochsner Clinic Foundation
Steele, Elizabeth A.	Univ of New Mexico Sch of Med
Stier, Gary R.	Loma Linda Univ
Strom, Suzanne L.	Univ of California, Irvine
Sullivan, John T.	NW Univ Feinberg Sch of Med
Suresh, Maya S.	Baylor College of Medicine
Swide, Christopher E.	Oregon Health & Science Univ
Szeluga, Debra Jean	Univ of Iowa Hosp & Clinics
Szpisjak, Dale F.	National Capital Consortium
Tetzlaff, John E.	Cleveland Clinic Foundation
Torres, Augusto J.	MetroHealth-Case Wstrn Res
Tuman, Kenneth J.	Rush Univ Med Ctr
Turner, Judi A.	David Geffen Sch of Med UCLA
Tyagaraj, Kalpana C.	Maimonides Med Ctr
Unruh, Gregory K.	Univ of Kansas Med Ctr - K.C.
VadeBoncouer, Tim R.	Univ of Illinois Chicago
Waisel, David B.	Harvard Med Sch Childrens Hosp
Wajda, Michael C.	New York Univ Med Ctr
Wall, Russell T.	Georgetown Univ Hosp
Yarmush, Joel M.	New York Methodist Hosp
Yarnell, Ralph W.	Fletcher Allen Health Care
Yumul, Roya	Cedars-Sinai Medical Center

AACPD Members by Institution

AACPD Member	Institution
Khorasani, Arjang	Advocate Illinois Masonic
Sandison, Michael R.	Albany Medical Center
Scher, Corey	Albert Einstein/Montefiore
Suresh, Maya S.	Baylor College of Medicine
Dunn, Steven M.	Baystate Med Ctr
Mitchell, John D.	Beth Israel Deaconess Med Ctr
Azocar, Ruben	Boston Univ Med Ctr
Lekowski, Robert W.	Brigham & Women's Hosp
Aronsohn, Judith L.	Brookdale Univ Hosp
Yumul, Roya	Cedars-Sinai Medical Center
Tetzlaff, John E.	Cleveland Clinic Foundation
Maloney, Lisabeth L.	Dartmouth Hitchcock Med Ctr
Turner, Judi A.	David Geffen Sch of Med UCLA
Green, Michael S.	Drexel Univ Coll of Med
Kuhn, Catherine M.	Duke Univ Med Ctr
Philpot, Thomas E.	Emory Univ Sch of Med
Yarnell, Ralph W.	Fletcher Allen Health Care
Berger, Jeffrey S.	George Washington Univ Program
Wall, Russell T.	Georgetown Univ Hosp
Waisel, David B.	Harvard Med Sch Childrens Hosp
Alarcon, William H.	Henry Ford Health System
Gaiser, Robert R.	Hosp of Univ of Pennsylvania
Nakata, David A.	Indiana Univ Sch of Med
Nasr, Ned F.	John H. Stroger Jr., Hospital
Schwengel, Deborah A.	Johns Hopkins Hosp
Derdemezi, Jeanette	LA Cty Harbor, UCLA Med Ctr
Stier, Gary R.	Loma Linda Univ
Herron, Edwin W.	Louisiana St Univ Hth Sci Ctr
Kaye, Alan D.	Louisiana St Univ New Orleans
Murray, Amy M.	Loyola Univ Med Ctr
Tyagaraj, Kalpana C.	Maimonides Med Ctr
Cary, Christopher W.	Maine Med Ctr
Baker, Keith H.	Massachusetts General Hospital
Gaitan, Brantley	Mayo Clinic Arizona
De Ruyter, Marie L.	Mayo Clinic Florida
Long, Timothy R.	Mayo Sch of Grad Med Edu
Ebert, Thomas J.	Med College of Wisconsin
McEvoy, Matthew D.	Med Univ of South Carolina
Alleyne, Audrey	Medical College of Georgia
Torres, Augusto J.	MetroHealth-Case Wstrn Res
Levine, Adam I.	Mount Sinai Sch of Med
Freese, Kenneth J.	Nassau Univ Med Ctr
Szpisjak, Dale F.	National Capital Consortium

Beckman, William A.	Naval Med Ctr Portsmouth
Lujan, Eugenio	Naval Med Ctr-San Diego
Yarmush, Joel M.	New York Methodist Hosp
Pang, Leila Mei	New York Pres Hosp, Columbia
Savarese, John J.	New York Pres-Weill Cornell
Wajda, Michael C.	New York Univ Med Ctr
Sullivan, John T.	NW Univ Feinberg Sch of Med
Stedman, Robin B.	Ochsner Clinic Foundation
Roth, Andrew H.	Ohio State Univ Hosp
Swide, Christopher E.	Oregon Health & Science Univ
Eckert, Jill M.	Penn State Milton S Hershey
Tuman, Kenneth J.	Rush Univ Med Ctr
Nagy, Christopher J.	SAUSHEL
McAllister, Russell K.	Scott & White Memorial Hosp
Shulman, Mark S.	St Elizabeth's Med Ctr
Landa, Seth E.	St Joseph's Regional Med Ctr
Gadsden, Jeff C.	St Luke's Roosevelt Hospital
Pitera, Richard	St. Barnabas Med Ctr
Connors, Dean F.	St. Louis Univ Sch of Med
Macario, Alex	Stanford Univ Med Ctr
Karan, Suzanne B.	Strong Mem Hosp, Univ of Roch
Lema, Mark J.	SUNY at Buffalo
Gallagher, Christopher J.	SUNY at Stony Brook
Arica, Koray	Suny Downstate Med Ctr
Lopez, Carlos J.	SUNY Upstate Med Univ
Schartel, Scott A.	Temple Univ Hosp
McIlvaine, William	Texas Tech Univ El Paso
Hall, John K.	Texas Tech Univ Lubbock
McNulty, Stephen E.	Thomas Jefferson Univ Hosp
Ahmed, Mohammed I.	Tufts-New England Med Ctr
Primeaux, Paul J.	Tulane Univ Sch of Med
Davidson, Melissa L.	UMDNJ New Jersey Med Sch
Cirella, Vincent N.	UMDNJ-Robert W Johnson Med Sch
Singh, Amrik	Univ California Med Ctr- Davis
Lawrence, John	Univ Cincinnati Med Ctr
Norcia, Matthew P.	Univ Hosp Cleveland-Case Wstrn
Schell, Randall M.	Univ Kentucky Chandler Med Ctr
Fibuch, Eugene E.	Univ Missouri Kansas City
Simonson, Jean A.	Univ Nebraska Med Ctr
Black, Susan	Univ of Alabama at Birmingham
Jacobsen, Wayne K.	Univ of Arizona
Jaffar, Muhammad	univ of Arkansas for Med Sci
Strom, Suzanne L.	Univ of California, Irvine
Atwater, Benjamin I.	Univ of California, San Diego
Pardo, Manuel	Univ of California, San Fran
Hernandez, Michael R.	Univ of Chicago Hosp
Hawkins, Joy L.	Univ of Colorado, Denver
Euliano, Tammy Y.	Univ of Florida Med Ctr

VadeBoncouer, Tim R.	Univ of Illinois Chicago
Szeluga, Debra Jean	Univ of Iowa Hosp & Clinics
Unruh, Gregory K.	Univ of Kansas Med Ctr - K.C.
Clark, Laura L.	Univ of Louisville Hosp
Njoku, Mary J.	Univ of Maryland Sch of Med
Duduch, Eleanor	Univ of Massachusetts Med Sch
Lewis, Michael C.	Univ of Miami Sch of Med
Sanford, Theodore	Univ of Michigan Health System
Konia, Mojca R.	Univ of Minnesota
Calimaran, Arthur L.	Univ of Mississippi Med Ctr
Landrum, Alice L.	Univ of Missouri Columbia Hosp
Steele, Elizabeth A.	Univ of New Mexico Sch of Med
Mayer, David C.	Univ of North Carolina Hosp
Metro, David G.	Univ of Pittsburgh Med Ctr
Patel, Rajesh V.	Univ of Southern California
Craft, Robert M.	Univ of Tennessee- Knoxville
Knox, S. Lynn	Univ of Texas Med Branch Hosp
Marasigan, Brian	Univ of Texas Med Sch, Houston
Marco, Alan P.	Univ of Toledo Coll of Med
Souter, Karen J.	Univ of Washington Med Ctr
Chetty, Pramod K.	Univ Oklahoma Hth Sci Ctr
Rogers, James N.	Univ Texas Hth Sci Ctr San An
Giesecke, Noel Martin	Univ Texas Southwestern Med Ct
Ogden, L. Lazarre	Univ Utah Med Ctr
Nemergut, Edward C.	Univ Virginia Health System
Kranner, Paul	Univ Wisconsin Med Sch
Algren, John T.	Vanderbilt Univ Med Ctr
Shapiro, Jay H.	Virginia Commonwealth Univ
Helman, James D.	Virginia Mason Med Ctr
Nagle, Pamela C.	Wake Forest Univ Sch of Med
Cox, Thomas	Washington Univ St. Louis
Chidiac, Elie J.	Wayne State Univ
Driver, Richard P.	West Virginia Univ Sch of Med
Finegold, Helene	Western Pennsylvania Hosp
Soto, Roy G.	William Beaumont Hospital
Schwartz, Jeffrey J.	Yale New Haven Med Ctr

Membership Lists

AASPD Members by Name

AASPD Member	Institution	Specialty
Abernathy, James H.	Med Univ of South Carolina	Adult Cardiothoracic Anes
Adesanya, Adebola O.	Univ Texas Southwestern Med Ct	Critical Care Medicine
Agarwal, Rita	Univ of Colorado, Denver	Pediatric Anesthesiology
Andrews, William R.	Wake Forest Univ Sch of Med	Critical Care Medicine
Anitescu, Magdalena	Univ of Chicago Hosp	Pain Medicine
Anton, James M.	Baylor College of Medicine	Adult Cardiothoracic Anes
Apostolidou, Ioanna	Univ of Minnesota	Adult Cardiothoracic Anes
Ault, Michael L.	NW Univ Feinberg Sch of Med	Critical Care Medicine
Aunspaugh, Jennifer P.	Univ of Arkansas for Med Sci	Pediatric Anesthesiology
Bachman, Catherine R.	Univ of Chicago Hosp	Pediatric Anesthesiology
Banks, Dalia	Univ of California, San Diego	Adult Cardiothoracic Anes
Bannister, Carolyn F.	Emory Univ Sch of Med	Pediatric Anesthesiology
Beasley, Ralph D.	Dartmouth Hitchcock Med Ctr	Pain Medicine
Bernstein, Wendy K.	Univ of Maryland Sch of Med	Adult Cardiothoracic Anes
Bittner, Edward	Massachusetts General Hospital	Critical Care Medicine
Blau, William S.	Univ of North Carolina Hosp	Pain Medicine
Blum, James M.	Univ of Michigan Health System	Critical Care Medicine
Boddu, Krishna	Univ of Texas Med Sch, Houston	Pain Medicine
Brenner, Gary J.	Massachusetts General Hospital	Pain Medicine
Brock, Charles W.	University of South Florida	Pain Medicine
Caldwell, Matthew D.	Univ of Michigan Health System	Adult Cardiothoracic Anes
Capdeville, Michelle	Cleveland Clinic Foundation	Adult Cardiothoracic Anes
Chaney, Mark A.	Univ of Chicago Hosp	Adult Cardiothoracic Anes
Charchaflieh, Jean	Suny Downstate Med Ctr	Critical Care Medicine
Chen, Grace	Oregon Health & Science Univ	Pain Medicine
Cheung, Albert T.	Hosp of Univ of Pennsylvania	Adult Cardiothoracic Anes
Chiravuri, Srinivas	Univ of Michigan Health System	Pain Medicine
Cladis, Franklyn P.	Univ of Pittsburgh Med Ctr	Pediatric Anesthesiology
Cohen, Ira Todd	George Washington Univ Progra	Pediatric Anesthesiology
Cope, Doris K.	Univ of Pittsburgh Med Ctr	Pain Medicine
Culp, William C.	Scott & White Memorial Hosp	Adult Cardiothoracic Anes
Datta, Sukdeb	Vanderbilt Univ Med Ctr	Pain Medicine
Day, Miles R.	Texas Tech Univ Lubbock	Pain Medicine
De Leon-Casasola, Oscar A.	Suny at Buffalo	Pain Medicine
Deem, Steven A.	Univ of Washington Med Ctr	Critical Care Medicine
Dimitrova, Galina T.	Ohio State Univ Hosp	Adult Cardiothoracic Anes
Diwan, Sudhir A.	New York Pres-Weill Cornell	Pain Medicine
Dolinski, Sylvia Y.	Med College of Wisconsin	Critical Care Medicine
Doulatram, Gulshan	Univ of Texas Med Branch Hosp	Pain Medicine
Eaton, Michael P.	Strong Mem Hosp, Univ of Roch	Adult Cardiothoracic Anes
Enomoto, T. Miko	Oregon Health & Science Univ	Critical Care Medicine
Erdek, Michael A.	Johns Hopkins Hosp	Pain Medicine
Faris, Khaldoun	Univ of Massachusetts Med Sch	Critical Care Medicine

Ferrante, F. Michael	David Geffen Sch of Med UCLA	Pain Medicine
Field, Larry C.	Med Univ of South Carolina	Critical Care Medicine
Fitzsimons, Michael G.	Massachusetts General Hospital	Adult Cardiothoracic Anes
Fleming, Neal W.	Univ California Med Ctr- Davis	Adult Cardiothoracic Anes
Flick, Randall P.	Mayo Sch of Grad Med Edu	Pediatric Anesthesiology
Furukawa, Louise	Stanford Univ Med Ctr	Pediatric Anesthesiology
Ginsberg, Steven H	UMDNJ-Robert W Johnson Med Sch	Adult Cardiothoracic Anes
Glass, Nancy L.	Baylor College of Medicine	Pediatric Anesthesiology
Grathwohl, Kurt W.	SAUSHEL	Critical Care Medicine
Green, Jeffrey	Virginia Commonwealth Univ	Adult Cardiothoracic Anes
Greilich, Philip E.	Univ Texas Southwestern Med Ct	Adult Cardiothoracic Anes
Haddy, Steven M.	Univ of Southern California	Adult Cardiothoracic Anes
Hall, Steven C.	NW Univ Feinberg Sch of Med	Pediatric Anesthesiology
Halliday, Norman J.	Univ of Miami Sch of Med	Pediatric Anesthesiology
Hammonds, William D.	Medical College of Georgia	Pain Medicine
Hamza, Maged S.	Virginia Commonwealth Univ	Pain Medicine
Hartsell, Theresa L.	Johns Hopkins Hosp	Critical Care Medicine
Hayek, Salim M.	Univ Hosp Cleveland-Case Wstrn	Pain Medicine
Hensley, Frederick A.	Univ of Alabama at Birmingham	Adult Cardiothoracic Anes
Hill, Shanna S.	New York Pres-Weill Cornell	Adult Cardiothoracic Anes
Holder, Donna M.	Louisiana St Univ Hth Sci Ctr	Pain Medicine
Hurley, Robert W.	Univ of Florida Med Ctr	Pain Medicine
Ivie, Clarence S.	Fletcher Allen Health Care	Pain Medicine
Iyer, Chandramouli P.	Univ Texas Southwestern Med Ct	Pain Medicine
Junker, Christopher D.	George Washington Univ Hosp	Critical Care Medicine
Kabazie, Abraham J.	Western Pennsylvania Hosp	Pain Medicine
Kalra, Aman	Tufts-New England Med Ctr	Pediatric Anesthesiology
Kaplan, Richard F.	Children's National Med Ctr	Pediatric Anesthesiology
Karimi, Danielle Perret	Univ of California, Irvine	Pain Medicine
Kaynar, Ata M.	Univ of Pittsburgh Med Ctr	Critical Care Medicine
Kodavatiganti, Ramesh	Penn State Milton S Hershey	Adult Cardiothoracic Anes
Kohl, Benjamin A.	Hosp of Univ of Pennsylvania	Critical Care Medicine
Koshkin, Eugene	Univ of New Mexico Sch of Med	Pain Medicine
Koutrouvelis, Aristides	Univ of Texas Med Branch Hosp	Critical Care Medicine
Kroll, Henry R.	Henry Ford Health System	Pain Medicine
Lalwani, Kirk	Oregon Health & Science Univ	Pediatric Anesthesiology
Lamer, Tim J.	Mayo Sch of Grad Med Edu	Pain Medicine
Lammers, Cathleen R.	Univ California Med Ctr- Davis	Pediatric Anesthesiology
Landsman, Ira S.	Vanderbilt Univ Med Ctr	Pediatric Anesthesiology
Lawson, Erin F.	Univ of CA - San Diego Med Ctr	Pain Medicine
Layon, Abraham	Univ of Florida Med Ctr	Critical Care Medicine
Leibowitz, Andrew B.	Mount Sinai Sch of Med	Critical Care Medicine
Levan, Pierre T.	Loyola Univ Med Ctr	Adult Cardiothoracic Anes
Lindsay, David R.	Duke Univ Med Ctr	Pain Medicine
Lininger, Todd E.	Wayne State Univ	Pain Medicine
Liu, Linda Lin	Univ of California, San Fran	Critical Care Medicine
Lubenow, Timothy R.	Rush Univ Med Ctr	Pain Medicine
Mackey, Sean C.	Stanford Univ Med Ctr	Pain Medicine

MacKnight, Brenda	Western Pennsylvania Hosp	Adult Cardiothoracic Anes
Mahajan, Aman	David Geffen Sch of Med UCLA	Adult Cardiothoracic Anes
Mahajan, Gagan	Univ California Med Ctr- Davis	Pain Medicine
Martinez-Ruiz, Ricardo	Univ of Miami Sch of Med	Critical Care Medicine
Mason, Linda J.	Loma Linda Univ	Pediatric Anesthesiology
Matuszczak, Maria E.	Univ of Texas Med Sch, Houston	Pediatric Anesthesiology
McKenzie-Brown, Anne M.	Emory Univ Sch of Med	Pain Medicine
McQuitty, Christopher	Univ of Texas Med Branch Hosp	Adult Cardiothoracic Anes
Mihm, Frederick G.	Stanford Univ Med Ctr	Critical Care Medicine
Mitter, Nanhi R.	Johns Hopkins Hosp	Adult Cardiothoracic Anes
Mora Mangano, Christina T.	Stanford Univ Med Ctr	Adult Cardiothoracic Anes
Nader, Nader D.	Suny at Buffalo	Adult Cardiothoracic Anes
Nagda, Jyotsna V.	Beth Israel Deaconess Med Ctr	Pain Medicine
Nagi, Peter A.	Univ of Alabama at Birmingham	Pain Medicine
Nedeljkovic, Srdjan S.	Brigham & Women's Hosp	Pain Medicine
Niezgoda, Julie J.	Cleveland Clinic Foundation	Pain Medicine
Njoku, Dolores B.	Johns Hopkins Hosp	Pediatric Anesthesiology
O'Connor, Michael F.	Univ of Chicago Hosp	Critical Care Medicine
Onigkeit, James A.	Mayo Sch of Grad Med Edu	Critical Care Medicine
Osborne, Michael	Mayo Clinic Florida	Pain Medicine
Papadakos, Peter J.	Strong Mem Hosp, Univ of Roch	Critical Care Medicine
Papadimos, Thomas J.	Ohio State Univ Hosp	Critical Care Medicine
Peng, Yong G.	Univ of Florida Med Ctr	Adult Cardiothoracic Anes
Pham, Thoha M.	Univ of California, San Fran	Pain Medicine
Phillips, Joyce F.	Univ of New Mexico Sch of Med	Pediatric Anesthesiology
Popovich, Marc	Cleveland Clinic Foundation	Critical Care Medicine
Puskas, Ferenc	Univ of Colorado, Denver	Adult Cardiothoracic Anes
Raghavendra, Meda	Loyola Univ Med Ctr	Pain Medicine
Ramsay, James G.	Emory Univ Sch of Med	Critical Care Medicine
Rassias, Athos J.	Dartmouth Hitchcock Med Ctr	Critical Care Medicine
Rebstock, Sarah E.	Penn State Milton S Hershey	Pain Medicine
Reynolds, Paul I.	Univ of Michigan Health System	Pediatric Anesthesiology
Richards, Michael J.	Univ of Washington Med Ctr	Pediatric Anesthesiology
Rosenbaum, Stanley H.	Yale New Haven Med Ctr	Critical Care Medicine
Sadovnikoff, Nicholas	Brigham & Women's Hosp	Critical Care Medicine
Sarantopoulos, Constantine D.	Univ of Miami Sch of Med	Pain Medicine
Sarge, Todd	Beth Israel Deaconess Med Ctr	Critical Care Medicine
Schrum, Stefanie F.	Nemours Children's Clinic	Pediatric Anesthesiology
Schwartz, Alan Jay	Hosp of Univ of Pennsylvania	Pediatric Anesthesiology
Sciarra, John C.	Univ of Miami Sch of Med	Adult Cardiothoracic Anes
Sera, Valerie A.	Oregon Health & Science Univ	Adult Cardiothoracic Anes
Serban, Stelian I.	Mount Sinai Sch of Med	Pain Medicine
Shanewise, Jack S.	New York Pres Hosp, Columbia	Adult Cardiothoracic Anes
Shankar, Hariharan	Med College of Wisconsin	Pain Medicine
Sharma, Anshuman	Washington Univ St. Louis	Pediatric Anesthesiology
Sheinbaum, Roy	Univ of Texas Med Sch, Houston	Adult Cardiothoracic Anes
Shook, Douglas C.	Brigham & Women's Hosp	Adult Cardiothoracic Anes
Shore-Lesserson, Linda J.	Albert Einstein/Montefiore	Adult Cardiothoracic Anes

Shukry, Mohanad	Univ Oklahoma Hth Sci Ctr	Pediatric Anesthesiology
Sivaraman, Vadivelu	Univ of Maryland Sch of Med	Critical Care Medicine
Sladen, Robert N.	New York Pres Hosp, Columbia	Critical Care Medicine
Slaughter, Thomas F.	Wake Forest Univ School of Med	Adult Cardiothoracic Anes
Sniecinski, Roman	Emory Univ Sch of Med	Adult Cardiothoracic Anes
Soong, Wayne	NW Univ Feinberg Sch of Med	Adult Cardiothoracic Anes
Stafford-Smith, Mark	Duke Univ Med Ctr	Adult Cardiothoracic Anes
Staudt, Susan	Med College of Wisconsin	Pediatric Anesthesiology
Steiner, Jeffrey W.	Univ Texas Southwestern Med Ct	Pediatric Anesthesiology
Stone, Marc	Mount Sinai Sch of Med	Adult Cardiothoracic Anes
Sullivan, Erin	Univ of Pittsburgh Med Ctr	Adult Cardiothoracic Anes
Sun, Lena S.	New York Pres Hosp, Columbia	Pediatric Anesthesiology
Sundar, Sugantha	Beth Israel Deaconess Med Ctr	Adult Cardiothoracic Anes
Swain, Anshuman R.	Ohio State Univ Hosp	Pain Medicine
Tassone, Rosalie F.	Univ of Illinois Chicago	Pediatric Anesthesiology
Thomas, Donna-Ann M.	Suny Upstate Med Univ	Pain Medicine
Thompson, Annemarie	Vanderbilt Univ Med Ctr	Adult Cardiothoracic Anes
Tongprasert, Sujittra	Univ of Louisville Hosp	Pain Medicine
Torres, Maria D.	John H. Stroger Jr., Hospital	Pain Medicine
Trescot, Andrea	Univ of Washington Med Ctr	Pain Medicine
Tripi, Paul A.	Univ Hosp Cleveland-Case Wstrn	Pediatric Anesthesiology
Valley, Robert D.	Univ of North Carolina Hosp	Pediatric Anesthesiology
Venticinque, Steven G.	Univ Texas Hth Sci Ctr San An	Critical Care Medicine
Vorenkamp, Kevin	Univ Virginia Health System	Pain Medicine
Wagner, Dennis L.	Indiana Univ Sch of Med	Pain Medicine
Waisel, David B.	Harvard Med Sch Childrens Hosp	Pediatric Anesthesiology
Walega, David R.	NW Univ Feinberg Sch of Med	Pain Medicine
Walker, Scott G.	Indiana Univ Sch of Med	Pediatric Anesthesiology
Wallace, Mark S.	Univ of California, San Diego	Pain Medicine
Wang, Dajie	Thomas Jefferson Univ Hosp	Pain Medicine
Warren, Daniel T.	Virginia Mason Med Ctr	Pain Medicine
Watt, Stacey A	SUNY at Buffalo	Pediatric Anesthesiology
Weavind, Liza M.	Vanderbilt Univ Med Ctr	Critical Care Medicine
Weinberger, Michael L.	New York Pres Hosp, Columbia	Pain Medicine
Weldon, B. Craig	Duke Univ Med Ctr	Pediatric Anesthesiology
Wienecke, Gretchen M.	Univ Oklahoma Hth Sci Ctr	Pain Medicine
Wilson, William C.	Univ of California, San Diego	Pediatric Anesthesiology
Wright, Thelma B.	Univ of Maryland Sch of Med	Pain Medicine
Yanofsky, Samuel	Univ of Southern California	Pediatric Anesthesiology
Young, Christopher	Duke Univ Med Ctr	Critical Care Medicine
Zaidi, Saleem A.	Univ of Texas Med Sch, Houston	Critical Care Medicine
Zestos, Maria M.	Wayne State Univ	Pediatric Anesthesiology
Zwass, Maurice S.	Univ of California, San Fran	Pediatric Anesthesiology

Membership Lists

AASPD Members by Institution

AASPD Member	Institution	Specialty
Shore-Lesserson, Linda J.	Albert Einstein/Montefiore	Adult Cardiothoracic Anes
Anton, James M.	Baylor College of Medicine	Adult Cardiothoracic Anes
Glass, Nancy L.	Baylor College of Medicine	Pediatric Anesthesiology
Nagda, Jyotsna V.	Beth Israel Deaconess Med Ctr	Pain Medicine
Sarge, Todd	Beth Israel Deaconess Med Ctr	Critical Care Medicine
Sundar, Sugantha	Beth Israel Deaconess Med Ctr	Adult Cardiothoracic Anes
Nedeljkovic, Srdjan S.	Brigham & Women's Hosp	Pain Medicine
Sadovnikoff, Nicholas	Brigham & Women's Hosp	Critical Care Medicine
Shook, Douglas C.	Brigham & Women's Hosp	Adult Cardiothoracic Anes
Kaplan, Richard F.	Children's National Med Ctr	Pediatric Anesthesiology
Capdeville, Michelle	Cleveland Clinic Foundation	Adult Cardiothoracic Anes
Niezgoda, Julie J.	Cleveland Clinic Foundation	Pain Medicine
Popovich, Marc	Cleveland Clinic Foundation	Critical Care Medicine
Beasley, Ralph D.	Dartmouth Hitchcock Med Ctr	Pain Medicine
Rassias, Athos J.	Dartmouth Hitchcock Med Ctr	Critical Care Medicine
Ferrante, F. Michael	David Geffen Sch of Med UCLA	Pain Medicine
Mahajan, Aman	David Geffen Sch of Med UCLA	Adult Cardiothoracic Anes
Lindsay, David R.	Duke Univ Med Ctr	Pain Medicine
Stafford-Smith, Mark	Duke Univ Med Ctr	Adult Cardiothoracic Anes
Weldon, B. Craig	Duke Univ Med Ctr	Pediatric Anesthesiology
Young, Christopher	Duke Univ Med Ctr	Critical Care Medicine
Bannister, Carolyn F.	Emory Univ Sch of Med	Pediatric Anesthesiology
McKenzie-Brown, Anne M.	Emory Univ Sch of Med	Pain Medicine
Ramsay, James G.	Emory Univ Sch of Med	Critical Care Medicine
Sniecinski, Roman	Emory Univ Sch of Med	Adult Cardiothoracic Anes
Ivie, Clarence S.	Fletcher Allen Health Care	Pain Medicine
Junker, Christopher D.	George Washington Univ Hosp	Critical Care Medicine
Cohen, Ira Todd	George Washington Univ Progra	Pediatric Anesthesiology
Waisel, David B.	Harvard Med Sch Childrens Hosp	Pediatric Anesthesiology
Kroll, Henry R.	Henry Ford Health System	Pain Medicine
Cheung, Albert T.	Hosp of Univ of Pennsylvania	Adult Cardiothoracic Anes
Kohl, Benjamin A.	Hosp of Univ of Pennsylvania	Critical Care Medicine
Schwartz, Alan Jay	Hosp of Univ of Pennsylvania	Pediatric Anesthesiology
Wagner, Dennis L.	Indiana Univ Sch of Med	Pain Medicine
Walker, Scott G.	Indiana Univ Sch of Med	Pediatric Anesthesiology
Torres, Maria D.	John H. Stroger Jr., Hospital	Pain Medicine
Erdek, Michael A.	Johns Hopkins Hosp	Pain Medicine
Hartsell, Theresa L.	Johns Hopkins Hosp	Critical Care Medicine
Mitter, Nanhi R.	Johns Hopkins Hosp	Adult Cardiothoracic Anes
Njoku, Dolores B.	Johns Hopkins Hosp	Pediatric Anesthesiology
Mason, Linda J.	Loma Linda Univ	Pediatric Anesthesiology
Holder, Donna M.	Louisiana St Univ Hth Sci Ctr	Pain Medicine
Levan, Pierre T.	Loyola Univ Med Ctr	Adult Cardiothoracic Anes

Raghavendra, Meda	Loyola Univ Med Ctr	Pain Medicine
Bittner, Edward	Massachusetts General Hospital	Critical Care Medicine
Brenner, Gary J.	Massachusetts General Hospital	Pain Medicine
Fitzsimons, Michael G.	Massachusetts General Hospital	Adult Cardiothoracic Anes
Osborne, Michael	Mayo Clinic Florida	Pain Medicine
Flick, Randall P.	Mayo Sch of Grad Med Edu	Pediatric Anesthesiology
Lamer, Tim J.	Mayo Sch of Grad Med Edu	Pain Medicine
Onigkeit, James A.	Mayo Sch of Grad Med Edu	Critical Care Medicine
Dolinski, Sylvia Y.	Med College of Wisconsin	Critical Care Medicine
Shankar, Hariharan	Med College of Wisconsin	Pain Medicine
Staudt, Susan	Med College of Wisconsin	Pediatric Anesthesiology
Abernathy, James H.	Med Univ of South Carolina	Adult Cardiothoracic Anes
Field, Larry C.	Med Univ of South Carolina	Critical Care Medicine
Hammonds, William D.	Medical College of Georgia	Pain Medicine
Leibowitz, Andrew B.	Mount Sinai Sch of Med	Critical Care Medicine
Serban, Stelian I.	Mount Sinai Sch of Med	Pain Medicine
Stone, Marc	Mount Sinai Sch of Med	Adult Cardiothoracic Anes
Schrum, Stefanie F.	Nemours Children's Clinic	Pediatric Anesthesiology
Shanewise, Jack S.	New York Pres Hosp, Columbia	Adult Cardiothoracic Anes
Sladen, Robert N.	New York Pres Hosp, Columbia	Critical Care Medicine
Sun, Lena S.	New York Pres Hosp, Columbia	Pediatric Anesthesiology
Weinberger, Michael L.	New York Pres Hosp, Columbia	Pain Medicine
Diwan, Sudhir A.	New York Pres-Weill Cornell	Pain Medicine
Hill, Shanna S.	New York Pres-Weill Cornell	Adult Cardiothoracic Anes
Ault, Michael L.	NW Univ Feinberg Sch of Med	Critical Care Medicine
Hall, Steven C.	NW Univ Feinberg Sch of Med	Pediatric Anesthesiology
Soong, Wayne	NW Univ Feinberg Sch of Med	Adult Cardiothoracic Anes
Walega, David R.	NW Univ Feinberg Sch of Med	Pain Medicine
Dimitrova, Galina T.	Ohio State Univ Hosp	Adult Cardiothoracic Anes
Papadimos, Thomas J.	Ohio State Univ Hosp	Critical Care Medicine
Swain, Anshuman R.	Ohio State Univ Hosp	Pain Medicine
Chen, Grace	Oregon Health & Science Univ	Pain Medicine
Enomoto, T. Miko	Oregon Health & Science Univ	Critical Care Medicine
Lalwani, Kirk	Oregon Health & Science Univ	Pediatric Anesthesiology
Sera, Valerie A.	Oregon Health & Science Univ	Adult Cardiothoracic Anes
Kodavatiganti, Ramesh	Penn State Milton S Hershey	Adult Cardiothoracic Anes
Rebstock, Sarah E.	Penn State Milton S Hershey	Pain Medicine
Lubenow, Timothy R.	Rush Univ Med Ctr	Pain Medicine
Grathwohl, Kurt W.	SAUSHEL	Critical Care Medicine
Culp, William C.	Scott & White Memorial Hosp	Adult Cardiothoracic Anes
Furukawa, Louise	Stanford Univ Med Ctr	Pediatric Anesthesiology
Mackey, Sean C.	Stanford Univ Med Ctr	Pain Medicine
Mihm, Frederick G.	Stanford Univ Med Ctr	Critical Care Medicine
Mora Mangano, Christina T.	Stanford Univ Med Ctr	Adult Cardiothoracic Anes
Eaton, Michael P.	Strong Mem Hosp, Univ of Roch	Adult Cardiothoracic Anes
Papadakos, Peter J.	Strong Mem Hosp, Univ of Roch	Critical Care Medicine
De Leon-Casasola, Oscar A.	Suny at Buffalo	Pain Medicine
Nader, Nader D.	Suny at Buffalo	Adult Cardiothoracic Anes

Watt, Stacey A	SUNY at Buffalo	Pediatric Anesthesiology
Charchaflieh, Jean	Suny Downstate Med Ctr	Critical Care Medicine
Thomas, Donna-Ann M.	Suny Upstate Med Univ	Pain Medicine
Day, Miles R.	Texas Tech Univ Lubbock	Pain Medicine
Wang, Dajie	Thomas Jefferson Univ Hosp	Pain Medicine
Kalra, Aman	Tufts-New England Med Ctr	Pediatric Anesthesiology
Ginsberg, Steven H	UMDNJ-Robert W Johnson Med Sch	Adult Cardiothoracic Anes
Fleming, Neal W.	Univ California Med Ctr- Davis	Adult Cardiothoracic Anes
Lammers, Cathleen R.	Univ California Med Ctr- Davis	Pediatric Anesthesiology
Mahajan, Gagan	Univ California Med Ctr- Davis	Pain Medicine
Hayek, Salim M.	Univ Hosp Cleveland-Case Wstrn	Pain Medicine
Tripi, Paul A.	Univ Hosp Cleveland-Case Wstrn	Pediatric Anesthesiology
Hensley, Frederick A.	Univ of Alabama at Birmingham	Adult Cardiothoracic Anes
Nagi, Peter A.	Univ of Alabama at Birmingham	Pain Medicine
Aunspaugh, Jennifer P.	Univ of Arkansas for Med Sci	Pediatric Anesthesiology
Lawson, Erin F.	Univ of CA - San Diego Med Ctr	Pain Medicine
Karimi, Danielle Perret	Univ of California, Irvine	Pain Medicine
Banks, Dalia	Univ of California, San Diego	Adult Cardiothoracic Anes
Wallace, Mark S.	Univ of California, San Diego	Pain Medicine
Wilson, William C.	Univ of California, San Diego	Pediatric Anesthesiology
Liu, Linda Lin	Univ of California, San Fran	Critical Care Medicine
Pham, Thoha M.	Univ of California, San Fran	Pain Medicine
Zwass, Maurice S.	Univ of California, San Fran	Pediatric Anesthesiology
Anitescu, Magdalena	Univ of Chicago Hosp	Pain Medicine
Bachman, Catherine R.	Univ of Chicago Hosp	Pediatric Anesthesiology
Chaney, Mark A.	Univ of Chicago Hosp	Adult Cardiothoracic Anes
O'Connor, Michael F.	Univ of Chicago Hosp	Critical Care Medicine
Agarwal, Rita	Univ of Colorado, Denver	Pediatric Anesthesiology
Puskas, Ferenc	Univ of Colorado, Denver	Adult Cardiothoracic Anes
Hurley, Robert W.	Univ of Florida Med Ctr	Pain Medicine
Layon, Abraham	Univ of Florida Med Ctr	Critical Care Medicine
Peng, Yong G.	Univ of Florida Med Ctr	Adult Cardiothoracic Anes
Tassone, Rosalie F.	Univ of Illinois Chicago	Pediatric Anesthesiology
Tongprasert, Sujittra	Univ of Louisville Hosp	Pain Medicine
Bernstein, Wendy K.	Univ of Maryland Sch of Med	Adult Cardiothoracic Anes
Sivaraman, Vadivelu	Univ of Maryland Sch of Med	Critical Care Medicine
Wright, Thelma B.	Univ of Maryland Sch of Med	Pain Medicine
Faris, Khaldoun	Univ of Massachusetts Med Sch	Critical Care Medicine
Halliday, Norman J.	Univ of Miami Sch of Med	Pediatric Anesthesiology
Martinez-Ruiz, Ricardo	Univ of Miami Sch of Med	Critical Care Medicine
Sarantopoulos, Constantine D.	Univ of Miami Sch of Med	Pain Medicine
Sciarra, John C.	Univ of Miami Sch of Med	Adult Cardiothoracic Anes
Blum, James M.	Univ of Michigan Health System	Critical Care Medicine
Caldwell, Matthew D.	Univ of Michigan Health System	Adult Cardiothoracic Anes
Chiravuri, Srinivas	Univ of Michigan Health System	Pain Medicine
Reynolds, Paul I.	Univ of Michigan Health System	Pediatric Anesthesiology
Apostolidou, Ioanna	Univ of Minnesota	Adult Cardiothoracic Anes
Koshkin, Eugene	Univ of New Mexico Sch of Med	Pain Medicine

Phillips, Joyce F.	Univ of New Mexico Sch of Med	Pediatric Anesthesiology
Blau, William S.	Univ of North Carolina Hosp	Pain Medicine
Valley, Robert D.	Univ of North Carolina Hosp	Pediatric Anesthesiology
Cladis, Franklyn P.	Univ of Pittsburgh Med Ctr	Pediatric Anesthesiology
Cope, Doris K.	Univ of Pittsburgh Med Ctr	Pain Medicine
Kaynar, Ata M.	Univ of Pittsburgh Med Ctr	Critical Care Medicine
Sullivan, Erin	Univ of Pittsburgh Med Ctr	Adult Cardiothoracic Anes
Haddy, Steven M.	Univ of Southern California	Adult Cardiothoracic Anes
Yanofsky, Samuel	Univ of Southern California	Pediatric Anesthesiology
Doulatram, Gulshan	Univ of Texas Med Branch Hosp	Pain Medicine
Koutrouvelis, Aristides	Univ of Texas Med Branch Hosp	Critical Care Medicine
McQuitty, Christopher	Univ of Texas Med Branch Hosp	Adult Cardiothoracic Anes
Boddu, Krishna	Univ of Texas Med Sch, Houston	Pain Medicine
Matuszczak, Maria E.	Univ of Texas Med Sch, Houston	Pediatric Anesthesiology
Sheinbaum, Roy	Univ of Texas Med Sch, Houston	Adult Cardiothoracic Anes
Zaidi, Saleem A.	Univ of Texas Med Sch, Houston	Critical Care Medicine
Deem, Steven A.	Univ of Washington Med Ctr	Critical Care Medicine
Richards, Michael J.	Univ of Washington Med Ctr	Pediatric Anesthesiology
Trescot, Andrea	Univ of Washington Med Ctr	Pain Medicine
Shukry, Mohanad	Univ Oklahoma Hth Sci Ctr	Pediatric Anesthesiology
Wienecke, Gretchen M.	Univ Oklahoma Hth Sci Ctr	Pain Medicine
Venticinque, Steven G.	Univ Texas Hth Sci Ctr San An	Critical Care Medicine
Adesanya, Adebola O.	Univ Texas Southwestern Med Ct	Critical Care Medicine
Greilich, Philip E.	Univ Texas Southwestern Med Ct	Adult Cardiothoracic Anes
Iyer, Chandramouli P.	Univ Texas Southwestern Med Ct	Pain Medicine
Steiner, Jeffrey W.	Univ Texas Southwestern Med Ct	Pediatric Anesthesiology
Vorenkamp, Kevin	Univ Virginia Health System	Pain Medicine
Brock, Charles W.	University of South Florida	Pain Medicine
Datta, Sukdeb	Vanderbilt Univ Med Ctr	Pain Medicine
Landsman, Ira S.	Vanderbilt Univ Med Ctr	Pediatric Anesthesiology
Thompson, Annemarie	Vanderbilt Univ Med Ctr	Adult Cardiothoracic Anes
Weavind, Liza M.	Vanderbilt Univ Med Ctr	Critical Care Medicine
Green, Jeffrey	Virginia Commonwealth Univ	Adult Cardiothoracic Anes
Hamza, Maged S.	Virginia Commonwealth Univ	Pain Medicine
Warren, Daniel T.	Virginia Mason Med Ctr	Pain Medicine
Andrews, William R.	Wake Forest Univ Sch of Med	Critical Care Medicine
Slaughter, Thomas F.	Wake Forest Univ School of Med	Adult Cardiothoracic Anes
Sharma, Anshuman	Washington Univ St. Louis	Pediatric Anesthesiology
Lininger, Todd E.	Wayne State Univ	Pain Medicine
Zestos, Maria M.	Wayne State Univ	Pediatric Anesthesiology
Kabazie, Abraham J.	Western Pennsylvania Hosp	Pain Medicine
MacKnight, Brenda	Western Pennsylvania Hosp	Adult Cardiothoracic Anes
Rosenbaum, Stanley H.	Yale New Haven Med Ctr	Critical Care Medicine

AASPD Members by Subspecialty

AASPD Member	Institution	Specialty
Shore-Lesserson, Linda J.	Albert Einstein/Montefiore	Adult Cardiothoracic Anes
Anton, James M.	Baylor College of Medicine	Adult Cardiothoracic Anes
Sundar, Sugantha	Beth Israel Deaconess Med Ctr	Adult Cardiothoracic Anes
Shook, Douglas C.	Brigham & Women's Hosp	Adult Cardiothoracic Anes
Capdeville, Michelle	Cleveland Clinic Foundation	Adult Cardiothoracic Anes
Mahajan, Aman	David Geffen Sch of Med UCLA	Adult Cardiothoracic Anes
Stafford-Smith, Mark	Duke Univ Med Ctr	Adult Cardiothoracic Anes
Sniecinski, Roman	Emory Univ Sch of Med	Adult Cardiothoracic Anes
Cheung, Albert T.	Hosp of Univ of Pennsylvania	Adult Cardiothoracic Anes
Mitter, Nanhi R.	Johns Hopkins Hosp	Adult Cardiothoracic Anes
Levan, Pierre T.	Loyola Univ Med Ctr	Adult Cardiothoracic Anes
Fitzsimons, Michael G.	Massachusetts General Hospital	Adult Cardiothoracic Anes
Abernathy, James H.	Med Univ of South Carolina	Adult Cardiothoracic Anes
Stone, Marc	Mount Sinai Sch of Med	Adult Cardiothoracic Anes
Shanewise, Jack S.	New York Pres Hosp, Columbia	Adult Cardiothoracic Anes
Hill, Shanna S.	New York Pres-Weill Cornell	Adult Cardiothoracic Anes
Soong, Wayne	NW Univ Feinberg Sch of Med	Adult Cardiothoracic Anes
Dimitrova, Galina T.	Ohio State Univ Hosp	Adult Cardiothoracic Anes
Sera, Valerie A.	Oregon Health & Science Univ	Adult Cardiothoracic Anes
Kodavatiganti, Ramesh	Penn State Milton S Hershey	Adult Cardiothoracic Anes
Culp, William C.	Scott & White Memorial Hosp	Adult Cardiothoracic Anes
Mora Mangano, Christina T.	Stanford Univ Med Ctr	Adult Cardiothoracic Anes
Eaton, Michael P.	Strong Mem Hosp, Univ of Roch	Adult Cardiothoracic Anes
Nader, Nader D.	Suny at Buffalo	Adult Cardiothoracic Anes
Ginsberg, Steven H	UMDNJ-Robert W Johnson Med Sch	Adult Cardiothoracic Anes
Fleming, Neal W.	Univ California Med Ctr- Davis	Adult Cardiothoracic Anes
Hensley, Frederick A.	Univ of Alabama at Birmingham	Adult Cardiothoracic Anes
Banks, Dalia	Univ of California, San Diego	Adult Cardiothoracic Anes
Chaney, Mark A.	Univ of Chicago Hosp	Adult Cardiothoracic Anes
Puskas, Ferenc	Univ of Colorado, Denver	Adult Cardiothoracic Anes
Peng, Yong G.	Univ of Florida Med Ctr	Adult Cardiothoracic Anes
Bernstein, Wendy K.	Univ of Maryland Sch of Med	Adult Cardiothoracic Anes
Sciarra, John C.	Univ of Miami Sch of Med	Adult Cardiothoracic Anes
Caldwell, Matthew D.	Univ of Michigan Health System	Adult Cardiothoracic Anes
Apostolidou, Ioanna	Univ of Minnesota	Adult Cardiothoracic Anes
Sullivan, Erin	Univ of Pittsburgh Med Ctr	Adult Cardiothoracic Anes
Haddy, Steven M.	Univ of Southern California	Adult Cardiothoracic Anes
McQuitty, Christopher	Univ of Texas Med Branch Hosp	Adult Cardiothoracic Anes
Sheinbaum, Roy	Univ of Texas Med Sch, Houston	Adult Cardiothoracic Anes
Greilich, Philip E.	Univ Texas Southwestern Med Ct	Adult Cardiothoracic Anes
Thompson, Annemarie	Vanderbilt Univ Med Ctr	Adult Cardiothoracic Anes
Green, Jeffrey	Virginia Commonwealth Univ	Adult Cardiothoracic Anes
Slaughter, Thomas F.	Wake Forest Univ School of Med	Adult Cardiothoracic Anes

MacKnight, Brenda	Western Pennsylvania Hosp	Adult Cardiothoracic Anes
Sarge, Todd	Beth Israel Deaconess Med Ctr	Critical Care Medicine
Sadovnikoff, Nicholas	Brigham & Women's Hosp	Critical Care Medicine
Popovich, Marc	Cleveland Clinic Foundation	Critical Care Medicine
Rassias, Athos J.	Dartmouth Hitchcock Med Ctr	Critical Care Medicine
Young, Christopher	Duke Univ Med Ctr	Critical Care Medicine
Ramsay, James G.	Emory Univ Sch of Med	Critical Care Medicine
Junker, Christopher D.	George Washington Univ Hosp	Critical Care Medicine
Kohl, Benjamin A.	Hosp of Univ of Pennsylvania	Critical Care Medicine
Hartsell, Theresa L.	Johns Hopkins Hosp	Critical Care Medicine
Bittner, Edward	Massachusetts General Hospital	Critical Care Medicine
Onigkeit, James A.	Mayo Sch of Grad Med Edu	Critical Care Medicine
Dolinski, Sylvia Y.	Med College of Wisconsin	Critical Care Medicine
Field, Larry C.	Med Univ of South Carolina	Critical Care Medicine
Leibowitz, Andrew B.	Mount Sinai Sch of Med	Critical Care Medicine
Sladen, Robert N.	New York Pres Hosp, Columbia	Critical Care Medicine
Ault, Michael L.	NW Univ Feinberg Sch of Med	Critical Care Medicine
Papadimos, Thomas J.	Ohio State Univ Hosp	Critical Care Medicine
Enomoto, T. Miko	Oregon Health & Science Univ	Critical Care Medicine
Grathwohl, Kurt W.	SAUSHEL	Critical Care Medicine
Mihm, Frederick G.	Stanford Univ Med Ctr	Critical Care Medicine
Papadakos, Peter J.	Strong Mem Hosp, Univ of Roch	Critical Care Medicine
Charchaflieh, Jean	Suny Downstate Med Ctr	Critical Care Medicine
Liu, Linda Lin	Univ of California, San Fran	Critical Care Medicine
O'Connor, Michael F.	Univ of Chicago Hosp	Critical Care Medicine
Layon, Abraham	Univ of Florida Med Ctr	Critical Care Medicine
Sivaraman, Vadivelu	Univ of Maryland Sch of Med	Critical Care Medicine
Faris, Khaldoun	Univ of Massachusetts Med Sch	Critical Care Medicine
Martinez-Ruiz, Ricardo	Univ of Miami Sch of Med	Critical Care Medicine
Blum, James M.	Univ of Michigan Health System	Critical Care Medicine
Kaynar, Ata M.	Univ of Pittsburgh Med Ctr	Critical Care Medicine
Koutrouvelis, Aristides	Univ of Texas Med Branch Hosp	Critical Care Medicine
Zaidi, Saleem A.	Univ of Texas Med Sch, Houston	Critical Care Medicine
Deem, Steven A.	Univ of Washington Med Ctr	Critical Care Medicine
Venticinque, Steven G.	Univ Texas Hth Sci Ctr San An	Critical Care Medicine
Adesanya, Adebola O.	Univ Texas Southwestern Med Ct	Critical Care Medicine
Weavind, Liza M.	Vanderbilt Univ Med Ctr	Critical Care Medicine
Andrews, William R.	Wake Forest Univ Sch of Med	Critical Care Medicine
Rosenbaum, Stanley H.	Yale New Haven Med Ctr	Critical Care Medicine
Nagda, Jyotsna V.	Beth Israel Deaconess Med Ctr	Pain Medicine
Nedeljkovic, Srdjan S.	Brigham & Women's Hosp	Pain Medicine
Niezgoda, Julie J.	Cleveland Clinic Foundation	Pain Medicine
Beasley, Ralph D.	Dartmouth Hitchcock Med Ctr	Pain Medicine
Ferrante, F. Michael	David Geffen Sch of Med UCLA	Pain Medicine
Lindsay, David R.	Duke Univ Med Ctr	Pain Medicine
McKenzie-Brown, Anne M.	Emory Univ Sch of Med	Pain Medicine
Ivie, Clarence S.	Fletcher Allen Health Care	Pain Medicine
Kroll, Henry R.	Henry Ford Health System	Pain Medicine

Wagner, Dennis L.	Indiana Univ Sch of Med	Pain Medicine
Torres, Maria D.	John H. Stroger Jr., Hospital	Pain Medicine
Erdek, Michael A.	Johns Hopkins Hosp	Pain Medicine
Holder, Donna M.	Louisiana St Univ Hth Sci Ctr	Pain Medicine
Raghavendra, Meda	Loyola Univ Med Ctr	Pain Medicine
Brenner, Gary J.	Massachusetts General Hospital	Pain Medicine
Osborne, Michael	Mayo Clinic Florida	Pain Medicine
Lamer, Tim J.	Mayo Sch of Grad Med Edu	Pain Medicine
Shankar, Hariharan	Med College of Wisconsin	Pain Medicine
Hammonds, William D.	Medical College of Georgia	Pain Medicine
Serban, Stelian I.	Mount Sinai Sch of Med	Pain Medicine
Weinberger, Michael L.	New York Pres Hosp, Columbia	Pain Medicine
Diwan, Sudhir A.	New York Pres-Weill Cornell	Pain Medicine
Walega, David R.	NW Univ Feinberg Sch of Med	Pain Medicine
Swain, Anshuman R.	Ohio State Univ Hosp	Pain Medicine
Chen, Grace	Oregon Health & Science Univ	Pain Medicine
Rebstock, Sarah E.	Penn State Milton S Hershey	Pain Medicine
Lubenow, Timothy R.	Rush Univ Med Ctr	Pain Medicine
Mackey, Sean C.	Stanford Univ Med Ctr	Pain Medicine
De Leon-Casasola, Oscar A.	Suny at Buffalo	Pain Medicine
Thomas, Donna-Ann M.	Suny Upstate Med Univ	Pain Medicine
Day, Miles R.	Texas Tech Univ Lubbock	Pain Medicine
Wang, Dajie	Thomas Jefferson Univ Hosp	Pain Medicine
Mahajan, Gagan	Univ California Med Ctr- Davis	Pain Medicine
Hayek, Salim M.	Univ Hosp Cleveland-Case Wstrn	Pain Medicine
Nagi, Peter A.	Univ of Alabama at Birmingham	Pain Medicine
Lawson, Erin F.	Univ of CA - San Diego Med Ctr	Pain Medicine
Karimi, Danielle Perret	Univ of California, Irvine	Pain Medicine
Wallace, Mark S.	Univ of California, San Diego	Pain Medicine
Pham, Thoha M.	Univ of California, San Fran	Pain Medicine
Anitescu, Magdalena	Univ of Chicago Hosp	Pain Medicine
Hurley, Robert W.	Univ of Florida Med Ctr	Pain Medicine
Tongprasert, Sujittra	Univ of Louisville Hosp	Pain Medicine
Wright, Thelma B.	Univ of Maryland Sch of Med	Pain Medicine
Sarantopoulos, Constantine D.	Univ of Miami Sch of Med	Pain Medicine
Chiravuri, Srinivas	Univ of Michigan Health System	Pain Medicine
Koshkin, Eugene	Univ of New Mexico Sch of Med	Pain Medicine
Blau, William S.	Univ of North Carolina Hosp	Pain Medicine
Cope, Doris K.	Univ of Pittsburgh Med Ctr	Pain Medicine
Doulatram, Gulshan	Univ of Texas Med Branch Hosp	Pain Medicine
Boddu, Krishna	Univ of Texas Med Sch, Houston	Pain Medicine
Trescot, Andrea	Univ of Washington Med Ctr	Pain Medicine
Wienecke, Gretchen M.	Univ Oklahoma Hth Sci Ctr	Pain Medicine
Iyer, Chandramouli P.	Univ Texas Southwestern Med Ct	Pain Medicine
Vorenkamp, Kevin	Univ Virginia Health System	Pain Medicine
Brock, Charles W.	University of South Florida	Pain Medicine
Datta, Sukdeb	Vanderbilt Univ Med Ctr	Pain Medicine
Hamza, Maged S.	Virginia Commonwealth Univ	Pain Medicine

Warren, Daniel T.	Virginia Mason Med Ctr	Pain Medicine
Lininger, Todd E.	Wayne State Univ	Pain Medicine
Kabazie, Abraham J.	Western Pennsylvania Hosp	Pain Medicine
Glass, Nancy L.	Baylor College of Medicine	Pediatric Anesthesiology
Kaplan, Richard F.	Children's National Med Ctr	Pediatric Anesthesiology
Weldon, B. Craig	Duke Univ Med Ctr	Pediatric Anesthesiology
Bannister, Carolyn F.	Emory Univ Sch of Med	Pediatric Anesthesiology
Cohen, Ira Todd	George Washington Univ Progra	Pediatric Anesthesiology
Waisel, David B.	Harvard Med Sch Childrens Hosp	Pediatric Anesthesiology
Schwartz, Alan Jay	Hosp of Univ of Pennsylvania	Pediatric Anesthesiology
Walker, Scott G.	Indiana Univ Sch of Med	Pediatric Anesthesiology
Njoku, Dolores B.	Johns Hopkins Hosp	Pediatric Anesthesiology
Mason, Linda J.	Loma Linda Univ	Pediatric Anesthesiology
Flick, Randall P.	Mayo Sch of Grad Med Edu	Pediatric Anesthesiology
Staudt, Susan	Med College of Wisconsin	Pediatric Anesthesiology
Schrum, Stefanie F.	Nemours Children's Clinic	Pediatric Anesthesiology
Sun, Lena S.	New York Pres Hosp, Columbia	Pediatric Anesthesiology
Hall, Steven C.	NW Univ Feinberg Sch of Med	Pediatric Anesthesiology
Lalwani, Kirk	Oregon Health & Science Univ	Pediatric Anesthesiology
Furukawa, Louise	Stanford Univ Med Ctr	Pediatric Anesthesiology
Watt, Stacey A	SUNY at Buffalo	Pediatric Anesthesiology
Kalra, Aman	Tufts-New England Med Ctr	Pediatric Anesthesiology
Lammers, Cathleen R.	Univ California Med Ctr- Davis	Pediatric Anesthesiology
Tripi, Paul A.	Univ Hosp Cleveland-Case Wstrn	Pediatric Anesthesiology
Aunspaugh, Jennifer P.	Univ of Arkansas for Med Sci	Pediatric Anesthesiology
Wilson, William C.	Univ of California, San Diego	Pediatric Anesthesiology
Zwass, Maurice S.	Univ of California, San Fran	Pediatric Anesthesiology
Bachman, Catherine R.	Univ of Chicago Hosp	Pediatric Anesthesiology
Agarwal, Rita	Univ of Colorado, Denver	Pediatric Anesthesiology
Tassone, Rosalie F.	Univ of Illinois Chicago	Pediatric Anesthesiology
Halliday, Norman J.	Univ of Miami Sch of Med	Pediatric Anesthesiology
Reynolds, Paul I.	Univ of Michigan Health System	Pediatric Anesthesiology
Phillips, Joyce F.	Univ of New Mexico Sch of Med	Pediatric Anesthesiology
Valley, Robert D.	Univ of North Carolina Hosp	Pediatric Anesthesiology
Cladis, Franklyn P.	Univ of Pittsburgh Med Ctr	Pediatric Anesthesiology
Yanofsky, Samuel	Univ of Southern California	Pediatric Anesthesiology
Matuszczak, Maria E.	Univ of Texas Med Sch, Houston	Pediatric Anesthesiology
Richards, Michael J.	Univ of Washington Med Ctr	Pediatric Anesthesiology
Shukry, Mohanad	Univ Oklahoma Hth Sci Ctr	Pediatric Anesthesiology
Steiner, Jeffrey W.	Univ Texas Southwestern Med Ct	Pediatric Anesthesiology
Landsman, Ira S.	Vanderbilt Univ Med Ctr	Pediatric Anesthesiology
Sharma, Anshuman	Washington Univ St. Louis	Pediatric Anesthesiology
Zestos, Maria M.	Wayne State Univ	Pediatric Anesthesiology

Concurrent Schedules - Friday, November 4, 2011

7:00 a.m. - 6:00 p.m. **Registration**

AACPD Concurrent Session

Moderator: Theodore J. Sanford, Jr. M.D.

8:00 - 9:00 a.m. **Grooming the Next PD: They're Not Making This Any Easier**
Theodore J. Sanford, Jr., M.D.

9:00 - 9:45 a.m. **New Strategies in Achieving Duty Hour Compliance**
Catherine M. Kuhn, M.D.

9:45 - 10:30 a.m. **Coffee Break and Networking**

10:30 - 11:15 a.m. **Best Practices**
Karen J. Souter, M.B.B.S., M.Sc., F.R.C.A.; Robert M. Craft, M.D.; Debra Szeluga M.D., Ph.D.; Leila Mei Pang, M.D.

11:15 a.m. - Noon **Communicating with the RRC**
Neal H. Cohen, M.D., M.P.H., M.S.; Patricia M. Surdyk, Ph.D.

AACPD Concurrent Session

Moderator: Theodore J. Sanford, Jr. M.D.

1:30 - 3:30 p.m. **Social Media: Use & Abuse of Electronic Communication**
Moderator: L. Lazarre Ogden, M.D.

Resident and Applicant Social Media Use
Amy Murray, M.D.

MAYO Clinic Social Media Policy
Timothy Long, M.D.

Survey of Social Networking: Implications to Solutions
Russell K. McAllister, M.D.

Institutional Perspectives
Rita M. Patel, M.D.

Question and Answer Session

3:30 - 3:45 p.m. **Coffee Break and Networking**

3:45 - 4:15 p.m. **The NRMP- What's New and What's Going to be New**
Mona M. Signer

4:15 - 4:30 p.m. **Question and Answer Session**

4:30 - 6:00 p.m. **AACPD Business Meeting**

Concurrent Schedules - Friday, November 4, 2011

7:00 a.m. - 6:00 p.m. Registration

AAAC Concurrent Session

Moderator: Jeffrey R. Kirsch, M.D.

9:00 - 9:25 a.m. **Service Agreement Negotiations 101**
Kevin K. Tremper, Ph.D., M.D.

9:25 - 9:50 a.m. **How to Prevent Yourself from Being Fired**
Ronald G. Pearl, M.D., Ph.D.

9:50 - 10:10 a.m. **Personal Development as a Chair; Importance of Becoming a Leader in the Hospital/SOM/University**
Joanne M. Conroy, M.D.

10:10 - 10:35 a.m. **Coffee Break and Networking**

10:35 - 10:55 a.m. **How Do You Develop a Culture of Scholarship That Will Be Meaningful To Your Faculty, Dean and RRC**
Mark F. Newman, M.D.

10:55 - 11:20 a.m. **Compensation Models: How to Incentivize, But Not Upset Your Faculty Too Much**
John A. Ulatowski, M.D., Ph.D.

11:20 - 11:45 a.m. **What a New Chair Needs to Know About the RRC**
Margaret Wood, M.B.Ch.B.

11:45 a.m. - Noon **Question and Answer**

AAAC Concurrent Session

Moderator: Berend Mets, M.B.Ch.B., Ph.D.

1:30 - 1:50 p.m. **Perfect Storm**
Kevin K. Tremper, Ph.D., M.D.

1:50 - 2:10 p.m. **Creating Value from Day 1: Seven Step Program**
David A. Zvara, M.D.

2:10 - 2:30 p.m. **Accountable Care Organization and Impact on Anesthesiology**
Patricia A. Kapur, M.D.

2:30 - 3:00 p.m. **Discussion and Comments**

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

3:30 - 4:10 p.m. **Debate: The Role of International Medical Graduates Certification and Recognition from the ABA...**
Kevin K. Tremper, Ph.D., M.D.; David L. Brown, M.D.

4:10 - 4:30 p.m. **Discussion and Comments**

4:30 - 5:00 p.m. **Case Based Scenarios**
Judith Jurin Semo, J.D., Esq.

5:00 - 5:15 p.m. **Discussion and Comments**

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

AASPD Concurrent Session

Subspecialty Program Directors Morning Session I
Moderator: Robert N. Sladen, M.B.Ch.B.

9:00 - 9:45 a.m. **How Effective are our Fellowship Programs in Training Faculty? An Employer's Perspective**
Warren S. Sandberg, M.D., Ph.D.; David L. Brown, M.D.; Margaret Wood, M.B.Ch.B.

9:45 - 10:30 a.m. **Update 2011: The New RRC Program Requirements**
Linda J. Mason, M.D.; Neal H. Cohen, M.D., M.P.H., M.S.

10:30 - 10:45 a.m. **Coffee Break and Networking**

Subspecialty Program Directors Morning Session II
Moderator: Linda J. Mason, M.D.

10:45 – 11:15 a.m. **The Pediatric Anesthesia Match: A Match Made in Heaven?**
Nancy L. Glass, M.D., M.B.A.

11:15 a.m. - Noon **Are Fellows Adults? Applying Adult Learning Principles to Fellow Education**
Robert R. Gaiser, M.D., M.S.Ed.

12:00 p.m. **Lunch on your own or Program Directors Meetings**

AASPD Concurrent Session

1:30 - 3:00 p.m. **Program Directors Break-Out Meetings by Specialty**

Pain Medicine
Moderator: Gary J. Brenner, M.D., Ph.D.

Critical Care
Moderator: Benjamin A. Kohl, M.D.

Pediatric Anesthesiology
Moderator: Scott G. Walker, M.D.

Adult Cardiothoracic
Moderator: Jack S. Shanewise, M.D.

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

3:30 - 5:00 p.m. **AASPD Business Meeting and Subspecialty Updates**
Moderator: Robert N. Sladen, M.B.Ch.B.

Pain Medicine
Moderator: Gary J. Brenner, M.D., Ph.D.

Critical Care
Moderator: Benjamin A. Kohl, M.D.

Pediatric Anesthesiology
Moderator: Scott G. Walker, M.D.

Adult Cardiothoracic
Moderator: Jack S. Shanewise, M.D.

Program Schedule - *Saturday, November 5*

7:00 - 8:00 a.m.	**Continental Breakfast**
8:00 - 9:15 a.m.	**General Session 1: Healthcare & Audit** Moderator: Berend Mets, M.B.Ch.B., Ph.D.
8:00 - 8:25 a.m.	**Healthcare Reform: What it Could Mean to Academic Anesthesiologists** Joanne M. Conroy, M.D.
8:25 - 8:50 a.m.	**New CMS Guidelines and How to Survive a CMS Audit** Zeev N. Kain, M.D., M.B.A.
8:50 - 9:15 a.m.	**Discussion and Comments**
9:15 - 9:45 a.m.	**Coffee Break and Networking**
9:45 - 11:25 a.m.	**General Session 2: Future of Anesthesiology and Training** Moderator: Berend Mets, M.B.Ch.B., Ph.D.
9:45 - 10:10 a.m.	**Future of Anesthesiology** Warren Sandberg, M.D., Ph.D.
10:10 - 10:50 a.m.	**Pro-Con Debate: Training the Right Number of Anesthesiologists for the Future** David A. Zvara, M.D.; John F. Butterworth, IV, M.D.
10:50 - 11:25 a.m.	**Discussion and Comments**
11:25 a.m. - 12:30 p.m.	**General Session 3: CRNA & Anesthesia Assistant Practice** Moderator: Jane C.K. Fitch, M.D.
11:25 - 11:30 a.m.	**Scope of Practice: CRNAs / AAs** Jane C.K. Fitch, M.D.
11:30 - 11:45 a.m.	**Co-exisiting Residency and AA Training Program** Matthew P. Norcia, M.D.
11:45 a.m. - Noon	**Co-exisiting Residency and CRNA Training Program** Sally R. Raty, M.D.
Noon - 12:15 p.m.	**How To Get AAs In Your State** Matthew P. Norcia, M.D.
12:15 - 12:30 p.m.	**Discussion and Comments**
12:30 - 1:30 p.m.	**Lunch Provided**
1:30 - 3:00 p.m.	**General Session 4: Mock RRC Committee Meeting and Milestone Project** Moderator: Berend Mets, M.B.Ch.B., Ph.D.
1:30 - 2:30 p.m.	**Mock RRC Committee Meeting** Neal H. Cohen, M.D., M.P.H., M.S.; Patricia M. Surdyk, Ph.D.; Linda J. Mason, M.D.; Margaret Wood, M.B.Ch.B.; William Hart
2:30 - 2:50 p.m.	**ACGME Milestones Project: How it will Affect Residency Training** Neal H. Cohen, M.D., M.P.H., M.S.
2:50 - 3:00 p.m.	**Discussion and Comments**
3:00 - 3:20 p.m.	**Coffee Break and Networking**

Program Schedule - *Saturday, November 5 (cont.)*

3:20 - 6:00 p.m.	**General Session 5: Faculty Evaluation and ASA Update** Moderator: Berend Mets, M.B.Ch.B., Ph.D.
3:20 - 3:40 p.m.	**How to Improve a Disruptive Faculty Member** Steven J. Barker, Ph.D., M.D.
3:40 - 4:00 p.m.	**Annual Faculty Reviews: Best Practices** Jeffrey L. Apfelbaum, M.D.
4:00 - 4:20 p.m.	**Ongoing Professional Practice Evaluation: Best Practices** Randall M. Clark, M.D.
4:20 - 4:45 p.m.	**Discussion and Comments**
4:45 - 5:00 p.m.	**ASA Structure** Jane C.K. Fitch, M.D.
5:00 - 5:15 p.m.	**Update from SAAA Director to ASA** Steven J. Barker, Ph.D., M.D.
5:15 - 6:00 p.m.	**ASA Update** Jerry A. Cohen, M.D.
6:30 - 8:00 p.m.	**Reception**

Program Schedule - *Sunday, November 6*

7:00 - 7:30 a.m.	**Continental Breakfast**
7:30 - 8:00 a.m.	**SAAA Business Meeting**
8:00 a.m. - Noon	**General Session 6: Updates** Moderator: Berend Mets, M.B.Ch.B., Ph.D.
8:00 - 8:45 a.m.	**Update from the ACGME** Thomas Nasca, M.D., M.A.C.P.
8:45 - 9:00 a.m.	**Discussion and Comments**
9:00 - 9:30 a.m.	**Anesthesiology RRC Update** Neal H. Cohen, M.D., M.P.H., M.S.
9:30 - 9:45 a.m.	**Discussion and Comments**
9:45 - 10:15 a.m.	**Coffee Break and Networking**
10:15 - 10:30 a.m.	**FAER Update** Denham S. Ward, M.D., Ph.D.
10:30 - 11:00 a.m.	**ABA Update** David L. Brown, M.D.
11:00 - 11:30 a.m.	**In-Training Exam Update** Cynthia A. Lien, M.D.
11:30 - Noon	**Discussion and Comments**
Noon	**Adjourn**

SAAA 2012 Annual Meeting

November 2-4, 2012

Hyatt Regency San Francisco

San Francisco, CA

Plan to Attend These SAAA Future Meetings

SAAA 2013 Annual Meeting

November 1-3, 2013

Westin Philadelphia Hotel

Philadelphia, PA

AACPD Presentaion Material

Moderator: Theodore J. Sanford, Jr. M.D.

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Institutional Perspectives
Rita M. Patel, M.D.

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Mona M. Signer

Grooming the Next PD: They're Not Making This Any Easier

Theodore J. Sanford, Jr., M.D.

At the completion of this session the participants will be able to:

1. Identify the attributes that are essential to being a successful program director.
2. Recognize the importance of the language used by the ACGME and RCs in the requirements of Anesthesia Core Programs.
3. Incorporate several best practices into the participant's program management.

The Next Program Director: They're Not Making This Any Easier

Theodore J. Sanford Jr. M.D.
The Georgine M. Steude Professor of Anesthesia Education
Core Program Director
University of Michigan

Note: These are my own opinions and do not represent the University of Michigan or AACPD

Core Program Director-Job Description

- **Not a glamorous job**
  - **You are the ultimate SLJO**
  - **You are the department chair's XO**
- **Program directors make the chair look good**
  - **Or bad**
- **You and your chair must be on the same page!**

General Characteristics of PD

1. Start as Junior Faculty; express strong interest in the education components of their department.

2. Accept numerous small tasks….writing the tutorial schedules, moderating conferences, mentoring a difficult resident….developing on-line content etc..

General Characteristics of PD

3. Serve on various departmental and hospital committees as the Anesthesia Rep etc..

4. You express a great deal of interest in the resident education mission of the department. And you have your own philosophy for what makes for a successful resident training program.

Should not be surprised when asked to run the Core Program

Core Program Directors..

- "*Should- continue in his or her position for a length of time*"
  - This is not a 1-2 year assignment, more like 5 years to understand everything and go through the trauma of a site visit…like JACHO
  - Remember when you take the reins you inherit years of someone else's successes, recruits and headaches

Demographics of PDs

- Median age ~52
- ~75% Men
- 66% Professor or Associate Professor
- Median appointment is about 4 years!
- Turn-over is averaging 15-20%/year!
- 20% Time limited certificates

» Data from Timothy Long et al Mayo Clinic-JCA 2010

Other Attributes of a PD

- Thick Skin
- Humility- not everything you do will be perfect and you will miss quite a few things (some only once though)
- Be realistic- you will not change the world in a day
- Accept suggestions from the residents
- Good communication skills
- Be able to say no
- Be able to ask for help
- Be able to make unpopular changes

Other Attributes of a PD

- Trustworthy-
- Buy-in with GME philosophy-
  - Do not take the job if you think that your department PD will change the direction of the current DIO
- Honesty- be willing not to sugar-coat evaluations of residents. "Oh, they'll be ok"
- Communication skills- be able to delineate and communicate your expectations to the residents in the program.
- Commitment- Probably should be #1 on the list.

General Education of the PD

1. Must learn the 2008 RRC Requirements!
2. 2008 RRC Requirements- 7556 words
   a. Allows for some individual interpretations- but……
3. Must learn the ACGME-RRC vocabulary
4. ACGME- feels it necessary to define what some words mean
   a. May not always agree with an RRC's interpretations
   b. Published 3 **Glossary of Terms** in last 18 months.

Anesthesiology RRC 2008 Requirements

The Program*	146	Required*	10
Must*	142	Obtain	10
Not	44	Submit	9
Should*	40	Evaluate	8
Provide	37	Necessary	7
May	32	Minimum	6
Requires*	32	Report	4
PD*	29	Responsible	4
Ensure	17	Substantial	3
Approve	13	Verify	3
Supervision	13	Comply	3
Duty Hours*	11	Shall*	2
Monitor	10	Oversee	1

* In the glossary

"On Further Review"

- 106 "musts" are Common Program Requirements
  - 35 additional are anesthesia RRC
- 32 "musts" added for July 2011
- 9 "fatigues"- for July 2011
  - Only 4 times in 2008 RRC
- 14- "demonstrates"

MUST(s)-Things to consider----

- "The Program Director Must"
  - *Maintain oversight- all rotations, faculty appointments etc..*

How are you going to do this?

The Chair usually hires faculty

MUSTs- CBY

- CBY
  - FY 12 more PGY 1 matches than PGY2
  - Intern advocate
  - Determine- the sequence of rotations
  - Review quarterly evals on in-house interns
  - Review- Duty hours- set up for disaster?
    - Who takes the "hit"? Surgery, Medicine, ED?
  - Review outside CBYs quarterly

Education Program

- *Administer and Maintain an educational environment conducive to educating the residents in each of the ACGME competency areas.*
- Oversee and ensure quality of education
- *Approve a local director at each participating site who is accountable for resident education-* better run this past the Chair
- Approve the selection of program faculty as appropriate

Education Program

- Evaluate program faculty and approve the continued participation of program faculty based on evaluation- this is the chair's job!
- Monitor resident supervision at all participating sites
- Prepare and submit all information required and requested by the ACGME program information ADS
  - ensure that all submitted information is correct and complete
- Provide- residents with documented semi-annual reviews of performance with feedback

Duty Hours

- *Implement policies and procedures consistent with the institutional and program requirements for resident duty hours and working environment including moonlighting to that end the PD must*
  - Distribute these policies and procedures to the residents and faculty
  - Monitor resident duty hours according to the sponsoring institutional policies with a frequency sufficient to ensure compliance with ACGME
  - Adjust schedule as necessary to mitigate excessive service demands and/or fatigue- BUT YOU DON'T KNOW until you know!
  - If applicable monitor the demands of at-home call.
- Monitor-duty hours, need for back up support, distribution of cases

PD Musts

- **Comply**- with institutional policies
- **Confirm**- that all residents completing the program have met the requirement for the 48 month continuum
- Regularly- **review** the residents clinical experience logs and **verify** their accuracy when transmitted to the RRC
- **Ensure**- that there is a substance abuse policy
- **Ensure**- the means to monitor appropriate distribution of cases among the residents.
- **Require**- residents maintain electronic case logs
- **Document**- faculty involvement in lectures, clinical supervision, and tutorials

Faculty- Musts

- There are 9 musts for the 'faculty'. I tell you this because you have to **ensure** that this is happening in your department, even though it should be the chair's job…when it comes time for the RRC site visit you will be on the hook, so think of yourself as the canary in the mine….someone has to do it.

Faculty Musts

1. Ensure a sufficient number of faculty at each site to instruct and supervise
   a. Devote sufficient time to the educational program… a strong interest in education of residents
2. Faculty must have current certification from the ABA.

19

Faculty Musts

3. *"the number of faulty must be sufficient to provide each resident with adequate supervision, which shall not vary substantially with the time of the day of the week. In the clinical anesthesia setting, faculty members should not direct anesthesia at more than two anesthetizing locations simultaneously."*

   Better be sure on this one, since the RRC electronic PIF specifically asks if this is true….its a yes or no with a space for explaining…but there is no excuse that has been accepted…not even emergency cases that have to go before you can get a second faculty in house.

20

Faculty Musts

4. Current license etc..
5. Qualified non-physician faculty
6. Must **establish** and **maintain** an environment of scholarship and inquiry and research
   Peer reviewed funding, publications, presentations at meetings, national committees
7. All of the above **must** be present in the program
8. **Must** regularly participate in didactics, journal clubs, rounds etc..
9. **Assure** that didactic and clinical teaching faculty is provided by faculty with documented interests in the subspecialty involved

21

Program Director Hats

Facility Manager	Librarian
Housekeeper	Compliance Officer
Scheduler	Recorder
Administrator	Disciplinarian
Auditor	Recruiter
Good Cop	Bad Cop
H.R. Director	Arbitrator
Soft Shoulder	Publisher
Recovery Monitor	Chief cook/bottle washer

22

Facility Manager

- Ensure adequate resources for resident education
  - Space and equipment
  - Meeting rooms, classrooms
  - Computer support including access to medical information-(We used to call this a library)
- Must provide appropriate on-call rooms that are gender specific– in fact you **should** have a written policy!

23

Human Resource Specialist

- Resident Recruitment
  - Must **comply** with institutional requirements
  - Cannot appoint more residents than you are approved for by the RRC
  - (Expected to keep a well stocked residency of happy residents who will speak well of your program during recruiting season)

24

Resident Transfers

- Must **obtain** a written or electronic verification of previous training experiences and a summative competency-based performance evaluation from the transferring program
- **Must check** the NRMP match history- do you know where to look? NRMP R3 system

25

Auditor

- Adequate case loads etc..
  - Must **verify** volume and variety of cases-
  - So you need to determine a way to monitor how cases are distributed.
    - I do this by making out a yearly schedule that assigns subspecialty blocks- where appropriate and have my clinical director do the daily schedules based on my yearly blocks. CA-1s may be harder to schedule.

26

Educator/Publisher

- Common Program v. RRC specific requirements
  - Recent site reviewers have focused mostly on the Common Program Requirements-leaving the electronic PIF to the RRC.
    - Annual survey
    - Duty Hours

27

Educator/Publisher

ACGME Core Competencies

RRC has inculcated the Core program specifics with the 6 core competencies/ 25 sub-competencies

1. Patient Care-
   a. Case Logs now moved to Web Based and you must know how to access this to monitor the cases on the Web

2. Medical Knowledge- assessment methods…AKTs, ITE, Mock Orals, daily evals in ORs.

3. Practice Based-Learning and Improvement- How do you do this one?

28

Educator/Publisher

4. Interpersonal and Communication Skills- many ways to evaluate, PD needs to decide

5. Professionalism- “you know it when you see it”

6. Systems Based Practice- Never heard of this until 8 years ago

29

Evaluator

PD oversees this

1. We use MEDHUB
2. PD **must assure** that residents are evaluated in a timely manner- We use e-mail reminder system
3. Residents **should** be encouraged to evaluate faculty too. This was a focus of site reviews
4. PD provides semi-annual review- If you take the job you need to figure a mechanism for you to do this.
5. Set up a spread sheet, and then figure out how to provide feedback

30

Evaluator

'PD **must** provide a summative evaluation for each resident upon the completion of the program…..

Verify that resident has demonstrated ability to practice without supervision!'

Program Evaluation

RRC says annual program evaluation.

a. Survey both residents and faculty
b. Make changes based on this annual survey
(My feeling is that you should not wait to do an annual survey to make changes)
c. Changes must be approved by the teaching faculty! How dumb is this?

New Duty Hours Rules

- PD must review and approve any duty hour/time off submissions that exceed the maximum allowed!
- 16 Hours of duty for interns! OUCH!
- PD need to develop a mechanism for dealing with these new rules!

How to Deal with the Chair

Best advice-

Rule One- The Chair always wins
Rule Two- Get over it,
Rule Three- See rule 1

This is not a contest of wills- the bottom line is the residents, and what is good for the program as a whole!

How to Deal with Faculty

1. You will not win a popularity contest
   a. RRC Guidelines- not open for interpretation by individual faculty
   b. Send them the guidelines
   c. Send them the Core Competencies
   d. Make it easy for them to do the evaluations
   e. Difficult faculty- that's why you have a chairperson

How to Deal with Residents

- Chief Resident(s) are crucial
  - Rumor, hearsay, innuendo—bad
- Meet with the chief(s) regularly
  - Quarterly resident meetings
- Listen to what they have to say
- Keep an open door
- Keep and open mind
- Be willing to change!

Dealing with GME, ACGME, RRC, NRMP

- **GME-** do their required paperwork on time- always
  - They can make your life good or bad
- **ACGME-** do their paperwork too!
  - Find their website, and visit it often
- **RRC-** Do not try to outguess, they have rules that are for the general population
  - You are not that special!
- **NRMP-** see rule one for the chairs-
  - No sense of humor!

Resources

- ACGME web site-http://www.acgme.org/acWebsite/home/home.asp
- AACPD- (that's us!)
  - http://www.aapd-saac.org/aacpd.htm
- ABA- http://www.theaba.org
- Weekly updates from ACGME by e-mail

P.I.F Preparation

- This is now electronic
- RRC will use this document during reviews
- Be very careful to be sure it is complete
  - Helpful to review and update your PIF every 3-6 months.
  - There are lots of changes in ACGME documentation requirements- only seem to show up in ACGME Newsletters!

Watch For These!!!!!

- **ACGME e-Communication**
- **October 18, 2010**
-
- *Welcome to this week's issue of* ACGME e-Communication. *We welcome feedback on the newsletter. Comments may be sent to ACGMECommunications@acgme.org. Questions about information posted in the newsletter should be directed to the appropriate staff contacts.*

Take Home

1. This is not a part time job
2. Get help, a good administrator; assistant PD depending on the size of your program
3. Stay ahead of the paperwork game
   1. Automate anything you can. (site visitor said we had too much paper)
   2. You are the ultimate Compliance Officer

Take Home

- 4. Always consider 'should', 'shall', as MUST
- 5. Keep every correspondence you send to residents, GME, ACGME, RRC, your faculty!
- 6. You must be creative with how to document 'musts'
- 7. Don't give up.

New Strategies in Achieving Duty Hour Compliance

Catherine M. Kuhn, M.D.

Objectives:

After attending this session, attendees will:

1. Describe the differences in duty hour requirements between 2003 and present.
2. Define national, institutional and departmental challenges in compliance with the requirements.
3. Summarize the unintended consequences of the implementation of the 2011 ACGME requirements.
4. List strategies employed to comply with duty hours and mitigate fatigue.
5. Develop an appreciation for the existing literature regarding patient safety and duty hours changes.

Summary:

For decades, academic medical centers have relied upon a resident-centric, hierarchical approach to patient care. Requirements for supervision of care by senior residents and faculty were loosely defined. Junior trainees bore the largest burden of direct patient care, and training hours were largely unregulated. Although typical duty hours varied by specialty, it was not uncommon for trainees to work over 100 hours per week.

The Libby Zion case in 1984 generated a great deal of discussion about the conditions for graduate medical education and the potential for errors and patient safety problems when trainees were fatigued. The publication "To Err is Human" from the Institute of Medicine in 1999 has illuminated the challenges in creating a safer health care system, including the impact of fatigue on patient care. Increased scrutiny from accrediting bodies has resulted in a call for limitation of trainee duty hours, originating initially in the state of New York and now mandated through duty hours requirements of the Accreditation Council for Graduate Medical Education.

Faced with these requirements, programs and institutions have developed a variety of strategies to achieve duty hour compliance. However, as occurs in any large scale system change, unintended consequences have occurred, and debate continues about whether these duty hour changes have improved or worsened the educational experience of our trainees. Even harder to elicit is whether these changes have improved the quality and safety of patient care, and patient satisfaction with the care they receive.

The presentation will review the current duty hour policies of the ACGME, as well as more specific supervision requirements now in place. Various strategies for compliance with duty hours, and their advantages and disadvantages will be discussed. Finally, the existing literature regarding the effect of restricted duty hours on residency education and on patient safety will be considered.

Selected References:

1. Howard SK, Rosenkind MR, Katz JD et al. Fatigue in anesthesia—implications and strategies for patient and provider safety. Anesthesiology 2002; 97:1281-94.
2. Lockley SWS, Cronin JW, Evans EE et al. Effect of reducing interns' weekly work hours on sleep and attentional failures. New Engl J Med 2004; 351:1829-37.
3. Fletcher KE, Underwood III W, Davis SQ et al. Effect of work hours reduction on residents' lives: a systematic review. JAMA 2005; 294: 1088-1100.
4. Swide CE and Kirsch JR. Duty hours restrictions and their effect on resident education and academic departments: the American perspective. Curr Opin Anaesth 2007; 20: 580-4.
5. Landrigan CP, Fahrenkopf AM, Levin D et al. Effects of the Accreditation Council on Graduate Medical Education duty hours limits on sleep, work hours, and safety. Pediatrics 2008; 122: 250-8.
6. Jagganathan J, Vates GE, Pouratian N et al. Impact on the Accreditation Council on Graduate Medical Education work hour regulations on neurosurgical resident education and productivity. J Neurosurg 2009; 110: 820-7.
7. Antiel RM, Thompson SM, Reed DA et al. ACGME duty hour recommendations: a national survey of residency program directors. New Engl J Med 2010 e12 (1-6), accessed Oct. 21, 2011.
8. Kashner TM, Henley SS, Golden RM et al. Studying the effects of ACGME duty hours limits on resident satisfaction: results from the VA learners' perception survey. Acad Med 2010; 85:1130-9.
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10. Reed DA, Fletcher KE, and Arora VM. Systematic review: association of shift length, protected sleep time, and night float on patient care, residents' health, and education. Ann Intern Med 2010; 153:829-42.
11. Jamal MH, Rousseau MC, Hanna WC et al. Effect of the ACGME duty hours restrictions on surgery residents and faculty: a systematic review. Acad Med 2011; 86:34-42.
12. McCoy CP, Halvoreen AJ, Loftus CG et al. Effect of 16-hour duty periods on patient care and resident education. Mayo Clin Proc 2011; 86:192-6.

Also:

Shangvai, D. The phantom menace of sleep-deprived doctors. New York Times Magazine, Aug 5, 2011. http://www.nytimes.com/2011/08/07/magazine/the-phantom-menace-of-sleep-deprived-doctors.html?_r=1 accessed October 21, 2011

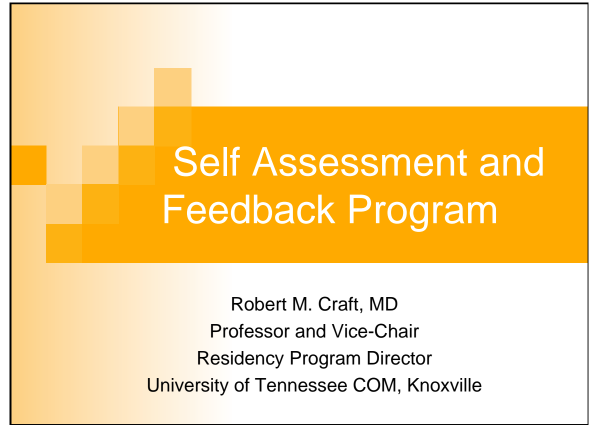
Best Practices

Karen J. Souter, M.B.B.S., M.Sc., F.R.C.A.; Robert M. Craft, M.D.; Debra Szeluga M.D., Ph.D.; Leila Mei Pang, M.D.

Learning Objective

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

1. Describe the potential program benefits of resident self-assessment and faculty feedback;
2. Describe the aspects of effective feedback;
3. Implement resident self-assessment and feedback into his/her program.
4. Describe verification of proficiency and be able to apply the example (obtaining consent) to the educational objectives in their own program.

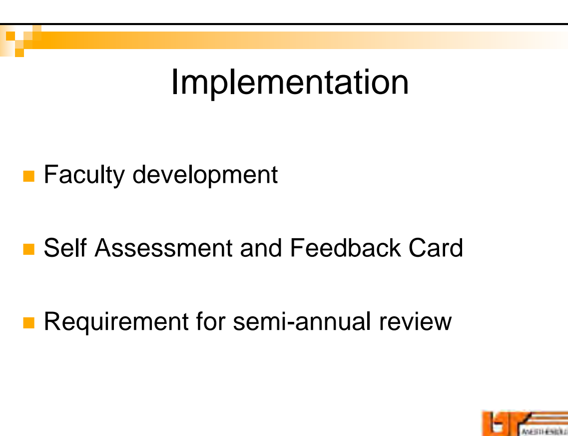


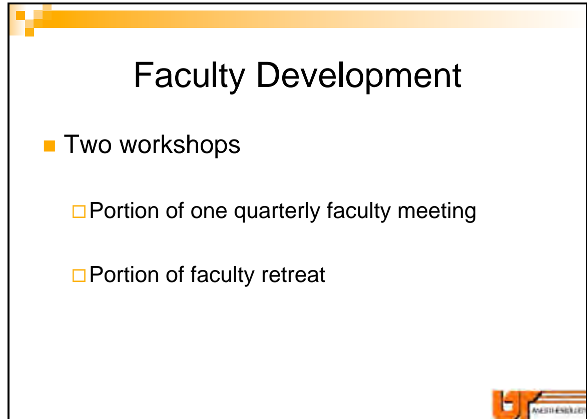
Goals and Objectives

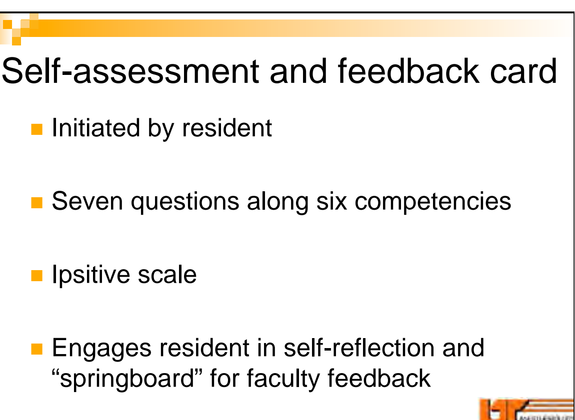
- Engage residents in self-reflection
- Teach "advanced" competencies
- Focus for faculty development

Outcomes

- Included in PIF as "Best Practice", learning activity for PBL&I, and faculty development
- Maximum review cycle length and mentioned by site reviewer







Self-assessment and feedback card

- Patient Care:

  Did you give compassionate, appropriate, and effective patient care, and competently perform all medical and invasive procedures?
- Medical Knowledge:

  Did you demonstrate adequate basic and clinical science knowledge, and apply this knowledge to patient

Self-assessment and feedback card

- Interpersonal and Communication Skills:

  Did you work as a team with nurses, other health care professionals, patients and their families?
- Systems-Based Practice:

  Did you utilize awareness of the larger health care system to provide patient care of optimal value**?**

Self-assessment and feedback card

- Professionalism:

  Did you demonstrate a commitment to carrying out professional responsibilities (including complete charting and documentation)?

  Did you adhere to ethical principles, and demonstrate a responsiveness to patients and society that superseded self-interest?

Self-assessment and feedback card

- What did you learn today?
- What do you plan to improve? How?
- Resident Name: _______________ Signature:________________
- Staff Name:___________________ Signature:________________
- Date of Encounter:_____
- Date of Feedback:_____

Requirement for Semi-Annual Review

- Each resident must have 5 cards for each month rotation within department
- Participation considered aspect of professionalism

Summary of Self-Assessment and Feedback

- Provides a structure to establish self-reflection, which is essential to life-long learning
- May allow for teaching and actual improvement in the “advanced” competencies
- Can be utilized to satisfy several program requirements

Verification of Proficiency

Debra Szeluga, MD, PhD
Program Director
Vice Chair for Education
University of Iowa

Verification of Proficiency (VOP)

- Determination that trainee can perform a skill to a predetermined target level of ability
- Does not imply "mastery" or ability to perform independently, but a ***safe*** level of skill
- Why?
  - Duty hour limits, efficiency, patient safety

Steps

- Instructional module is developed
- Proficiency exam is developed
- Curriculum is taught and learned
- Application of the skill is tested in a simulated environment
- Performance is videotaped and evaluated
  - Pass – ok to perform in real life
  - Fail – trainee needs additional practice

Instructional Module

- Objectives
- Assumptions
- References
- Description of the Laboratory Module
- Description of the Procedure
- Common Errors
- Video
- Supplies and Preparation

Anesthesia Consent VOP

- Curriculum taught to CA1 residents (orientation)
- Guided practice in clinical setting (first 2-4 months)
- Facilitated practice with "patients" (video-taped) and debriefed (month 2)
- VOP (video-taped) and debriefed (month 4)

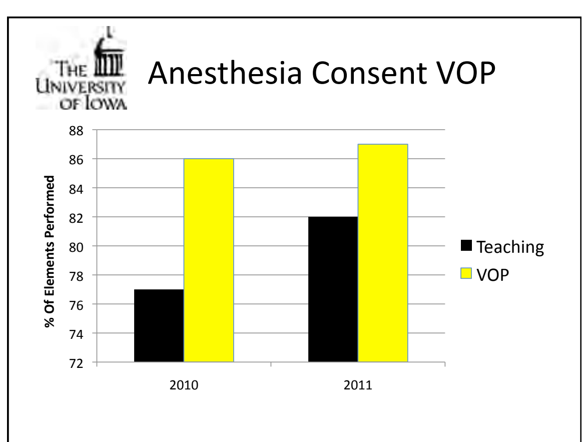
Anesthesia Consent VOP

- Communication
  - Content
  - Tone
  - Non-verbal
  - Calm, confident, caring
- Introduction
  - Confirm patient identity
  - Introduce self and name faculty

Anesthesia Consent VOP

- Basic Information
  - Review pertinent history
  - Examine airway, heart and lungs
- Consent
  - Explain the anesthesia plan (options) in sufficient detail and without medical jargon
  - Review major risks
  - Review minor risks
  - Offer opportunity for questions

Anesthesia Consent VOP



Anesthesia Consent VOP

- Feedback
  - From residents:
    - great experience
    - self reflection of performance
  - From "patient":
    - level of confidence
    - establishment of rapport
    - use of jargon
    - (no comments about medical content)

Anesthesia Consent VOP

- Feedback from faculty:
  - reaffirmed patient safety
  - described to patient what they would see in OR
  - good use of humor
  - introduce self as Dr….
  - incomplete airway/lung/heart exam
  - incomplete review of risks
  - avoid jargon

Best Practice: Department Academic Evenings

Leila Mei Pang, MD
Professor of Clinical Anesthesiology
College of Physicians & Surgeons of Columbia University
New York Presbyterian Hospital
New York, NY

Columbia University

Upon completion of this session, the participants should be able to
- Identify elements suitable for an academic evening
- Determine key faculty in their department to evaluate submissions
- Design an similar event for their own department

Columbia University

DISCLOSURES

None

Columbia University

Historical Background

- Started in 1998
- A departmental committee to ranks the abstracts
- Invited Distinguished Judge reviews the abstracts and award prizes
- Began with 1st, 2nd, and 3rd prizes
- Has expanded to 1st and 2nd prize
  - Basic Research
  - Clinical Research
  - Case Reports
  - Poster

Columbia University

Examples of Guest Judges

Year	Guest Judge	Institution
1998	Paul Barash, MD	Yale University
2007	Mark F. Newman, MD	Duke University Medical Center
2008	Jonathan Moss, MD, PhD	The University of Chicago
2009	Ronald G. Pearl, MD, PhD	Stanford University School of Medicine
2010	Neil Cohen, MD, MPH, MS	University of California, San Francisco
2011	Philip D. Lumb, MB, BS	University of Southern California

Columbia University

Number of Abstracts Submitted (Residents/Fellows)

Year	Basic Research	Clinical Research	Case Reports	Total
1998	14			14
2007	12 (4)	8 (4)	9 (7)	29 (15)
2008	9 (3)	18 (11)	6 (3)	33 (17)
2009	5 (1)	29 (23)	3 (0)	37 (24)
2010	10 (6)	26 (17)	6 (6)	42 (29)
2011	9 (4)	21 (15)	13 (13)	43 (32)

Columbia University

Year	Basic Research	Clinical Research	Case Report	Poster
1998	H. T. Lee, MD, PhD Systemic pretreatment with adenosine preserves rabbit renal function after ischemia and reperfusion			
2009	S. Park, PhD Sphinganine 1-phosphate ameliorates both Acute Liver Failure and Acute Kidney Injury Induced by Hepatic Ischemia and Reperfusion in Mice	C. Guerra, MPH Three year Mortality After Intensive Care for Medicare Beneficiaries in the United States	Minjae Kim, MD Kidney-specific Reconstituion of the A1 Adenosine Receptor in A1 Adenosine Knockout Mice Reduces Renal Ischemia-Reperfusion Injury	
2010	S. Park, PhD Paneth Cell Activation After Acute Kidney Injury Causes Liver and Intestine Injury and Systemic Inflammation in Mice	Steven Yap, MD Interleukin-6 Increases in Humans Undergoing Laparoscopic Nephrectomy	Traci Stein, PhD, MPH "Scratching" Beneath the Surface: An integrative Psychosocial Approach to Pruritis and Pain	Connie Chung, MD Isoflurane Attenuates Inflammation Induced by Acute Kidney Injury in Small Intestine
2011	C. David Mintz, MD, PhD Commonly Used Anesthetics Interfer with Axon Guidance via a GABAergic Mechanism	Christopher Webb, MD Unintentional Dural Puncture with Tuohy Needle Increases Risk of Chronic Headache	Lloyd Meeks, MD Determination of Brain Death on Veno-Arterial Extracorporeal Membrane Oxygenation in Adults	David Cabanero Ferri, DMV, PhD Withdrawal from Repeated Morphine Administration Induces Long-lasting Hyperalgesia and Increases the Insertion of Calcium-permeable AMPA Glutamine Receptors in Spinal Cord Synapses

Communicating with the RRC

Neal H. Cohen, M.D., M.P.H., M.S.; Patricia M. Surdyk, Ph.D.

This discussion will address the most effective ways of working with the RRC and ACGME to evaluate anesthesia training programs, ensure compliance with accreditation requirements and improve the education of residents and fellows. Drs. Cohen and Surdyk will review some of the most frequently-asked questions that come to the RRC, especially around processes and procedures.

Participants will:

1. Recognize who, when, where, why, and how to communicate with the RRC.
2. Review key elements of ACGME policies and procedures that govern program accreditation.
3. Associate key elements of the program review process with continuous quality improvement and successful educational outcomes.

Amy Murray, M.D.

Notes:

Facebook… and the Anesthesiology Residency Applicant

Amy Murray, M.D.
Associate Professor
Program Director
Department of Anesthesiology
Loyola University Medical Center
Maywood, IL

Learner Objectives

- Recognize Facebook as a popular social media
- Identify student and anesthesiology residency applicants' use of Facebook during interview season
- Discuss the role of anesthesiology program directors' use of Facebook during interview season
- Relate Professionalism and use of Facebook aided by applicants' perspectives

History of Facebook

- Founded in 2004 by Mark Zuckerberg and friends (for Harvard students)

History of Facebook

"Facebook is a social utility that helps people communicate more efficiently with their friends, family and coworkers. The company develops technologies that facilitate the sharing of information through the social graph, the digital mapping of people's real-world social connections."

History of Facebook

- Founded in 2004 by Mark Zuckerberg and friends (for Harvard students)
- >800 million "active users" (returned to the site within the last 30 days)

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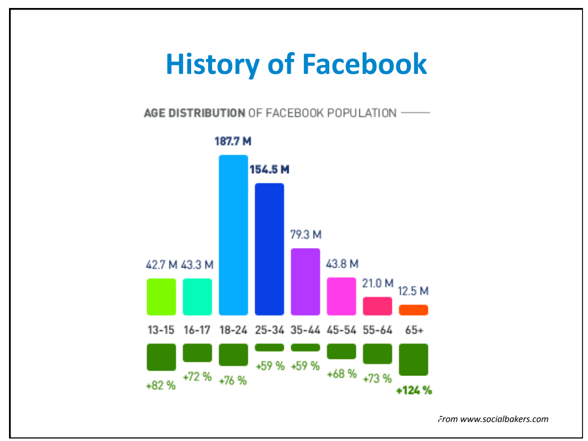
- Largest majority between 18-34 yrs old

History of Facebook

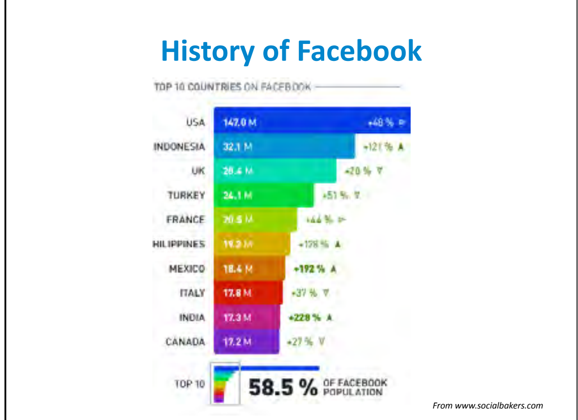


From www.socialbakers.com

History of Facebook

- Founded in 2004 by Mark Zuckerberg and friends (for Harvard students)
- >800 million "active users" (returned to the site within the last 30 days)
- Largest majority between 18-34 yrs old
- About 150 million users in U.S.

History of Facebook



From www.socialbakers.com

History of Facebook

- Founded in 2004 by Mark Zuckerberg and friends (for Harvard students)
- >800 million "active users" (returned to the site within the last 30 days)
- Largest majority between 18-34 yrs old About 150 million users in U.S.
- About 150 million users in U.S.
- Average user has 130 "friends"

- Wall Street Journal Sept 2008-John Heichinger
  - "College Applicants, Beware: Your Facebook Page is Showing"
  - 500 top colleges, 10% of admissions officers looked at social-networking sites to evaluate applicants
  - 38% said content "negatively affected" their views of the applicant
  - 25% said content "improved their views"

- Kaplan Test Prep's 2010 Survey of College Admissions Officers:
  - 80% of schools answered that an applicant requested admissions officers to be their friend on Facebook or MySpace
  - 82% of schools use Facebook to recruit prospective students
  - 56% of schools use Twitter to recruit prospective students
  - 56% of schools use YouTube to recruit prospective students

- The intersection of online social networking with medical professionalism. LA Thompson, et al. *J Gen Intern Med* 2008; 23(7): 954-957
  - 501 students and 312 residents University of Florida-Gainesville
  - 64% of students and 13% of residents had Facebook accounts
  - Only 37% of users made settings private
  - 40% joined on line groups (most benign, some concerning)
  - 70% random sites had photos with alcohol

- Unprofessional behavior in medical school is associated with subsequent disciplinary action by a state medical board. Papadakis MA, et al. *Teach Learn Med* 2004; 79 (3):244-249
  - UCSF School of Medicine, retrospective
  - Students from 1943-1989, who received disciplinary action by Medical Board of California from 1990-2000
  - 95% were deficiencies in professionalism (sexual misconduct, negligence, mental illness, inappropriate prescribing, conviction of a crime, endangering patients through use of drugs or alcohol…)
  - Disciplinary action by a medical board was strongly associated with prior unprofessional behavior in medical school (more than twice as likely)

"We have shown that problematic behavior in medical school at UCSF predicted subsequent disciplinary action of the physician by the state medical board. Our findings add to the call for better evaluation tools of personal characteristics of medical students and of applicants to medical school."

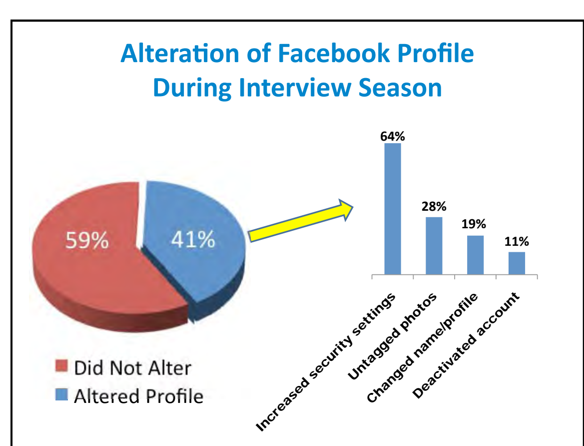
- StudentNetwork.com (November 2008)
  - “We are all human beings. Who the heck cares if you are not a ROBOT 24 hours a day. The public no longer wants to reward physicians as special, prestigious, etc.”
  - “What other people can find on the internet about us is just a reflection of who we really are. This reflection can be exact, or not. Every time we use the internet we leave our ‘fingerprints’”.
  - “I was a huge party goer/drinker in college (drunk more than sober) graduated top 5% of med school class, 255 on Step 1, just landed a top ortho residency. If someone had judged me based on my undergrad, there would be one less future great ortho surgeon around here.”

- “I would never judge someone based on their past or what they do in their free time as long as it is not harming others.”
- “Your patients are probably going to be googling you as well,-how do you want them to perceive you? Cool party goer who could be hungover on call or the put-together controlled physician? BTW, most residencies have parties hosted by the program director involving alcohol.”

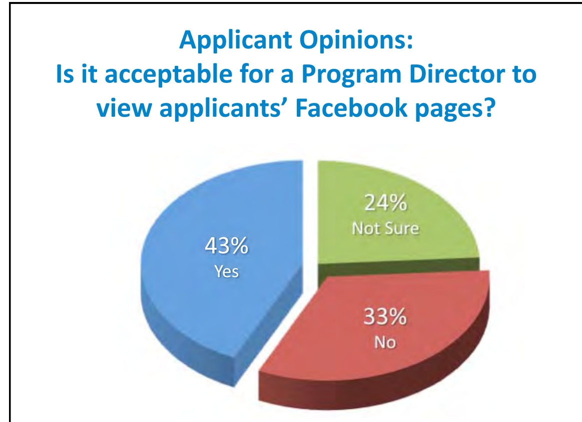
Facebook Among Anesthesiology Residency Applicants (99 Respondents)

16%
84%
Facebook Users
Non-Users

Alteration of Facebook Profile During Interview Season



Applicant Opinions: Is it acceptable for a Program Director to view applicants’ Facebook pages?



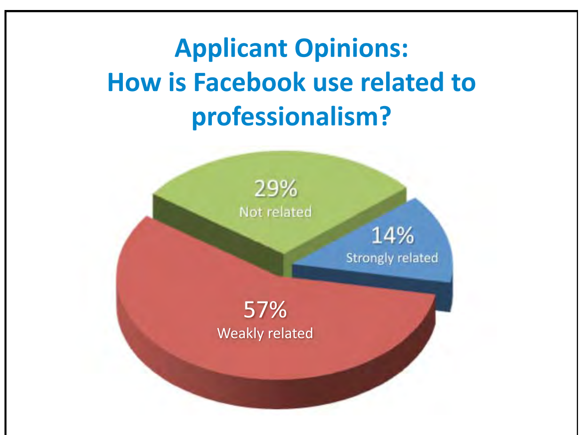
Applicant Opinions: Is it acceptable for a Program Director to view applicants’ Facebook pages?

- Yes – 43%
  - *“public site is fair game”*
  - *“but you see ‘unaskable’ things (race, family, religious issues)”*
  - *“applicants shouldn’t have anything to hide”*
  - *“all my potential employers will view my page”*

- Not sure – 24%
  - *"an invasion of privacy"*
  - *"I'm afraid it may lead to bias in that the program director may find those applicants with facebook more 'socially appealing' than those without pages."*
  - *"like inviting program director to a bar with your friends"*
  - *"never know what is offensive to others"*

- No – 33%
  - *"can be taken out of context"*
  - *"irrelevant to application"*
  - *"like inviting program director into your apartment"*

Applicant Opinions: How is Facebook use related to professionalism?



Applicant Opinions: How is Facebook use related to professionalism?

- Strongly related - 14%
  - *"our profession requires that we project a professional public reputation"*
- Weakly related - 57%
  - *"Facebook is part of modern culture" and "ingrained in our society"*
  - *"a shift in public opinion that private indiscretion cannot coexist with professional integrity"*
- Not related - 29%
  - *"Facebook should be used completely for social purposes"*

Departmental Facebook Page?

- Only 10% of applicants would find a program more attractive with a Facebook page.
- 98% of the applicants used departmental website during interview season.

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8. Papadakis MA, Hodges CS, Tehrani A, Kohatsu ND. Unprofessional behavior in medical school is associated with subsequent disciplinary action by a state medical board. Teach Learn Med 2004; 79 (3): 244-249.
9. www.StudentNetwork.com, posted November 24, 2008, accessed October 15, 2010.

MAYO Clinic Social Media Policy

Timothy Long, M.D.

Objectives

1. Identify and understand fundamental issues that must be addressed to develop an appropriate social media policy.
2. Provide an outline for creation of a program or institutional social media policy.
3. Identify mechanisms to promote compliance.

Social Media Guidelines for Emloyees

Personal Participation as Individuals

The following are guidelines for Mayo Clinic employees and students who participate in social media. Social media includes personal blogs and other websites, including Facebook, LinkedIn, MySpace, Twitter, YouTube or others. These guidelines apply whether employees and students are posting to their own sites or commenting on other sites:

1. Follow all applicable Mayo Clinic policies. For example, you must not share confidential or proprietary information about Mayo Clinic and you must maintain patient privacy. Among the policies most pertinent to this discussion are those concerning patient confidentiality, government affairs, mutual respect, political activity, Computer, E-mail & Internet Use, the Mayo Clinic Integrity Program, photography and video, and release of patient information to media.

2. Write in the first person. Where your connection to Mayo Clinic is apparent, make it clear that you are speaking for yourself and not on behalf of Mayo Clinic. In those circumstances, you should include this disclaimer: "The views expressed on this [blog; website] are my own and do not reflect the views of my employer." Consider adding this language in an "About me" section of your blog or social media profile.

3. If you identify your affiliation to Mayo Clinic, your social media activities should be consistent with Mayo's high standards of professional conduct.

4. If you communicate in the public internet about Mayo Clinic or Mayo Clinic-related matters, you must disclose your connection with Mayo Clinic and your role at Mayo.

5. Be professional, use good judgment and be accurate and honest in your communications; errors, omissions or unprofessional language or behavior reflect poorly on Mayo, and may result in liability for you or Mayo Clinic. Be respectful and professional to fellow employees, business partners, competitors and patients. Employees are strongly encouraged to view the Center for Social Media's core courses curriculum series on professionalism (Social Media 120-129).*

6. Ensure that your social media activity does not interfere with your work commitments.

7. Mayo Clinic strongly discourages "friending" of patients on social media websites. Staff in patient care roles generally should not initiate or accept friend requests except in unusual circumstances such as the situation where an in-person friendship pre-dates the treatment relationship.

8. Mayo Clinic discourages staff in management/supervisory roles from initiating "friend" requests with employees they manage. Managers/supervisors may accept friend requests if initiated by the employee, and if the manager/supervisor does not believe it will negatively impact the work relationship.

9. Mayo Clinic does not endorse people, products, services and organizations. On social media websites such as LinkedIn, where your affiliation to Mayo Clinic is known, personal recommendations should not be given or requested.

10. Unless approved by the Department of Public Affairs, your social media name, profile, handle and URL should not include Mayo Clinic's name or logo.

11. Ask the Department of Public Affairs (77)4-5005 if you have any questions about what is appropriate to include in your social media profile(s).

**Mayo employees who are first time visitors to the Social Media Health Network will have to register for a free account in order to view the curriculum.*

Mayo Clinic Social Media Policy
Big Brother or Andy Warhol?

Timothy R. Long, M.D.
Department of Anesthesiology
Mayo School of Graduate Medical Education
Rochester, MN

Objectives

- Understand the importance of social media use to the Mayo Clinic Mission
- Identify and understand fundamental issues that must be addressed to develop an appropriate social media policy
- Provide an outline for creation of a program or institutional social media policy
- Identify mechanisms to promote compliance

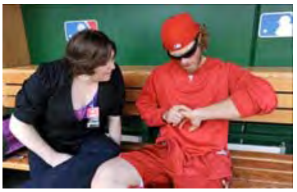
Social Media
Do we have to participate?

- Culture of your organization?
- Others will still be talking about you
- Can't control but can manage
  - Clear policies
  - Awareness and education
  - Monitoring

Why Patients Come to Mayo Clinic

- 84% word of mouth
- Accelerated by social media tools

Fortuitous Twitter chat, Jayson Werth story led to end of wrist pain



http://www.usatoday.com/news/health/2010-04-12-wristpain12_ST_N.htm

Less than 24 hours after my initial appointment, I not only had a new diagnosis – a UT split tear – but had surgery to correct the problem. As I write this, my right arm is in a festive green, but other otherwise annoying cast. The short-term hassle, however, should be more than worth the long-term gain – the potential for a future without chronic wrist pain. <u>A future, that without Twitter and those in the medical community willing to experiment with new communication tools, might not exist for me.</u>

Richard Berger, M.D., Ph.D.

"…Social media has driven this into practice in less than 2 years, when it takes 17 years on average"

Spontaneous Coronary Artery Dissection: A Disease-Specific, Social Networking Community–Initiated Study

Marysia S. Tweet, MD; Rajiv Gulati, MD, PhD; Lee A. Aase, BS; and Sharonne N. Hayes, MD

OBJECTIVE: To develop and assess the feasibility of a novel method for identification, recruitment, and retrospective and prospective evaluation of patients with rare conditions.

PATIENTS AND METHODS: This pilot study is a novel example of "patient-initiated research." After being approached by several members of an international disease-specific support group on a social networking site, we used it to identify patients who had been diagnosed as having at least 1 episode of spontaneous coronary artery dissection and recruited them to participate in a clinical investigation of their condition. Medical records were collected and reviewed, the original diagnosis was independently confirmed by review of imaging studies, and health status (both interval and current) was assessed via specially designed questionnaires and validated assessment tools.

RESULTS: Recruitment of all 12 participants was complete within 1 week of institutional review board approval (March 18, 2010). Data collection was completed November 18, 2010. All participants completed the study questionnaires and provided the required medical records and coronary angiograms and ancillary imaging data.

CONCLUSION: This study involving patients with spontaneous coronary artery dissection demonstrates the feasibility of and is a successful model for developing a "virtual" multicenter disease registry through disease-specific social media networks to better characterize an uncommon condition. This study is a prime example of patient-initiated research that could be used by other health care professionals and institutions.

Mayo Clin Proc. 2011;86(9):845-850

Mayo Clinic Center for Social Media

- August 2010
- Improve health globally
  - Accelerating effective application of social media tools throughout Mayo
  - Spur broader and deeper engagement in social media by hospitals, medical professionals and patients

http://socialmedia.mayoclinic.org/about-3/

Mayo Clinic Center for Social Media Mission

- Lead the social media revolution in health care, contributing to health and well being for people everywhere
  - Grow social media use by Mayo
  - Create resources for use at Mayo
  - Share resources with organizations wanting to use social media in health and health care

Social Media Health Network

- Membership group associated with Center
- For organizations wanting to use social media to promote health, fight disease, and improve health care
- Dues based on organization revenues
- >80 member organizations

http://socialmedia.mayoclinic.org/network/

Unique Challenges of Social Media Dan Goldman, J.D.

- Speed
- Reach
- Generation of "Lifecasters"
- Blurring of professional/public lines

http://socialmedia.mayoclinic.org

It Matters to the Public….

- "Anybody who isn't smart enough to figure out what's OK to post on the Internet has absolutely no business being in charge of other people's health"
- "As professionals, doctors, teachers, lawyers, etc., are held to a certain standard. If that's not your cup of tea, find a different job"

Greysen et al. J Gen Internal Medicine 2010;25(11):1227-9

Unique Issues in Healthcare

- Privacy
  - HIPAA
  - Public Relations
- Practice of Medicine

Nurse suspended for op pics on Facebook

- Ethical issues becoming "friends" with patients

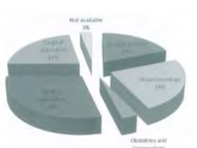
http://socialmedia.mayoclinic.org

Facebook activity of residents and fellows and its impact on the doctor—patient relationship

Ghassan Moubarak,[1] Aurélie Guiot,[2] Ygal Benhamou,[3] Alexandra Benhamou,[4] Sarah Harin[4]

Survey 170 residents and fellows (France)

- 6% had received friend request
- None would automatically accept
- 85% automatically decline
- 15% decide on individual basis



J Med Ethics 2011;37:101-104

Scenario 1

- Resident involved in an online chat session with nursing staff while a case finishes in the O.R.
- Others online noted concerns with complaints
  - Long case
  - Dr. X taking forever
  - Working over 13 hours

Scenario 2

- A trainee makes derogatory comments on Facebook about another physician at Mayo.
- He complains about a specific department referring patients to him and told them to "Go F&*# Yourselves."
- The conversation involves a number of his Facebook friends, some of whom are other Mayo trainees and physicians.

Scenario 3

- An outside PD emails you about concerning photos posted on Student Doctor Network.
- Photos depict clubbing parties in swimsuits, drinking and compromising positions.
- Visual identification implicates your trainee.
- Your trainee admits to posts but claims it is personal, all during off-hours.

Scenario 4

- Office of Patient Affairs surfaces concern from a student about a resident who is “facebooking” with a friend who is a minor and returning inpatient.

- Printed Facebook pages confirm inappropriate and misleading conversation.

Why Have a Policy?

- Institution
  - Brand name, reputation, trade secrets, etc
- Patient
  - HIPPA
- Medical profession
  - Professionalism
- Employees (residents/fellows)

AMA Policy (Simplified)

- Maintain patient confidentiality
- Check your privacy settings/monitor
- Maintain “appropriate” boundaries with patients
- Separate personal and professional content
- Police ourselves as physicians
- Recognize that content may have negative consequences and can undermine public trust

http://www.ama-assn.org/ama/pub/meeting/professionalism-social-media.shtml

Do You Have a Social Media Policy?

- HIPPA

- Professionalism

- Mutual Respect

- Computer, Network, Internet Use

Key Components

- Use during work time
- Who can speak on your behalf?
- Blurring
  - Disclaimer
  - Don’t identify as employee if inconsistent
  - “Friending” patient
- Patient privacy and dignity
- Business confidentiality

Key Components

- Anonymous posts
- FTC endorsement and testimonial guidelines
- Restrictions on lobbying and political activity
- Harassment of other employees
- Intellectual property
- False advertising

Social Media Policy General Thoughts

- No one size fits all
- Many policies available as starting point
- Evolving
- How to handle crisis

Social Media Code of Ethics

Blog posts and comments will be accurate and factual.

Mayo Clinic will acknowledge and correct mistakes promptly.

When corrections are made, Mayo Clinic will preserve the original post, showing by strikethrough what corrections have been made, to maintain integrity.

Social Media Code of Ethics

- Mayo Clinic will delete spam and/or comments that are off-topic.
- Mayo Clinic will reply to emails and comments when appropriate.
- Mayo Clinic will link directly to online references and original source materials.
- Mayo Clinic staff will disclose conflicts of interest and will not attempt to conceal their identity or that they work for Mayo Clinic.

Mayo Clinic Guidelines for Employees

- Follow all Mayo Clinic Policies (i.e. confidentiality)
- Speaking for yourself, not on behalf of Mayo
- Disclose your connection with Mayo
  - Judgment, accuracy, etc.
- Use personal E-mail
- If inconsistent with or could negatively impact Mayo, do not identify your connection with Mayo
- Be respectful to others
- Activities do not interfere with work commitments

http://sharing.mayoclinic.org/guidelines/for-mayo-clinic-employees/

Guidelines are Evolving

- More specific for user
  - Friend patient, employee, etc
- Work in progress
- Education modules “strongly encouraged”

Education and Awareness

- Compliance and Integrity training
- Mayo Orientation
- Department Orientation
  - Computer use in O.R., social media, texting, e-mail use, etc

Other Resources

- Mayo Clinic Center for Social Media
  http://socialmedia.mayoclinic.org/
  - Use, Responsibility, and Opportunity
  - Friday Faux Pas
- Social Media Policies
  http://socialmediagovernance.com/policies.php

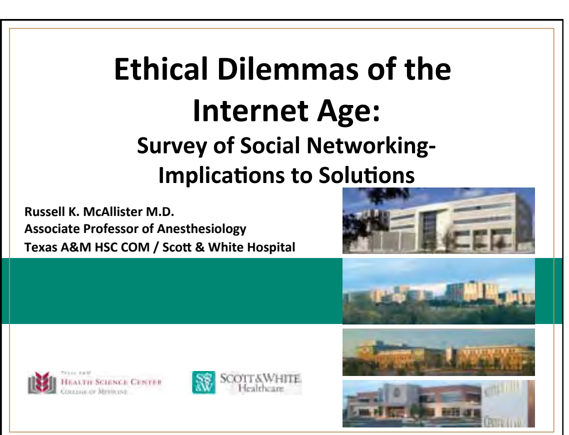
Summary

- Clearly written policy a must
- Education and awareness
- Consistent policy interpretation
- Early identification and intervention

Summary

- Communication and coordination among:
  - Program
  - School
  - Leadership
  - Legal and Compliance

Notes:



Definitions

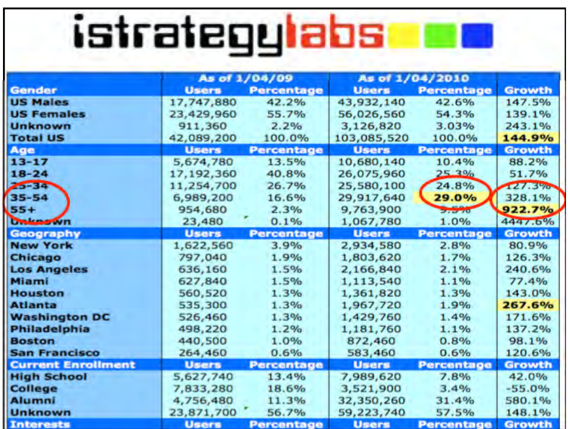
- **Blog**- A journal that is frequently updated and intended for public consumption; generally represents the personality of the author or the site.
- ***Examples***: www.pandabearmd.com or www.fatdoctor.blogspot.com ; **Twitter** is a more recent form of an instantaneous "mini" blog
- **Internet Forums**- a website that allows real time discussion between individual "posters" who have shared interests. Some are moderated and some are free of any oversight
- ***Example***: www.studentdoctornetwork.com

Definitions

- **Social Networking Site**- Allows users to create profiles for themselves, to upload pictures, and to become "friends" with other users; most social networking sites have privacy controls that allow users to choose who can view their profiles or contact them.
- ***Examples***: Facebook; MySpace; LinkedIn
- **Media sharing site**: Enables users to share media (videos, music, photos) with other users.
- ***Examples***: Video-Youtube or GoogleVideo; Photos-Flickr or Photobucket

Benefits of Social Media

- **Education**-instructional videos, podcasts etc
- **Networking**-with colleagues
- **Reconnecting with Friends**-planning reunions etc
- **Sharing and communication with family**-photos, messages etc


istrategylabs

	As of 1/04/09		As of 1/04/2010		
Gender	**Users**	**Percentage**	**Users**	**Percentage**	**Growth**
US Males	17,747,880	42.2%	43,932,140	42.6%	147.5%
US Females	23,429,960	55.7%	56,026,560	54.3%	139.1%
Unknown	911,360	2.2%	3,126,820	3.03%	243.1%
Total US	42,089,200	100.0%	103,085,520	100.0%	**144.9%**
Age	**Users**	**Percentage**	**Users**	**Percentage**	**Growth**
13-17	5,674,780	13.5%	10,680,140	10.4%	88.2%
18-24	17,192,360	40.8%	26,075,960	25.3%	51.7%
25-34	11,254,700	26.7%	25,580,100	24.8%	127.3%
35-54	6,989,200	16.6%	29,917,640	**29.0%**	328.1%
55+	954,680	2.3%	9,763,900	9.5%	**922.7%**
Unknown	23,480	0.1%	1,067,780	1.0%	4447.6%
Geography	**Users**	**Percentage**	**Users**	**Percentage**	**Growth**
New York	1,622,560	3.9%	2,934,580	2.8%	80.9%
Chicago	797,040	1.9%	1,803,620	1.7%	126.3%
Los Angeles	636,160	1.5%	2,166,840	2.1%	240.6%
Miami	627,840	1.5%	1,113,540	1.1%	77.4%
Houston	560,520	1.3%	1,361,820	1.3%	143.0%
Atlanta	535,300	1.3%	1,967,720	1.9%	**267.6%**
Washington DC	526,460	1.3%	1,429,760	1.4%	171.6%
Philadelphia	498,220	1.2%	1,181,760	1.1%	137.2%
Boston	440,500	1.0%	872,460	0.8%	98.1%
San Francisco	264,460	0.6%	583,460	0.6%	120.6%
Current Enrollment	**Users**	**Percentage**	**Users**	**Percentage**	**Growth**
High School	5,627,740	13.4%	7,989,620	7.8%	42.0%
College	7,833,280	18.6%	3,521,900	3.4%	-55.0%
Alumni	4,756,480	11.3%	32,350,260	31.4%	580.1%
Unknown	23,871,700	56.7%	59,223,740	57.5%	148.1%
Interests	**Users**	**Percentage**	**Users**	**Percentage**	**Growth**

Facebook demographics

- 1) The 55+ year old demographic is growing fastest, with a 923% growth rate from 2009 to 2010
- 2) The 35-54 year old demographic is not far behind with a 328% growth rate

A Series of Fictitious Scenarios Based on Real Life Scenarios

Scenario #1-The Harmless Internet Forum Discussion

- An anesthesia resident who frequents Student Doctor Network includes personal information on his "signature" that includes his medical school and residency program names. He outlines an occurrence in the PACU of a case that was "completely mismanaged" and noted that it was blatant "malpractice" resulting in the death of a patient.

Scenario #1-The Harmless Internet Forum Discussion

During the description of the case, the resident describes specific details including the patient's age, weight, coexisting diseases, type of surgery performed, and detailed events that occurred in the PACU. The patient's situation is a very uncommon combination of symptoms, rare diseases, and events.

Scenario #1-The Harmless Internet Forum Discussion

What potential problems may be encountered by the resident?

Scenario #1-The Harmless Internet Forum Discussion

- A suit is filed, and the opposing attorneys, in an attempt to find out more about the disease, do a Google search of the keywords. One of the top hits on the search brings up the SDN thread on the topic.
- The resident's identification is found out and they receive a subpoena to testify in court.

The effect of blogging on medical malpractice

In 2007, a blogging pediatrician known as Flea live blogged his medical malpractice trial. He shared his thoughts on the defense strategy and frank, unflattering opinions of the opponent's legal counsel. The plaintiff's attorney discovered the blog, confronted him during cross examination, and the case was settled the next day.

"On the Internet, nobody knows you're a dog."

Medical Weblogs

- An analysis of 271 medical weblogs (written by a nurse or physician) in 2006 revealed the following:
- 57% provided sufficient data to reveal their identities
- Individual patients were described in 42% of the blogs
- Of those describing patients, ~17% included sufficient information for patients to identify their doctors or themselves
- Three of the blogs showed identifiable patient photos
- Patients were portrayed in a negative light in ~18% of the blogs

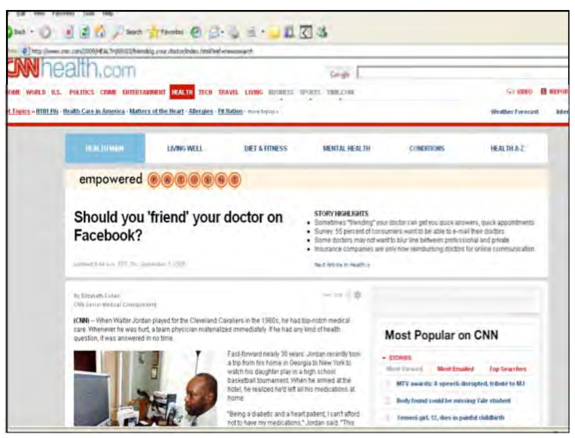
Lagu T et. al., J Gen Intern Med. 2008 Oct;23(10):1642-6

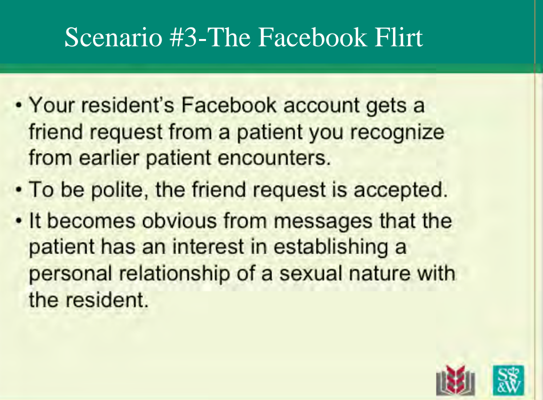
Scenario #2-The Friend Request

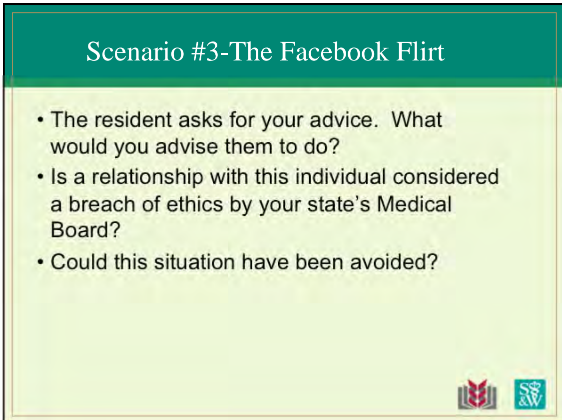
- A resident who frequents Facebook gets a friend request that they do not recognize. They accept the request and it turns out to be a patient they have seen in the clinic previously.
- What should they do next?
- What potential ethical dilemmas exist?

Scenario #2-The Facebook Friend Request

- What if the patient wishes to discuss their medical problems?
- Should you give medical advice on Facebook?
- Are you comfortable with them having access to your profile?
- The doctor-patient relationship may be refocused on the needs of the doctor based on items posted on the physician's Facebook
- A physician may inadvertently post a public message to a patient that violates confidentiality

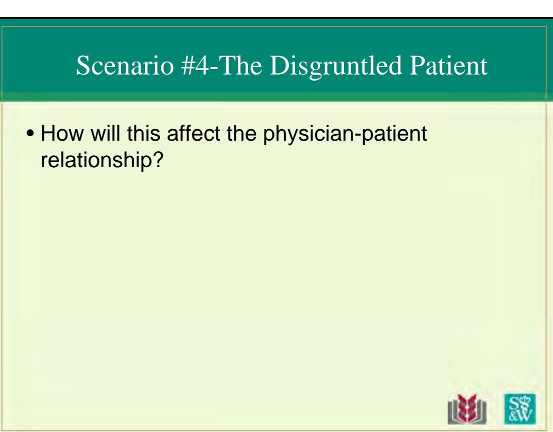






Scenario #4-The Disgruntled Patient

- A patient encounter at the hospital with a resident physician does not go as smoothly as it might have. The patient is angry with the resident and decides to do a "Google" search to find out more information about them.
- One of the links on Google shows an unflattering picture lifted from a Facebook website where a friend of the physician had posted pictures of the resident in compromising situations involving alcohol and implied drug use.



Frequency and content of online social networking by medical students and residents

- Facebook use common among medical trainees (44.5%)
- The majority of Facebook accounts (83%) listed at least one form of personally identifiable info
- Only ~one third (37%) of accounts were private
- 70% of accounts exhibited alcohol or implied excessive drinking

Thompson LA et al J Gen Intern Med. 2008;23(7):954-957.

Frequency and content of online social networking by medical students and residents

- Revisiting the same cohort in 2009 found that a significant majority (85.5%) of the Facebook profiles made use of available privacy features and were less likely to reveal personal information such as a home address
- Incriminating photos were also decreased significantly

Black EW et. al. J Grad Med Ed; June 2010; 289-293

Scenario #5-The Job Interview

- A graduating resident interviews at what they consider to be their dream job. They are surprised to find out that they have been passed over for the position, even though it would appear that they were the most qualified applicant and the interview had gone so well.
- The resident contacts a friend who is in the group who reveals that the group was disturbed by the unprofessional content of the person's Facebook page and decided that they were not compatible.

Screening potential employees

- According to a study conducted by Careerbuilder.com, 22% of 31,000 employers surveyed said they search social networks to screen candidates.
- One-third of those said they found information on sites like Facebook and MySpace that eliminated candidates from consideration.

Top areas of concern employers found on social networking sites:

- Information about alcohol or drug use (41% of managers said this was a top concern)
- Inappropriate photos or information posted on a candidate's page (40%)
- Poor communication skills (29%)
- Bad-mouthing of former employers or fellow employees (28%)
- Inaccurate qualifications (27%)
- Unprofessional screen names (22%)
- Notes showing links to criminal behavior (21%)
- Confidential information about past employers (19%)

Scenario #6-The Video Everyone Thought Was Funny

- The hospital CEO calls you and your resident into their office to discuss a video that was posted on youtube that very clearly shows the resdient in an inebriated state on Bourbon Street in New Orleans.
- The video has been shown multiple times throughout the hospital and most thought the resident was riotously funny during their Mardi Gras celebration.

Scenario #6-The Video Everyone Thought Was Funny

- Unfortunately, several colleagues and patients have also viewed the video and found the resident's behavior to be in poor taste and offensive.
- The video has caused an unsettling division within the hospital and caused several complaints from patients who don't feel confidence in the resident's abilities based on the video.

Scenario #6-The Video Everyone Thought Was Funny

- How could this have been avoided?
- If the video was uploaded by someone else, is it still the resident's fault?
- What would be the reaction of the state Medical Board or the ABA if they were alerted to the existence of this video?
- Would this affect their "professionalism" evaluation by the clinical competence committee?

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Health | Health care

YouTube surgery video spells trouble for docs

Philippine surgeons cheer after removing object from patient's rectum

Associated Press

MANILA, Philippines – A video posted on YouTube showing Philippine doctors laughing while removing an object from a patient may lead to charges against the surgeons and cost them their medical licenses, officials said Wednesday.

The unauthorized nearly 3-minute video of a noisy operating room shows doctors and nurses laughing, giggling and cheering.

At one point, a hand appears with a cell phone camera taking a close-up picture of the surgery.

Health care videos

Free health clinic opens in Los Angeles

Massive free health clinic in L.A.

Health care loophole could be deadly for patients

INTERACTIVE

Dose of reality

Scenario #7-The Odd Tattoo

- A senior surgery resident finds an interesting and unique genital tattoo on a patient who is anesthetized. They use their camera phone to snap a photo and send it to a colleague. Over the next few days, the photo is sent out to several thousand email accounts and posted on several photo host sites.
- The patient becomes aware of the photo that was taken without his consent and sues the hospital.
- The surgery resident is subsequently fired, 3 months before expected graduation.

Scenario #7-The Odd Tattoo

- Did the resident act unethically?
- Was it right to fire the resident?
- When is it okay to photograph a patient?
- Have you ever sent an email to someone only to find out it was forwarded on without your knowledge?
- What control do we have over emails that are sent from our account?

Can social media affect board certification??

Scenario # 8-Board Certification Risks

- A young group of physicians who communicate on Student Doctor Network begin a thread to discuss their recent board exam and many questions are discussed in detail and reproduced in their entirety within the public forum
- Is this a breech of contract with the certifying board?
- Are these doctors at risk?

Scenario #8-Board Certification Risks

- The American Board of Internal Medicine has sanctioned 139 doctors for cheating on exams it uses for board certifications when they deliberately shared questions from the exam with a review course director
- Sharing this information on medical forums has occurred frequently in the past and could be a source of risk in the future
- The hardline approach by the ABIM sends a strong message that this type of behavior is not tolerated

Scenario #9-The Unhappy Patient

- You are alerted to the fact that one of the patients on your pain service has “tweeted” and posted on his Facebook page that the doctors at Hospital “X” are “trying to kill” him. He includes many very negative comments about the hospital, doctors, and nurses
- His Twitter page has over 200 followers and he has over 800 “Facebook friends”
- Due to the fact that he is friends with many employees of the hospital, it becomes well known throughout the hospital that this patient is dissatisfied

Scenario #9-The Unhappy Patient

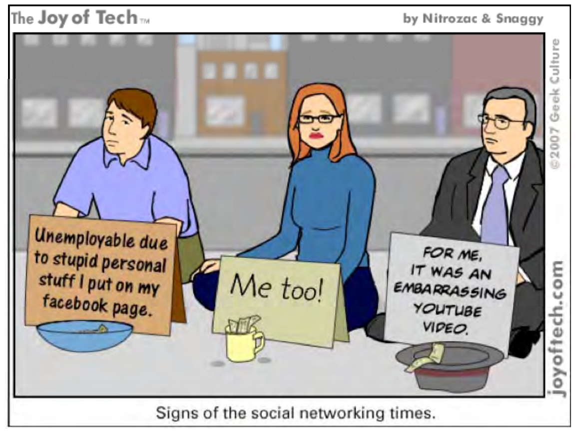
- What is the best next step?
- How is this different from how this scenario would have occurred 5 years ago?

Physician Ethics on Facebook

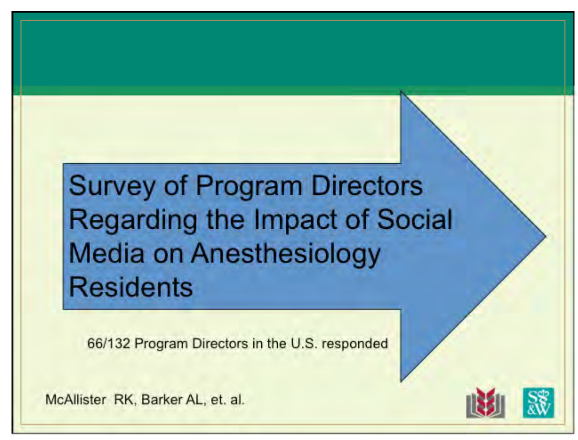
- Keep official medical activities off of Facebook
- Never require patients to participate in Facebook or have it influence the physician-patient relationship
- Never “friend” patients
- Do not accept “friend” requests from patients
- Avoid Facebook groups with explicit or unprofessional/ offensive content with the knowledge that these may be viewed by patients

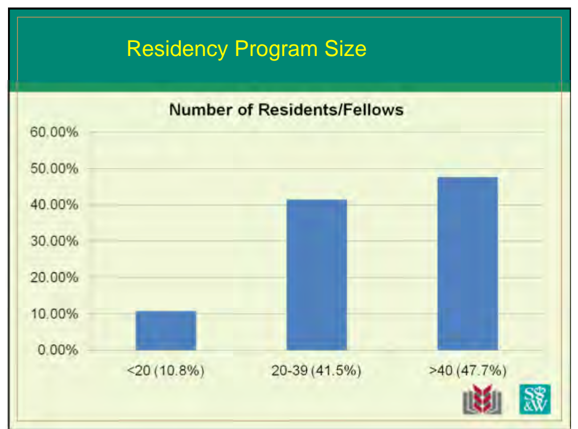
Physician Ethics on Facebook

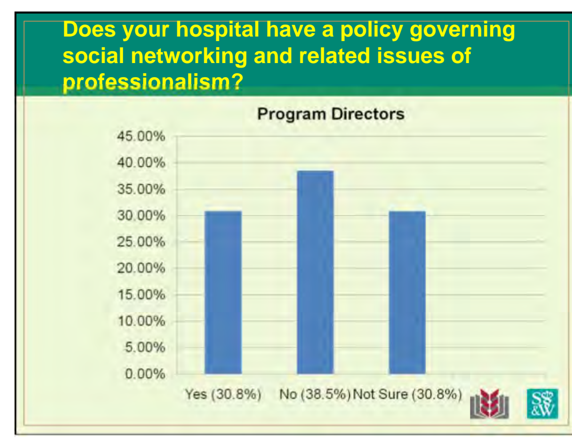
- Take extreme care with privacy settings
- Exercise discretion when using Facebook for personal communications
- Never misrepresent yourself on Facebook by using a false name or persona
- Never give medical advice via Facebook
- Never share patient information via Facebook
- Keep “wall posts” in concord with standard ethical practices of being a physician

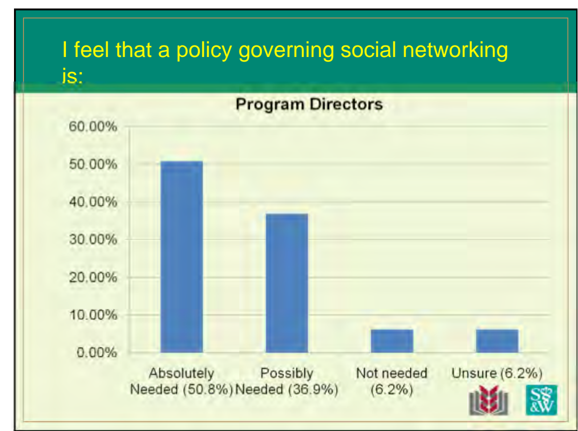


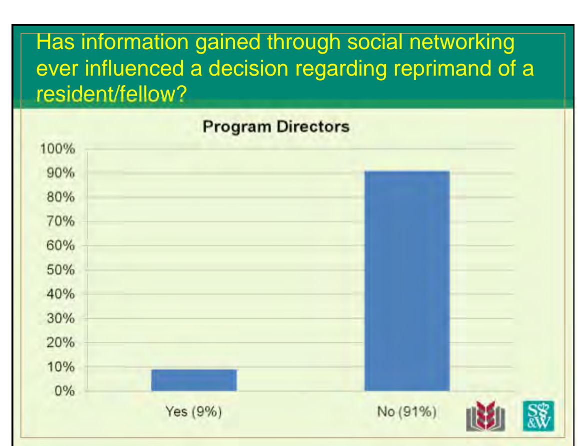
Signs of the social networking times.

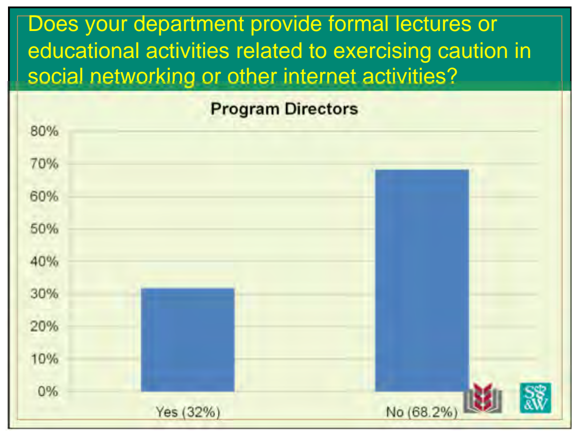


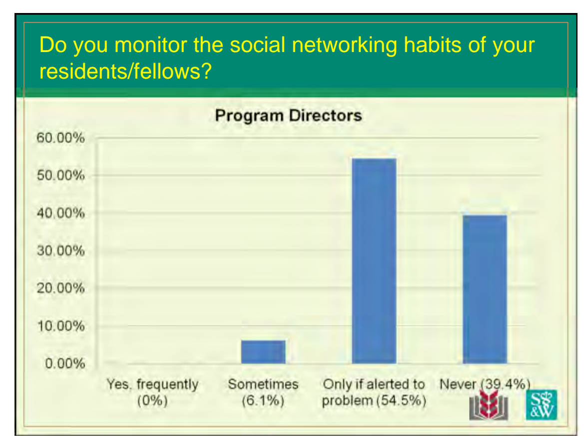


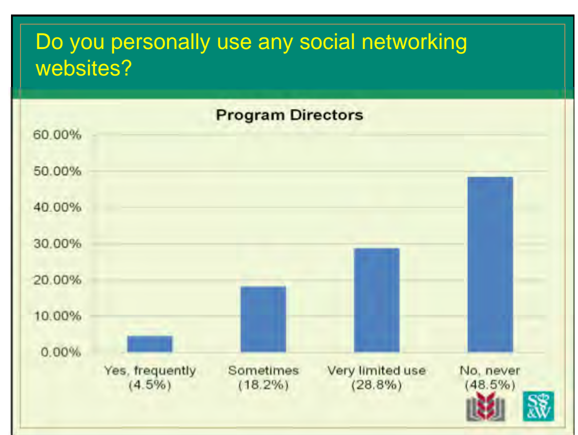


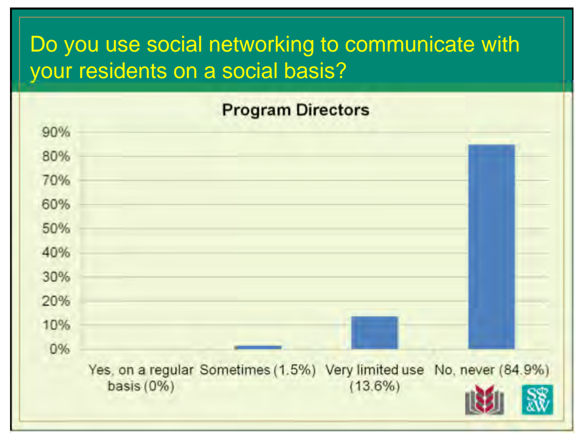


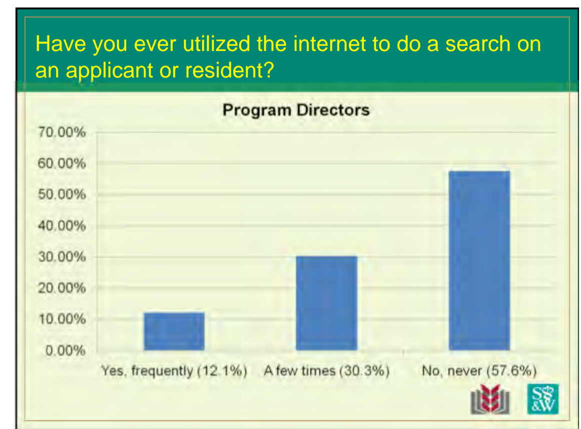


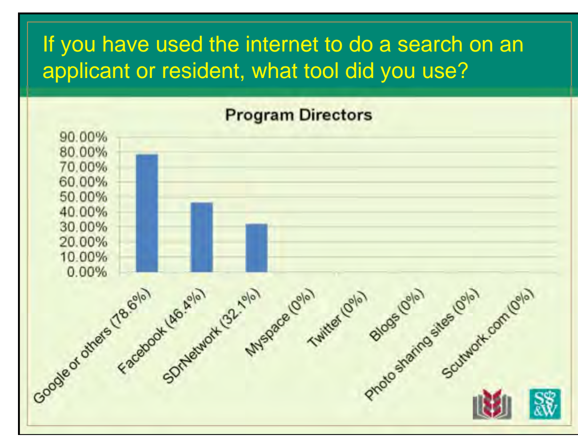

Does your department provide formal lectures or educational activities related to exercising caution in social networking or other internet activities?
Program Directors
80%
70%
60%
50%
40%
30%
20%
10%
0%
Yes (32%)
No (68.2%)


Do you monitor the social networking habits of your residents/fellows?
Program Directors
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Yes, frequently (0%)
Sometimes (6.1%)
Only if alerted to problem (54.5%)
Never (39.4%)


Do you personally use any social networking websites?
Program Directors
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Yes, frequently (4.5%)
Sometimes (18.2%)
Very limited use (28.8%)
No, never (48.5%)

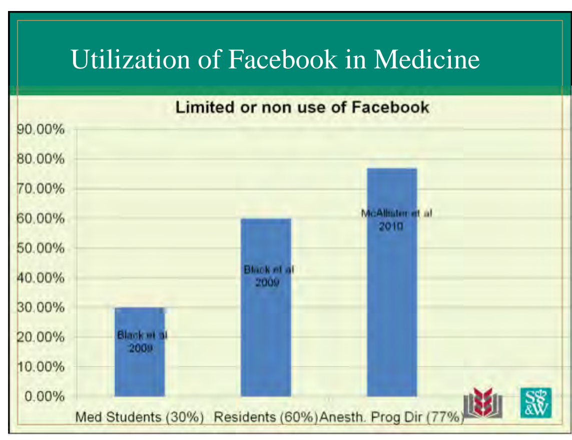

Do you use social networking to communicate with your residents on a social basis?
Program Directors
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Yes, on a regular basis (0%)
Sometimes (1.5%)
Very limited use (13.6%)
No, never (84.9%)

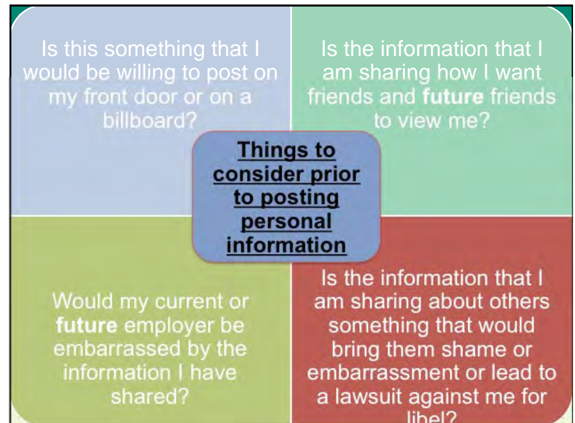

Have you ever utilized the internet to do a search on an applicant or resident?
Program Directors
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Yes, frequently (12.1%)
A few times (30.3%)
No, never (57.6%)


If you have used the internet to do a search on an applicant or resident, what tool did you use?
Program Directors
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Google or others (78.6%)
Facebook (46.4%)
SDNetwork (32.1%)
Myspace (0%)
Twitter (0%)
Blogs (0%)
Photo sharing sites (0%)
Scutwork.com (0%)

Inadequate mentorship on the dangers of social networking

- It is highly probable that physicians in training will find it difficult to receive mentorship and guidance regarding judicious and ethical usage of online social forums from older clinicians, who tend to have less experience in participating in these forums



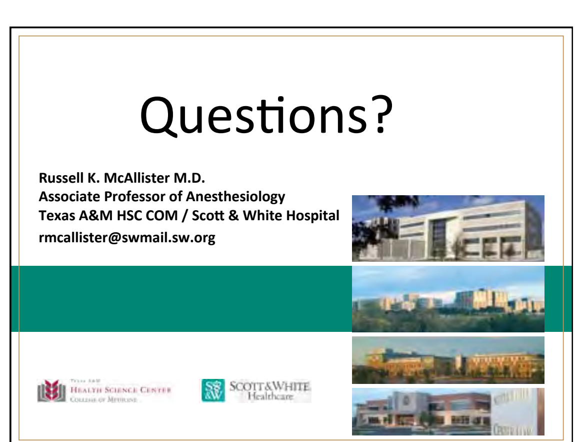


How-to: Effectively manage your Facebook privacy settings with three simple lists

By Nilay Patel posted Jul 13th 2010 11:00AM

I used to love Facebook. I was in law school at Wisconsin when it launched, and everyone I knew on the site was basically a peer -- people who I'd known well or at least met in person at some point. Then... I graduated. Suddenly having a Facebook account full of pictures from blurry nights in Madison and Pulitzer Prize-caliber dirty jokes from my friends wasn't so awesome anymore -- especially once I started working for Engadget and lots and lots of people I didn't actually know (or, somewhat even worse, only knew professionally) started looking at my personal page. So I needed a system -- a way to still use Facebook to share personal stuff with friends, professional stuff with colleagues, and awesome stuff with everyone, all without blurring any lines or accidentally sharing too much with people I don't know.

RELATED POSTS


Questions?
Russell K. McAllister M.D.
Associate Professor of Anesthesiology
Texas A&M HSC COM / Scott & White Hospital
rmcallister@swmail.sw.org
Health Science Center
Scott&White
Healthcare

Institutional Perspectives

Rita M. Patel, M.D.

Objectives

1. Should a program director “google” invited applicants just to see if there are any red flags - all applicants or just ones who seem to warrant it?
2. Should one make decisions on applications based on these results?
3. How much digging should one do to find out about a resident or applicant?
4. Should we be Facebook, Twitter, Linked-in, or Myspace friends/followers with residents?
5. How do we handle unprofessional behavior on internet and social media websites?

Rita M Patel MD

Professor & Vice-Chair, Education
Department of Anesthesiology
Associate Dean for Graduate Medical Education
University of Pittsburgh School of Medicine
ACGME/NRMP Designated Institutional Official
UPMC

OBJECTIVES

- Describe the development of GME Social Media Guidelines at a large Academic Institution
- Discuss how the Human Resource Department may impact upon the development of social media policies or guidelines
- Provide examples of social media education for residents & fellows

About 10 years ago
As Program Director
Call from Division Chief

"Rita, one of our residents was arrested by University police last night. They called the Pittsburgh Police. He was observed visiting unauthorized websites on the computers in the PBL classroom at the med school…"

post-gazette.com NEWS/HEALTH

It's 'too late' to assure security of patient data
Saturday, April 14, 2007
By Steve Twedt, Pittsburgh Post-Gazette

A Web site containing Social Security numbers and other personal information for nearly 80 UPMC patients was still accessible on the Internet yesterday -- and computer security experts say the patients can never be entirely assured the content will be gone.
"It is too late. Once something is on the public Web, the only fundamentally safe security assumption you can make is that it is in the public domain forever," said Art Manion, a computer security expert at CERT, part of Carnegie Mellon University's Software Engineering Institute.

SuperBowl XLIII 2009
Steelers 27 Cardinals 23

As DIO
Call from Senior Vice-President

"Rita, a resident posted on YouTube a video of Physicians & Nurses celebrating SuperBowl win in XXX hospital area…"

October 2010 – Facebook Posting
Director of Nursing calls
Vice-President for Medical Affairs
Who calls the Residency Program Director
Who calls me

Hi, George! Remember that hot nurse, Nancy, in ICU? Well, today she was wearing white pants and you could see through them to her sparkly underwear!!! I told her that I like them!

2010 GME Programs and Trainees

	Programs	Residents/Fellows
ACGME ACCREDITED 37R + 73F	110	1358
SIEP	49	64
AOA	11	19
UNIV OF PITT 6 Dental and 2 Pharmacy	8	55
PODIATRY	1	17
TOTAL	179	1513

Is there anyone here who does not want to retract something they have done or said?

Is there anyone here who has never exercised poor judgment?

"It is too late. Once something is on the public Web, the only fundamentally safe security assumption you can make is that it is in the public domain forever,"

said Art Manion, a computer security expert at CERT, part of Carnegie Mellon University's Software Engineering Institute.

Posting of Unprofessional Content by Medical Students– JAMA 2009 – ShockMD.com - Quote

- 60% of medical schools in the US participated in an anonymous electronic survey to assess online posting of unprofessional content by medical students 60% of these 47/78 reported incidents of students posting unprofessional online content
- Sexual-Relational Content, Provocative photos of students, requesting inappropriate friendships with patients on facebook
- Negative comments on specific medical schools using profanity or other disparaging language in reference to speicific faculty courses or rotations
- Intoxication or substance abuse, eg. Videos depicting intoxication
- Patient privacy at risk, blog posts with enough detail to ID pts

GMEC – Program Director Development Committee

- Responsibility-Assist PDs in compliance with institutional policies & procedures
  - development of materials, dissemination of information & education of program directors
- PDs: OB-GYN; Internal Medicine-Pediatrics; Critical Care Medicine; Radiology; Pathology; Child Neurology; Transitional Year
- Review websites, literature, policies on topic being addressed
- Final product is policy + educational materials
  - Evaluation (Annual Program Evaluation Template)
  - Recruitment (Post-Match Questionnaire)
  - Supervision (Program Checklist for Compliance)
- With Social Media – materials in advance of policy

Guide to Electronic Communication UPMC GME Orientation – June/July 2011

Resident and Fellow-Specific Guide in development

- You need to know this to thrive

Links to existing Policies

- UPMC Policy on Social Networking-HSHR0748
- UPMC ME Guidelines on Professional Conduct in the Teacher-Learner Relationship
- UPMC ME Harassment-Free Workplace Policy

Sample Violations

- Status update on Facebook “Nurse Jackie looked HOT today”
- Resident blog post: photo of a baby just discharged with best wishes to the family and thanks to the care team
- YouTube video of residents’ pub crawl: “Magee Ob/Gyn Residents gone wild!”

Sample Violations

- Residents answers this email with medical advice:
  - “Dear Doc—my fibromyalgia pain is really flaring up. What should I do?”
- Resident takes a minute on the ward to check Facebook on her smartphone. Attending walks up behind her, quickly forming an opinion of her work ethic.

Top 10 list (in no particular order)

- Never friend patient or family
- Never give medical advice
- Never take a photo with your equipment
- Never post a photo with any part of a patient
- Never use the UPMC/University name

Top 10 list

- Never post a clinical story
- Never post anything you would not want your grandmother to see
- Always be collegial
- Do not spend precious training time social networking

UPMC Policy – HSHR0748

UPMC
POLICY AND PROCEDURE MANUAL

POLICY: HS-HR0748 *
INDEX TITLE: Human Resources

SUBJECT: Social Networking
DATE: January 31, 2011

I. POLICY

Knowledge sharing through Social Networking is recognized as critical for some areas of UPMC. While this practice is supported, this policy educates staff on acceptable practices as all staff must protect patient and proprietary information.

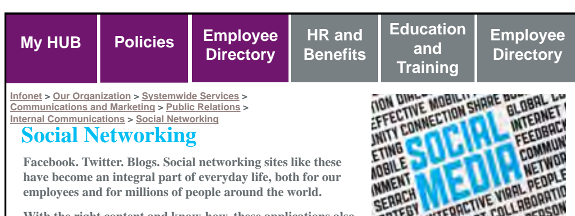
UPMC has a Social Networking policy that governs the actions of individuals employed by or associated with UPMC and its domestic affiliates. The Policy’s written guidelines, which are based on UPMC’s mission, vision, values, and ethics, outline how people must conduct themselves when engaging in Social Networking activities while a Representative and/or Staff Member of UPMC. UPMC Staff Members must follow the UPMC Code of Conduct and all policies.

For purposes of this policy Social Networking is defined to include, but is not be limited to, online communities of people and/or online sites and tools that allow for the exchange of knowledge and ideas such as, Facebook, MySpace, LinkedIn, blogs, peer-to-peer networks, Twitter, etc.

My HUB | Policies | Employee Directory | HR and Benefits | Education and Training | Employee Directory

Infonet > Our Organization > Systemwide Services > Communications and Marketing > Public Relations > Internal Communications > Social Networking

Social Networking



Facebook. Twitter. Blogs. Social networking sites like these have become an integral part of everyday life, both for our employees and for millions of people around the world.

With the right content and know-how, these applications also can be powerful networking and business tools. They also add entertainment and enrichment to our lives

We believe it is important for UPMC and its representatives to share information and ideas through social networking and online communities. We want to encourage staff to have fun with social media while remaining professional as a UPMC employee. As an employee, you can be the face of UPMC in the online world.

This site is dedicated to helping you navigate the waters of social networking. Remember, in online social networks, the lines between public and private, as well as personal and professional, can be blurred. The best advice is to use good judgment and common sense when participating, as well as following UPMC’s Code of Conduct and other applicable policies.

UPMC Medical Education Policies and Procedures

Department: Graduate Medical Education

Title: **Guidelines for the use of internet, social networking, and electronic communication**

Purpose: To provide guidance and clarification about the use of internet, social networking, and electronic communication. These guidelines are meant to be used in conjunction with the UPMC Policy on Social Networking-HSHR0748, the UPMC ME Guidelines on Professional Conduct in the Teacher-Learner Relationship, the UPMC ME Harassment-Free Workplace Policy, and all other relevant policies governing resident and fellow professional behavior.

Scope: All UPMC Medical Education-sponsored Residency and Fellowship programs

When professional courtesy could get physicians in trouble - kevinmd.com

When offering professional courtesy discounts, physicians should make sure that their good deeds also comply with applicable laws.

HIMSS urges Congress: Create a national patient identifier - fiercehealthit.com

HIMSS has asked Congress to support the development of a "nationwide patient identity solution" to promote interoperability and reduce errors related to mismatches between health data and patients. Read more...

amednews: Medical error calls for honest disclosure :: Sept. 12, 2011 ... American Medical News - ama-assn.org

Ethics Forum - A column that answers questions on ethical issues in medical...

ACO Pioneers to launch by year's end? - fiercehealthcare.com

Despite fears about the tight timetable, the Pioneer accountable care organizations (ACOs) could launch by the end of the year, said Centers for Medicare and Medicare Services (CMS) Administrator Read more...

Should Medicare pay for procedures that have no proven benefit? - kevinmd.com

If these interventions offer no benefit, why then does Medicare continue to pay for them?

Linked In – Director of Human Resources

From – Using Social Networking Sites for Hiring May Lead to Discrimination Claims – Protected Groups

- Age
- Citizenship
- Disability
- Gender Identity or Expression
- Genetic Information
- Marital Status/parental status
- National origin/ancestry
- Pregnancy
- Race/color
- Religion
- Sex
- Sexual orientation
- Veteran's status/military status

You might not ask about these, esp sex orientation, religion. But, you might find this out through posting on facebook or other sites. Info might not influence decision, but difficult to prove, esp if that person is not hired. Drinking & ADA Society for Human Resource Management 3/19/2010 – Directly quoted

Firing Employees for Facebook Posts Violated NLRA

- Source: 9/8/2011 – Society for Human Resource Management – Directly quoted
- NLRB administrative law judge found that employer unlawfully discharged 5 employees after they complained about working conditions, workload & staffing issues
- First social media case that involved a non-unionized workplace
- Ordered them to be reinstated with back pay
- Employers cannot simply require that there be no communication between them via facebook or twitter.
- "conversations around the water cooler"
- NLRA section 7 rights apply even if workforce is not unionized

NLRB Actively Engaged in Examining Employee Social Media Use

- 9/16/2011 – Society for Human Resource Management- Directly Quoted
- Concerted activities for the purpose of collective bargaining or other mutual aid or protection
- "protected concerted activity" applies for 2 purposes (1) terms and conditions of employment and (2) can be interpreted as working with, or on behalf of, other employees
  - Does not protect personal gripes
  - Or comments that do not pertain to work conditions
- "Disparaging Remarks" "Inappropriate Discussion" "Use of the Company Logo"
- Should include language of section 7 in any social media policy

Employee Use of Social Media: Laws Fail to Keep Pace with Technology

- 3/16/2011 – Society for Human Resource Management – Directly Quoted
- Definition of social media " any web-based application that allows people to broadcast information to an entire network"
- User-defined: Facebook; Open – You Tube
- Stored Communications Act – protects privacy of electronic communications while they are being transmitted. Google search is not protected, because it is public
- Fair Credit Reporting Act – use of third party for background checks, requires consent from applicant
- Genetic Information Non-Discrimination Act – prohibts any questions that get at genetic information
- Common Law Privacy Principles – "intrusion upon seclusion"

www.shockmd.com- Medical Students & Residents Use of Social Media, Accessed 10/15/2011 – Direct Quote

- Communication among PBL members or tutorial groups
- YouTube video clips of physical exam & Dx procedures
- Use visual models on YouTube for explanation of complex science concepts
- Watching Surgery on YouTube to prepare for OR the next day
- Podcasts of live lectures for access off campus, at the gym or during travel
- Specialty Orientiation by following on facebook prof orgs, ie. ACSurg, AAPeds, ACPhysicians
- Using facebook to exchange experiences about residency
- Residents interested in **physician-only online social networks** sermo, medscape connect, tiromed, and doctorshangout.com.

Dr. Shock's Blog - Comments

- "Exactly why I shut my facebook down. It wasn't worth it in the long run to have my private life in the public space once I get out of school and enter the profession in full. Too hard to monitor what pictures are taken of you, who tags you, what type of comments your friends leave and the access people have".
- "I try to hold down personal information on facebook . Facebook is indeed something between friends but you're usually not sure whose listening in.
- "Trying to teach about "digital footprint" to medical students which is a good first step to help professional conduct"

www.sanfranonline.com/internet-mktg/career/cert-mst_social media

- **Position Yourself for a Variety of Rewarding Roles**
- Social Media Marketing Manager
- Social Media Manager
- Social Media Director
- Social Media Analyst
- Social Media Developer

Accessed 10/21/2011

- ***NEW* Advanced Social Media Marketing Certificate**
- Complete this video-based online social media marketing program in just 8 weeks or less! Then start reaping the rewards of your career-building certificate from the University of San Francisco, ranked a best university by *U.S. News & World Report.*

Thank You

- Rita M Patel MD
- rpatel@pitt.edu
- patelrm@upmc.edu

The NRMP- What's New and What's Going to be New

Mona M. Signer

At its May 2011 meeting, the Board of Directors adopted the following resolution: *Beginning with the 2013 Main Residency Match, programs participating in the Main Residency Match must register and attempt to fill all their positions in the Match except for those specialties or programs participating in other national matching programs.*

Background

In October 2010, the Data Release and Research Committee (DRRC) reviewed a study of positions that had been filled outside the 2008 Main Residency Match and recommended the Board of Directors explore whether the NRMP should require that all positions be placed in the Match. The Board concurred with the DRRC recommendation and voted to create an ad hoc committee to study the feasibility of requiring institutions participating in the Main Residency Match to fill all of their positions through the Main Residency Match or another national matching program. The Committee was chaired by Dr. Savoia, and Committee members were Drs. Guralnick, Jenson, Munzing, Terhune, and Zalneraitis, along with Mmes. Mure and Wiley.

The Ad Hoc Committee began its work in November 2010. It prepared a white paper summarizing the data from the 2008 Match and reviewed the history of the NRMP's consideration of an "all-in" policy. To solicit comments, the white paper was posted to www.nrmp.org and sent to all NRMP program directors, medical school officials, and institutional officials registered in the Registration, Ranking, and Results System as well as to all program director organizations with specialties participating in the Match.

In addition, as part of the 2011 Main Residency Match, the NRMP conducted an on-line survey of registered program directors. Responses were received from more than 1,800 of the 2,900 survey recipients, including more than half of the Internal Medicine program directors and nearly one-third of those in Family Medicine, Pediatrics, Pathology, and Psychiatry—all specialties that fill significant numbers of positions outside the Match. Overall, one-quarter of the respondents reported selecting at least one resident outside the Match, but the percentage was significantly higher for Internal Medicine (55%) and programs located in New Jersey (63%) and New York State (38%). More than half cited the "need to be competitive" as the reason for filling positions outside the Match; 51 percent cited other reasons such as being able to compete for DOs and IMGs who do not participate in the Match, holding positions for exceptional applicants, and an inability to fill positions with U.S. graduates through the Match.

At its May 2011 meeting, the Board discussed the survey results and the comments it had received to date, focusing its discussion on three issues: (1) whether the policy should be institution-based or program-based, (2) whether the policy should include both PGY-1 and PGY-2 positions, and (3) whether there were appropriate exceptions to the policy.

In debating whether the policy should be institution-based or program-based, the Board acknowledged that an institution-based policy would be most analogous to the NRMP's current rule for offering positions to U.S. allopathic senior students but also agreed that two problems would arise from an institution-based policy. First, in certain specialties, such as Family Medicine, the program is de facto the institution and those programs likely would opt out of the Match regardless of whether the policy were institution-based or program-based. Second, it would be difficult to enforce the policy for positions filled through other national matching programs such as the Urology Match and the AOA Match. Thus, the Board voted to make the policy program-based.

With respect to whether the policy should encompass both PGY-1 and PGY-2 positions, the Board agreed with the Ad Hoc Committee that it would be appropriate to incorporate not only PGY-1 positions, but also PGY-2 positions for which the NRMP provides matching services. Thus, all Preliminary Medicine, Preliminary Surgery, Transitional Year, and categorical positions must be filled through the Match, as well as PGY-2 positions in advanced programs (specialties such as Diagnostic Radiology, Radiation Oncology, Dermatology, and Neurology that include both categorical and advanced programs).

Finally, the Board discussed but made no decision about possible exceptions to the policy, instead asking staff to continue to solicit comments from constituents.

Current Considerations

Subsequent to the Board's decision in May 2011, staff updated the white paper posted to www.nrmp.org (included under this tab) and continued soliciting comments (included under this tab) on possible exceptions to the policy. Several themes have emerged, including exceptions for:

- "accelerated" programs such as those in Family Medicine where students commit to a specific program during medical school and enter residency training prior to completing four years of medical school
- rural scholars programs where third-year medical students apply and, if accepted, conduct a research project beginning in their fourth year and continuing through residency
- combined clinical-research programs where the first year of training is not clinical
- positions reserved for foreign-nationals who bring funding from governmental entities in their home countries
- programs in rural and geographically underserved areas
- resident transfers into a different program in the same specialty
- mid-career specialty changes
- residents who are off-cycle, where training would not begin in July
- programs dually-accredited by the ACGME and the American Osteopathic Association
- IMGs who require visas, because of the additional processing time required

Discussion

Historically, the NRMP has allowed "accelerated" and rural scholars programs to offer positions outside the Match to students from LCME-accredited medical schools. This practice creates an exception to the current NRMP policy requiring programs to offer positions to U.S. allopathic senior students only through the Match. Similarly, an exception has been granted to combined clinical-research programs recruiting U.S. seniors, although it is possible for those programs to create separate tracks within the R3 System for research-focused positions. A separate track also could be created by programs that wish to reserve positions for foreign-nationals who bring funding from governmental entities in their home countries.

The NRMP has never considered whether programs in rural and geographically underserved areas have a more difficult time recruiting applicants. Were the Board to grant an exception, it could consider using the U.S. Health Services and Resources Administration list of Medically Underserved Areas and Populations (http://bhpr.hrsa.gov/shortage/).

Under certain circumstances and provided training will begin on July 1, residents who are transferring to a different program in the same specialty and those who are making mid-career specialty changes could obtain their positions through the Match.

- If the applicant is applying to categorical programs and will repeat the PGY-1 year, he/she could be required to use the Match; however, if the applicant is transferring into a categorical program and will not repeat PGY-1, he/she could not be required to use the Match because the NRMP does not provide matching services for categorical programs other than in PGY-1 positions.

- If the applicant is applying to advanced programs—those where specialty training begins in PGY-2 the year after the Match—the applicant could be required to use the Match because a "reserved" track could be created so that PGY-2 training would commence in the year of the Match.

Applicants who are "off-cycle" could be required to use the Match, depending upon when training would begin. Currently, the NRMP allows U.S. seniors who graduate "off-cycle" to accept positions outside the Match provided training will begin prior to February 1. If training would begin after February 1, the student must use the Match as a sponsored applicant. The Board may wish to use the same definition of "off-cycle" for applicants who are not U.S. seniors.

Programs dually-accredited by the ACGME and the American Osteopathic Association (AOA) participate in both matches by placing some positions in each. The total equals the number of positions the program wishes to fill that year. Because AOA Match Day occurs before the NRMP rank order list deadline, programs revert to the NRMP any positions not filled in the AOA Match. With implementation of the Match Week Supplemental Offer and Acceptance Program (SOAP), dually-accredited programs that place unfilled positions in the NRMP will not receive ERAS applications from applicants participating in the NRMP; however, the NRMP cannot require the AOA Match to prevent its participating programs from filling positions outside the Match, just as it cannot require the Urology Match or the San Francisco Match to abide by that policy.

Effect of Visa Status
A major concern of some GME program directors is whether foreign-national IMGs who require visas will be able to begin training "on time" if they are required to use the Match. Using data on IMGs who obtained J-1 visas for which the ECFMG was the sponsor, NRMP staff compared the "on time" arrival status of those who obtained their positions through the Match and outside it. "On time" arrival was defined as beginning training between June 1 and July 31, and In GME included IMGs who began a residency between June 1 and December 31 of the Match year.

Match Year	Match?	J1 Status?	In GME	Late	Late
2009	**Yes**	**Yes**	**1,046**	**28**	**2.7%**
2009	No	Yes	70	11	15.7%
2009	Yes	No	1,895	50	2.6%
2009	No	No	167	22	13.2%
2010	**Yes**	**Yes**	**1,079**	**44**	**4.1%**
2010	No	Yes	48	8	16.7%
2010	Yes	No	1,617	67	4.1%
2010	No	No	143	21	14.7%

The data show that the percentage of IMGs who were "late" was lowest for those who participated in the Match *and* who were on J-1 visas.

Next Steps
The Board must decide whether any circumstances merit an exception to the "all-in" policy. If exceptions are warranted, they will be codified by the Board at its May 2012 meeting, when it adopts the Match Participation Agreement that will be in effect for the 2013 Main Residency Match.

AAAC Presentaion Material

Moderator: Jeffrey R. Kirsch, M.D.

Service Agreement Negotiations 101
Kevin K. Tremper, Ph.D., M.D.

How to Prevent Yourself from Being Fired
Ronald G. Pearl, M.D., Ph.D.

Personal Development as a Chair; Importance of Becoming a Leader in the Hospital/SOM/University
Joanne M. Conroy, M.D.

How Do You Develop a Culture of Scholarship That Will Be Meaningful To Your Faculty, Dean and RRC
Mark F. Newman, M.D.

Compensation Models: How to Incentivize, But Not Upset Your Faculty Too Much
John A. Ulatowski, M.D., Ph.D.

What a New Chair Needs to Know About the RRC
Margaret Wood, M.B.Ch.B.

Moderator: Berend Mets, M.B.Ch.B., Ph.D.

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

Creating Value from Day 1: Seven Step Program
David A. Zvara, M.D.

Accountable Care Organization and Impact on Anesthesiology
Patricia A. Kapur, M.D.

Debate: The Role of International Medical Graduates Certification and Recognition from the ABA...
Kevin K. Tremper, Ph.D., M.D.; David L. Brown, M.D.

Case Based Scenarios
Judith Jurin Semo, J.D., Esq.

Service Agreement Negotiations 101

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

Learning Objectives

1. To be knowledgeable of the overriding objectives of a negotiation between a Department of Anesthesiology Chair and an institution with respect to institutional support.

2. To be knowledgeable of the areas which are of most conflict in hospital negotiations and how to approach the negotiating process openly and effectively.

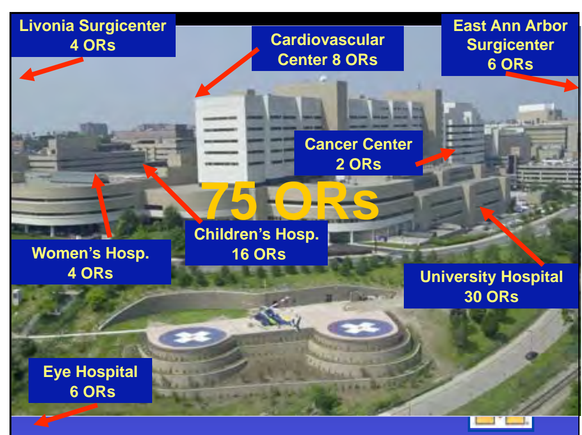
Negotiating a Service Agreement

Kevin K. Tremper, PhD, MD
Robert B. Sweet Professor and Chair
Department of Anesthesiology

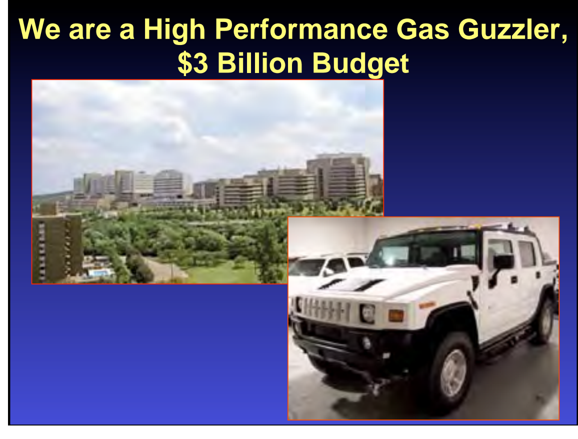
I'm afraid we may refer to now, as the good old days

I'm afraid we may refer to now, as the good old days

Financial pressures for all make cooperation more important then ever

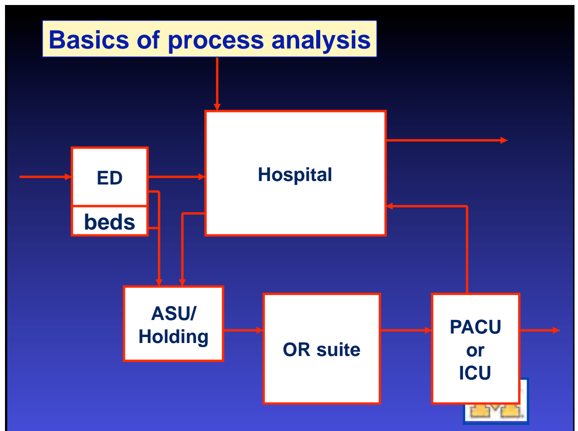


We are a High Performance Gas Guzzler, $3 Billion Budget



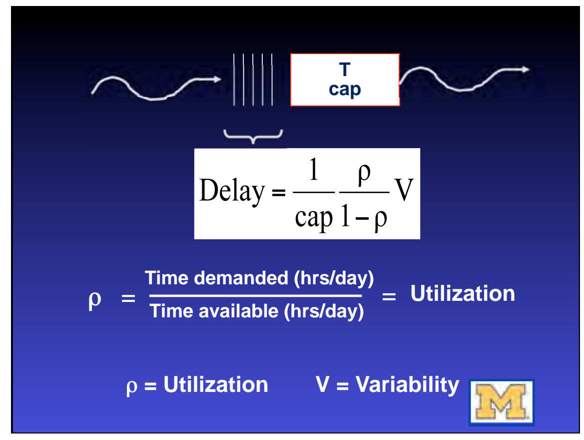
The OR is the Financial Engine of the Clinical Enterprise

$80 Million in Profit (FY 2010)


Basics of process analysis
ED
beds
Hospital
ASU/
Holding
OR suite
PACU
or
ICU

GO
BREW!

GO
BREW!
Why is there
always a line?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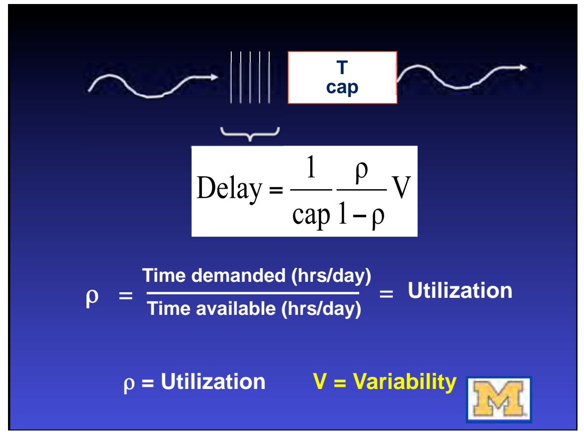
ρ = Utilization
V = Variability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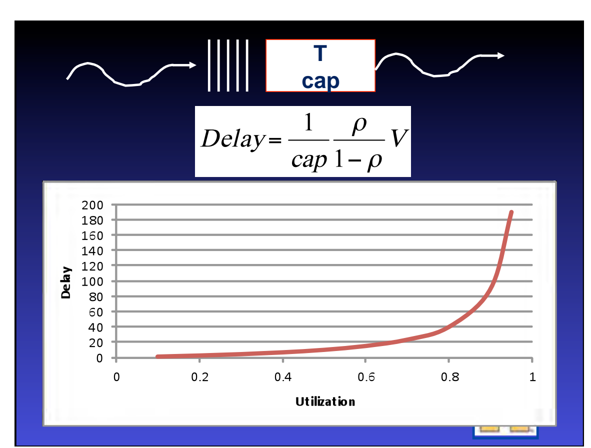
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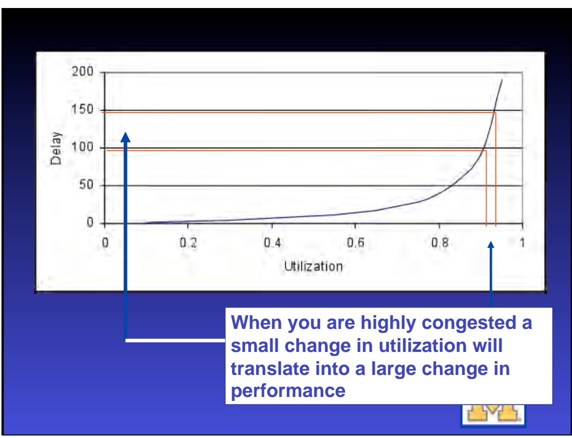
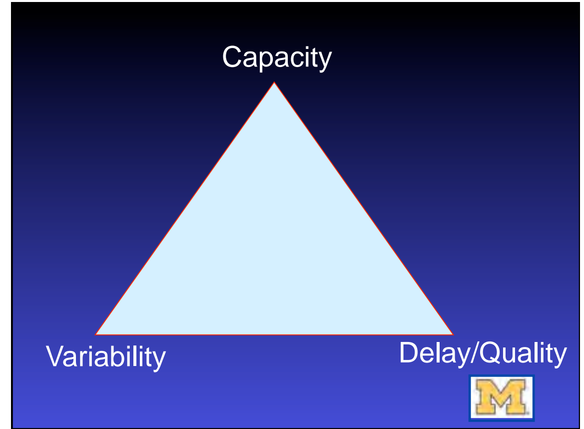
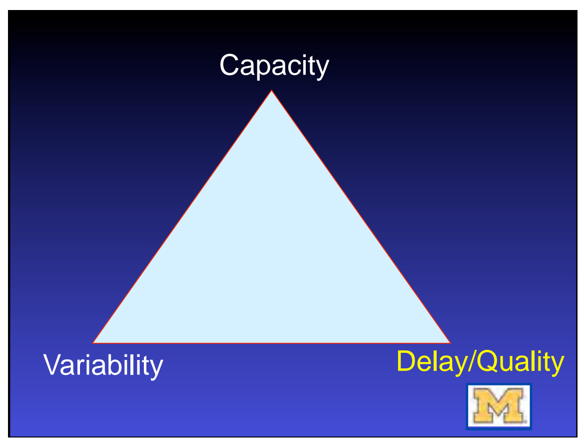
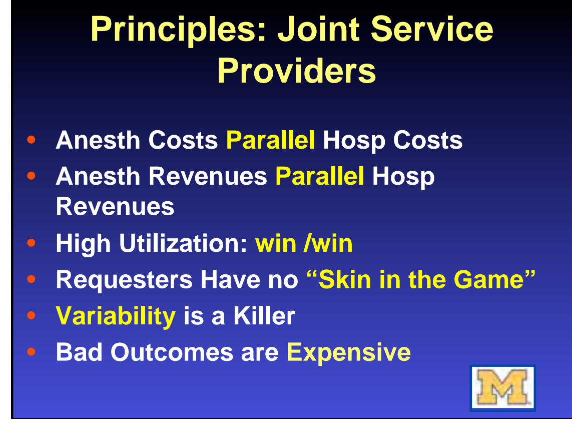


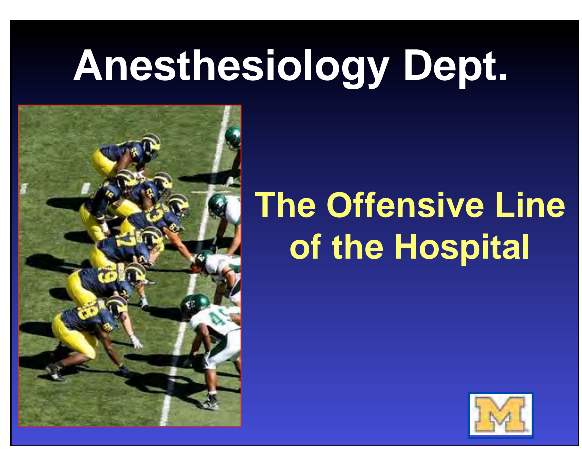




Principles: Joint Service Providers

- Anesth Costs Parallel Hosp Costs
- Anesth Revenues Parallel Hosp Revenues
- High Utilization: win /win
- Requesters Have no "Skin in the Game"
- Variability is a Killer





Start: Describe Your Needs

Educational → Strong Residency

Research → Strong Faculty

Discuss Hospital Service Needs

Clinical & Admin Services

- ORs : Coverage & Management
- OB
- Off Sites
- ICUs
- APS
- Sedation
- Preop Clinic
- JCAHO/SCIP/etc Help

Areas of Difficulty

- CRNA Costs
- Offsite Services
- Academic Costs (time)
- Poor Utilization

Areas of Difficulty

- CRNA Costs
- Offsite Services
- Academic Costs (time)
- Poor Utilization

Too Many ORs

Be Completely Open with your Costs

Be Willing to Provide Services at Costs (total costs)

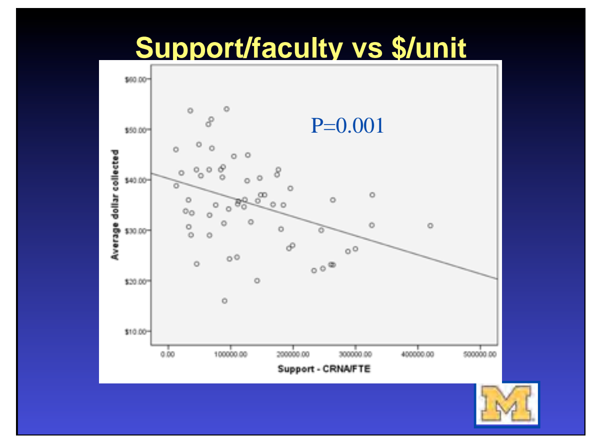
Be Completely Open with your Costs

Be Willing to Provide Services at Costs (total costs)

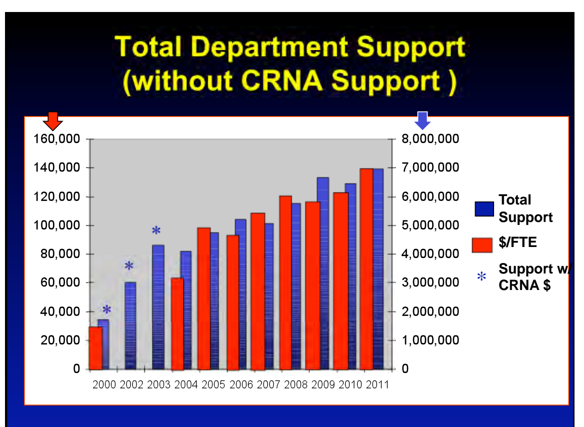
- Salaries from AAMC & SAAC
- Add Admin/Academic Support
- And All Overhead

SAAA Salary Survey National Average (50th %)

	2000	2010	2011	2007	2008	2009	2010	2011
INST	144,250	281,500	269,000	256,182	259,500	271,146	281,500	269,000
ASST	183,000	305,250	306,145	273,920	288,000	299,203	305,250	306,145
ASSC	210,000	337,000	334,289	300,781	315,679	328,725	337,000	334,289
PROF	239,182	350,305	348,550	311,163	323,600	339,209	350,305	348,550



Total Department Support (without CRNA Support)



New Calculation

Sites Covered = OR Covered (38) + Non ORs (9) +

\# of Faculty/day:

OB	=	1.3
ICU	=	1.4
Acute pain	=	1.1
Pain clinic	=	2.0
Preop clinic	=	1.0
Other faculty	=	0.8
		54.6

"Sites Covered" = 54.6
Faculty = 54.5

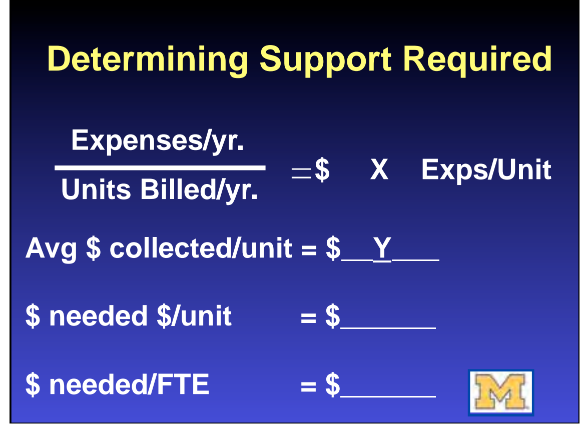
"Average" Department Clinical Coverage

- ORs = 37.5
- Offsites= 9.1
- OB = 1.3
- ICU = 1.4
- APS = 1.1
- Pain = 2.0
- Preop = 1.0

53.4

$$\frac{\text{Faculty}}{\text{Sites}} = \frac{54.5}{53.4} = 1.02$$

$$\frac{\text{Res/CRNA}}{\text{Sites}} = \frac{85.6}{53.4} = 1.60$$



"Average" Department

57.3 Faculty 11,109 units/faculty

Total Expense / Total Units = $35,281,498 / 588,092 = $59.99/unit (needed)

$/unit needed	$59.99
$/unit collected	$35.75
$/unit support	$24.44/unit

Support $24.44 x 588,092 =$14,372,968
or $250,837/faculty

Your Goal

Provide the Safest most Cost-Effective
& Efficient Anesthesia Care

Your Goal

Provide the Safest most Cost-Effective
& Efficient Anesthesia Care

Competitive Academic Salary
Competitive Academic Environment

Good Luck !

How to Prevent Yourself from Being Fired

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

From Donald Trump on The Apprentice to news reports about corporate downsizing, everyone is worried about job security. This is particularly true of academic chairs who serve "at the pleasure of the Dean" and can be dismissed from their chair positions without warning and frequently without stated cause. For an anesthesia department chair whose academic future may end with such dismissal, the prospect of being fired can be an overwhelming concern.

There are only limited data on how frequently anesthesia chairs are fired. There is general agreement that firings were at their peak in the late 1990's when almost one-third of departments either had a new chair or an interim chair at the annual SAAC meetings. Although some of those vacancies were due to either planned retirement or voluntary resignations, it was a period of frequent firings when resources were insufficient to meet the expectations of the hospital or the medical school. Data on the percentage of chair positions filled by first-time chairs in clinical departments (not simply anesthesia) confirms a peak to approximately 13% around the year 2000, with a subsequent decline below 5% by 2005 (Rayburn, 2009). Despite myths that department chairs are likely to be fired at specific time frames, retention curves for clinical chairs are linear, with 5- and 10-year retention rates of 69% and 46%. The duration of clinical chair positions has been compared to other fields, with medical school deans averaging 3.9 years and NFL head coaches 3.2 years; of course, their salaries and severance packages may compensate for the short tenure.

There are also limited data on why chairs are fired. In an outstanding book for the AAMC, Julien Biebuyck, the former chair of anesthesia at Penn State, noted that chairs may be dismissed for misbehavior, scientific misconduct, mismanagement of funds, and conflicts of personality. The entire book is worth reading because it emphasizes that chairs are often chosen for their success in areas such as research rather than for important characteristics such as leadership.

There are multiple articles and books on how to avoid being fired in non-medical positions, as well as an excellent article on the "Ten Commandments" for a psychiatry chair (Winstead) and how to be a good academic leader (Detsky). In addition, the journal Academic Medicine frequently hast relevant articles such as a description of how deans and hospital CEO's differ in their expectations of a clinical chair (Souba). My comments below on how to avoid being fired are a synthesis of many of these sources as well as observations based on my personal experience (as well as the firing of 2 of the 3 chairs who preceded me at Stanford).

One article on chair turnover begins, "Members of the Council of University Chairs…have become increasingly concerned about the apparent loss of academic chairs. Their tenures seem shorter, and turnover is greater. Churning of chairs can be highly detrimental to leadership and to departmental as well as institutional success. Furthermore, replacement of a chair requires a large allocation of faculty time and institutional resources" (Rayburn, 2009). Although this statement could apply to our specialty, the article concerned chair turnover in obstetrics and gynecology. However, the quote does emphasize that (with very rare exceptions) everyone wants a new chair to be successful. In fact, during the first several years of a new chair, there are only a few issues which will result in being fired. I have grouped them into prohibited actions, failure to provide adequate clinical service, losing money, offensive behavior, losing the support of the department, and inadequate skills:

Prohibited Actions: Some actions are illegal, ethical, or cross obvious lines, such as misappropriation of funds, physical abuse, sexual harassment, and gender or racial discrimination. No advice should be necessary on how to avoid these situations. Other actions may be less clear but violate stated departmental and institutional policies. New chairs should attend their institution's orientation sessions, read the faculty handbook, and review departmental policies. During your time as chair, it is inevitable that you and/or the department will have legal actions threatened, so make a friend of the school's ombudsman and lawyers and seek advice frequently from other chairs and the dean to avoid such situations or, if they do occur, to have their support behind you.

Failure to provide adequate clinical service: When a new chair is recruited for a department of anesthesiology, there is a clear expectation that the chair run the department in such a manner as to provide adequate clinical service. Although there may be a grace period if service previously was inadequate, failure to provide the anticipated level of clinical service without a justification can end a chair's appointment. In general, there are only three acceptable responses if you cannot provide the expected clinical service. The first is to convince the institution that the resources available to you are insufficient. Unfortunately, this is a difficult argument since you accepted the position with these resources. The second response is to emphasize changes which have occurred beyond your control such as an expansion of locations, decreased reimbursements, increased salary costs, or inadequate hospital resources (such as lack of OR nurses). If you need to make an argument based on resources, you should align yourself with the surgeons who hopefully will back your request to the hospital or school for more support. The third response to justify inadequate clinical service is to claim that the expectations of the surgeons are unrealistic in terms of horizontal spread (multiple rooms with few cases) or call coverage. In these situations, OR nursing is frequently your best ally since they also have difficulty providing cost-efficient service. In the syllabus presentations this year and from prior years on the SAAA website, you will find multiple tips on how to negotiate these issues.

Losing money: As a new chair, the expectation is that you have negotiated the resources and have the right skills so that the budget will be balanced (if not profitable). Although small losses are acceptable for a period of time, any significant deficits need to be justified to the institution (similar to the inability to provide the expected level of clinical service). In both cases, a realistic plan to fix the problem can justify additional time.

Offensive behavior: Academic institutions by and large encourage collaborative behavior. Although there are clearly times when you need to take an unpopular position, repeatedly offending other powerful people (being an asshole) frequently results in the end of your appointment. Treat other people, especially other chairs and the dean, with the same respect you want to be treated with. Be aware of how your behavior is perceived. Pick your battles carefully, and be careful that you focus on the issues and not allow them to become personal. As one article said, "Don't paint targets on your back."

Losing the support of the department: 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.

Inadequate skills: The job of an anesthesia chair is complex and demand-

ing and requires leadership skills, financial knowledge, interpersonal skills, and long hours. Some anesthesia chairs take the position without a realistic assessment of whether they have the right skills for the job. This is usually obvious to everyone involved during the first year. All chairs should avail themselves of the multiple opportunities to increase their skills in these areas to allow them to become more effective over time..
The above issues are the most likely ones to lead to dismissal during the initial year or two as a chair. The following comments are provided to enhance success throughout your entire term:

Stewardship of the department: Stewardship 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. 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 is challenging 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 yourself and the department and then be sure to meet them.

Management of the department: 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 who 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. Finally, when issues are discussed, focus on coming to the best decision for the department, rather than having people agree that your view is correct.

Be involved: It is easy for a chair to be so focused on departmental issues that he becomes isolated from the faculty. Humans are social animals, and they want to relate on a personal level to those around them. Faculty, especially junior faculty, are intimidated by the role of the chair, even though the chair should be representing the faculty. Be sure to spend time with the faculty on an individual basis. Know their families and their unique issues. Most chairs have annual review meetings with each faculty member. Although this is time consuming, it allows the faculty to feel that you are concerned about them individually and are connected to the department. If you know what is going on in your department, you will not be caught by surprise. Chairs are almost never fired when they have the support of their faculty; chairs almost never continue in their positions when they do not. In addition, be involved with your institution, volunteer for committees, and be recognized as a true leader. Good citizenship is not always rewarded, but it is always recognized.

Network with other chairs, the Dean, and the CEO: As mentioned, humans are social creatures, and chairs are no exception. As chair, your relationship with faculty is automatically changed. At the same time, you now belong to a new network of peers, namely your fellow chairs. Your best guarantee against being fired is to have the support of your fellow chairs, the Dean, and the CEO.

Managing the difficult conversation: One of the important responsibilities of leadership is having difficult conversations with faculty, staff, or trainees regarding problems with their performance and behavior. These conversations are not pleasant, and it is easy to find reasons to postpone them in hopes that the issues will resolve over time. Unfortunately, avoiding these conversations forfeits an opportunity for effective intervention, makes subsequent actions such as probation or dismissal more difficult, as well as risking having an avoidable disaster occur. The department and the institution expects you to deal with these situations, but you may want to seek the advice of senior faculty, the Dean, or your HR department regarding specific issues in advance.

Know when to step down: We all know about the athlete, the singer, or the politician who tarnished a spectacular career by continuing too long. The same is also true of anesthesia chairs, but in this case it is the department that suffers. If you focus on the concept of stewardship, you will recognize when your energy, your skills, your style, or your relationships with the school and the hospital are no longer serving the purposes of the department. One way to avoid being fired is to step down as chair on your own terms. In addition, there are situations where the department is placed in an untenable situation, such as being forced to cut academic programs because of inadequate clinical revenue. In such cases, you need to be willing to put your chair position at risk in order to bargain effectively for the department.

Care for yourself: A recent study of anesthesia chairs demonstrated that only 34% had high current job satisfaction, 59% had evidence of moderate or high burnout, and 46% had a moderate or extreme likelihood of stepping down within the next two years (De Oliveira). We promote the concept of wellness for our faculty and residents, but few of us practice it for ourselves. Be sure to spend time with family and friends, develop support networks with other chairs, and cultivate other interests. There will be life after being chair, so plan for it. Being chair should be one of the most positive experiences of your life. If you are not enjoying it, figure out what needs to change and change it.

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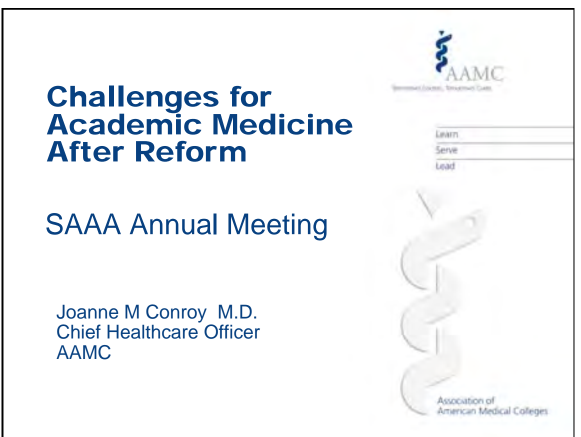
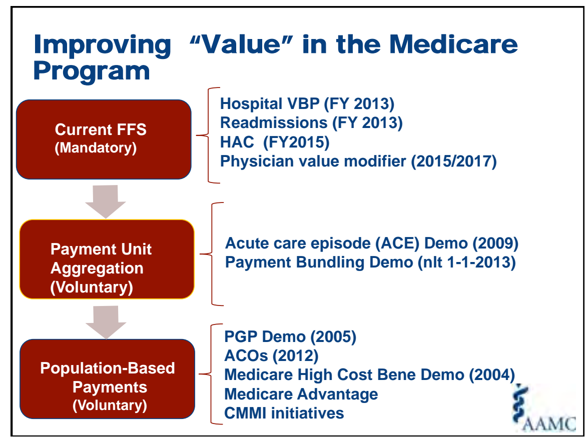
Personal Development as a Chair; Importance of Becoming a Leader in the Hospital/SOM/University

Joanne M. Conroy, M.D.

Notes:





Unfortunately, the recent debt discussions could result in have additional economic impacts

Education

- Undergraduate Loans
- Indirect Graduate Medical Education

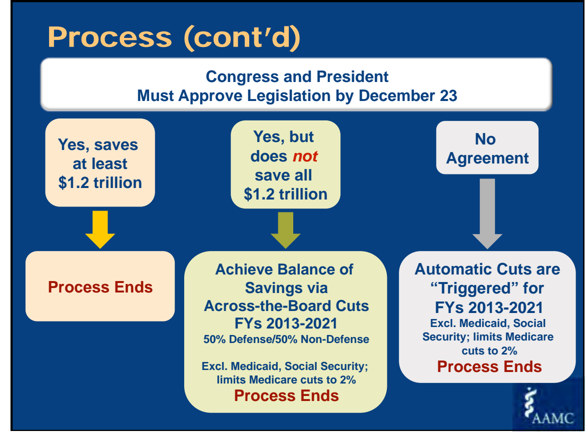
Research

- Proposed NIH salary cap reduction

Clinical Care

- Medicare, Medicaid, cuts and threats of tiering with Health Insurance Exchanges …threaten financial stability

AAMC



Potential Targets: Medicaid

- Up to $100 billion in FMAP streamlining
- $26 to $51 billion through phasing down/out Medicaid provider taxes

Unclear impact on AAMC member institutions but likely to disproportionately affect practice plans and teaching hospitals

Potential Targets: Medicare

$14 to $26 billion/10 yr in phasing out payments for bad debts

- Up to $1 billion/yr for AAMC institutions

$14 to $70 billion/10 yr reduction in DGME/IME payments

- Up to $6 billion/yr for AAMC institutions

Three Institutions: Committee vs Sequester for Medicare

	IME cut	Bad Debt	PPS 2%	Doc 2%
NE1	$32 m/yr	$ 2.5 m/yr	$ 5 million	$ 5 million
MidAtl1	$47 m/yr	$ 1.1 m/yr	$ 7 million	$ 6 million
West1	$31 m/yr	$ 2.3 m/yr	$4 million	$ 4 million

Excludes potential Super Committee cuts to Medicaid

Excludes potential Sequestration cuts to discretionary

Cannot account for action on SGR

AAMC

The Message

- Academic medicine fulfills vital role of education, patient care, and discovery
- Disproportionate reductions to AAMC member institutions will reduce the number of physicians trained, reduce access to vital services, and turn the clock back on treatments and cures
- Cuts to providers should not be focused on a small group of institutions that do what others cannot or will not do
- Cuts to research will erode our long term economic growth and success as a nation

Physician Issues on Horizon

- SGR 'fix' vs. patches after Dec 31st
- Changes to geographic adjusters in payment
- Quality reporting mandatory for physicians
- Public reporting ('physician compare')
- Sunshine Act
- HIT meaningful use requirements
- Physician pay 'value' modifier
- Medicaid payment rates
- Primary care vs. specialty reimbursement

Sustainable Growth Rate (SGR)

Sustainable Growth Rate: Without Congressional action a **29.5% decrease** to physician payment on January 1, 2012

Fixing the problem:

- $300 billion for 10 year solution
- 1-2 year "fix" more likely @ $12-31 billion with a 34-38 percent cut on January 1, 2014

In Congress:

- Hearings in House Energy & Commerce and Ways &Means Committees; no Senate activity

Physician advocacy community:

- Continued push for full SGR repeal
- Joint Select Committee on Deficit Reduction is the last best opportunity to address **permanent** SGR reform in the Medicare physician payment system

AAMC

Sustainable Growth Rate (SGR)

September MedPAC SGR Discussion:

- Replace the SGR formula
- Primary care services would remain unchanged over the next 10 years; all other services would be cut 5.9% each of the next three years (~20% total decrease) and then a 7 year freeze
- Brings SGR repeal cost down to $200B

•MedPAC identified $235B in previously suggested offsets

•This list included previous MedPAC recommendations and options suggested by other groups

•MedPAC approved proposal at October meeting

Medicare Clinician Quality/Value Programs

Potential Incentives	2012	2013	2014	2015	2016	2017
PQRS	0.5%	0.5%	0.5%			
OR						
PQRS – MOC Option	1.0%	1.0%	1.0%			
eRx Incentive[a]	1.0%	0.5%				
OR						
EHR Incentive	Varies	Varies	Varies	Varies	Varies	

Potential Reductions	2012	2013	2014	2015	2016	2017
eRx Incentive	-1%	-1.5%	-2%			
PQRS				-1.5%	-2.0%	-2.0%
EHR Incentive				-1.0%	-2.0%	-3.0%
Value modifier[c]				TBD	TBD	TBD
Total Possible Reduction	-1%	-1.5%	-2%	-2.5%+	-4%+	-5%+

[a] Cannot receive the Medicare EHR Incentive and eRx incentive, but can receive both Medicaid EHR Incentive and eRx Incentive
[b] Opportunity to recoup full amount and more.
[c] Adjustment could be positive or negative.

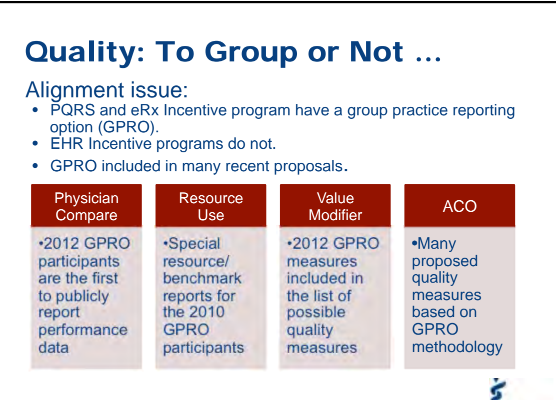
Value Modifier Proposals

Law: Starting in 2015 for certain practices and 2017 for all practices, CMS is required to pay differentially based on quality and cost composites.

Proposal: 2015 modifier based on 2013 performance period

Proposed Quality Measures	Proposed Cost Measures
1. PQRS Core Measure set 2. PQRS GPRO Measures 3. Medicare EHR Incentive Program measures	1. Total per capita 2. Total per capita for COPD, heart failure, coronary artery disease, and diabetes
Seeking comments on: • Outcome measures (hospitalization rates) • Care transition measures • Patient safety/experience/ functional measures	Potential future measures: • Episodes of care • Consider short-term MS-DRG measure

2012 Physician Fee Schedule Proposed Rule Federal Register
pp. 42909-42914



What Are Academic Members Saying About GPRO?

Positives

Took the "guessing out" of what to report for each physician

"Relatively" easy compared to claims-based reporting

Immediate performance feedback through reporting tool (although incentive check & benchmark data did not come early)

Challenges

Some patients attributed to practice based on specialty care or referrals

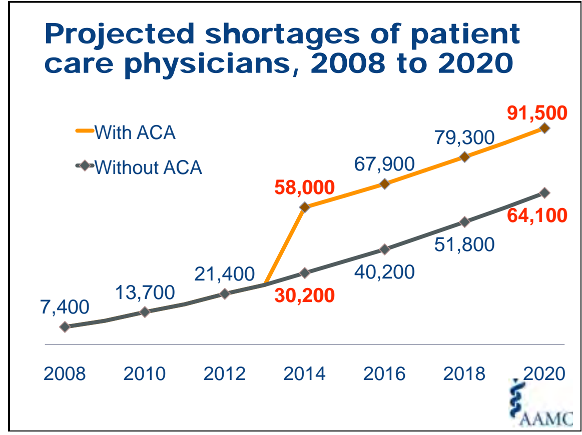
Intensive 5-week period to complete data submission

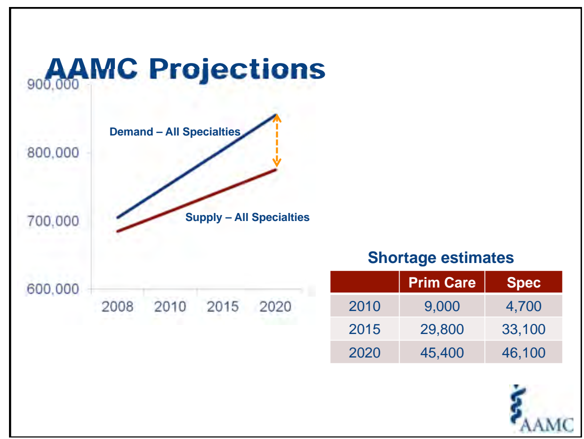
Measures mostly primary care – what is the role of specialists?

Reactions to GPRO based on the experience of 4 academic medical groups

Impact of ACA on Workforce

- Resident redistribution: adds ~**200 PC doctors & gen surgeons per year** (2,000 /10 years)
- HHS workforce grants: adds **500 primary care** doctors over 10 years
- **32 million into system**, many without prior insurance with pent up needs
- Over next 20 years, **36 million people added to Medicare** (using the most services) ~ 20% of the population (up from 13%)





	Prim Care	Spec
2010	9,000	4,700
2015	29,800	33,100
2020	45,400	46,100

Key Workforce Questions

Will there be continued growth in GME?

What impact will team based medicine and other new care models (ACOs, HIZs, medical home) have on productivity/efficiency?

What is the work hour trajectory over a physicians career? Is the new generation of physicians different?

What has the greatest impact on quality and efficiency? Education or practice environment?

Key Workforce Questions

Do we know what medical schools and hospitals are the most efficient providers of UME and GME? How would we determine that…what metrics … cost and outcomes?

How do we incentivize students to enter needed specialties?

IRB ratio/ inpatient Medicare admissions…are these really as relevant in an ambulatory focused environment for formula funding?

Is debt and compensation adversely shaping our medical workforce?

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Regardless of the model….more work still be to done to

Goal	Strategy
▪ Decrease cost growth rate	Provide real time cost of care data
▪ Decrease administrative costs	Include residents and faculty in system reengineering teams
▪ Decrease variations in care	Agree on what can be standardized and what can not in the educational environment
▪ Reduce medical errors	Create a safe place for reporting
▪ Make better decisions about end-of-life care	Teach residents that it is important to know when not to do something as it is to know when to intervene

Hospital Implementation Issues

Medicare cuts to hospitals = $155 B/10 years

- Hospital price transparency
- Community benefit reporting reqs/IRS
- Readmissions policies FY 2013
- Value based purchasing FY 2013
- Medicaid/Exchange expansion 2014
- Hosp Acquired Conditions reductions FY 2015

Level of insurance/payment vs. market basket, productivity, and DSH cuts

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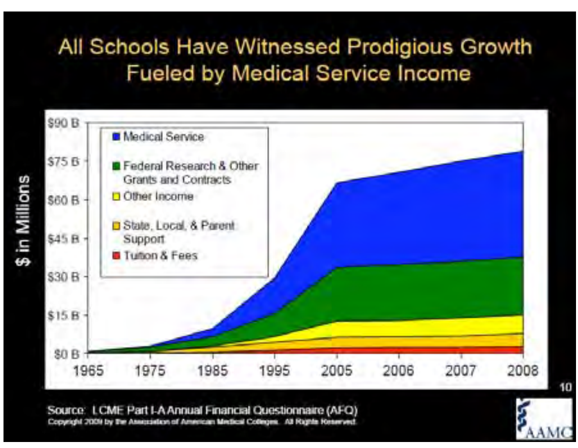
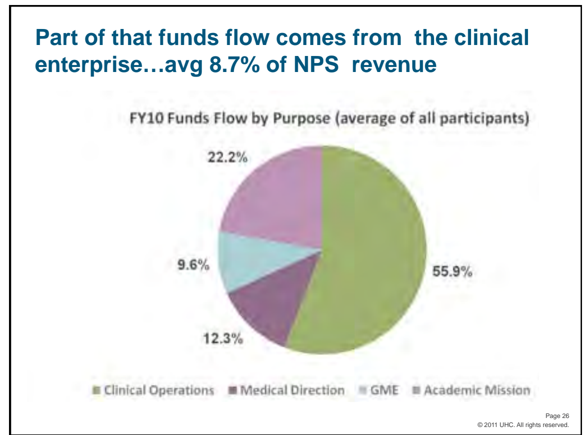
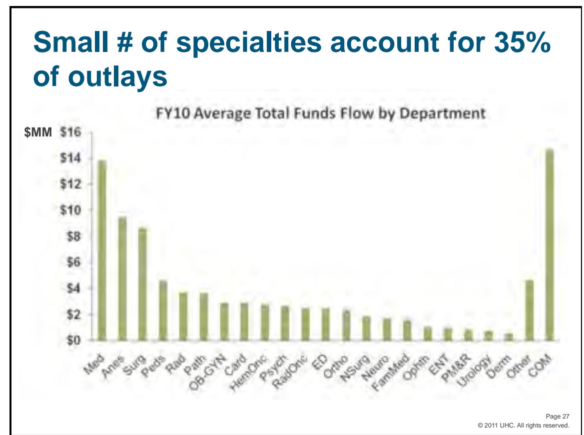






Moving Toward a New Paradigm: What's Needed?

- Alignment between hospital and SOM/ practice plan
- Incentives that drive accountability across the organization
- Flexibility to adapt to changing market and financial conditions
- Ability to measure ROI

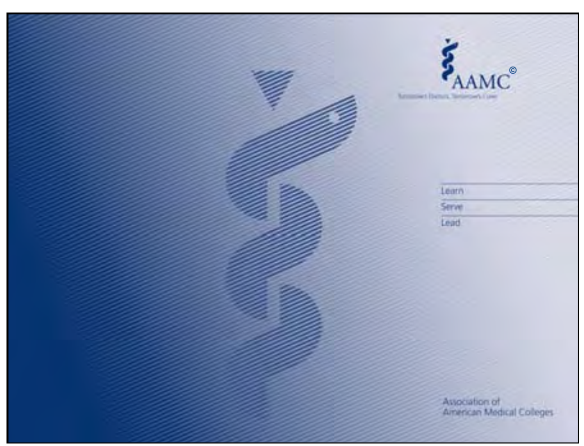
The Challenges of Change

You cannot change your destination overnight, but you can change your direction overnight"

Jim Rohn

It is not necessary to change. Survival is not mandatory.

W. Edwards Deming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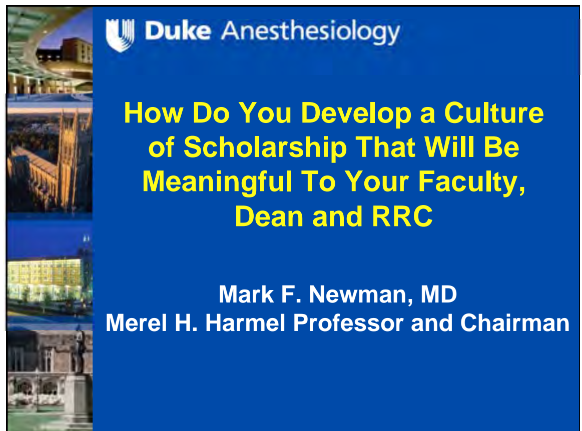
Learn
Serve
Lead
Association of
American Medical Colleges

How Do You Develop a Culture of Scholarship That Will Be Meaningful To Your Faculty, Dean and RRC

Mark F. Newman, M.D.

Notes:



Objectives

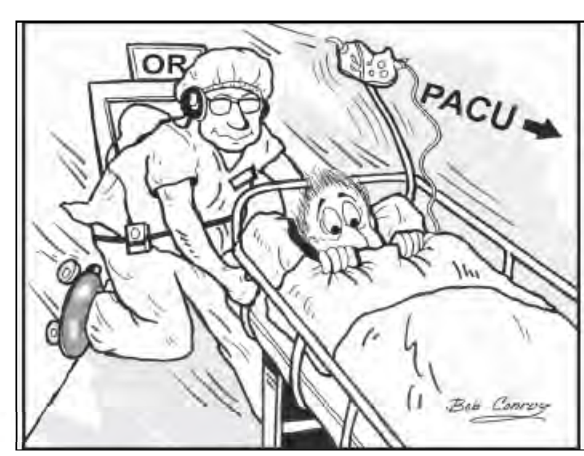
- Understanding the focus of your customers (Faculty, Dean and RRC)
- Institutional strengths and alignment
- Return on investment
- Data, negotiation, communication and "Public Relations"
- Critical mass and culture

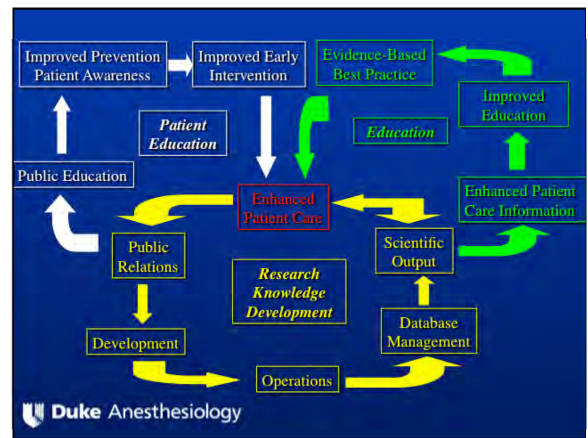
Duke Anesthesiology

External and Internal Pressures

- Anesthesiology
  - Production pressure
  - Relative cost of providers
  - Broadening range of anxious, "lower" cost competitors
  - Difficulty of differentiating outcome in low risk situations

Duke Anesthesiology





SOM Structure and Priorities

- Relationship to faculty practice and hospital (Duke: Dean no oversight of FP)
- Dean's Incentives
  - NIH funding, ranking and trajectory
  - National reputation (US News…..)
  - Selectivity and diversity of medical students
  - MD-PhD program ranking and success
- Are there any incentives for the Dean to grow the clinical practice?

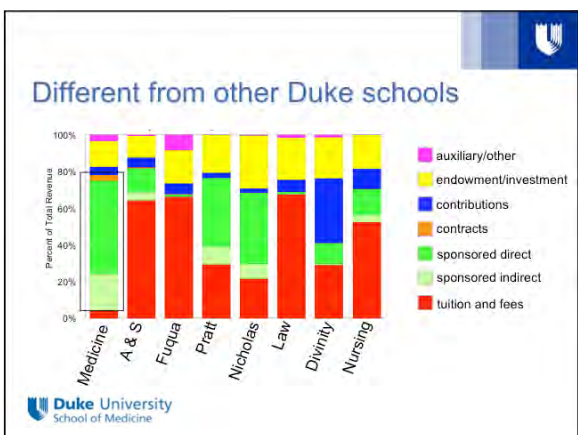
Duke Anesthesiology

Dean's Perspective

"The dollars are not unimportant, but what I care about most is that our faculty make contributions that will ultimately lead to improvements in health. I always like hearing about new dollars coming in, but I get more excited hearing about advances that come from our faculty's scholarship. They last a lot longer and go much further than the money…."

Dean Nancy Andrews, DUSOM

Duke Anesthesiology



Challenges to AHC's to 2016

Clinical revenues remain flat in aggregate & margins decline, despite increasing volumes:

- Affordable Care Act
  - Medicare cuts in payments to providers
  - Loss of DSH
  - Loss of IME
  - Expansion in Medicaid (HIE)
- Medicaid reductions
- High cost of care at AHCs, reduced commercial insurance reimbursement & lowered payor tolerance
  - Tiering (e.g., Food Lion & DUHS)
  - Decreased ability to cost-shift
  - Flattening commercial rates
  - Shift from commercial to HIE

Drivers of Increasing AHC Shortfall

- Biomedical research & educational costs outpace normal inflation & tuition increases
- NIH funding (4-5% decrease is projected)
- Economic downturn (endowment & philanthropy continues to be down)
- Increased government oversight, difficulty managing academic-industry relationships
  - Conflict of interest
  - Regulatory pressures
- Increased IT, infrastructure & regulatory expenses

RRC Expectations

- Research output – peer reviewed success
- Educational scholarship, chapters, PBLD, etc.
- Leadership/participation in subspecialty or national societies
- Presenting at national meetings including educational offerings
- Bottom-line – faculty are engaged in things in addition to clinical care

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Alignment
Opportunities for alignment in your institution (go with success)
Create clear process for return on investment for investors (Dean, Hosp, Faculty)
What infrastructure is needed?
Data…Data…Data…
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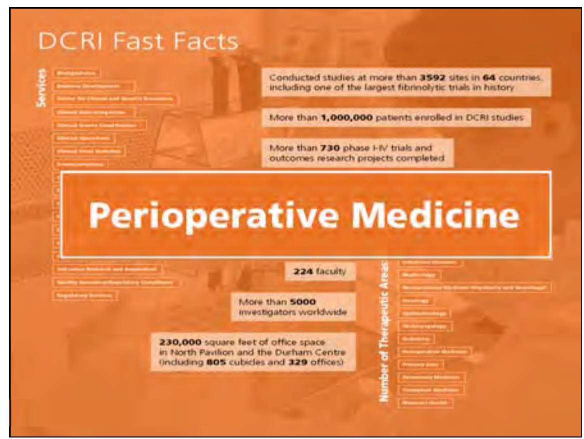
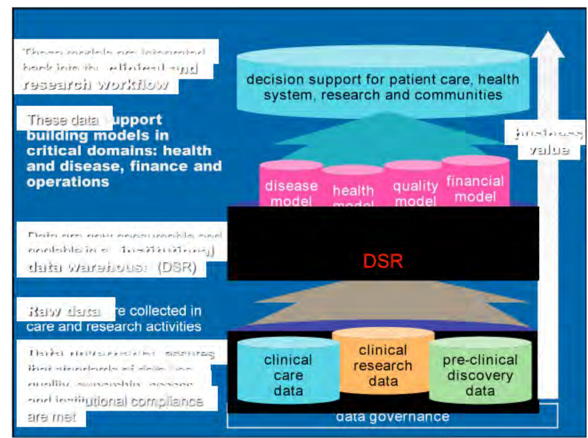
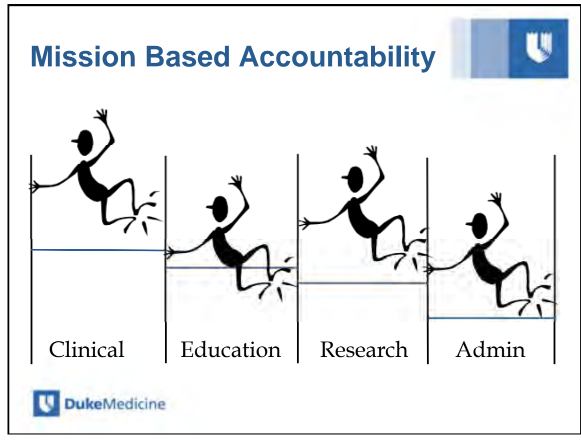


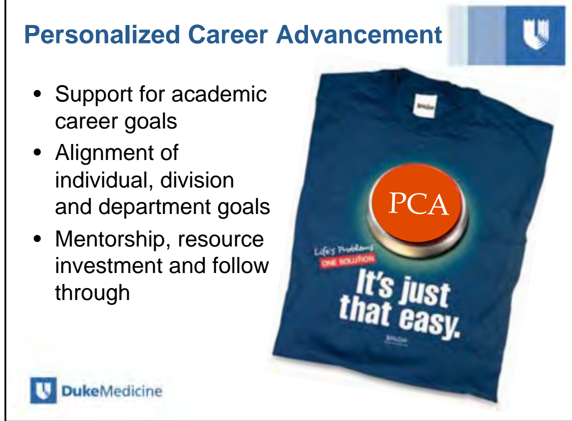
DCRI Fast Facts
Services
Conducted studies at more than 3592 sites in 64 countries, including one of the largest fibrinolytic trials in history
More than 1,000,000 patients enrolled in DCRI studies
More than 730 phase I-IV trials and outcomes research projects completed
Perioperative Medicine
224 faculty
More than 5000 investigators worldwide
230,000 square feet of office space in North Pavilion and the Durham Centre (including 805 cubicles and 329 offices)
Number of Therapeutic Areas



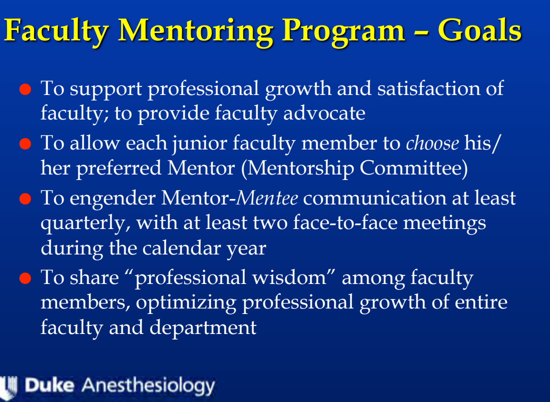
decision support for patient care, health system, research and communities
upport building models in critical domains: health and disease, finance and operations
disease model
health model
quality model
financial model
DSR
data warehouse (DSR)
e collected in care and research activities
clinical care data
clinical research data
pre-clinical discovery data
data governance



Mission Based Accountability
Clinical
Education
Research
Admin
DukeMedicine



Personalized Career Advancement
Support for academic career goals
Alignment of individual, division and department goals
Mentorship, resource investment and follow through
PCA
It's just that easy.
DukeMedicine



Faculty Mentoring Program – Goals
To support professional growth and satisfaction of faculty; to provide faculty advocate
To allow each junior faculty member to choose his/her preferred Mentor (Mentorship Committee)
To engender Mentor-Mentee communication at least quarterly, with at least two face-to-face meetings during the calendar year
To share "professional wisdom" among faculty members, optimizing professional growth of entire faculty and department
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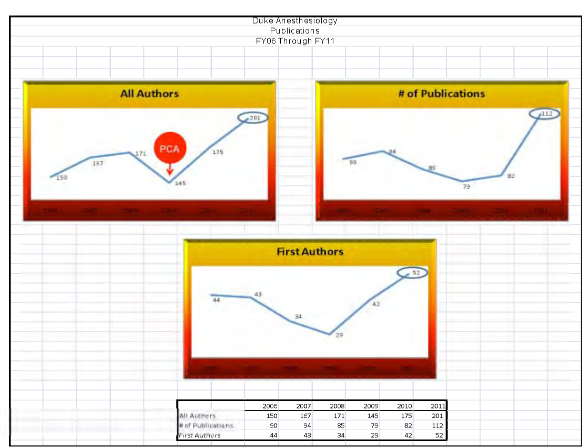

	2006	2007	2008	2009	2010	2011
All Authors	150	167	171	145	175	201
# of Publications	90	94	85	79	82	112
First Authors	44	43	34	29	42	52

Academic Career Enrichment Scholars (ACES)

- ACES-5 integrates both residency and fellowship training into a continuum. This continuum provides a total of 9-12 months research experience and subspecialization within the 5 years.
- ACES-6 is designed to integrate intensive research training into the residency and early faculty sequence.
- Both programs provide additional stipend support and are designed to attract top recruits and provide opportunity for academic progression.

Endowed Professorships

- Merel H Harmel Professorship – Chairman
- JG Reves Professorship – Pending
- Hans Karis Professorship – Critical Care
- Duke Distinguished Professor – Basic Sci
- Duke Distinguished Professor – Bioinform
- Duke Distinguished Professor – ????

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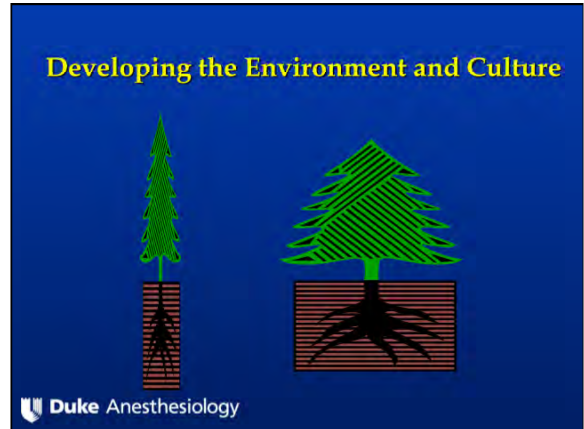


Chairman's Goal

Alignment of goals for key constituents
Strong focus on faculty member achieving maximum potential through:

- Provision of adequate resources
- Mentoring
- Teamwork
- Goal setting (Don't set goals to low)
- Pushing!!!!!!!

Duke Anesthesiology

Compensation Models: How to Incentivize, But Not Upset Your Faculty Too Much

John A. Ulatowski, M.D., Ph.D.

Notes:

What a New Chair Needs to Know About the RRC

Margaret Wood, M.B.Ch.B.

The presentation will describe the role of the RRC in ensuring uniform minimum standards for residency programs in the United States. The lecture will discuss the role of the Chair and Program Director in the management of the residency program, advice on the preparation of the Program Information Form (PIF) and other important issues. Some personal reflections will be offered on lessons learned as a chair on how to balance the administrative and compliance issues of importance to a residency program, along with providing a substantive education program for residents during their training. The environment for resident education has become more challenging increasing the demands on the Program Director and Chair. Numerous issues have received heightened attention from the public, hospital administrators and residents which include safety, discipline and personnel issues which need to be addressed by departments. Innovations in education are also of interest to the RRC.

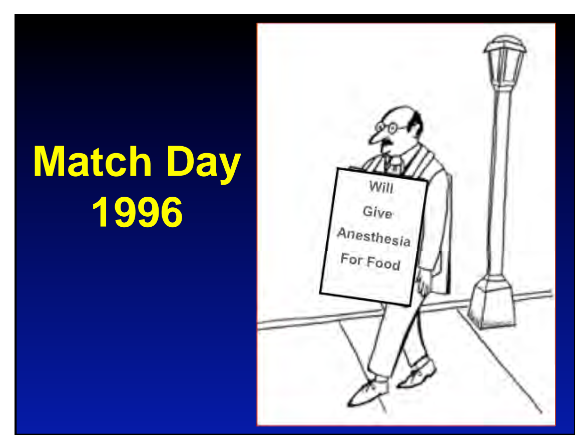
Perfect Storm

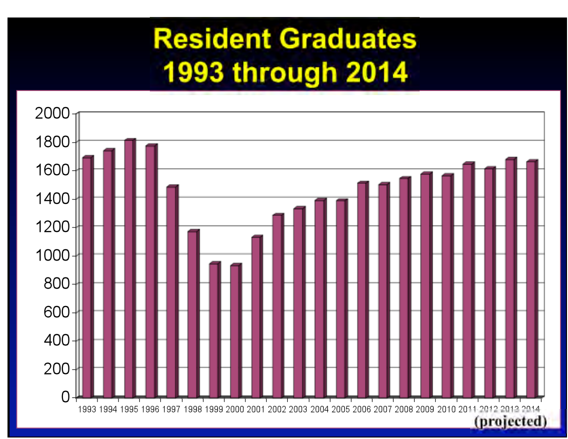
Kevin K. Tremper, Ph.D., M.D.

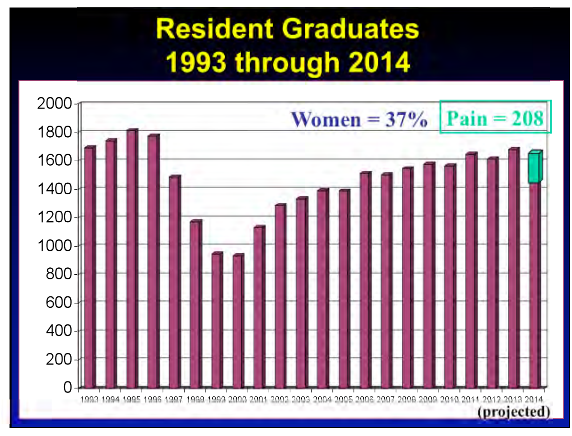
Learning Objectives

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.







Survey Response Rate

2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
58%	72%	64%	65%	73%	60%	61%	60%	59%	60%	62%	50%*

* Need More Respondents

"Average" Department (2010/2011)

Faculty	54.5 FTE
Residents	14/Class
Interns	81% have 9.9 interns
CRNAs	100% have 36.2 CRNAs

"Average" Department Clinical Coverage

- ORs = 37.5
- Offsites= 9.1
- OB = 1.3
- ICU = 1.4
- APS = 1.1
- Pain = 2.0
- Preop = 1.0

53.4

$\frac{\text{Faculty}}{\text{Sites}} = \frac{54.5}{53.4} = 1.02$

$\frac{\text{Res/CRNA}}{\text{Sites}} = \frac{85.6}{53.4} = 1.60$

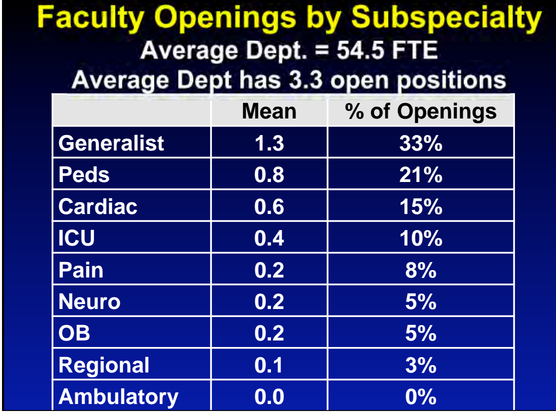
Average Job Openings for Faculty/Department

Year	2000	2001	2002	2003	2004	2005	2010	2011	2010	2011
# Openings/ Department	3.8	3.9	3.4	3.8	2.7	2.8	3.4	3.9	3.4	3.9
% Faculty/ Department	9.7 %	8.7 %	6.8 %	7.3%	5.9%	5.5%	6%	7%	6%	7%
Estimated Number of Faculty Openings	≈400	≈400	≈400	≈400	≈350	≈350	≈345	≈450	≈345	≈450

Average Job Openings for Faculty/Department

Year	2000	2001	2002	2003	2004	2005	2010	2011	2010	2011
# Openings/ Department	3.8	3.9	3.4	3.8	2.7	2.8	3.4	3.9	3.4	3.9
% Faculty/ Department	9.7 %	8.7 %	6.8 %	7.3%	5.9%	5.5%	6%	7%	6%	7%
Estimated Number of Faculty Openings	≈400	≈400	≈400	≈400			≈345	≈450		≈450

SAAA Salary Survey 5.3%



Faculty Openings by Subspecialty

Average Dept. = 54.5 FTE

Average Dept has 3.3 open positions

	Mean	% of Openings
Generalist	1.3	33%
Peds	0.8	21%
Cardiac	0.6	15%
ICU	0.4	10%
Pain	0.2	8%
Neuro	0.2	5%
OB	0.2	5%
Regional	0.1	3%
Ambulatory	0.0	0%

Faculty Openings by Subspecialty

Average Dept. = 54.5 FTE

Average Dept has 3.3 open positions

	Mean	% of Openings
Generalist	1.3	33%
Peds	0.8	21%
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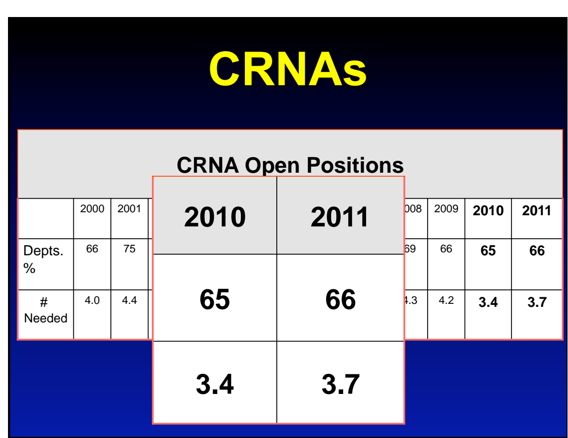
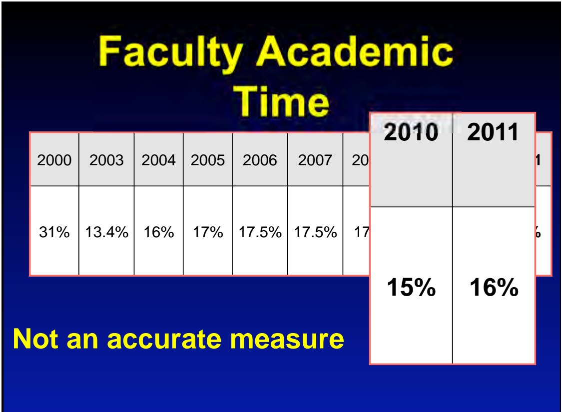
OB	0.2	5%
Regional	0.1	3%
Ambulatory	0.0	0%



CRNAs

CRNA Open Positions

	2000	2001	2010	2011	...08	2009	2010	2011
Depts. %	66	75	65	66	...69	66	65	66
# Needed	4.0	4.4	3.4	3.7	...3	4.2	3.4	3.7



Revenue: Sources and Total

	2000	*	2010	2011
Clinical Revenue	$11,718,925 $340,404/ FTE (n=78)	-	$25,438,037 $443,836/FTE (n=70)	$25,127,995 $444,822/FTE (n=52)
Research Revenue	$1,038,759 $23,067/ FTE (n=67)	-	$1,851,084 $24,129/FTE (n=70)	$1,344,803 $19,546/FTE (n=52)
Institut. Support	$1,235,000 $34,300/ FTE (n=77)	-	$8,652,268 $166,759/FTE (n=70)	$8,709,893 $177,065/FTE (n=52)
Total Revenue	$14,682,989 $424,300/ FTE (n=79)	-	$36,822,613 $648,830/FTE (n=70)	$35,824,618 $649,786/FTE (n=52)
Total Expense	$13,768,981 $387,512/ FTE (n=79)	-	$36,527,333 $642,351/FTE (n=69)	$35,614,486 $645,233/FTE (n=52)

* 2001 or 2003 surveys did not ask for these data.

Margin Analysis FY 2000 - 2011

Dept. Margin	2010	2011	2005
(+) Margin/ FTE	57% 27,849	52% 28,121	50% 37,100
(-) Margin/ FTE	25% 36,166	36% 36,321	40% 49,900

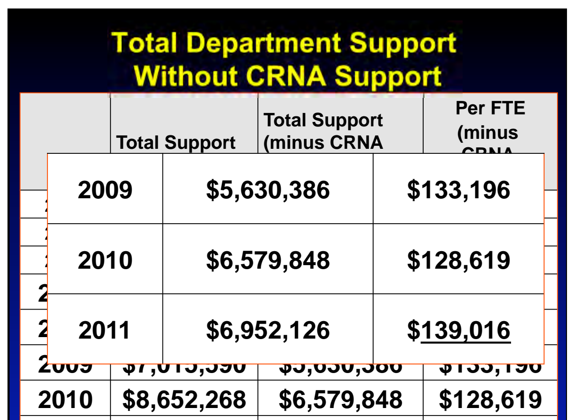
Dept. Margin						2011
(+) Margin/ FTE	68% 29,400	60% 26,111	53% 29,961	53% 33,236	57% 27,849	52% 28,121
(-) Margin/ FTE	23% 39,900	26% 28,778	29% 59,369	24% 26,017	25% 36,166	36% 36,321

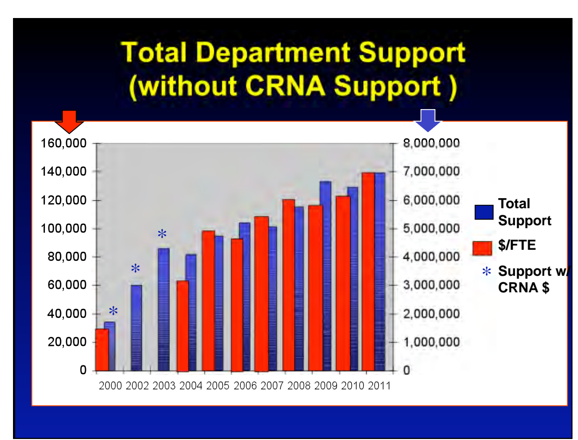
Total Department Support (Hospital, Med School and Other)

Year	2000	2002	2003	2004	2005	2006
Total Support	1,235,000	…	…	…	…	5,455,400
$/FTE	34,000	…	…	…	…	120,100

Year	2010	2011
	8,652,268	8,709,893
	166,759	177,065

Year	2007				2011
Total Support	5,196,26				8,709,893
$/FTE	112,962	146,465	160,381	166,759	177,065





Institutional Support 2011

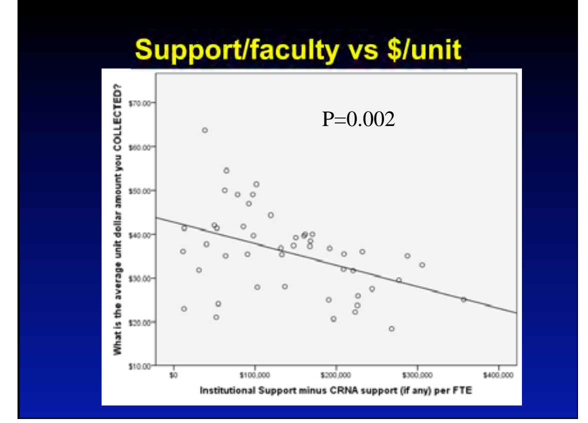
Total support / FTE = $177,065

(Support – CRNA)/FTE = $139,016

Support/site = $137,914

Median Margin = $ 165,246 or $ 3,414/FTE

Support/faculty vs $/unit



SAAA Salary Survey National Average (50th %)

	2010	2011
INST	281,500	269,000
ASST	305,250	306,145
ASSC	337,000	334,289
PROF	350,305	348,550

	2000	2007	2008	2009	2010	2011
INST	144,250	256,182	259,500	271,146	281,500	269,000
ASST	183,000	273,920	288,000	299,203	305,250	306,145
ASSC	210,000	300,781	315,679	328,725	337,000	334,289
PROF	239,182	311,163	323,600	339,209	350,305	348,550

SAAA Salary Drop 3 out of 4

	2010	2011
INST	281,500	269,000
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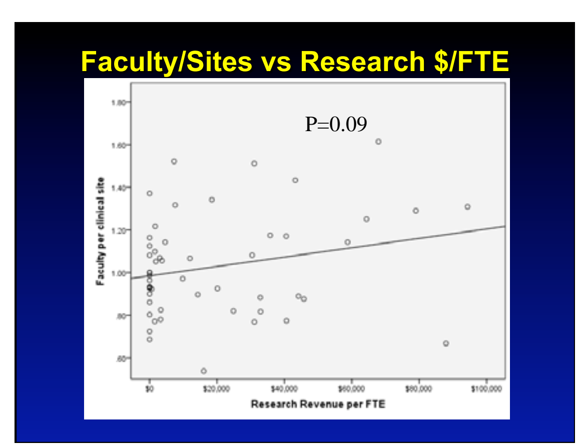
PROF	239,182	311,163	323,600	339,209	350,305	348,550

Clinical Sites and Faculty Assigned

Faculty/ Clinical Sites	1.0	1.6	0.4
Research Revenue/ Faculty	$19,546	$94,340	$0

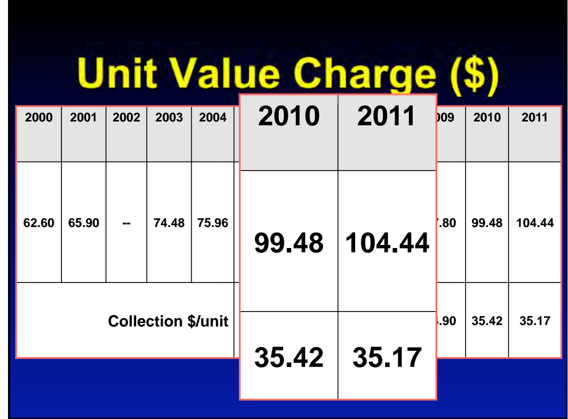
Clinical Anesthetizing	MEAN	MAX	MIN	SD
TOTAL	53.8			
Faculty/Clinical Sites	1.0	1.6	0.4	0.2
Research Revenue/ Faculty	$19,546	$94,340	$0	$25,429

Faculty/Sites vs Research $/FTE



Subspecialty Compensation
(Only 33% pay more)

	Mean	Min.	Max.
Cardiac	$18,444	$ 0	$75,000
ICU	$ 9,722	$ 0	$50,000
Peds	$15,889	$ 0	$45,000
Pain	$17,806	$ 0	$125,000
OB	$ 3,889	$ 0	$30,000
Neuro	$ 3,889	$ 0	$30,000
Other	$ 7,719	$ 0	$88,933



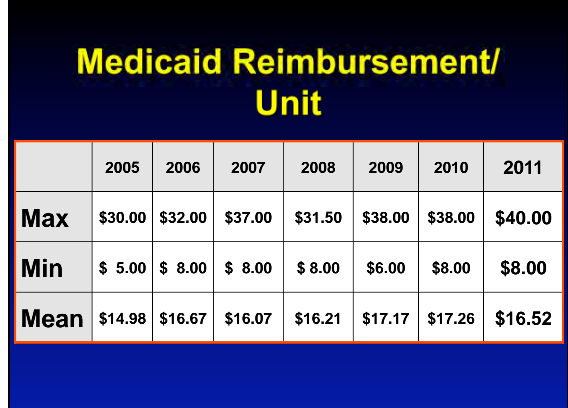
Unit Value Charge ($)

	2000	2001	2002	2003	2004	…09	2010	2011
	62.60	65.90	--	74.48	75.96	…80	99.48	104.44
Collection $/unit						…90	35.42	35.17

2010	2011
99.48	104.44
35.42	35.17

Units Billed per Faculty

2004	2005	2006	2007	2008	2009	2010	2011
11,954	11,320	12,193	12,124	11,179	10,720	11,199	11,111



Medicaid Reimbursement/ Unit

	2005	2006	2007	2008	2009	2010	2011
Max	$30.00	$32.00	$37.00	$31.50	$38.00	$38.00	$40.00
Min	$ 5.00	$ 8.00	$ 8.00	$ 8.00	$6.00	$8.00	$8.00
Mean	$14.98	$16.67	$16.07	$16.21	$17.17	$17.26	$16.52

Late Pay

No	30%
Yes	70%
If yes,	
How much $/hr.	$149.00/hr ± $30.00
How much Time	4:50 pm ± 42 min.

Conclusions:

1. Faculty openings the same/Up ?
2. Department finances are same/ not improving!
3. Faculty salaries are decreasing.
4. Departments' institutional support is still increasing.
5. Support is due to poor collection rate ... Not academic time or site/ faculty utilization.

Conclusions:

6. More faculty/site associated with Increased Research $$
7. Overtime pay average $149/hr starting at 5:00 pm.
8. AIMS: 64% have/will have in 12 mo.
9. AIMS & Liability: 5 cases
   - 1 Beneficial
   - 0 Detrimental
   - 4 Neither B or D

Publications

1. *Financial Environment of Academic Anesthesia.* Advances in Anesthesia, Mosby, Inc., Chapter 1, vol 19, pp. 1-35, 2001.
2. *A Demographic, Service, and Financial Survey of Anesthesia Training Programs in the United States.* Anesth Analg 2003; 96:1432-46.
3. *Faculty and Finances of United States Anesthesiology Training Programs: 2002-2003.* Anesth Analg 2004; 99:1185-92.
4. *Trends in Financial Status of United States Anesthesiology Training Programs: 2000 to 2004. Anesth Analg 2006; 102:517-23.*
5. *Five-Year Follow-Up on the Work Force and Finances of United States Anesthesiology Training Programs: 2000 to 2005. Anesth Analg 2007; 104:863-68.*
6. *Six-Year Follow-Up on Work Force and Finances of the United States Anesthesiology Training Programs: 2000 to 2006. Anesth Analg, 2009; 108:263-272.*
7. *Seventh and Eighth Year Follow-Up on Workforce and Finances of the United States Anesthesiology Training Programs: 2007 and 2008. Anesth Analg, 2009; 109:897-899.*
8. *Workforce and Finances of the United States Anesthesiology Training Programs: 2009-2010. Anesth Analg, 2011; 112:1480-1486.*

Creating Value from Day 1: Seven Step Program

David A. Zvara, M.D.

Congratulations, you're a Chairman! You have worked hard for this and the recognition of your success is evident in the appointment. Your work has now changed dramatically and the sooner you come to terms with the new requirements, establish a game plan and work to achieve specific benchmarks, the more likely you will succeed in your new position. There are many approaches to success. The number of self-help books, seminars, pamphlets, DVDs and lectures like this one allow each learner to find material suited to personal style, learning aptitudes and available time for self improvement. What is certain is that leadership is a skill, like any other, and success in leadership demands attention, time, study, commitment, and practice. Listed below are seven steps that will assist you in establishing a successful start as a new (or continuing) chairman.

Establish your "dot"

One of my mentors said that we are all judged by how well we "move the dot."
"Which dot?" I asked.
"Doesn't matter," he said. "Pick one."

Although I disagree in that some "dots" are more notable than others, the principle remains the same. You must establish your starting line and pick a dot to move. Importantly, this conscious process of determining where you are requires thoughtful self assessment, benchmarking, and realistic appraisal of current strength and weakness. At the University of North Carolina we prepare a table each year placing our department on a continuum compared to the SAAA data gathered in the annual summary. This allows us to evaluate areas of opportunity, areas of vulnerability, and importantly, areas for leveraged negotiation with the healthcare system.

We like using the national database information. It's not perfect, but we find it helpful. You might not chose to use these data, but whatever you do, establish your starting line, pick a "dot" and monitor your progress as you move your dot up and to the right.

Value your business manager

Pay attention: your most valuable employee going forward will be your business manager. This person will be at the center of your budgetary process and hence at the very heart of every decision, every hire, and every initiative that you plan for the department. This person will guide you, advise you, bail you out (figuratively), and set you up for actualizing your envisioned future. Trust in each other, communication and the confidence in his or her abilities are paramount for a successful relationship. Bottom line: don't mess this one up.

This first position under critical review must be the business manager. Although when you first arrive, you will depend on this person to help you get up and running, don't assume that this person will be the right person for you in the long term. This may sound harsh, but your business manager is your most important employee. This person must have the skills you require to manage the business. Beyond this, he or she will be your "chief of staff". Nothing happens without their involvement or awareness. Make sure you either develop the relationship with the existing manager or seek someone that fits your style.

Remember: who you select on your team will now have greater impact on your success than at any other time in your life. Make this decision your best decision. You will not regret the time or effort in making this an early priority.

Outline a new CME plan

What do you really know about managing a multimillion dollar business and scores of employees? Really, be honest with yourself. Sadly, the selection process and the grooming process for Chair positions are inadequate on many levels. Few of us, when accepting our first chairmanship, have the administrative or fiduciary experience required for the position. Rather, we have a demonstrated track record of surrogate success in other areas. So, here's my suggestion: develop a CME plan for your new position. Remember, chairmanship (read: leadership) is a skill that can be learned. Some days, you "hit it out of the park", and other days, it's "back to the gym." Get used to it.

Here is a simple three step plan to jump start your learning curve:

1) Develop a reading list. There are scores of books on leadership, management, accounting, negotiation, "winning", "losing" and the like. Sometimes, I feel like I've read them all and they are, to a degree, redundant after a while. Still, a message you hear at one time, may reflect a changing work situation. It was there before, but not applicable until now. Don't be afraid to re-read material. Here are three of my favorite books: *Good to Great* by Jim Collins, *You're in Charge – Now What?* By Thomas Neff and James Citrin, and *The Laws of Leadership* by John Maxwell.
2) Visit successful programs. Don't be shy about this. Learn from those around you. In my first two years as a chairman, I visited (with sole intention of learning as a student), the University of Michigan, University of Alabama at Birmingham, Washington University, Mount Sinai, Montefiore, and Tulane. I asked to meet with the Chairman, business manager, Chief of Clinical Operations and others. I took notes and asked questions. I have gained something from each visit, and I still do this when traveling. Consider this as a "best practice" approach to chairmanship. You will be amazed at how different departments and people manage the same problems that you face.
3) Seek professional CME activities. There are tons of CME courses for ongoing education in management. Take advantage of them. This conference is but one example. This is now your job; learn to do it well.

Understand your manpower model

The biggest tool in your bag is your manpower model. What do I mean by this? When negotiating with your hospital, many chairmen make the mistake of poorly quantifying effort. The more you can do this, the better leverage you will have when seeking partners in creating your team. When I first become chair, I remember one division chief coming to me stating we needed to hire "one or two more people." Why not hire 1.3 FTE, or 2.2 FTE, I thought? Or for that matter, why not zero or four? How did the division chief assess need? In short, the division chief had no formal metric quantifying effort, but rather was using a "gut feeling" on staffing levels. This intuitive sense can be quite accurate, but as your domain of responsibilities grow (remember, you're now the chair of the entire department!), the intuitive model fails and the bandwidth of error increases. You need something far more precise.

We use a "days worked" model at UNC. We quantify effort based on appointment status, clinical FTE contribution, and lately, eFTE status (effective FTE status when accounting for call related time, additional academic time and other non-clinical obligations). We have a precise

model that calculates need to the 100th decimal place. It's not a perfect representation of all needs, but it is extremely powerful. The greatest power comes when negotiating with the Dean and CFO for resource allocation. Imagine this scenario: you enter the Dean's office and seek supplemental funding for a new faculty person. Without a detailed manpower model, based upon objective assumptions of work loading and responsibility, you soon fall into an argument over money ("Why do you need so much?"). With a manpower model, you can depersonalize the argument and seek agreement over institutional direction. This is what the Dean wants to see and hear. It's not about the money; it's about the confidence in your stewardship of the department and your contribution to institutional goals.

Using our manpower model, I know exactly the number of sites we staff, the hours required to staff these areas and the number of clinical shifts for our faculty, CRNAs and residents must fill to meet these duties. As an example, at UNC, we have 8678 clinical shifts for the faculty per year to staff our general OR. This is not an estimate; it is an exact accounting of the work load. There are professional programs to help you with this and there are homegrown products as well. Ask around; successful chairs understand their manpower needs backwards and forwards.

Manage expenses and revenue (it's a business, after all)

Remember this: you were hired to manage a business. A former Chairman told me once, "Success in research and education are wonderful, and will fill you with a sense of accomplishment and pride, but if you close an operating room, you will lose your job." So what can you do to ensure the success of the business? Step one: don't hire a business manager; hire the *right* business manger, and as outlined above, create a plan for learning, and develop a manpower model. What's needed further is for you to change your mindset and understand your new role. There are half dozen "quick" victories. Here's what I recommend in the early go:

1) Do an internal audit of all expenses. Find out where the money is going. You will be surprised at what you find. For example, at UNC I learned that we owned a company car. Really? A car? It's gone and I don't think it has impacted patient care, yet.
2) Review your managed care contracts. Set up a meeting with your institution's chief contract negotiating agent and discuss your departmental status. When I first called our chief contracting agent, he told me that, "I was the first anesthesiologist that he had *ever* spoken to." We meet monthly now, and I am on our negotiating team. By the way, our contracts have improved 26% in the last 36 months.
3) Quantify everything. Yes, put a price tag on all of your activities. What does it cost to start a new educational initiative? What does it cost to allow research time for someone? This is foreign thinking for most of us, but with this mental discipline your can now strategically move the department in the areas of greatest corporate return on investment. Remember, nothing is free.
4) Don't be afraid to spend money. Investing in people and programs is what you do; don't be afraid; be smart.

Invest (a lot of) time in your people

Despite the tips on finance above, you are really in the people business. Eight-five percent of your expenses will be in payroll and 100% of patient care is delivered by the people you employ. As a chairman, you will have a personal responsibility to each and every one of your employees. This is a thrilling and awesome component of your job. Although at times people will approach you with seemingly small issues, you must always remember that for that person, at that time, it is *their* most important problem. Get ready for it.

As a first step, you should set up a listening agenda. I met with every faculty member and took notes when I first arrived. I asked a series of basic questions: What should we preserve and why? What do you hope I do? What are you concerned I might do? What are you concerned I might not do? What advice do you have for me? Is there anything else? The information gained and early relationship building was well worth the effort.

Navigate your local politics

A healthcare CEO told me once when discussing a colleague who lost their leadership job that conflict often came down to "People or money." And then he added, cryptically, "And we can almost always solve the money problems." Your success hinges on your ability to build meaningful relationships with others. This includes those in your department, those in parallel positions and, yes, your multiple bosses. Oh, don't be fooled for a minute: you now have more bosses than any other employee in at the hospital. Your now answer to your faculty, your residents, your staff, your fellow chairmen, your dean, the COO, the CFO, the CIO and about every other "O" your can think of.

You will make mistakes along the way, and these mistakes may cost the institution money. Rarely, will these mistakes result in your dismissal (assuming no illegal activity or gross negligence), if you have solid relationships with your constituents. Understand this and actively work on developing these ties. Don't fall into the trap of thinking that your achievements and actions will be enough to ensure continued success. Take time to build these relationships, nurture them, treat then with respect and never abuse the privilege given you as an institutional leader.

Look around, there are many brilliant people that have lost their position because of an inability to navigate local politics. This is a component of leadership. Relationship building is a leadership skill, so don't be afraid to acknowledge the important of practicing and developing this component of your job. Remember, this effort isn't about you; it's about obtaining the essential elements required in your new position allowing corporate success. Work on your relationships and you will be a more effective chairman for your department.

Under promise and over deliver

Yes, adopt this cliché: under promise and over deliver. In our compensation plan at UNC, each year that I've been there, our bonus distribution has exceeded faculty expectations. Was this by chance? I'll let you decide. Each year, we have out performed our budget and the CFO and Dean see our department as a financial model of success. Luck, right? Maybe, but my business manager and I are very aware of over promising and under delivering on any good or service over which we have responsibility.

This is a universal principle in any service organization. As a chairman, your words will carry weight. People will listen to what you say and what promises you make. You must walk the fine line a creating an exciting and motivating vision of the future, while at the same time, ensuring that you can follow through on your promises. Promising rose gardens and candy canes only works for so long if all you can deliver are dirt piles and empty candy wrappers. Get the picture?

Oh yea, this was tip number eight, when only promising to deliver seven….. J

Summary

Serving as a chair is the greatest job I have ever had. I see it as totally binary: you either love it or hate it. These few tips above are really just a superficial brushing of what it takes to succeed. Here's the take home message: success is measured over time, leadership is a practiced skill, and that those around you want you to succeed. Good luck.

Accountable Care Organization and Impact on Anesthesiology

Patricia A. Kapur, M.D.

Learning Objectives

Attendees will be able

1. to apply knowledge of ACO's and bundled payment methodologies to their own practices;

2. to appreciate the importance of cost-effectiveness and quality measures to future payment paradigms;

3. to realize the necessity to increase their Department's portfolio of responsibilities and contributions to the health system when such new payment methodologies come into play.

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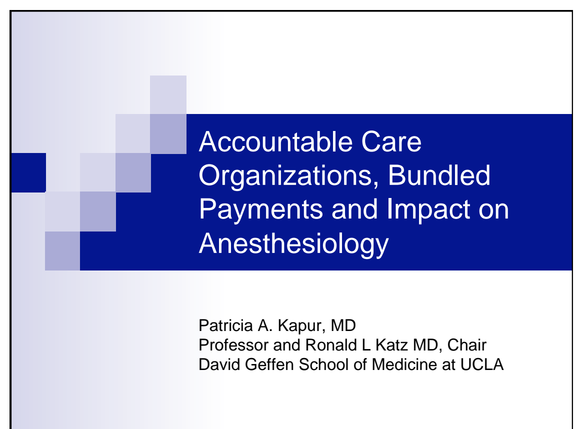


Simplified Structure of Health Reform Coverage

Expansion to projected 32 million more Americans from 2014-2019:

- Estimated 16 million into expanded Medicaid programs
- Estimated 16 million able to buy private insurance through state-based exchanges with government subsidies
- Individual and employer mandates
- Insurance Market Reforms – broaden and stabilize private coverage; eliminate pre-existing condition restrictions

Simplified Structure of Health Reform: Payment and Delivery System Transformation

- Delivery/payment reforms & experiments to slow growth rate of health care spending
- Accountable Care Organizations, pilot and demonstration projects
- Comparative Effectiveness Research to make sure the right care gets to the right patient at the right time

CMS Payment and Delivery Reform Efforts

- Readmissions prevention program.
- Medical Homes: All-payer national pilot; Medicaid "health homes".
- Community-based care transitions programs.
- Federal coordinated care office to better coordinate care of "dual eligibles" (Medicare + Medicaid).

CMS Payment/Delivery Reform Efforts, cont.'

- **Bundled payment pilots.**
- **Value-based purchasing.**
- **Accountable Care Organizations:**
  - **Includes private payors and Medicare Shared Savings Program.**
  - **Provides all levels of care to large numbers of patients.**
  - **Population-based care; pro-active preventive care.**
  - **Providers at risk for quality outcomes and cost-effectiveness.**

Accountable Care Organizations

1. ACO's forming in private sector between payors, eg: Blue Shield, and healthcare institutions.
2. ACO's in the Medicare Shared Savings Program:

   - "One-sided" option: ACO's not responsible for costs above expenditure target for the first two years; receive lower share of the savings compared to two-sided option.

   - Two-sided option: ACO's share in savings and risk liability for losses beginning in the first performance year.

ACO options, cont.'

3. ACO's under the "Pioneer" and "Transitions" programs from the Center for Medicare and Medicaid Innovation.
   - "Pioneer" program: 15 organizations to be selected; more aggressive quality/savings targets; providers accept more risk.
   - Transitions program for organizations formerly part of the Medicare Physician Group Practice Demonstration; including among others Dartmouth-Hitchcock, Mayo, Geisinger.

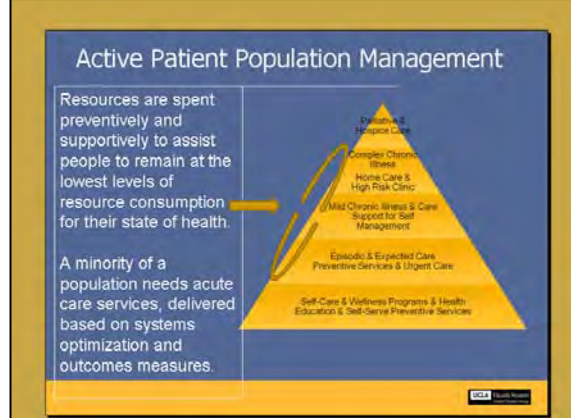
ACO's may be a combination of 1 and 2, or 1 and 3

ACO Themes

- Emphasis on care coordination across multiple organizations – not all owned or controlled by the primary organization.
- Systems Practice: mergers, consolidation, acquisition of physician practices.
- Eliminating unnecessary costs
- Living on Medicare rates.

ACO Themes, cont'.

- Chronic care management, Medical Home, and patient-centered primary care.
- 360-degree, 24/7 continuum of care.
- System-wide EMR.
- "Embedded" nurses in primary care practices; telephonic monitoring/case management.



Health Reform May Create Substantial Risks for Academic Medical Centers

Potential Cuts in Graduate Medical Education payments (GME) under Medicare:

- Medicare program provides the primary financial support for graduate medical training of residents and fellows, and also helps to support care of underinsured and uninsured at AMC's and teaching hospitals.
- Residency and fellowship programs exist in 681 institutions; more than 300 sponsor only one residency program, primarily primary care programs in small, often rural locations.
- GME = 2 parts: Direct Medical Education and Indirect Medical Education.
- IME intended to reimburse institutions for higher costs of training residents who are "learning by doing" .

Reductions in GME Funding

- The Medicare Payment Advisory Commission (MedPAC) has determined that these Indirect Medical Education (IME) add-on payments are significantly greater than the additional patient care costs that teaching hospitals experience.
- Fiscal Commission, among others, recommended reducing the IME adjustment.
- Current proposal to reduce the IME adjustment by 10 percent beginning in 2013.
- Plan estimated to save approximately $9 billion over 10 years.

Concerns voiced by ACGME, etc.

- Institutions may respond by reconfiguring residency and fellowship programs to meet patient care needs.
- Institutions may add more highly technical subspecialty programs, reduce number of "pipeline" programs.
- Institutions may turn to pharmaceutical or medical device industries to support education and training programs.
- Residents may need to pay tuition for training in some specialty and subspecialty programs.
- Financial pressures on residents may prompt them to forego completion of additional training to enter clinical practice early.
- Institutional faculty support may be reduced.

Challenges for Academic Medical Centers in Patient Care

- Impact of quality and outcomes measures initiatives on payment environment for Medicare, Medicaid, and private pay.
- Need to justify or reduce higher costs.
- Face fundamental choice: cede more routine care to community hospitals and focus on most severely ill patients?
- Make case for differential payment based on severity.
- How to handle the influx of patients as coverage expands in 2014.

The Progression to ACO's…

Penalties for healthcare-acquired conditions.

- "Never" events.

"Value-based" purchasing based on:

- Cost-effectiveness.
- Quality and outcomes measures.

Penalties for re-admissions.

Bundled payments.

ACO's

Goals of CMS "Bundling for Care Improvement" Initiative

Improve overall quality and value:

- Drive physician collaboration through financial incentives as a mechanism to improve efficiency and achieve sustainable results
- Reduce or stabilize growing costs to Medicare for acute care services by maximizing the use of available capacity in high quality providers
- CMS has reported $42.3 million in savings in the current Acute Care Episode (ACE) Demonstrations with substantial increases in clinical quality. $7 million in Co-Insurance costs.

"Acute Care Episode" Bundled Payment Demonstration Results

- After 2 years, the ACE Demonstrations produced impressive results: All participants saw increases/improvements in clinical outcomes.
- Participants saw decreases in cost per case via average length-of-stay and/or supply cost unit price decreases through vendor consolidation.
- One participant realized increased market share from Medicare and commercial plans.
- Further integration by and between the physicians and hospitals lead to other efforts to reduce care costs.

Model 4 –Global Fee Components

Most Similar to Current ACE Demonstration

- Can select DRGs Sponsor wishes to include.
- Episode begins 3 days prior to admission and ends at discharge.
- Paid as a single fee (Part A/B Services) to Sponsor; Physicians paid by Sponsor.
- Minimum discount 3% if DRGs selected are more than current ACE listing; greater discount is expected if Sponsor stays with current ACE scope (28 Cardiac and 9 Ortho DRGs).

Model 4 - Global Fee Components, cont.

- Can keep any savings; must pay back any excess spending (paid to non-participants) within 30-day post discharge period.
- Risk includes related or unrelated re-admission risk.
- Can propose quality measures to report; must still report full set of hospital quality metrics required by CMS.

Common Payment Aligns Goals

Typical Global Fee Arrangements- Model 4 as an Example:

- Sponsor contracts with CMS for a negotiated global fee per DRG.
- Sponsor contracts with physicians at a single fee based upon +/-historical Medicare rates.
- Incentive is developed to meet all CMS mandated Quality/Access/Efficiency metrics.
- Utilize clinical performance protocols to optimize outcomes.
- Hospital savings is the source of any incentive payout to physicians; limited to 50% of total pro-fees paid and 50% of total actual savings.

Typical Model 4 Flow of Funds

- Sponsor agrees to flat rates per episode with all Providers.
- Sponsor sends Bundled Bid to CMS.
- Sponsor bills CMS upon 30 days post discharge.
- Sponsor may pay physicians in any time frame sooner than payment from CMS.
- Physicians submit “No-Pay” claims to CMS for assurance of care delivery.
- Reconciliation by CMS annually to agreed rates.

CMS Bundled Model Application Process

Sponsor must establish:

- Financial model and arrangements.
- Organizational structure and governance.
- Current quality and efficiency metrics at 90th percentile.
- Cost savings opportunities and quality improvement.
- Provider engagement and partnerships.
- Care re-design.
- Marketing plan to beneficiaries.

CMS Bundled Model Application **Selection Criteria and Weights**

- 40 points: Financial Model
  - Overall savings to Medicare.
  - Risk adjustment (if applicable).
  - Anticipated actions that will result in lower spending.
- 25 points: Quality and Patient Centeredness
  - Proposed mechanisms to improve quality and patient experience of care.
  - Proposed quality metrics.
  - Quality assurance and continuous quality improvement.
  - Beneficiary protections.

CMS Bundled Model Application **Selection Criteria and Weights**

- 20 points: Demonstration Design
  - Definition of episode.
  - Level of provider engagement and participation.
  - Care improvement.
  - Design for gain-sharing.
- 15 points: Organizational Capabilities, Prior Experience, and Readiness
  - Financial arrangements.
  - Commitment and credentials of executives and governance bodies.
  - Success and readiness to participate.
  - Partnerships.

CMS Bundled Payment Pilot: What's In It for Hospitals?

- Strengthen service line:
  - Reduction of costs
  - Enhanced operational efficiency
  - Enhance clinical quality
  - Improved patient experience
- Protect current & build future market share
  - Preferred provider status within region
- Build organizational mastery to manage to fixed budget
- Stepping-stone in physician integration, supporting progress toward clinical integration or ACO
  - Alignment in care management
  - Co-management of clinical services

CMS Bundled Payment Pilot: What Is In It for Physicians?

- Potential volume increase.
- Protect current and build future Medicare market share.
- Pay physicians more quickly if in Model 4.
- Co-management of clinical services affecting them.
- Improved quality and patient experience.
- Incentive possible of 150% of Medicare payment.
- Effective and integrated care coordination.

CMS Bundled Payment Pilot: What's in it for Physician Groups?

Medical Groups Can Sponsor a CMS Bundled Payment:

- Increase revenue for Medicare FFS patients.
- Leverage care management tools with a hospital partner.
  - May improve specialty relationships and overall costs of care for all patients.
  - Potentially leverage arrangement for HMO patients with hospitals and contracted physicians.
- Teaming up on a pilot basis in preparation for ACO's with hospitals.

Critical Success Factors Under Bundling

- Physician leadership and co-management
- Targeted education to participants
- Best practices in cost, efficiency and effectiveness
- 90th percentile in quality
- Legal structures able to handle gain-sharing

Opportunities for Anesthesiology with Bundled Payments

- Take a larger role to manage the interventional experience from the decision to provide a procedure, until the patient's care is returned to the longitudinal provider, ie: "Surgical Home".
  - Pre-procedural screening and optimization
  - Pre, intra-, and post-procedural care
  - Critical care, step-down, and pre-discharge care.
  - In- and Outpatient acute & chronic pain management
  - Palliative and hospice care.

Anesthesiology opportunities, cont.'

- Organizationally manage procedural, recovery, critical care, and pain management areas; assure optimum quality and cost-effective productivity and throughput.
- Manage professional staffing expense by utilizing diverse providers, each functioning at the top of their license.
- Become the "go to" acute care resource for the institution, eg:
  - Trauma care.
  - Code and Rapid response teams.
  - Line placement and cardiac rescue imaging.

“We always overestimate the change that will occur in the next two years and underestimate the change that will occur in the next ten.”

Bill Gates Jr.

Debate: The Role of International Medical Graduates Certification and Recognition from the ABA...

Kevin K. Tremper, Ph.D., M.D.; David L. Brown, M.D.

Learning Objectives

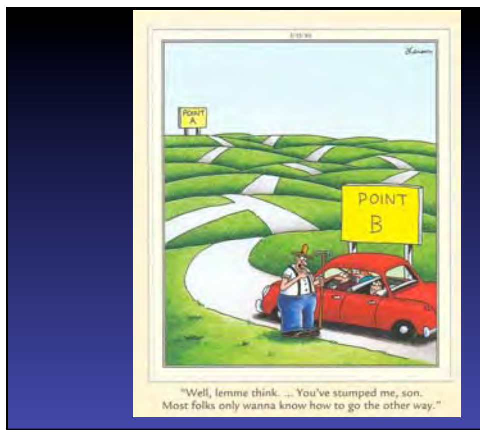
1. To be knowledgeable of the mechanisms by which the American Board of Anesthesiology allows IMG anesthesiologists who enter the ABA process and how that compares to the processes in the American Board of Radiologists.

2. To be conversant in the pros and cons of supporting U.S. licensed, trained, physicians in anesthesiology who have Boards from other countries to be allowed to enter the ABA process.

ABA Alternate Pathway

ABA Alternate Pathway

The Pro Tremper
Versus
The Amateur Brown



The Goal:

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The Best Possible Health Care for our Patients

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To That End we feel Board Certification Helps Insure More Qualified Specialists

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Why Else would have Boards?

25% of the Practicing Physicians in the US are IMGs

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Without Boards We/They Cannot Insure their Qualifications… or Continuing Qualifications: MOCA

Therefore, in 2001 the American Board of Radiology Started an IMG Alternate Pathway

IMGs may take the ABR Exams if:

1. They are Board Certified (in home country)
2. Sponsored by and work in An Approved Residency Training program for 4 yrs

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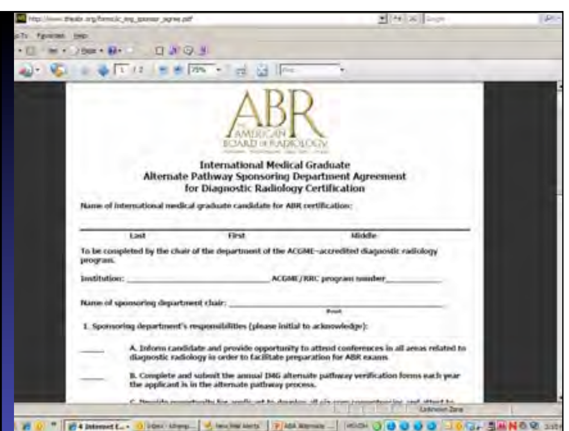
THE END



ABR
THE AMERICAN BOARD OF RADIOLOGY

International Medical Graduate
Alternate Pathway Sponsoring Department Agreement
for Diagnostic Radiology Certification

Name of international medical graduate candidate for ABR certification:

____
Last First Middle

To be completed by the chair of the department of the ACGME–accredited diagnostic radiology program.

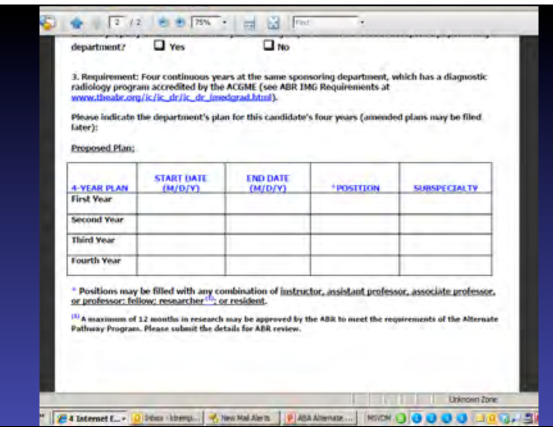
Institution: ______________________ ACGME/RRC program number____________

Name of sponsoring department chair: ______________________________
Print

1. Sponsoring department's responsibilities (please initial to acknowledge):

_____ A. Inform candidate and provide opportunity to attend conferences in all areas related to diagnostic radiology in order to facilitate preparation for ABR exams.

_____ B. Complete and submit the annual IMG alternate pathway verification forms each year the applicant is in the alternate pathway process.



department? ☐ Yes ☐ No

3. Requirement: Four continuous years at the same sponsoring department, which has a diagnostic radiology program accredited by the ACGME (see ABR IMG Requirements at www.theabr.org/ic/ic_dr/ic_dr_imedgrad.html).

Please indicate the department's plan for this candidate's four years (amended plans may be filed later):

Proposed Plan:

4-YEAR PLAN	START DATE (M/D/Y)	END DATE (M/D/Y)	*POSITION	SUBSPECIALTY
First Year				
Second Year				
Third Year				
Fourth Year				

* Positions may be filled with any combination of instructor, assistant professor, associate professor, or professor; fellow; researcher [1]; or resident.

[1] A maximum of 12 months in research may be approved by the ABR to meet the requirements of the Alternate Pathway Program. Please submit the details for ABR review.

Are we afraid that "unqualified" People will become ABA Certified ???

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If so ... maybe our Boards are too easy !!!

Are we afraid that "unqualified" People will become ABA Certified ???

If so ... maybe our Boards are too easy !!!

Are we trying to Protect our Turf or Our Patients?

I Rest My Case

THE AMERICAN BOARD OF ANESTHESIOLOGY

ALTERNATE ENTRY PATH UPDATE

David L. Brown, M.D.
Secretary, ABA
November 6, 2011

Alternate Entry Pathway (AEP)

- 7-year pilot program (July 1, 2007-2014)
- **Purpose:** Encourage outstanding internationally trained and certified anesthesiologists, who come to the United States, to become productive research members of U.S. academic anesthesiology programs.

Alternate Entry Pathway (AEP)

- Pre-existing track record of scholarship
- Not intended to be junior faculty development program
- 4 years of continuous experience in an academic anesthesiology department commences on or after 7/1/2007
- Resident training not acceptable (One year of fellowship is acceptable)

Alternate Entry Pathway (AEP)

- In-Training Examination is required annually
- Support from department for academic career considered
- Guard against "recruitment promises"
- Focus on outstanding

Alternate Entry Pathway (AEP)

- Prospective approval is required at least 4 months in advance.
- Each program may have a maximum of 2 individuals enrolled in the pathway at any time.

7/2007 – 8/2011
# of Programs Approved = 29
# of Individuals Approved = 42

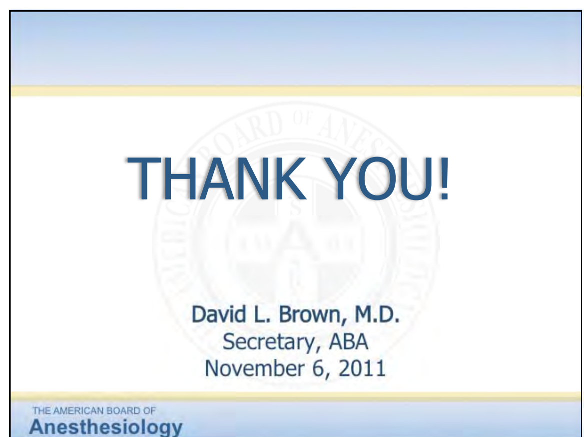
Alternate Entry Pathway (AEP)

- 15 individuals of original AEP group were admitted into the ABA examination system and took the 2011 ABA Part 1 Examination
- 15 of the 15 individuals passed the examination – 100% success rate

Alternate Entry Pathway (AEP)

- Again, this is a 7-year <u>pilot program</u> (July 1, 2007-2014)
- We will be analyzying outcomes of pilot program following 2014 to determine next steps

THE AMERICAN BOARD OF
Anesthesiology



Case Based Scenarios

Judith Jurin Semo, J.D., Esq.

Objectives:

1. Identify examples of how federal regulations affect real-life practice.
2. Discuss strategies to minimize exposure for noncompliance with regulatory requirements.

Disclosures

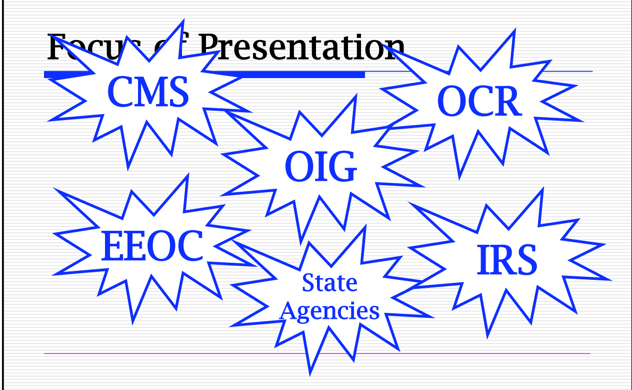
- In private law practice
  - Advise clients on potential liability issues

Overview

- Prohibitions against discrimination
  - Americans with Disabilities Act
  - Age discrimination
- CMS regulatory requirements: facilities
  - CMS Interpretive Guidelines
    - Hospitals
    - ASCs

Overview

- CMS payment issues
  - Recovery audit contractors
- Patient privacy
  - HIPAA & HITECH breach notification
- Payment & compensation
  - Gainsharing & quality incentives
  - PQRS



Overview

- Many other “landmines” beyond scope of this presentation
  - Anesthesia billing compliance
  - Antitrust
  - Kickbacks (demands from facilities)
  - HIPAA basics
  - Labor/unionization

Bans on Discrimination

- In dealing with employees – whether senior or junior
  - Must consider potential for the faculty member to claim illegal discrimination
- Federal law bars discrimination on many grounds
  - Race, color, religion, sex, national origin, disability, genetic information, or age

Bans on Discrimination

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

Americans w/Disabilities Act

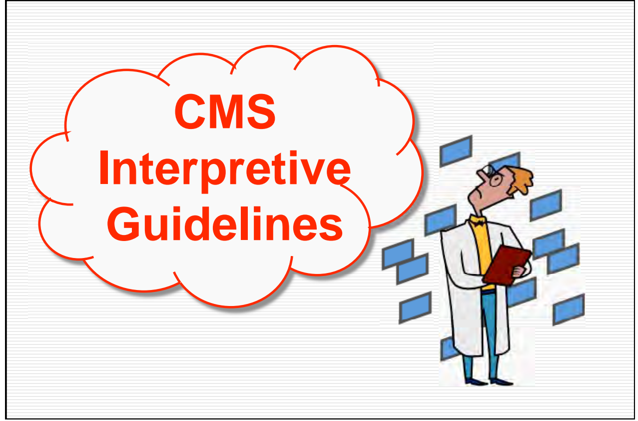
- Prohibits discrimination on basis of disability in employment
- Protects "*qualified individuals with disabilities*"
  - Physical or mental impairment that substantially limits one or more major life activities
  - Record of such an impairment, or
  - Is regarded as having such an impairment

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

- Are actions to deal with increasingly incompetent anesthesiologist
  - Based upon a documented record of inability to perform, or
  - Seemingly sudden decision to terminate
    - Without documentation
    - Without fair process



CMS Interpretive Guidelines

- Clarify conditions of participation (for facilities) in Medicare program
- New IGs issued in December 2009
  - Hospitals (updated in 2011)
  - ASCs (updated in 2011)
- Updated provisions regarding Anesthesia Services

CMS IGs: Hospitals (2009-2010)

- Supervision & immediate availability
  - In discussing supervision of CRNAs/AAs:
    - Hospitals must establish policies for supervision
      - An anesthesiologist is considered "immediately available" only if he/she is physically located within the same area as the CRNA or AA

CMS IGs: Hospitals (2009-2010)

- CMS on "same area" – *e.g.*
  - In the same operative/procedural suite, or
  - In the same L&D suite, AND
- "Not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed"

CMS Interpretive Guidelines – Anesthesia Services (2011)

- 2011 IGs:
  - All discussion of what constitutes "immediate availability" has been deleted
  - Regulation identifies supervision
    - Up to each Hospital to implement
      - In practical terms, what constitutes immediate availability

CMS IGs: Hospitals

- Preanesthesia evaluation
  - Within 48 hrs prior to any inpatient or outpatient surgery/procedure
  - Six elements listed – similar to ASA stds
    1. Review medical history
    2. Interview, examine patient
    3. Note anesthesia risk
    4. I.D. potential anesthesia problems
    5. Additional evaluation as needed
    6. Develop plan of care

CMS Interpretive Guidelines – Preanesthesia Evaluation

- Loosening of time frame for preanesthesia evaluation
  - *"Some individual elements contributing to the pre-anesthesia evaluation may be performed prior to the 48-hour timeframe.*
  - *These elements cannot be performed > 30 days prior to surgery or a procedure requiring anesthesia services."*

CMS Interpretive Guidelines – Preanesthesia Evaluation

- *Must review any elements performed prior to 48-hour timeframe*
- *Must document any appropriate updates documented*
  - *Within the 48-hour timeframe*

CMS Interpretive Guidelines – Postanesthesia Evaluation

- A postanesthesia evaluation must be completed & documented no later than 48 hours after surgery or a procedure requiring anesthesia services
  - By any practitioner who is qualified to administer anesthesia (not the PACU nurse)
  - *"This need not be the same practitioner who administered the anesthesia to the patient."*

CMS IGs: Hospitals

- Postanesthesia evaluation
  - Within 48 hrs after surgery/procedure
  - Seven elements listed
    1. Respiratory function
    2. CV function
    3. Mental status
    4. Temperature
    5. Pain
    6. N&V
    7. Postop hydration

Originally, IGs req'd completion prior to discharge of outpatients; this req't deleted in May 2010 update

CMS Interpretive Guidelines – Postanesthesia Evaluation

- Calculation of 48-hour timeframe begins at point patient is moved into the designated recovery area
- *The evaluation generally should not be performed immediately at the point of movement from the operative area to the designated recovery area.*

CMS Interpretive Guidelines – Postanesthesia Evaluation

- Accepted standards of anesthesia care indicate that the evaluation should not begin until the patient is sufficiently recovered from anesthesia so as to participate in the evaluation, *e.g.*
  - Answer questions appropriately
  - Perform simple tasks"

CMS Interpretive Guidelines – Postanesthesia Evaluation

- Does your postanesthesia evaluation document all seven elements?
- Must be completed by "individual qualified to administer anesthesia"
  - Not by PACU nurse
- ASA has documentation templates to assist anesthesiologists in complying with the IGs

CMS IGs: ASCs

- Similar requirements on
  - Supervision & immediate availability
    - Physically present in the ASC and
    - "Prepared to immediately conduct hands-on intervention if needed"
  - Pre-anesthesia evaluation
    - Is ASC an appropriate setting, given risks associated w/anesthesia
  - Post-anesthesia evaluation pre-discharge

IGs: Patient Selection in ASCs

- From CMS Interpretive Guidelines for ASCs (revised Dec. 2009):
  - (After noting that ASCs should consider whether to accept ASA IV pts . . .)
  - "For many patients classified as ASA PS level III, an ASC may also not be an appropriate setting, depending upon the procedure and anesthesia."

Recovery Audit Contractors

- Recovery audit contractors (RACs)
  - Paid on a contingency fee basis to identify & recoup Medicare overpayments
    - RACs collect money from providers (that's you)
    - Also identify underpayments

Recovery Audit Contractors

- Started with a demonstration program (Medicare Modernization Act of 2003)
- Tax Relief and Health Care Act of 2006 made RAC program permanent
  - Expansion of RAC program to all 50 states by 2010
- RACs paid on a contingency fee basis
  - From 9% - 12.5%

RAC Review Process

- Post payment review
  - Use FI, carrier, MAC Medicare policies (NCDs, LCDs & CMS manuals)
- Two types of review:
  - Automated (no medical record)
    - 8 Certainty service incorrectly coded or not covered
  - Complex (medical record required)

RAC Review Process

- RACs can go back 3 yrs from date claim paid
  - Cannot review claims paid prior to October 1, 2007
- CMS approves issues for review prior to widespread RAC review
- Approved issues are posted to RAC websites

RAC Collection Process

- RAC issues a demand letter
- Medicare (via the MAC) recoups by offset unless provider has
  - Submitted a check, or
  - Submitted a valid (& timely) appeal
    - 8 Must file within 30 days of receipt of the overpayment letter to stop recoupment

Preparing for RACs

- Internal review of compliance
- Review RAC websites for areas of persistent improper payments
  - Also review OIG reports
- Implement procedures to respond promptly to RAC requests for medical records
  - Make sure RAC has correct address

Preparing for RACs

- Keep track of denied claims
  - Correct these previous errors
- Determine corrective actions needed to ensure compliance & avoid submitting incorrect claims
- Bottom line: RAC program produces huge returns – compliance more important than ever

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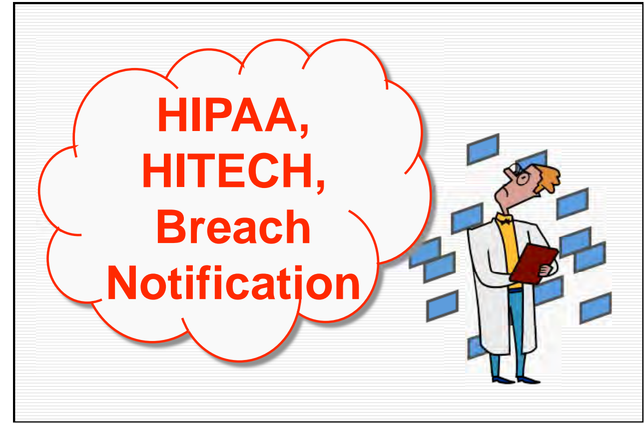
Others Reviewing Claims

- MACs – Medicare Administrative Contractors
- ZPICs – Zone Program Integrity Contactors
  - Conduct investigations
  - Support law enforcement
  - Some to focus on Medicare billing "hot" targets
- MICs – Medicaid Integrity Contractors
- Private payor audits, as well



HIPAA & HITECH

- In past, HIPAA privacy & security enforcement largely focused on obtaining voluntary compliance
  - Through technical assistance
- HITECH Act (Health Information Technology for Economic and Clinical Health Act)
  - Major changes

HITECH Privacy & Security

- Establishes mandatory breach reporting for covered entities & their business associates (BAs)
- Applies most HIPAA privacy & security rules directly to BAs
- Creates new HIPAA privacy requirements
- Establishes new civil & criminal penalties for noncompliance
- Expands enforcement authority to states

HITECH Breach Notification

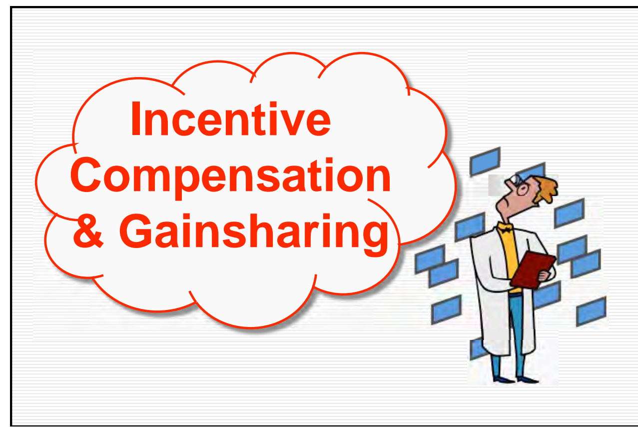
- Mandates covered entities & BAs to notify affected individuals, HHS, & media outlets
  - If unsecured PHI is accessed, acquired, or disclosed by or to an unauthorized person
- Must notify the media if more than 500 individuals of a particular state are affected

HITECH Breach Notification

- More important than ever to identify where PHI (protected health information) is maintained
  - Do your Dep't members have PHI on
    - Handheld devices?
      - Smart phones?
    - Thumb drives?
    - PCs?

HITECH Compliance

- To limit exposure
  - Limit the types of PHI faculty members may download
  - Require encryption of all devices
    - Encryption per HHS/NIST standards
  - Retrain staff on HIPAA & HITECH requirements



Gainsharing & Quality Incentives

- Continued talk of performance-based compensation
  - Including incentive compensation and gainsharing
- Need to be sensitive to regulation of how these arrangements are structured
  - CMS proposed rule (2008) on incentive compensation not finalized

Gainsharing Defined

An arrangement under which a hospital gives physicians a share of the reduction of the hospital's cost savings attributable in part to the physicians' efforts

Concerns

- CMS & OIG have expressed deep concern
  - Potential for gainsharing & incentive payment program to have **adverse effect on patient care**

Concerns

- May be hard to define the line between
  - A gainsharing or incentive compensation payment, versus
  - A payment to induce a physician to reduce or limit items or services furnished to Medicare or Medicaid beneficiaries

Reduce ALOS in PACU

Reduce budget deficits

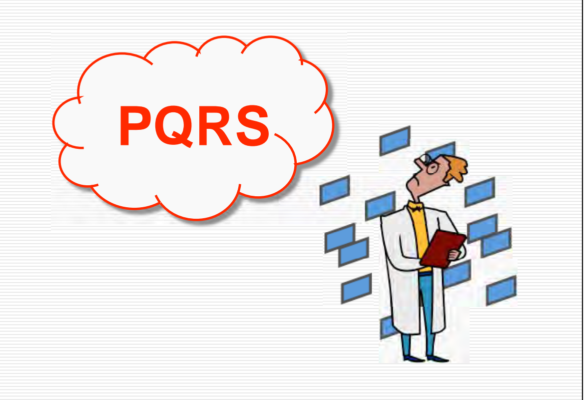
Reduce turnover time

OIG & CMS Views

- OIG has issued advisory opinions providing guidance on how to structure arrangements
- In three 2008 rules, CMS addressed concerns with gainsharing & incentive-based compensation
  - ➔ CMS issued very detailed proposed rule on the topic – not yet finalized

Incentive-Based Compensation

- Given very clear OIG and CMS regulatory concerns with gainsharing and incentive-based compensation
  - ➔ Take OIG and CMS guidance into account in structuring any programs
    - Proper protections to ensure no adverse effect on patient care
    - Notice to patients



PQRS

- Physician Quality Reporting System
  - ➔ No longer an initiative
- Money available:
  - ➔ 2011 1.0%
  - ➔ 2012-2014 0.5%
  - ➔ 2015 -1.5%
  - ➔ 2016 on -2.0%

PQRS: Anesthesiology Msrs

- #30, Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics
- #76, Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol
- #193, Perioperative Temperature Management (Normothermia)

PQRS

- In 2011
  - ➔ Threshold to qualify for bonus dropped
    - From valid PQRS Quality Data Codes (QDCs) submitted for 80% of eligible cases
    - To 50% of QDCs

Conclusion

- As businesses, your Dep'ts must comply with many federal regulations
- In addition, many different federal agencies regulate health care
- With technological advances, even more need to protect against abuse
- Regulation of health care is inevitable
  - ➔ And is likely to increase

Subspecialty Program Directors Morning Session I
Moderator: Robert N. Sladen, M.B.Ch.B.

How Effective are our Fellowship Programs in Training Faculty? An Employer's Perspective
Warren S. Sandberg, M.D., Ph.D.; David L. Brown, M.D.; Margaret Wood, M.B.Ch.B.

Update 2011: The New RRC Program Requirements
Linda J. Mason, M.D.; Neal H. Cohen, M.D., M.P.H., M.S.

Subspecialty Program Directors Morning Session II
Moderator: Linda J. Mason, M.D.

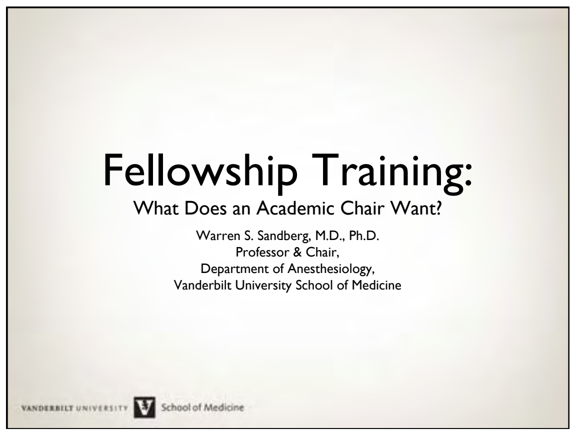
The Pediatric Anesthesia Match: A Match Made in Heaven?
Nancy L. Glass, M.D., M.B.A.

Are Fellows Adults? Applying Adult Learning Principles to Fellow Education
Robert R. Gaiser, M.D., M.S.Ed.

How Effective are our Fellowship Programs in Training Faculty? An Employer's Perspective

Warren S. Sandberg, M.D., Ph.D.; David L. Brown, M.D.; Margaret Wood, M.B.Ch.B.

Notes:



Disclosures

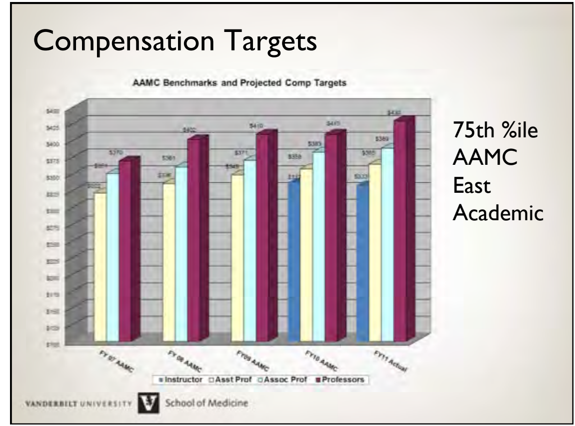
- I have received honoraria from Masimo in the past for consulting.
- The Department of Anesthesiology of Vanderbilt University School of Medicine has developed an AIMS which is licensed to Acuitec.
  - I have no relationship with Acuitec
  - There is a nominal gain for the department when Acuitec makes sales

VANDERBILT UNIVERSITY School of Medicine

A High Stakes Resource

- Anesthesiologists (anesthetists) are everywhere
- Necessary adjunct to procedural medicine
- Expensive!
  - Typical academic dept: 50 anesthesiologists
  - Total expense/FTE: about $600K/year
- Revenue does not keep up with expenses
  - Institutional support to academic depts: about $100K/FTE-year
- This is real money ($5M/year)

VANDERBILT UNIVERSITY School of Medicine



A Higher Stakes Resource

- Differential for some fellowship trained specialties is about $40k/year
- But they fill important super-specialized niches
- Faculty hires tend to 'stick'

VANDERBILT UNIVERSITY School of Medicine

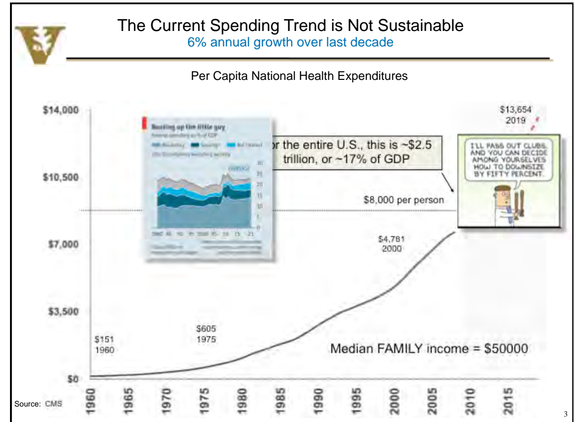
Niche = necessary?

- Maybe for now
- But...
  - APRNs doing pain procedures (supervised by chiropractors)
  - NPs doing critical care
  - CRNAs doing thoracic, cardiac & pedi cardiac
  - Hospitalists doing postops, preops and postop care
  - QZ billing - 1:6, 1:8 coverage ratios
  - Nurses with doctorates
- These were all interesting 'concepts' 10y ago

VANDERBILT UNIVERSITY School of Medicine

Moreover

- New healthcare economy WILL push salaries down into CRNA ranges
- AND / OR
- Payors will stop considering professional fees for anesthesia services
- What is perceived as a shortage will become a glut



A Proposition

- Excellent clinical skills, professionalism and medical knowledge (& the rest of the CCs) are *required* for a place at the table.
- To stay off the menu - need to offer something that can't be commoditized.
  - That wouldn't be 'caring', 'professionalism', 'ownership', 'vigilance' - the other guys have all that just as much!
- Clinical fellowship as commonly conceptualized and implemented is necessary but no longer sufficient.

Assertion

- What separates '-ologists' from '-ists' are:
- Complexity (management of)
  - Individual case level
  - System level
    - Management
    - Leadership
    - Policy
- Creation of new knowledge that improves the science and the process

What I Ask Potential New Hires

- Describe any quality improvement projects you did during fellowship, including implementation, uptake and assessment of outcomes / impact.
- Describe any research projects that you carried out to the point of submission to a peer-reviewed journal.
- Who could I call at your prior institution who would describe you as a solution-oriented problem solver in the practice?

Do Fellowship Programs Train Physicians to Become Faculty?

David L. Brown, M.D.
Chair, Anesthesiology Institute
Cleveland Clinic

Do Fellowship Programs Train Physicians to Become Faculty?

2011 Training Data: ACGME and ABA Sources

Subspecialty	Programs	Positions approved	ABA fellows
CCM	48	144	88
Pain	80	341	203
Peds Anes	46	208	186
Adult CT Anes	56	166	139

Do Fellowship Programs Train Physicians to Become Faculty?

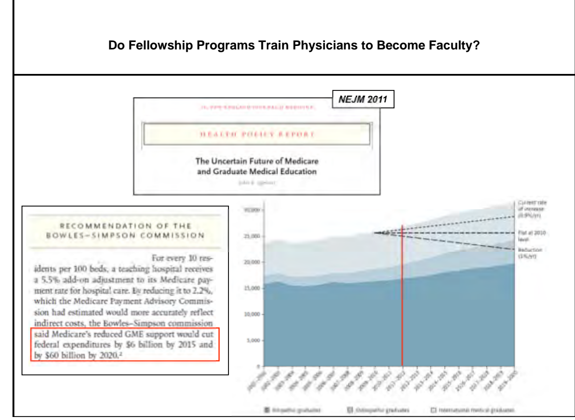
- ACGME accredited programs (n=~600)
  - primarily a clinical training setting
- Non-accredited programs (unknown numbers)
  - significant variability in training setting
- Research underpinnings?
- Education focus?

Do Fellowship Programs Train Physicians to Become Faculty?

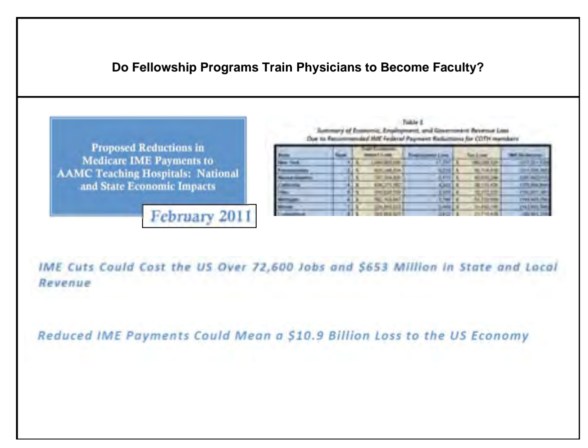
Perceived deficits in fellowship graduates

- Clinically adequate if good program and good fellow matched
- Independent clinical decision-making may still lack based on core training program
- Almost all lack research grounding; unless fellowship extended – or - development program offered as young faculty
- Clear mentorship path and resources appear to be key

Do Fellowship Programs Train Physicians to Become Faculty?



Do Fellowship Programs Train Physicians to Become Faculty?



Do Fellowship Programs Train Physicians to Become Faculty?

Distribution Methodology

- First, hospitals in states with new medical schools;
- Second, hospitals that have exceeded their resident cap at the time of enactment of the legislation;
- Third, hospitals that emphasize training in community health center or community-based settings or in hospital outpatient departments;
- Fourth, hospitals eligible for electronic health record (HER) incentive payments, and;
- Fifth, all other hospitals.

September
Twenty-Three
2 0 1 1

TO: Chief Executive Officers

FROM: Kenneth E. Raske, President

RE: Congress Introduces New Resident Cap Relief

Requirements

- at least 50% of slots are used for a shortage specialty residency program;
- the total number of slots is not reduced prior to the increase; and
- the ratio of residents in a shortage specialty program is not decreased prior to the increase.

Today, U.S. Senate Finance Committee Members Bill Nelson (D-FL) and Charles Schumer (D-NY), along with Senate Majority Leader Harry Reid (D-NV), introduced the Resident Physician Shortage Act of 2011. The legislation would increase the number of residency positions that

Do Fellowship Programs Train Physicians to Become Faculty?

- How do we adequately fund real scholars – academic physicians in the era of shrinking resources
- This will be a “will” issue – do we have it?

Update 2011: The New RRC Program Requirements

Linda J. Mason, M.D.; Neal H. Cohen, M.D., M.P.H., M.S.

Drs. Cohen and Mason will provide an update on the status of proposed revisions to subspecialty program requirements in Anesthesiology. They will discuss the integration of "common requirements for one-year subspecialty programs" into the existing Anesthesiology subspecialty requirements and respond to questions regarding the existing requirements.

Objectives

Participants will:

- Identify use of common language for all ACGME-accredited subspecialty programs in the context of the specialty-specific Anesthesiology program requirements.
- Clarify the timeline for moving forward with proposed revisions to subspecialty program requirements.
- Provide feedback regarding areas for consideration as the RRC considers revisions to subspecialty program requirements.

The Pediatric Anesthesia Match: A Match Made in Heaven?

Nancy L. Glass, M.D., M.B.A.

Match numbers:

Number of candidates who registered for the match

Number of candidates who submitted a Rank Order List

Number of positions in the Match

Number of positions outside the Match

Number of matched positions

Number of unmatched candidates:

What happened to the unmatched candidates? Why were they unmatched?

What happened to the unmatched SLOTS? Were they filled?

Lessons learned: What worked, what didn't. Feedback from the program directors about the process and results

Future directions: to be determined at this meeting

Are Fellows Adults? Applying Adult Learning Principles to Fellow Education

Robert R. Gaiser, M.D., M.S.Ed.

My objectives for the talk are:

1. Understand the principles of the adult learner
2. Design a plan to address barriers to learning for the adult
3. Identify if a fellow is a true adult learner
4. Modify your curriculum and educational goals to incorporate adult learning principles

Teaching adults requires a different skill set as adults learn differently. The concept of the adult learner was popularized by Malcolm Knowles in 1970. To differentiate the teaching of adults from the teaching of children, he proposed the principle of andragogy (the study of adult learning) as compared to pedagogy (the study of teaching children). Adult learners differ from children in motivation, learning orientation, the role of personal experience, and self-direction.

1. Motivation

In pedagogy, the motivation for the learning is the rewards/punishment system. Grades are assigned based upon the learning and these grades are to insure that the child learns. Adult learners do not receive the motivation from grades or from teacher approval. Motivation is established by the adult learner and is highly dependent upon the learner's goals. Many times a life experience or situation may stimulate the motivation to learn. An educator of adults must harness this motivation in the design of a curriculum. CPR has been studied as an example. If the learner had a high likelihood of working in a place where CPR is frequently used, this student was more likely to come to class prepared. The key to the application of motivation is to use those unique teaching moments. Once a deficiency is identified, the learner must recognize the deficiency and the impact of this deficiency on clinical care. With this information, the learner develops a motivation to learn. As such, the teacher must express a desire to connect with the learner as well as provide a challenge without frustrating or embarrassing the learner. One of the major problems with motivation is that its level is highly subject to barriers that affect it. A strong motivation may easily be weakened by these barriers. Some of these barriers include lack of time, poor environment, and a hostile instructor. Considering motivation, one must decide whether the fellow is a child or adult learner. An argument in favor of pedagogy is that motivation comes from a test. Those in pain medicine and critical care medicine have a board certification examination that motivates many fellows to learn. Furthermore, the RRC has generated a list of topics to be covered which guides the curriculum. However, true learning occurs from the motivation. These individuals have chosen to specialize in this area and are the most motivated learner. This motivation must be harnessed to insure life-long learning.

2. Learning Orientation

As opposed to the child learner whose learning orientation is subject oriented, the adult learner's orientation is task or problem oriented. Adults have a greater need to know the "why" they should learn. Knowledge is acquired when the learning is judged to be meaningful rather than the simple acquisition of information and facts out of context. If the teaching is related to day to day activities, the adult becomes more focused on the educational endeavor. The ability to use the knowledge effectively in new situations and diverse realistic contexts solidifies the learning. The effective teacher confronts the adult learner with problems and activities that provides opportunities to apply the new knowledge.

For the fellow, the curriculum must cover topics as outlined by the RRC. However, the fellow may not be exposed to these topics in the clinical situation. This principle of learning orientation explains why case conference is so effective. One approach would to be keep a file of cases addressing these less common topics to provide a learning opportunity that will allow the fellow to master the material. In regard to orientation, the fellow is clearly an adult.

3. Learning Preparedness and Role of Personal Experience

Children are forced to go to school and to learn. Learning preparedness does not play a role as the child does not have a choice. The opposite is true for the adult learner. Personal experience plays a major role in adult learning – it serves as a basis upon which new knowledge may be added. While personal experience is important to learning, it also creates obstacles. Adult learners may be less receptive to concepts due to biases created by personal experience. Personal experience requires the learner to rethink and revise the experience. The learning and the teaching must involve a deeper response to the situation that requires the learner to reflect upon the response. The problem with reflection is that it is difficult and requires self assessment. Reflection generates questions about knowledge, technique, or judgment. These questions cause the adult to seek opportunities such as reading, attending a meeting, discussing with a colleague, or attempting a simulation. The results from these learning opportunities are reflected upon and generate a response to the personal experience. The learner reflects again, evaluates, and attempts to apply the new knowledge.

Fellows are clearly prepared for learning. They have chosen the area to study and have a desire to learn as much as possible. Fellows must be taught to reflect as this core competency of practice-based learning allows the fellow to become a life-long learner.

4. Self-Direction

All of the previous principles of adult learning are based upon the following principle, unlike the child, who is dependent upon the teacher, the adult learner is self-directed and may choose learning opportunities regardless of the teacher's direction. Self-directed learning involving active participation of the learner does result in changes in clinical skill and patient management. Self-direction is dependent upon the learner. It is divided into five steps: assess one's needs, formulate goals, identify the available resources to achieve the goals, implement the learning strategy, and evaluate if the goal has been achieved. Self-directed learning is an internalized process and is not something that is done to a learner. As such, some learners are more self-directed than others. The major problem with self-directed learning is that physicians are poor assessors of their educational needs.

Keys to Success with the Education of Fellows

1. A lack of respect in the learning environment interferes with learning. The learner must feel safe to expose the lack of knowledge, while the teacher must show a commitment toward the education.

2. Remove barriers to learning. Any factor that decreases motivation decreases the chance of success. Learning opportunities must occur at a convenient time and location.

3. Learning is best enhanced by reinforcement. Reinforcement is a planned repetition of facts, skills and attitude in varied, engaging and compelling ways until the material is mastered. Repeating the material allows for the necessary reflection which internalizes the knowledge and creates accountability.

4. Approach the teaching in different styles. While there has been a strong push toward web based learning, tapes, and apps for the cell phone, it still cannot replace reading a textbook.

5. Be a role model. The fellow cannot be expected to be a life-long learner if the mentor does not demonstrate its importance. The residents observe the faculty and learn from their actions and from the consequences of their actions. Faculty teach far more than they know. Every word spoken, every action, every time the faculty choose not to speak, every sigh, smile, or curses is a lesson for the fellow.

6. Teach your fellows to be teachers.

What is the impact of the RRC regulations on the adult learner?
It becomes clear that fellows are adult learners trapped in a education system geared for the child learner. The challenge for the program director is to address this quandary.

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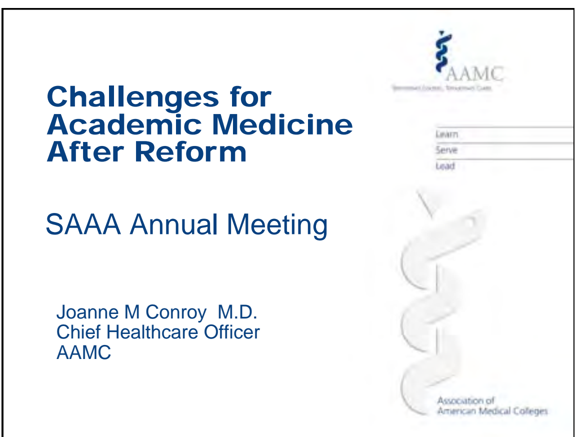
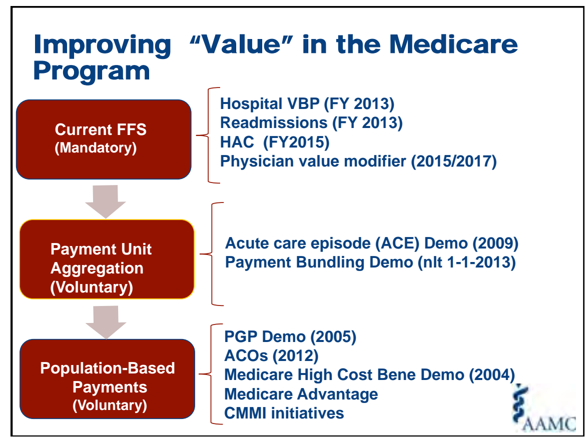
Presentaion Material - *General Session 1: Healthcare & Audit*

Healthcare Reform: What it Could Mean to Academic Anesthesiologists
Joanne M. Conroy, M.D.

New CMS Guidelines and How to Survive a CMS Audit
Zeev N. Kain, M.D., M.B.A.

Notes: ____





Unfortunately, the recent debt discussions could result in have additional economic impacts

Education

- Undergraduate Loans
- Indirect Graduate Medical Education

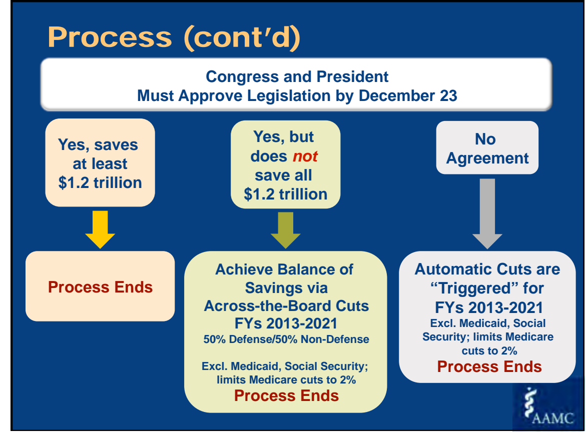
Research

- Proposed NIH salary cap reduction

Clinical Care

- Medicare, Medicaid, cuts and threats of tiering with Health Insurance Exchanges …threaten financial stability

AAMC



Potential Targets: Medicaid

- Up to $100 billion in FMAP streamlining
- $26 to $51 billion through phasing down/out Medicaid provider taxes

Unclear impact on AAMC member institutions but likely to disproportionately affect practice plans and teaching hospitals

Potential Targets: Medicare

$14 to $26 billion/10 yr in phasing out payments for bad debts

- Up to $1 billion/yr for AAMC institutions

$14 to $70 billion/10 yr reduction in DGME/IME payments

- Up to $6 billion/yr for AAMC institutions

Three Institutions: Committee vs Sequester for Medicare

	IME cut	Bad Debt	PPS 2%	Doc 2%
NE1	$32 m/yr	$ 2.5 m/yr	$ 5 million	$ 5 million
MidAtl1	$47 m/yr	$ 1.1 m/yr	$ 7 million	$ 6 million
West1	$31 m/yr	$ 2.3 m/yr	$4 million	$ 4 million

Excludes potential Super Committee cuts to Medicaid

Excludes potential Sequestration cuts to discretionary

Cannot account for action on SGR

AAMC

The Message

- Academic medicine fulfills vital role of education, patient care, and discovery
- Disproportionate reductions to AAMC member institutions will reduce the number of physicians trained, reduce access to vital services, and turn the clock back on treatments and cures
- Cuts to providers should not be focused on a small group of institutions that do what others cannot or will not do
- Cuts to research will erode our long term economic growth and success as a nation

Physician Issues on Horizon

- SGR 'fix' vs. patches after Dec 31st
- Changes to geographic adjusters in payment
- Quality reporting mandatory for physicians
- Public reporting ('physician compare')
- Sunshine Act
- HIT meaningful use requirements
- Physician pay 'value' modifier
- Medicaid payment rates
- Primary care vs. specialty reimbursement

Sustainable Growth Rate (SGR)

Sustainable Growth Rate: Without Congressional action a **29.5% decrease** to physician payment on January 1, 2012

Fixing the problem:

- $300 billion for 10 year solution
- 1-2 year "fix" more likely @ $12-31 billion with a 34-38 percent cut on January 1, 2014

In Congress:

- Hearings in House Energy & Commerce and Ways &Means Committees; no Senate activity

Physician advocacy community:

- Continued push for full SGR repeal
- Joint Select Committee on Deficit Reduction is the last best opportunity to address **permanent** SGR reform in the Medicare physician payment system

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Sustainable Growth Rate (SGR)

September MedPAC SGR Discussion:

- Replace the SGR formula
- Primary care services would remain unchanged over the next 10 years; all other services would be cut 5.9% each of the next three years (~20% total decrease) and then a 7 year freeze
- Brings SGR repeal cost down to $200B

•MedPAC identified $235B in previously suggested offsets

•This list included previous MedPAC recommendations and options suggested by other groups

•MedPAC approved proposal at October meeting

Medicare Clinician Quality/Value Programs

Potential Incentives	2012	2013	2014	2015	2016	2017
PQRS	0.5%	0.5%	0.5%			
OR PQRS – MOC Option	1.0%	1.0%	1.0%			
eRx Incentive[a]	1.0%	0.5%				
OR EHR Incentive	Varies	Varies	Varies	Varies	Varies	

Potential Reductions	2012	2013	2014	2015	2016	2017
eRx Incentive	-1%	-1.5%	-2%			
PQRS				-1.5%	-2.0%	-2.0%
EHR Incentive				-1.0%	-2.0%	-3.0%
Value modifier[c]				TBD	TBD	TBD
Total Possible Reduction	**-1%**	**-1.5%**	**-2%**	**-2.5%+**	**-4%+**	**-5%+**

[a] Cannot receive the Medicare EHR Incentive and eRx incentive, but can receive both Medicaid EHR Incentive and eRx Incentive
[b] Opportunity to recoup full amount and more.
[c] Adjustment could be positive or negative.

Value Modifier Proposals

Law: Starting in 2015 for certain practices and 2017 for all practices, CMS is required to pay differentially based on quality and cost composites.

Proposal: 2015 modifier based on 2013 performance period

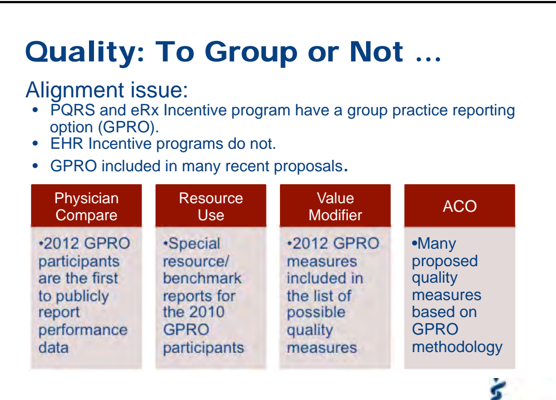
Proposed Quality Measures	Proposed Cost Measures
1. PQRS Core Measure set 2. PQRS GPRO Measures 3. Medicare EHR Incentive Program measures	1. Total per capita 2. Total per capita for COPD, heart failure, coronary artery disease, and diabetes
Seeking comments on: • Outcome measures (hospitalization rates) • Care transition measures • Patient safety/experience/ functional measures	Potential future measures: • Episodes of care • Consider short-term MS-DRG measure

***2012 Physician Fee Schedule Proposed Rule Federal Register* pp. 42909-42914**

Quality: To Group or Not …

Alignment issue:

- PQRS and eRx Incentive program have a group practice reporting option (GPRO).
- EHR Incentive programs do not.
- GPRO included in many recent proposals.



What Are Academic Members Saying About GPRO?

Positives

Took the "guessing out" of what to report for each physician

"Relatively" easy compared to claims-based reporting

Immediate performance feedback through reporting tool (although incentive check & benchmark data did not come early)

Challenges

Some patients attributed to practice based on specialty care or referrals

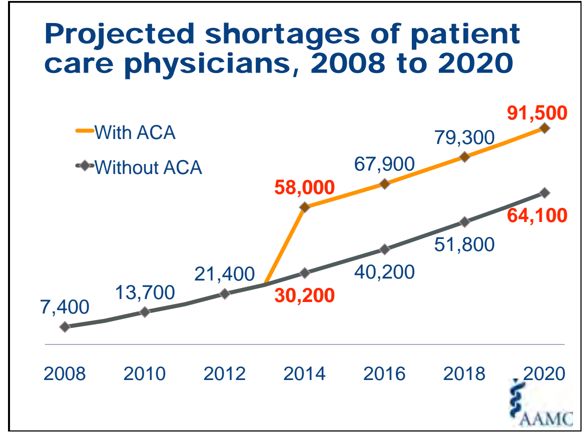
Intensive 5-week period to complete data submission

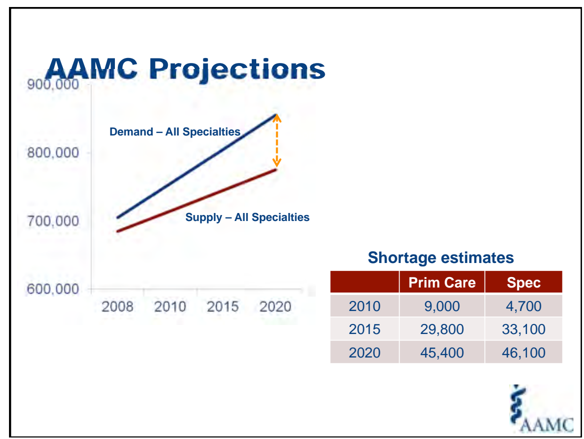
Measures mostly primary care – what is the role of specialists?

Reactions to GPRO based on the experience of 4 academic medical groups

Impact of ACA on Workforce

- Resident redistribution: adds ~**200 PC doctors & gen surgeons per year** (2,000 /10 years)
- HHS workforce grants: adds **500 primary care** doctors over 10 years
- **32 million into system**, many without prior insurance with pent up needs
- Over next 20 years, **36 million people added to Medicare** (using the most services) ~ 20% of the population (up from 13%)





	Prim Care	Spec
2010	9,000	4,700
2015	29,800	33,100
2020	45,400	46,100

Key Workforce Questions

Will there be continued growth in GME?

What impact will team based medicine and other new care models (ACOs, HIZs, medical home) have on productivity/efficiency?

What is the work hour trajectory over a physicians career? Is the new generation of physicians different?

What has the greatest impact on quality and efficiency? Education or practice environment?

Key Workforce Questions

Do we know what medical schools and hospitals are the most efficient providers of UME and GME? How would we determine that…what metrics … cost and outcomes?

How do we incentivize students to enter needed specialties?

IRB ratio/ inpatient Medicare admissions…are these really as relevant in an ambulatory focused environment for formula funding?

Is debt and compensation adversely shaping our medical workforce?

AAMC

Regardless of the model….more work still be to done to

Goal	Strategy
▪ Decrease cost growth rate	Provide real time cost of care data
▪ Decrease administrative costs	Include residents and faculty in system reengineering teams
▪ Decrease variations in care	Agree on what can be standardized and what can not in the educational environment
▪ Reduce medical errors	Create a safe place for reporting
▪ Make better decisions about end-of-life care	Teach residents that it is important to know when not to do something as it is to know when to intervene

Hospital Implementation Issues

Medicare cuts to hospitals = $155 B/10 years

- Hospital price transparency
- Community benefit reporting reqs/IRS
- Readmissions policies FY 2013
- Value based purchasing FY 2013
- Medicaid/Exchange expansion 2014
- Hosp Acquired Conditions reductions FY 2015

Level of insurance/payment vs. market basket, productivity, and DSH cuts

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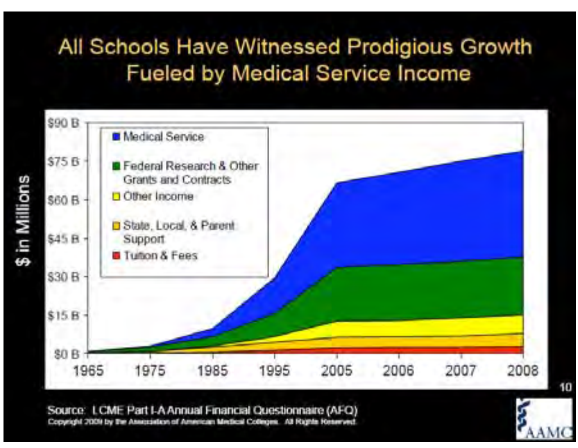
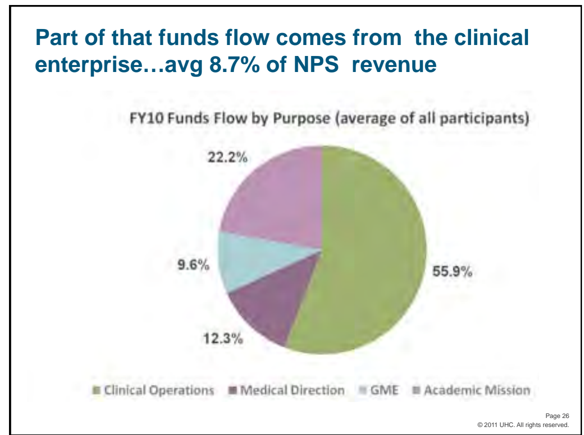
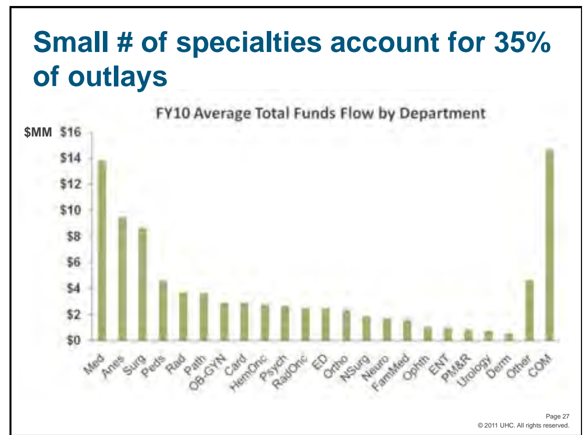






Moving Toward a New Paradigm: What's Needed?

- Alignment between hospital and SOM/ practice plan
- Incentives that drive accountability across the organization
- Flexibility to adapt to changing market and financial conditions
- Ability to measure ROI

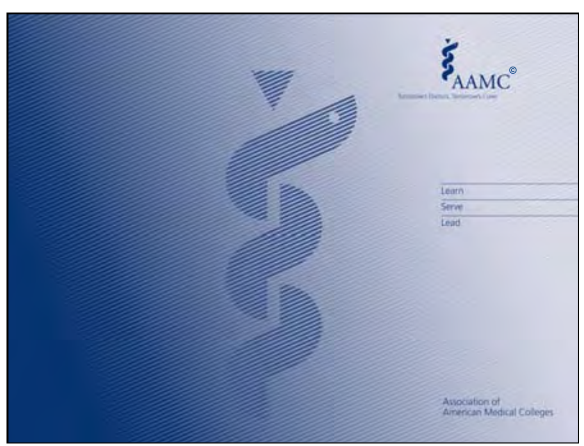
The Challenges of Change

You cannot change your destination overnight, but you can change your direction overnight"

Jim Rohn

It is not necessary to change. Survival is not mandatory.

W. Edwards Deming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Notes:

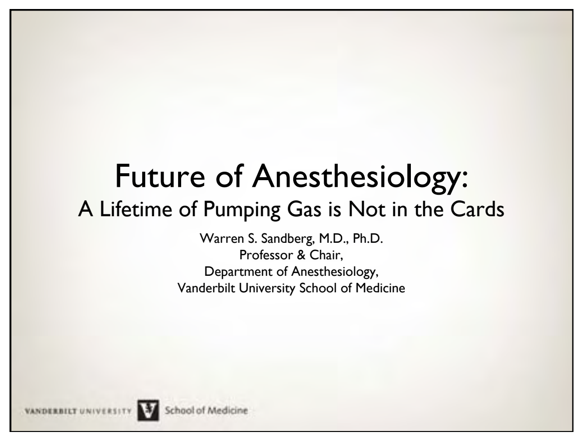
Presentaion Material - *General Session 2: Future of Anesthesiology and Training*

Future of Anesthesiology
Warren Sandberg, M.D., Ph.D.

Pro-Con Debate: Training the Right Number of Anesthesiologists for the Future
David A. Zvara, M.D.; John F. Butterworth, IV, M.D.

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

Notes:



Future of Anesthesiology:

A Lifetime of Pumping Gas is Not in the Cards

Warren S. Sandberg, M.D., Ph.D.
Professor & Chair,
Department of Anesthesiology,
Vanderbilt University School of Medicine

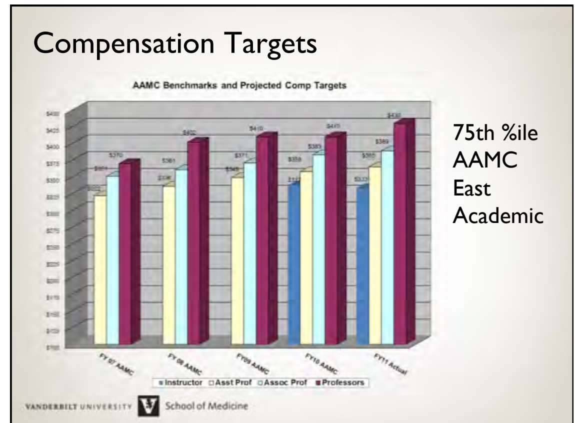
Disclosures

- I have received honoraria from Masimo in the past for consulting.
- The Department of Anesthesiology of Vanderbilt University School of Medicine has developed an AIMS which is licensed to Acuitec.
  - I have no relationship with Acuitec
  - There is a nominal gain for the department when Acuitec makes sales

A High Stakes Resource

- Anesthesiologists (anesthetists) are everywhere
- Necessary adjunct to procedural medicine
- Expensive!
  - Typical academic dept: 50 anesthesiologists
  - Total expense/FTE: about $600K/year
- Revenue does not keep up with expenses
  - Institutional support to academic depts: about $100K/FTE-year
- This is real money ($5M/year)

Compensation Targets

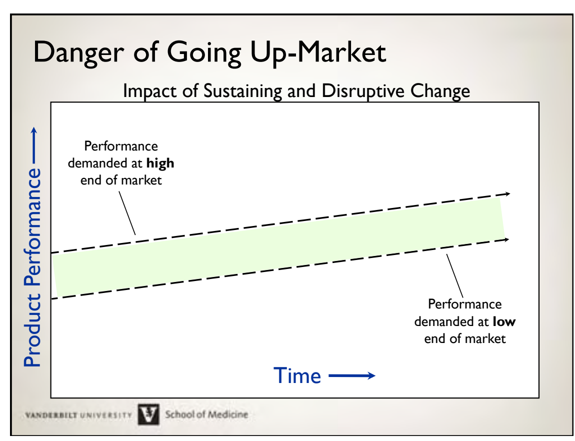


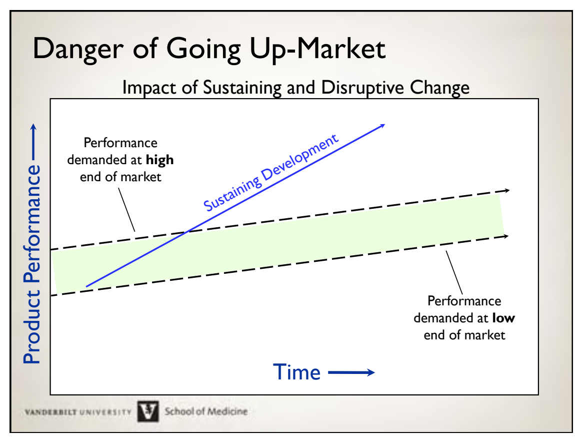
75th %ile AAMC East Academic

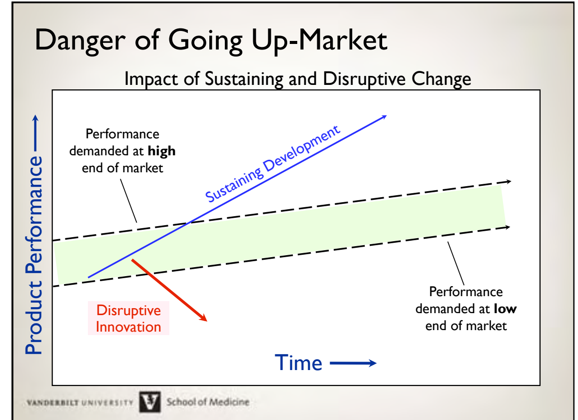
A Higher Stakes Resource

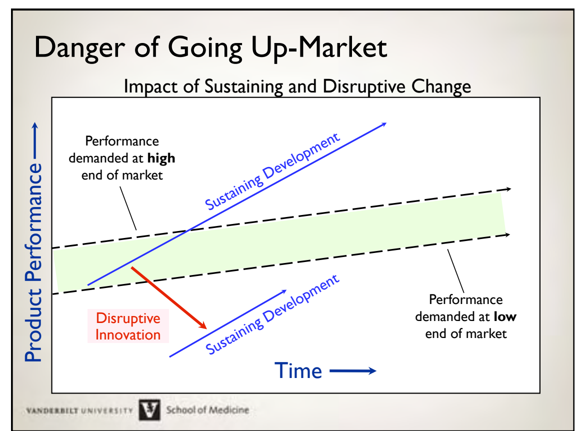
- 'Well - I'll just do a fellowship'
- Differential for some fellowship trained specialties is about $40k/year
- But they fill important super-specialized niches
- Faculty hires tend to 'stick'
- Does fellowship training assure career security?

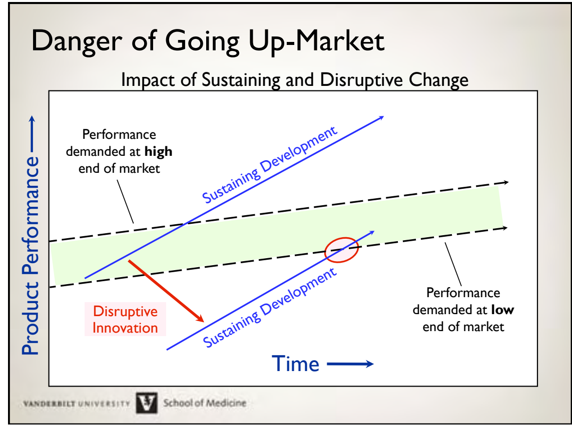
Danger of Going Up-Market

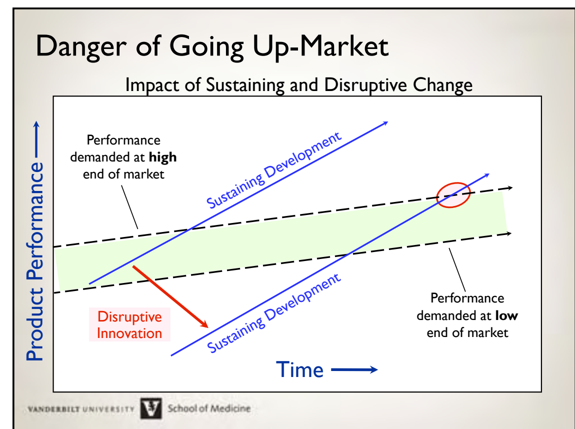






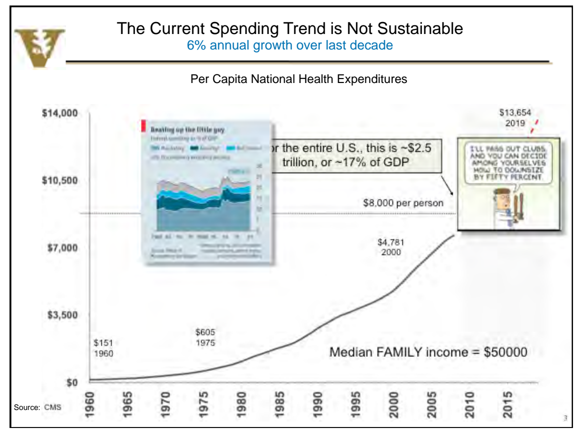


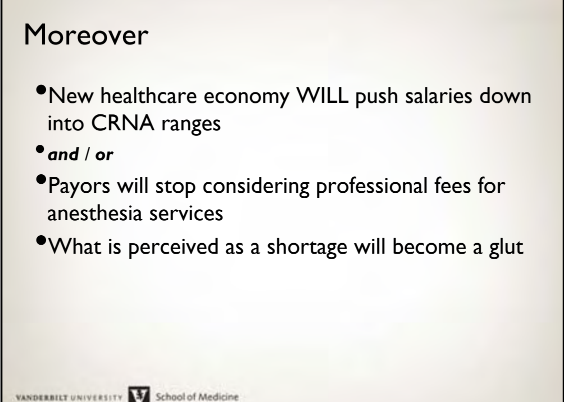




Niche = necessary?

- Maybe for now
- But…
  - APRNs doing pain procedures (supervised by chiropractors)
  - NPs doing critical care
  - CRNAs doing thoracic, cardiac & pedi cardiac
  - Hospitalists doing postops, preops and postop care
  - QZ billing - 1:6, 1:8 coverage ratios
  - Nurses with doctorates
- These were all interesting 'concepts' 10y ago





Assertion

- What separates '-ologists' from '-ists' are:
- Complexity (management of)
  - Individual case level
  - System level
    - Management
    - Leadership
    - Policy
- Creation of new knowledge that improves the science and the process

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Solution Oriented Problem Solvers:

- Catalysts work by bringing things into proximity and constraining their options
- Do not change the free energy of a reaction
- Lower the ACTIVATION energy

energy
reaction coordinate

Problem: Congested PACU and hospital

Goal: Directly discharge Lap chole patients home from PACU

Obstacle: Aligning Anesthesia, Surgery & Nursing

Solution: Catalyze project in ORF

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Multidisciplinary Approach

- Pre-surgical teaching in surgeon's office.
- Modification in surgical technique.
  - (Local anesthetic instillation)
- Specific anesthetic interventions (not stringently applied).
  - Minimize benzos.
  - Intensification of antiemetic prophylaxis.
  - Long acting opioid up front.
  - Succinylcholine infusion.
- Direct communication of discharge plan to PACU.

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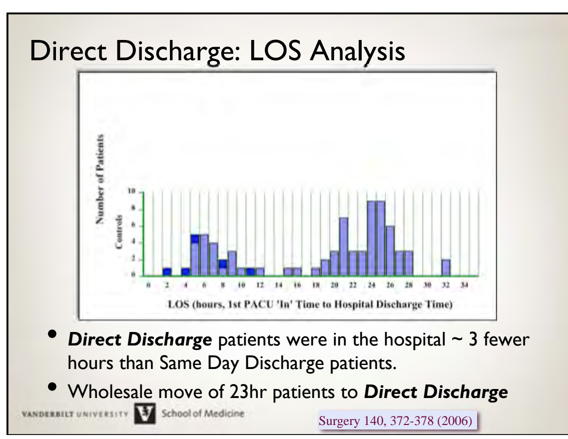

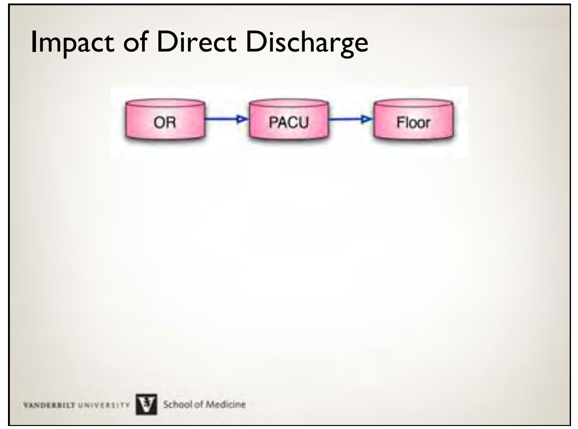

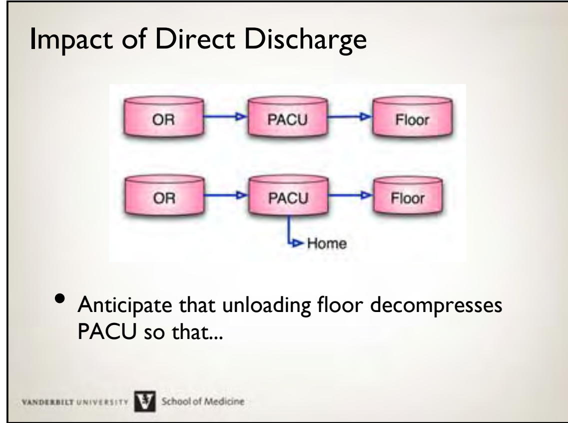

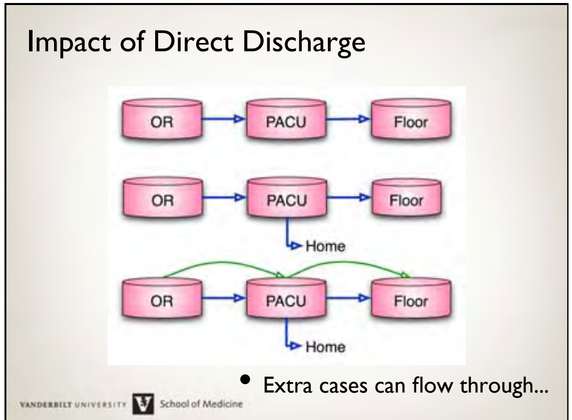

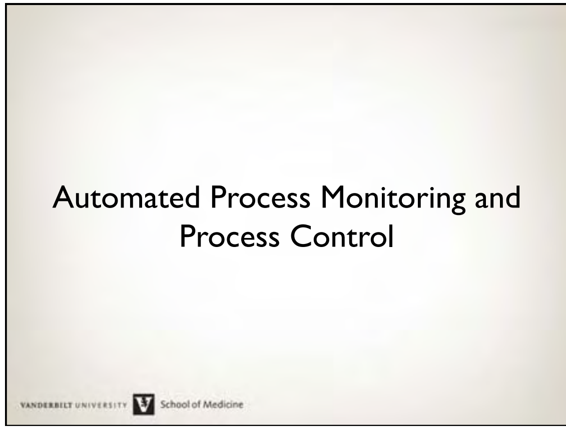

Information to the Clinician

- Most information is concealed - have to search.
- Moving up the slope of increasing value & impact of information:
  - Transparency
  - Active information
  - Integration
  - Augmented vigilance
  - Decision support
    - Managerial | Process of Care | Clinical
  - Automated Process Monitoring & Process Control

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Transparency

- Make information visible without searching

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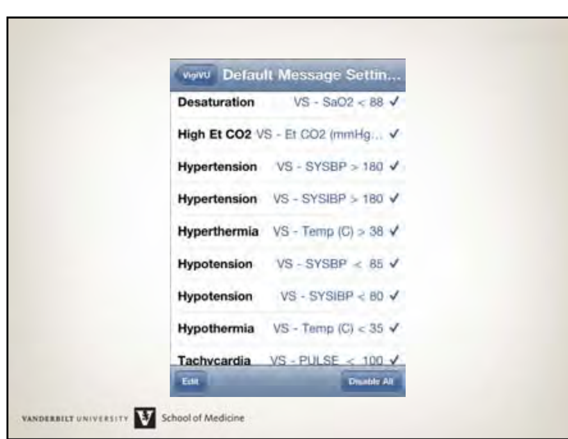
Augmented Vigilance

- Relevant information delivery
  - To the appropriate location
  - To the appropriate person
  - At the appropriate time

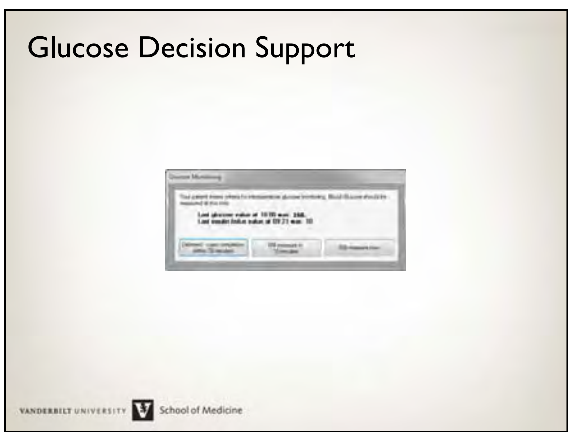


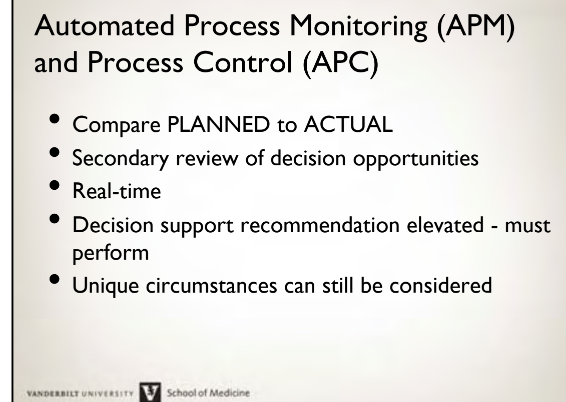
Integration

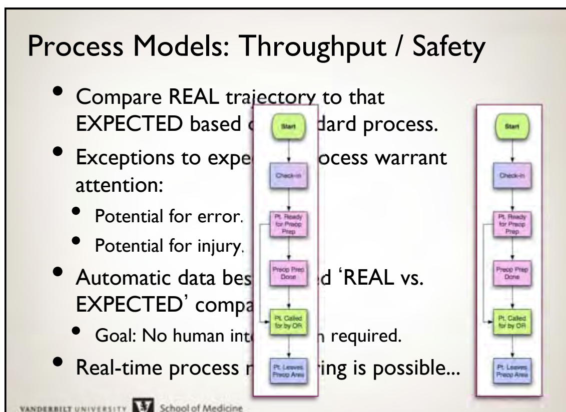
- Brings together information from multiple modalities
- Allows for high-level decision making

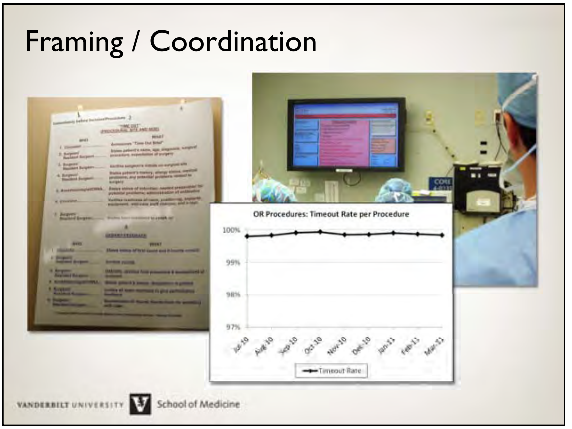
Decision Support (DS)

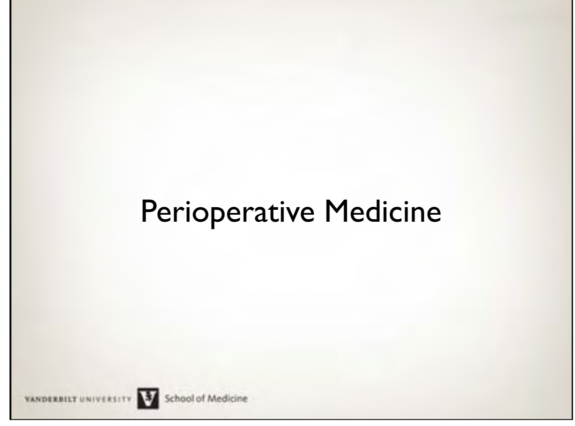
- Recommends one or more possible actions based on
  - Integrated data
  - Best practices
- Delivered through augmented vigilance

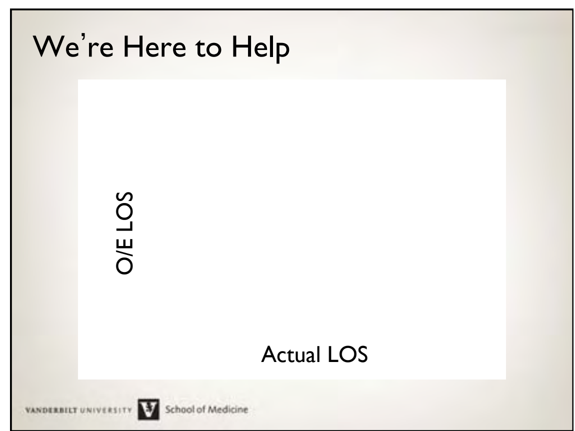

Glucose Decision Support
VANDERBILT UNIVERSITY School of Medicine

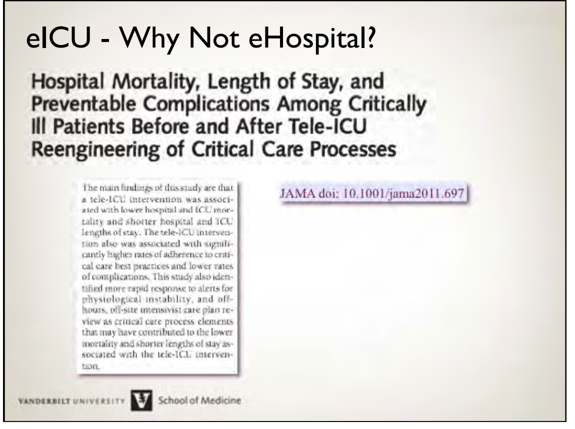

Automated Process Monitoring (APM) and Process Control (APC)
Compare PLANNED to ACTUAL
Secondary review of decision opportunities
Real-time
Decision support recommendation elevated - must perform
Unique circumstances can still be considered
VANDERBILT UNIVERSITY School of Medicine


Process Models: Throughput / Safety
Compare REAL trajectory to that EXPECTED based
dard process.
Exceptions to expe
ocess warrant attention:
Potential for error.
Potential for injury.
Automatic data bes
d 'REAL vs. EXPECTED' compa
Goal: No human int
required.
Real-time process
ing is possible...
Start
Check-in
Pt. Ready for Preop Prep
Preop Prep Done
Pt. Called for by OR
Pt. Leaves Preop Area
VANDERBILT UNIVERSITY School of Medicine


Framing / Coordination
OR Procedures: Timeout Rate per Procedure
100%
99%
98%
97%
Timeout Rate
VANDERBILT UNIVERSITY School of Medicine


Perioperative Medicine
VANDERBILT UNIVERSITY School of Medicine


We're Here to Help
O/E LOS
Actual LOS
VANDERBILT UNIVERSITY School of Medicine



eICU - Why Not eHospital?

Hospital Mortality, Length of Stay, and Preventable Complications Among Critically Ill Patients Before and After Tele-ICU Reengineering of Critical Care Processes

The main findings of this study are that a tele-ICU intervention was associated with lower hospital and ICU mortality and shorter hospital and ICU lengths of stay. The tele-ICU intervention also was associated with significantly higher rates of adherence to critical care best practices and lower rates of complications. This study also identified more rapid response to alerts for physiological instability, and off-hours, off-site intensivist care plan review as critical care process elements that may have contributed to the lower mortality and shorter lengths of stay associated with the tele-ICU intervention.

JAMA doi: 10.1001/jama2011.697

A Proposition

- Excellent clinical skills, professionalism and medical knowledge (& the rest of the CCs) are *required* for a place at the table.
- To stay off the menu - need to offer something that can't be commoditized.
  - That wouldn't be 'caring', 'professionalism', 'ownership', 'vigilance' - the other guys have all that just as much!
- Anesthesiologists had the safety / effectiveness / technology high ground.
- Time to take it back.

What I Ask Potential New Hires

- Describe any quality improvement projects you have done, including implementation, uptake and assessment of outcomes / impact.
- Describe any research projects that you carried out to the point of submission to a peer-reviewed journal.
- Who could I call at your prior institution who would describe you as a solution-oriented problem solver in the practice?

Pro-Con Debate: Training the Right Number of Anesthesiologists for the Future

David A. Zvara, M.D.; John F. Butterworth, IV, M.D.

SAAA 2011 Annual Meeting
November 4-6, 2011
Pro-Con Debate: Training the Right Number of Anesthesiologists

David A. Zvara, M.D.
Professor and Chair
University of North Carolina at Chapel Hill

The Assertion: We should train fewer Anesthesiologists.

Framing the Argument

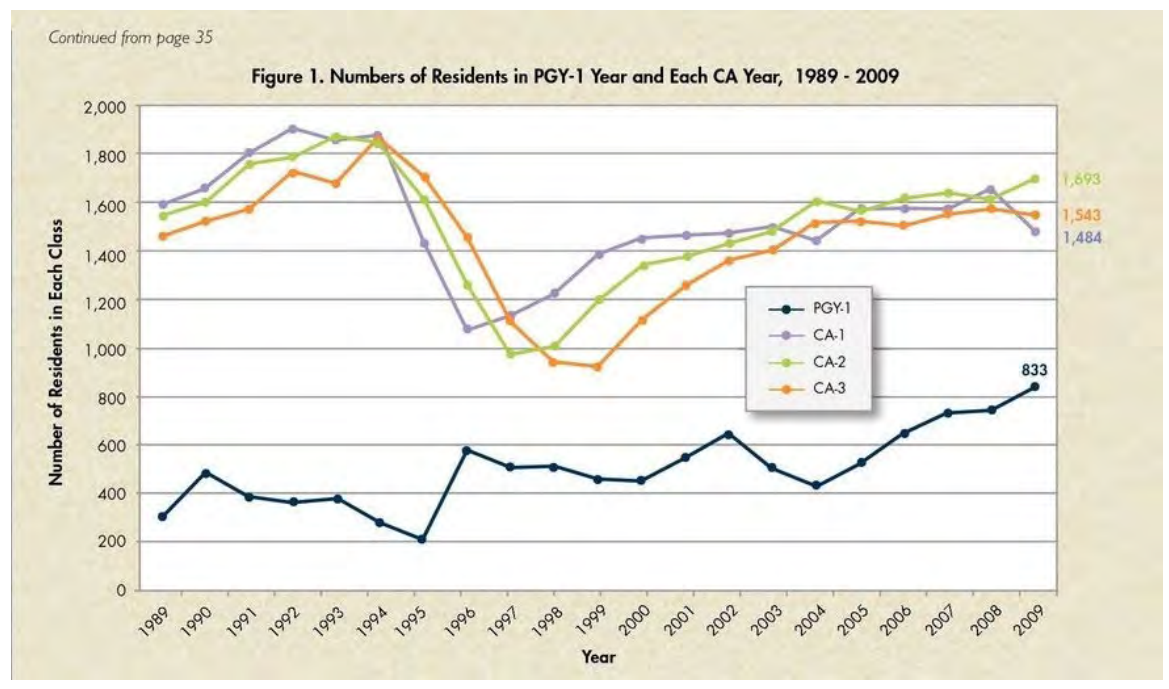
As Chairman and Program Directors of United States anesthesiology training institutions we are explicitly charged with the responsibility of training Anesthesiologists for the future healthcare workforce. How is the number of Anesthesiologists (ANs) trained per year determined? The American Board of Anesthesiology establishes the minimum requirements for experiential content, but provides no guidance on the number of graduates required per year to satisfy demand. The Residency Review Committee provides feedback through the accreditation process on program compliance with minimal case number achievement, but, again, has no global authority to determine the number of national trainees. Finally, through the reimbursement mechanisms of CMS, each training facility has a number of trainees approved for training, but as we all know, these numbers are exceeded in nearly every institution in the United States, and further, there is no recommendation on how many trainees there may be in any one discipline. In recent years, the most responsive guidance to ANs workforce contribution has come from market forces on perceived supply and demand. In 1996, the number of medical students choosing anesthesiology dropped precipitously on perceived changes in workforce need. This swing in supply has lead to more than a decade of shortages in ANs numbers and a real uptick in ANs reimbursement.

Given that there is no formal process for determining a comprehensive and coordinated plan for the number of anesthesiologists training in the United States, each program must determine how many to train locally. This simple fact begs the question: are we training the right number of Anesthesiologists for our future? How do we know? And more importantly, are we training Anesthesiologists for future work demands or are we training the Anesthesiologists for demands and workforce expectations soon obsolete?

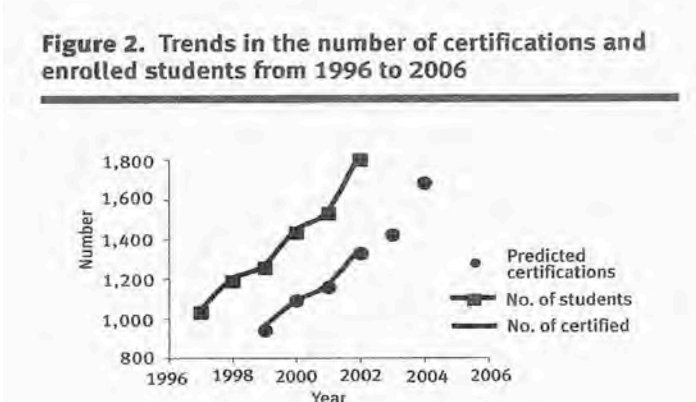
I pose an argument that we must fundamentally change our view of Anesthesiology training, that we must plan for a new definition of anesthesiologist contribution and that, in fact, we should train relatively fewer anesthesiologists to meet our future needs.

Our Current Workforce

The most recent information on the status of our workforce comes from a recently published report on labor markets in Anesthesiology published by the RAND Corporation[1]. Ethicon Endo-Surgery funded the study using survey based noneconomic and economic approaches to assess labor markets in anesthesiology currently and projected through 2020. The data were collected in 2007, at which time there were approximately 40,000 Anesthesiologists (ANs) and 39,000 licensed Certified Registered Nurse Anesthetists (CRNAs) and student CRNAs in the United States. The summary finding of the report is that we currently face a shortage of 3,800 Anesthesiologists and 1,282 CRNAs. These differences vary by state and by region (urban versus rural). Further, using the average clinical work week contributions (ANS contribute 49 hours per week and CRNAs 37 hours per week), average entry and exit rates from the recent past for both groups, and a growth rate in the demand for surgeries of around 1.6%, the RAND study projects a shortage of ANs by 2020 and an excess supply of CRNAs.



We have data on recent market forces in anesthesiology training[2]. As can be seen in the image, the number of physicians entering Anesthesiology plunged in the mid 1990's , likely due to perceived market forces related to entry positions available, reimbursement expectations and projections on future need. In contrast to physician market entry, CRNA growth shows a dramatically different trend[3] (below).



How does our work force compare globally? In Europe, the number of physicians per 100,000 population ranges from 4.1 in Turkey to 23.7 in Sweden[4]. In lesser developed countries, there is greater disparity with a range from 0.07 providers per 100,000 in Yeman to 1.41 per 100,000 in Swaziland[5]. In the United States, there are approximately 13.1 physician anesthesiologists per 100,000 people. This number can be compared to Germany at 21.2 per 100,000 (where there are no CRNAs) and France at 12.9/100,000 (where there are CRNAs). Interestingly, of the European countries with nurse anesthetists (Bulgaria, Czech Republic, Denmark, Estonia, France, Hungary, Iceland, Lithuania, Luxembourg, The Netherlands, Norway, Poland, Slovak Republic, Sweden and Switzerland), no country allows nurse anesthetists to provide anesthetic services independently, without the anesthesiologist's pre-evaluation and agreement.

The Fallacy of Predicting the Future by Looking Backward

By all accounts we are amidst a shortage of Anesthesiologists and CRNAs and this shortage for Anesthesiologists will continue through 2020. The assumption underlying all of the predictions, however, rests upon maintaining current anesthesiology care models to include AN independent practice, care team models and CRNA opt-out models. If future healthcare adheres to past performance and delivery paradigms, then the predictions hold. All may agree, however, future paradigms are likely to be different and unpredictable.

In a brilliant exposition on disruptive innovation, Warren Sandberg, MD, PhD outlined how companies and technologies are subject to changing innovation, performance enhancement and market demand[6]. Anesthesiology care and practice, as harsh as it seems, is no different from other goods and services and is subject to the same rules of global consumption and commerce. As a profession, our services are extraordinary, our care and innovation are superior, and yes, we now must recognize the fruit of this success and adapt our delivery of service to compete and survive in a new competitive market place.

Driving the change is the fact that anesthesiology is safer. In a 1954 report by Beecher and Todd, the anesthetic related death rate was 64 deaths per 100,000 procedures[7]. Contemporary literature places the anesthetic related death rate at 1.1 per million population per year[8]. In relation to previous reports, the mortality is approximately 1 death per 100,000 to 200,000 procedures.

One might ask: given this remarkable history of success, why change anything?

Facing a New Reality

Every success, every innovation in patient safety, every demonstrable metric of quality improvement over these past decades has been lead, created and implemented through Anesthesiologist leadership and scholarship. This is our proud heritage and one that we must never surrender. Our future contributions must remain in these areas of research, innovation, safety and systems healthcare management. Our patients are safer with an Anesthesiologist involved in care. At the same time, it is conceivable, that CRNAs, Anesthesia Assistants, and potentially others will play a greater role in hands-on bedside care. Our challenge is not to view this as a threat, but rather as an opportunity.

To be clear: our future does not include independent CRNA practice.

The new reality, however, leverages the gains made by Anesthesiologists in patient safety to extend care in an affordable model to our growing and aging patient population. We should embrace new models of care to include expanded coverage ratios, supervisory relationships and the like. At the level of the bedside, we must be there to ensure high quality care; as Chairs and Program Directors, we should focus on training leaders and innovators for this future and focus less on producing a work force to compete, operating room by operating room, against CRNAs. Looking forward, we can not legislate relevance or value; it is up to us to define our continuing contribution. Now is the time to envision and prepare the ground work for this future.

A Radical Proposal

We should focus less on how *many* Anesthesiologists we train and focus rather on *who* we train and *how* we train them. The Anesthesiologist of the future must be a team leader, an innovator and educator. The technical skills of delivery are now common place and readily adaptable to less skilled personnel. In computing, years ago an advanced degree was required to manipulate complex digital information. Today, there is more computing power and manipulation found in the hands of an eight year-old and a common desktop computer than at NASA when we first travelled to the moon in 1969. So too, in Anesthesiology, we must adapt, innovate, change and lead. Paraphrasing Jim Collins in his book, Good to Great: People are not our most important asset; the *right* people are[9].

The practical steps each of us can adapt immediately to train the right people include the following steps:

1) Limit the number of Anesthesiologists entering training. This will place market pressure on Anesthesiology as a desirable field for our best and brightest students.
2) Consciously select residents with a vision of contribution that includes team leadership, research and education contribution.
3) Extend our residency to five years. The curriculum should include the CBY year as is, no more than 2 years of basic anesthesiology, and 2 years to include either one of critical care medicine and research or 2 years of research.
4) Extend fellowships in critical care, pain, pediatrics, obstetrics, cardiothoracic and regional anesthesia to 3 years to include 12 months of clinical contribution and 24 months of research.
5) Establish a three year fellowship in research with a concomitant Doctorate of Philosophy degree.

In our general academic practice we should:

1) Embrace new compensation models for Anesthesiologists. One can argue, elevated salaries have attracted less academically inclined physicians resulting in a stunting of intellectual growth relative to other disciplines.
2) Structure, control and direct innovative care team models

3) Engage in hospital, state and national policy debate.
4) Seek education innovation with preparatory course work in scholarship, leadership and research early in training.
5) Find financial models that enhance time opportunities for faculty growth and development.
6) Support research, educational and leadership initiatives with financial contributions.

Summary

The only certain thing is change. Clinging to past models of training and performance metrics will place us in a great position to supply Anesthesiologists ready to accept the challenges of an outdated practice. We will not diminish our role with this redirection; rather, we will enhance our role and our ability to further post gains in patient safety.

As a profession we can either lead or be led. We can find the center of innovation and contribution or find ourselves marginalized in a trivial contest of professional boundary definitions. I hope that the next chapter in our illustrative history is as glorious as our last. Time will tell.

(Endnotes)

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Presentaion Material - *General Session 3: CRNA & Anesthesia Assistant Practice*

Scope of Practice: CRNAs / AAs
Jane C.K. Fitch, M.D.

Co-exisiting Residency and AA Training Program
Matthew P. Norcia, M.D.

Co-exisiting Residency and CRNA Training Program
Sally R. Raty, M.D.

How To Get AAs In Your State
Matthew P. Norcia, M.D.

Scope of Practice: CRNAs / AAs

Jane C.K. Fitch, M.D.

Objectives

1. Audience will learn about the differences in education among the various professions.

2. Audience will also learn about the differences in training among the various professions.

3. Audience will learn about the differences in clinical practice among the various professions.

CRNA & AA Practice

Jane C.K. Fitch, MD
Moderator
SAAA General Session 3
Saturday, November 5, 2011

CRNA & AA Practice

- Scope of Practice
  - Jane C.K. Fitch, MD
- Residency & AA training programs
  - Matt Norcia, MD
- Residency & CRNA training programs
  - Sally Raty, MD
- How to get AAs in your state
  - Matt Norcia, MD

Scope of Practice

- Disclosure
  - Former CRNA

Scope of Practice

- Scope of Practice
- Anesthesia Care Team Education & Training
  - Anesthesiologists
  - CRNAs
  - AAs

Co-exisiting Residency and AA Training Program

Matthew P. Norcia, M.D.

Learning objectives

1. Become more familiar the Anesthesiologist Assistant profession and how it is evolving.

2. Assess the significance of having an AA training program in existence with a residency program.

Co-existing Anesthesiology residency program and Anesthesiologist Assistant (AA) training program is an extremely rare situation when using residencies as the denominator but not uncommon when using AA training programs as the denominator. A brief look at the history of the AA profession reveals two distinct periods. The first period, from early 1970's to 2004, consisted of only two AA training programs. The second period, from 2004 to present, saw a significant increase in the number of programs to seven.

At this point there are only three co-existing situations in existence. The two original programs at Case Western Reserve in Cleveland and Emory were conceived and developed to exist in cooperation with the existing anesthesia residency programs. The third program is at the University of Texas at Houston/Texas Medical Center in collaboration with Case Western Reserve which is in its second year of existence and exists along side their residency as well.

Given the rarity of the situation very little data is available regarding any advantages or disadvantages. Only theoretical assumptions are possible. With that in mind a non-scientific survey of our clinical anesthesia residents (CA1 – CA3) and current fellows that graduated from our program was taken. Admittedly the data does not contain the power to draw any firm conclusions. At best it gives us an idea of the relationship between our residents and the AA training program. The results of the survey suggest a few points. Many residents entering their anesthesia training have little or no knowledge or conception of the profession. As their experience with AA's develops they tend to gain an acceptance and even support for the AA profession. Residents in training who are involved with teaching students might be better prepared when they become an attending.

Co-exisiting Residency and CRNA Training Program

Sally R. Raty, M.D.

After this presentation, the learner should be able to:

- Describe the potential benefits of having a nurse anesthesia program run alongside an anesthesiology residency program.
- Compare and contrast the attitudes and expectations of anesthesiology residents and student nurse anesthetists.
- Anticipate the policies and procedures needed to allow peaceful coexistence of an anesthesiology residency program and a nurse anesthesia program.

Background: Nurse anesthesia programs are accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs (COA) in a fashion similar to the Accreditation Council for Graduate Medical Education for anesthesiology residency programs. There are 131 ACGME accredited anesthesiology residency programs and 112 COA accredited nurse anesthesia programs in the US. Based on the 2011 COA Annual Report, nurse anesthesia programs are located primarily in 5 types of academic units: Nursing (64), Health Sciences (14), Medical College (4), Biology (4), Education (1), and Other (14). Completion of an accredited nurse anesthesia program leads to an additional degree. The most common degree offered following training as a nurse anesthetist is a Master of Science in Nursing or Nurse Anesthesia. Degrees of Doctor of Nursing Practice are becoming more common, and there are a few institutions that confer degrees of a Master of Science in Anesthesiology, Master of Science in Nurse Anesthesiology, or a Master of Anesthesiology Education. The length of training in nurse anesthesia varies from 24-36 months. The maximum accreditation cycle for a nurse anesthesia program is 10 years.

Per the Executive Summary of a survey distributed by the AANA to program directors of nurse anesthesia programs in 2006:

- 80% of respondents reported that at least one of their nurse anesthesia clinical sites coexist with an anesthesiology residency program.
- 70% of respondents indicated that 51% or more of their students' cases involve medically directed CRNAs.
- 29% of respondents reported having some non-medically directed CRNAs providing clinical anesthesia instruction in sites at their program.
    - 59% of this group reporting that less than 11% of their clinical site cases involve non-medically directed CRNAs.
- 80% of the respondents report that their programs have some student nurse anesthetist's cases directed by anesthesiologists, without teaching CRNAs.
- 73% of respondents "agree strongly" that having good relationships with anesthesiologists is "very important" to their programs.

1) Perspectives of the learners:
    a) Residents:
        i) I am a doctor.
        ii) I will be the "bottom line" for the patient. In fact, I cannot choose otherwise.
        iii) I can choose the tasks that I allow other students to do, why are these students different?
        iv) CRNAs are trying to put anesthesiologists out of work.
        v) I am getting paid while I learn. Getting paid means I add value to patient care , and I bring physician expertise.
    b) Nurse anesthesia students:
        i) I have ICU experience and have taken care of very ill patients.
        ii) I may be the "bottom line" for the patient, depending on my practice situation, and I need to be ready for that responsibility.
        iii) I am a student, and I should be given the opportunity to learn everything that I can.
        iv) I help cover the workload of the OR; so, I should be given good cases, too.
        v) I am paying tuition for this experience; so, I should have priority in terms of learning opportunities.

2) Advantages of having a nurse anesthesia program coexist with your residency program:
    a) Cross coverage for didactic conferences, exams, and group meetings.
    b) CRNA coverage for cases with low educational yield.
    c) Allows each group to understand how the other group is trained.
    d) Since 80% of anesthesia practices are in an Anesthesia Care Team (ACT) model, this training structure provides an early introduction to the ACT model.
    e) For the hospitals where SRNAs help cover the workload, this arrangement is financially advantageous.

3) Details to Consider (aka stuff I messed up on)
    a) Handling beginners
        i) All of our residents spend the first month in anesthesiology in "mentor mode" during which they are paired one-on-one with an attending anesthesiologist or with an upper level resident. The nurse anesthesia program had no such policy. The difference in supervision caused residents to feel undervalued at the beginning of their training. They expressed anger at being watched more closely which they equated with being trusted less/ thought less capable than the student nurse anesthetists.
    b) Coveted clinical experiences:
        i) Certain clinical experiences become coveted by residents. This tends to change over time. Regional anesthesia, non-cardiac intrathoracic, neonates, epidurals/ spinals and intracranial aneurysms are the current favorites. Our residents do cardiothoracic cases at 4 different clinical sites and can choose a 5th site if desired. The nurse anesthesia students do cardiac at only one of those clinical sites; so interaction and opportunity for friction are minimized. We have similarly separated the pediatric, obstetric and neuro-anesthesia experiences.

Regional anesthesia remains a challenge. The resident assigned to the Regional Anesthesia Rotation expects to place all peripheral blocks, and the nurse anesthesia student, if assigned to the patient under consideration for a regional technique, desires similar experience and to provide the complete anesthetic to the patient.

c) Leadership designations

i) Nurse anesthesia programs need a Medical Director. For 5-6 years, the same person was both the Director of Residency Training AND the Medical Director of the nurse anesthesia program. This was seen as a sort of betrayal by the residents.

d) Conferences

i) Historically, our weekly conference included the entire department: all faculty, residents, students, rotating residents, and research personnel. The conferences varied in content: visiting professors, case conference with questioning of residents, senior academic presentations, and quality assurance conferences in which complications are presented by the anesthesia team who provided the care. In the past few years, residents have requested that we "split" the conference so that members of the nurse anesthesia program only attend visiting professor conferences. Residents were uncomfortable being questioned on their medical knowledge and patient care during both case conference and quality assurance conferences, and preferred to present their senior academic projects to their peers (not all colleagues) which by their definition did not include anyone in the nurse anesthesia program.

e) Perceived upper hand

i) When on call at one clinical site, both residents and nurse anesthesia students carry service pagers that are called by nurses when a patient needs evaluation for or placement of a labor epidural. One pager had an easy-to-remember-number and the other did not. The easy-to-remember pager was called more often by the nurses, and it was methodically and deliberately kept as the pager passed from CRNA to SRNA and rarely fell into the hands of the on call residents.

f) Complement changes

i) At our institution, a change in resident complement number or a proposed rotation change of more than 10% of the residents on the service requires approval by a College Committee. This Committee considers all aspects of the request including impact on the training of other learners. When we requested an increase in resident complement, we were denied based on the projected impact on the nurse anesthesia program, as described by that program's director. However, when the nurse anesthesia program elected to increase its complement, they were permitted to do so without similar scrutiny.

g) Call teams

i) Our call teams routinely included a mix of residents and SRNAs with the occasional CRNA, all supervised by a faculty, in house, anesthesiologist. The senior resident on call assumes a leadership role among the team, assigning cases, trouble shooting and providing assistance to the team members. Some of the senior residents appear to play favorites among the call team members (ie. perirectal abscesses and appendectomies are preferentially assigned to the nurse anesthesia students while the residents are assigned the more complex cases and any case amenable to a regional technique). The student nurses complained about the treatment as inequitable, and we decided to try having "all resident" and "all SRNA/ CRNA" call teams assigned to separate nights. However, residents were critical of this arrangement, hypothesizing that by having call teams without residents, we were telling the hospital administration that the service could be run without residents. Not good; not good at all, and I never saw this one coming!

4) Other Issues to Consider

a) Politics

i) Our CRNA faculty are very active politically both at the state and national levels. They have held numerous offices including the President of AANA and have been vocal in their support of independent CRNA practice, their assertion that patient outcomes from nurse-only anesthesia care is equivalent to medically directed practice, and their opposition to the Medicare Teaching Rule. To their credit, our CRNAs do not bring their politics to work, but our residents are well aware of the views and activism of the CRNAs/ SRNAs, and the residents take it personally.

b) The "student" designation

i) At our institution, nurse anesthesia students are designated as **students** by all of our clinical sites. Over the years, **residents** and **students** are afforded different "benefits". For instance, for a while, all students were required to use remote parking rather than on site hospital parking; students were not eligible for meal tickets when on call, and student notes in the electronic medical record do not satisfy required documentation (eg. post-anesthesia note). This difference in benefits for residents and students led to pressure on departmental administration to change the designation of the nurse anesthesia students to "residents in nurse anesthesia" to which we never capitulated. One firestorm averted.

c) Medical Student Issues

i) Recruitment

(a) During interviews and rotations, nearly every medical student asks about "competition" for cases between the residents and the nurse anesthesia students. Despite showing the students our case numbers and rotations which clearly document clinical experience for the residents that exceeds the ACGME requirements by 200-400%, they often seem skeptical.

ii) Clinical Rotations

(a) Medical students from our home institution often rotate for 2-4 weeks at the county

hospital, where the presence of the nurse anesthesia program is the most apparent. Our medical students are assigned exclusively to a room with an anesthesiology resident. Depending on resident schedules, we may have to double up our students in rooms, if fewer residents are working on a particular day.

d) Academic Titles

   i) Our CRNAs have the academic titles patterned on "Instructor/ Assistant Professor etc. in Anesthesiology and Allied Health Sciences." The inclusion of "Anesthesiology" rather than "Nurse Anesthesia" clouds the educational distinction between physician and nurse and has not served us well (to put it mildly).

e) The ACGME Resident Survey

   i) The survey asks residents a variety of questions centered on interference with their learning by other groups. Even if the residents understand the questions and know that resident case numbers exceed the requirement, animosity toward other learner groups like SRNAs can become magnified during this anonymous survey. Perhaps the best approach is to frequently take the pulse of the residents in regards to the SRNA program and to address issues on an ongoing basis to both minimize friction and to reassure residents that their education is at the forefront of your concerns.

5) Conclusion:

   i) Resident education in anesthesiology can be enhanced by the presence of another group who can provide anesthesia care under the medical direction of anesthesiologist. However, to the extent that anesthesiology residents feel undervalued, or even equal in status to the other learners, or perceive a challenge to their status as physicians, friction among the groups is likely to develop. Deliberate and ongoing attention to these issues is critical in order to keep the focus on learning rather than on one-upmanship.

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How To Get AAs In Your State

Matthew P. Norcia, M.D.

Learning Objectives

1. To identify and explain the factors that influence the immigration of Anesthesiologist Assistants into a state or institution.
2. Describe the general process of establishing licensure for Anesthesiologist Assistants.
3. Differentiate the options for creating AA training program.
4. Identify resources to investigate expansion of the AA profession

Getting Anesthesiologist Assistants (AA's) to come to your state depends on three basic conditions: 1) whether or not your state will allow them to practice under licensure or under delegatory authority, 2) whether or not there are AA's already practicing in the state and 3) whether or not there is a training program in your state. Presently there are only 17 states, the District of Columbia and VA hospitals that allow AA's to practice.

If licensure is not a possibility and delegatory authority is not an option, then your state faces the most difficult challenge. It will need to overcome many hurdles to obtain legal permission for AA's to practice. First, there must be a strong desire and unity amongst the anesthesiologists and their state society to accept the challenge. They should agree that the need for AA's in the state outweighs the tremendous effort before them. It is important to maintain a covert posture as long as possible to minimize antagonism from opposing groups. Next, funds needed to cover legal fees, lobbyist fees; travel expenses and staffing expenses should be estimated and raised or secured prior to starting out. Perhaps the most important individuals to identify are the lobbyist and state legislator. Without good direction and insight into the law making process success is unlikely. Ally with the state medical board and keep them informed of any progress. Also, identify potential political obstacles early to plan for them accordingly. This information will come from a good lobbyist. Determination and perseverance are mandatory since most often more than one attempt through the legislative maze is necessary to achieve success.

Once AA's are permitted to practice in a state the next hurdle is recruitment. Again a firm commitment is needed. Many Anesthesiology departments have deeply embedded mid-level anesthesia providers. Introducing a new provider could generate tension in the work place. The new providers need to know they will be accepted by staff, faculty and hospital administrators. Initial tension usually subsides with time and as more AA's enter the health care system recruiting becomes easier.

The presence of an AA training program facilitates recruitment into your state and into the institution or health care system in which it resides. The two states (Georgia and Ohio) in the US with the most practicing AA's are the two states with the longest running training programs. The reason is probably two-fold. The best of the trainees from a program are likely to be identified early and are persuaded to stay as employees. Students from other programs are more likely to set up visiting rotations where established clinical training sites exist. Secondly, experienced AA's who are interested in teaching clinically and didactically are more inclined to migrate to areas with teaching potential.

There are basically two paths to creating an AA training program. The oldest and most common approach is to create a program de novo in a post-graduate school within a university setting. The typical post-graduate schools are schools of medicine and schools of allied health professions. The advantages of this approach are the retention of local control and identity for the program and the institution. Potential disadvantage is lack of experienced staff and faculty, generating a new curriculum, securing clinical training sites and opposition from competing groups.

Recently a second strategy was utilized. It differs in that an existing institution creates a new training program at a remote site but it remains part of the mother institution. Advantages of this approach include time-tested curriculum that cane be shared, more experienced personnel, less political battles, established reputation, collaborating with other highly respected institutions and possibly less expensive.

There are many individuals in the AA community that are ready and eager to act as resources of information concerning the AA profession. Information on a wide range of issues from establishing a clinical site for visiting students to recruiting AA's to starting an AA program can easily be obtained.from the following sources.

References

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www.anesthetist.org

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Resources

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Presentaion Material - *General Session 4: Mock RRC Committee Meeting and Milestone Project*

Mock RRC Committee Meeting
Neal H. Cohen, M.D., M.P.H., M.S.; Patricia M. Surdyk, Ph.D.; Linda J. Mason, M.D.; Margaret Wood, M.B.Ch.B.; William Hart

ACGME Milestones Project: How it will Affect Residency Training
Neal H. Cohen, M.D., M.P.H., M.S.

Mock RRC Committee Meeting

Neal H. Cohen, M.D., M.P.H., M.S.; Patricia M. Surdyk, Ph.D.; Linda J. Mason, M.D.; Margaret Wood, M.B.Ch.B.; William Hart

This session will provide the participants with an overview of how the RRC assesses individual programs at its meetings The process of program accreditation involves extensive review and assessment of each program by RRC members and detailed discussion about the strengths and areas for improvement of the program. Members of the RRC will conduct a mock meeting to demonstrate peer review at work in the process of program accreditation.

Participants will:

- Recognize the importance of accurate and clear documentation in the process of program review.
- Clarify expectations of the RRC in interpreting the specialty-specific and Common Program Requirements by observing the process of program review.
- Refine their interpretation of program accreditation letters of notification.

ACGME Milestones Project: How it will Affect Residency Training

Neal H. Cohen, M.D., M.P.H., M.S.

This session will provide a brief overview of the ACGME Milestones Project and its implications for educational programs in anesthesiology. The Milestone Project is designed to build on the concept of competencies and provide an important foundation upon which to develop meaningful graduated curriculum for resident training. At the same time, the milestones will provide a framework in which to ensure the public of the quality of graduate medical education.

This discussion will review the status of the Milestones Project within ACGME and provide an update on the initial work of identifying milestones for training in the core Anesthesiology residency programs. It will also provide an overview of the role of milestones as one critical component of a new accreditation system.

Presentaion Material - *General Session 5: Faculty Evaluation and ASA Update*

How to Improve a Disruptive Faculty Member
Steven J. Barker, Ph.D., M.D.

Annual Faculty Reviews: Best Practices
Jeffrey L. Apfelbaum, M.D.

Ongoing Professional Practice Evaluation: Best Practices
Randall M. Clark, M.D.

ASA Structure
Jane C.K. Fitch, M.D.

Update from SAAA Director to ASA
Steven J. Barker, Ph.D., M.D.

ASA Update
Jerry A. Cohen, M.D.

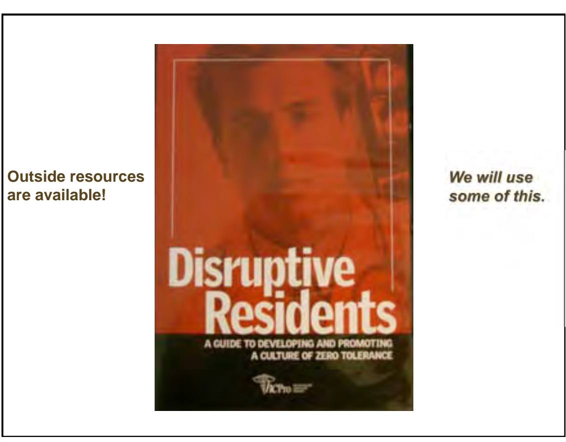
Notes: ___

How to deal with
THE DISRUPTIVE COLLEAGUE
resident or faculty member

Steven J. Barker, PhD, MD
Professor and Head, Anesthesiology
University of Arizona

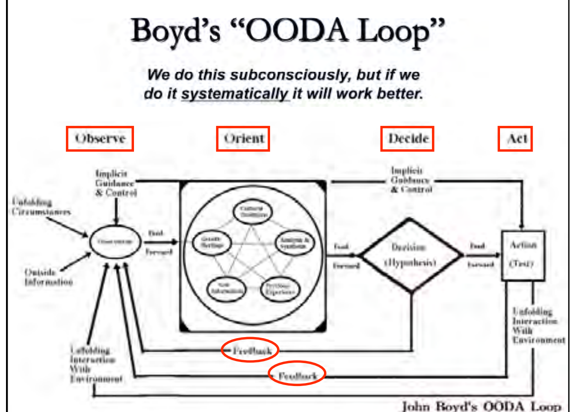
What is a disruptive colleague?

- "Trouble maker? Irritating?"
  - *Be more specific.*
- The DC is someone who:
  - Negatively impacts resident training, patient care, or the entire department, *OR*….
  - Causes breakdown of the team relationship that can compromise efficiency & safety, *OR*….
  - Impacts extra-dept relationships (e.g., surgeons).



Example #1:
The following stories are ALL TRUE!

- Neurosurgery *attending* turns up boom box at start of case.
- Anesthesia resident X asks for volume down.
- Neurosurgeon ignores request.
- *And then*…..



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STEP 1: *Get all sides!*
(Observe)

- Obvious, but often forgotten.
  - Maybe Resident X was provoked.
  - Neurosurgeon was a real a------?
  - Mitigating factors – death, illness, sleep loss?
- Interview third party witnesses. *Now!*
  - Everyone in OR #11 witnessed Example #1.
  - Do the witnesses have bias?
  - ***RECORD EVERYTHING!***

STEP #2: *Patterns?*
(Orient: Get in other person's shoes)

- Is this an isolated, unique incident?
- If other incidents….
  - What were the common features?
  - Anger issues? *(YES!!!!!)*
  - Honesty issues?
- Look for motives! *What was X's motivation, purpose or expected outcome?*

Example #2:
Message: don't get blind-sided!

- Two residents ask to meet with chair.
  - Reason given: *"It's personal."*
- Resident A and B enter my office, *with wives.*
  - Well, OK, maybe it's a family issue.
- *And then…….*

Step #3: *Hypothesis/Diagnosis*
(OODA: Decide)

- If isolated incident, counsel and move on?
- If a pattern of behavior:
  - Personality disorder? *('Don Juan Syndrome'?)*
  - Anger management?
  - Expected future if untreated? Tolerable?
- Get help in your diagnosis!
  - Make use of on-site counseling and psychiatric resources.

Step 4: *Intervention/Treatment*
(OODA: Act!)

- If behavior has potential for further dept disruption, *intervene now!* (Cancer?)
  - Remove the problem if not easily solved.
  - Not so easy today – *residents have rights.*
- Back to Example #2:
  - After counseling of all four (with experts), things quieted for a while, then….
  - Vandalism to cars.
  - Taunting, spreading rumors, etc.…
  - Resident A (the victim) left program. ***Bad Outcome!***

Lessons of Example #2:

- Chair convinced self that problem could be treated, solved to keep everyone happy. ***It could not!***
- In retrospect: *Resident B should have been removed.*
- This was a personality disorder, not compatible with health of the department.
- *Question is HOW? On what grounds?*

Example #3
The Really Obnoxious Resident

- Usually intelligent, clinically sound, extroverted, self-assured.
- And…… narcissistic, egocentric, lacking self-insight, overbearing.
- Here is how NOT to conduct an interview in response to a complaint about this person: *interview from "Disruptive Residents" follows.*

Example #3:
Message: be proactive, look out for whole dept.

- Resident C is regarded as intelligent, skilled, a 'resident advocate'.
- *But,* C is always highly critical of:
  - Attendings, *especially* chair.
  - Other residents.
  - Hospital, surgeons, etc.…nothing good enough.
- Chief residents are selected by an *advisory* vote of residents, then by faculty.

Example #3:
cont'd.

- C "campaigned," won chief election by one vote plurality.
- Chair interviewed C, regarding his mission, goals, strategies as Chief Resident.
- *And then…..*
- **Options?** ***What's my BATNA?***

After Orient, think "BATNA"
Best Alternative to Negotiated Agreement

- If negotiations fail:
  - What is your best alternative?
  - What is the other party's?
- Who has the better BATNA?
  - This will determine your negotiating stance.
- Do both parties understand the BATNA's?
  - If the other side's is better than yours, do they know it? *If not, keep your mouth shut!*
  - If your BATNA is better, make sure the other side knows.

Back to Resident C,
using OODA Loop

- We have Observed his behavior; we are Oriented *(he wants to change the world).*
- DECIDE:
  - *Dx:* Narcissistic personality disorder *(confirmed by Ψ).*
  - *Therefore*: this ain't gonna work.
- ACT:
  - *And then go back to……..*
- OBSERVE
  - Details will be revealed!
  - *So, here is an example of how to handle an interview with this exact resident. We all know him! (From "Disruptive Residents).*

Example #4
The outstanding but abusive faculty

- Dedicated, hard-working, skilled and knowledgeable, won teaching awards.
- "High-strung" perfectionist with high standards for residents.
- When those standards not met → *abusive, harrassing, demeaning.*
- Mistake: Because of A, tolerated C too long! Multiple counseling sessions, not enough *teeth!*
- Status: Unresolved.

PEARLS: *Do's and Don'ts*

- **DO** have a professional behavior policy; be sure everyone gets it.
- **DO** intervene early: **DON'T** ignore even isolated episodes.
- **DON'T** allow the subject to take control of the interview. *You must be the boss!*
- BATNA: **DO** be sure the subject understands the consequences *to him/ herself*. These are smart people!

CONCLUSIONS

- When you've seen one "difficult colleague," you've seen ONE.
- *BUT*, there are common features, and we should learn from one another's mistakes. *You've seen mine – let's talk about yours!*
- *Use a systematic approach:* I recommend OODA Loop, combined with BATNA. Allows you to adapt to changing situation.
- ***You stay ahead of your airplane,*** which will help keep you out of trouble.

THE END

Thank You!

Annual Faculty Reviews: Best Practices

Jeffrey L. Apfelbaum, M.D.

Objectives

1. Upon completion of this learning activity, participants should be able to identify, develop and apply mechanisms for faculty success.

2. Upon completion of this learning activity, participants should be able to associate, evaluate and differentiate mechanics to discuss necessary support and resources for faculty career development.

3. Upon completion of this learning activity, participants should be able to identify and interpret behaviors that may justify intervention or modification of a career path.

Introduction: The measurement of academic productivity of faculty in an academic medical center is both challenging and tedious, and most assuredly requires a great deal of subjective interpretation by the Chair.

Annual faculty reviews are an important part of the Chair's responsibilities to their faculty. Ideally they should be viewed as an opportunity to celebrate faculty successes; plan, develop and implement mechanisms for continued success; and provide advice and counsel as well as evaluate and determine the need for support and appropriate resources for career development. In some instances, the annual review provides an opportunity to influence behavior modification and if necessary, to alter career paths. In our department, the annual review includes the following:

1. A thorough and complete review of that faculty member's "P and L", aka Profit and Loss Statement. Included: Clinical, Research, Education funding and expenses.
2. A review of that faculty member's teaching evaluations by housestaff.
3. A review of that faculty member's teaching evaluations by medical students
4. A review of that faculty member's teaching evaluations of housestaff.'
5. A review of that faculty member's attendance and participation in departmental educational efforts.
6. A review of the goals and objectives as agreed upon at the previous year's annual review.
7. A review of that faculty member's goals and objectives for the upcoming academic year.
8. A review of the assessment of that faculty member's "team play" as provided by the departmental <u>clinical</u> coordinators.
9. A review of the assessment of that faculty member's educational contributions to departmental educational efforts as provided by the Core Program director and the Vice Chair for Education and Academic Affairs.
10. A discussion of measures of academic productivity as agreed upon for that faculty member within the confines of expectations in their track at our institution.

In this presentation, specific issues will be addressed which may be considered in assessing excellence in scholastic activities, teaching activities, and the provision of clinical care in an academic medical center.

Considerations For Retention and/or Promotion of the Tenure Track, Clinical Scholars Track, and Clinical Educators Track

Tenure track:

The standards to be applied should...assess the quality of performance in (1) research, (2) teaching and training..., (3) contribution to the intellectual community, and (4) service.... The...criterion of distinction in research should be given the greatest weight. ...members of the appointive body (should assess) the originality, rigor, and fundamental significance of the work and ... estimate the likelihood that the candidate is or will become a leading figure in his field."

Clinical scholars track

"This category of appointment is for a full-time faculty member who has demonstrated clinical scholarship and who has shown exemplary teaching skills. Such a person participates primarily in clinical service, clinical research and teaching. ...Clinical scholarship means publication in peer-reviewed journals of research or investigation done in clinical situations. Distinction in clinical scholarship might be attained, for example, in the development of new concepts in the practice of medicine, new interpretations which improve the diagnosis and treatment of patients and their diseases, critical reviews of the published scholarship of others, and instructive case studies." (Guidelines for Faculty and Academic Appointments, DBS).

The Clinical Educator Track

The sine qua non for appointment in the CE track should be substantial sustained active participation in organized teaching programs, including the communication of clinical skills, and where the quality of that teaching can be documented and evaluated. Independent research is not required nor is it precluded. Participation and/or cooperation in clinical scholarship may be encouraged. Promotion in the CE track should be based primarily upon outstanding contributions to teaching. This means documentable and evaluable contributions to teaching that are more than a simple byproduct of the provision of clinical services by the appointee. This could include the design and organization of new courses, approaches and curricula; the dissemination of information through venues such as continuing medical education for a, visiting lectures, and grand round type presentations; and direct publication related to teaching and learning. Promotion to associate professor should require regional recognition and promotion to full professor national recognition as an educator and/or clinician.

Factors Which May Be Considered in Assessing Teaching Excellence

Scholarly Activities (factors which may be considered in assessing scholarship excellence)

- Evidence of scholarly activity that promotes the advancement of clinical medicine or medical education.

- Evidence of scholarly activity judged by the principle of peer evaluation and recognition, whether the products of the scholarly activity are papers, books or chapters, invited lectures, or some other mode of communicating results and ideas on clinical subjects.

- Evidence of excellence in the mentorship of trainees and colleagues.

- Significant editorial services to textbooks and/or journals.

- Recipient of competitive funding which supports clinical education activities.

- Presentations on clinical topics at local and regional, or national, meetings.

- Important collaborative role in clinical trials/clinical investigation or projects that influence development of new or more effective health care systems.

- Demonstration of scholarship through continuing development and dissemination of outstanding teaching materials, including new curricular offerings, educational programs, text books, syllabi, computer programs, or videotapes that make a unique contribution to the quality and method of teaching within the University medical community and beyond the local community.

Teaching (factors which may be considered in assessing teaching excellence)

- Continuing and outstanding contributions to the teaching of medical students, residents, fellows, or postgraduate students, documented from departmental records and course director's records.

- Recognition of high-quality teaching should be available from formal evaluations of peers and students and from teaching awards. Examples are: objective evaluations of excellence in teaching from trainees; availability to students and trainees; positive style of interaction with students; clarity of exposition; knowledge of material taught and communication skills; helpfulness in learning, and the ability to stimulate further education and learning.

- Evidence of sustained contribution to medical education, either through customary teaching situations (lectures and one-on-one instruction) or through the preparation of educational materials, including educational brochures and learning aids, videotapes, textbook chapters, and reviews.

- Teaching activities that include achievements such as developing and implementing novel teaching methodologies, or a new and innovative course, shaping a core curriculum, or creating educational software or video programs.

- Demonstration of excellence and successful direction and improvement of a training program within an academic unit.

- Excellence in the administration and organization of teaching programs and creativity in their execution.

- Excellence of teaching demonstrated by invitations to lecture at other medical centers within the region and by participation in courses at the local and regional levels.

- Excellence of participation in the organization and/or presentation of postgraduate courses.

Clinical Care (factors which may be considered in assessing clinical excellence)

- Board certification

- Excellence in patient care as documented by written evaluations from peers, referring physicians and assessment by U of C colleagues.

- Evidence, as documented by letters from professional colleagues, peers, referring physicians, consultations, etc., of attainment of local and regional (and sometimes national) recognition as superior clinician and clinical teacher.

- Excellence of procedural skills, if applicable.

- Ability to work effectively as part of the health care team.

- Excellence of clinical productivity.

- Outstanding communication skills with colleagues, staff, medical students, trainees, and patients.

- Excellence as a role model and mentor for students, residents, fellows and colleagues.

- Major contributor to the institution's clinical programs. For example: introduction and evaluation of innovative approaches for patient care; development of standards for patient care; leadership or reorganization of clinical services; improvements in quality of care; outcomes measurement; patient satisfaction; involvement in utilization management; state medical society or specialty society/ academy involvement. Contributions to be documented by relevant peers.

- Leadership role in local and regional clinical affairs and professional organizations.

- Development of a regional or national reputation as an authority in a clinical field as demonstrated by patient referrals, invited visiting lectureships, and elected membership in professional societies.

Other (factors which may be considered in assessing teaching excellence)

- Contributions to the school and/or University by work on committees and task forces.

- Public service activities that relate to the health of the general public.

Leadership Role

- Demonstration of leadership through active participation in prestigious professional societies, through other academic recognition or awards, and through playing important roles in the institution.

- Leadership roles in national or international clinical affairs and professional organizations

<u>Examples of Teaching Comments of Faculty by Housestaff</u>

Although I did not work with Dr. A I interacted with him on numerous occasions. He has always been fair and helpful; My clinical exposure is understandably limited. It is fair to say that his teaching style is overt, honest, and well articulated;

Excellent teacher. Enjoyable to work with; Extremely impatient with residents. Is unable to convey to residents priorities for large or complicated cases. He just yells about everything; He possesses the skills and knowledge to be the best teacher in this department. Too much of this is lost when you become intolerant and intimidate for less than perfect behavior. Patience and respect, when he uses them, makes him an extraordinary teacher; One of Dr. B's strengths is his explanation of choices in an anesthetic plan and his ability to explain a patients' cardiovascular physiology;

Excellent; Don't change. She is highly respectful, insightful, helpful; Dr. C clearly takes teaching seriously, and does so in an encouraging and unintimidating manner;

I would prefer a teaching style other than "pimping," which is what Dr. D primarily does. Good enthusiasm, though; Excellent; Does not stand

by the resident. Nothing more needs to be said; I admire his energy and veracity. His confidence is at times an asset, but it equally hurts his persuasive and educational potential, polarizing would-be-learners against his message in defense of perceived arrogance and intolerance;

Dr. E's calm manner is much appreciated in hectic OR settings; One of the best; Patience, skill, composure exemplified;

I hope she doesn't lose her passion for teaching, but that she strives to recognize when a lesson is taught with little intervention, and saves her intervention for special opportunities each day; Every resident can learn something from Dr. F's excellent organizational skills

Wonderful teacher - practical, takes the time- methods are not teamwork-oriented at times - puts down the resident first - then later takes it back; One of the best. Appropriately demanding and engaging; Dr. G excels in guiding residents on senior call. He is one of the few attendings that discuss operational issues of an operating room setting;

Don't ever leave teaching; The sense of security in the room when Dr. H is on the case is overwhelming. Nothing can go wrong; Dr. H is an example of the kind of attending that I would like to be: Kind, sensitive, prepared, and useful;

Motivation, dedication, and skill make him great in teaching. He should try to "streamline" his message: at times his teaching style is manic; Dr. I has a good attitude towards his work, and is a pleasure to work with;

Dr. J always finds a way to create learning experiences in the OR; Always excellent; A wonderful resource; One of the faculty members who should be required to always have residents;

Freaky encyclopedia knowledge; Can be his way or the highway; I liked the fact that Dr. K utilizes evidence to support his choices in anesthetic care;

Dr. L has a wealth of knowledge that is sometimes not well-received by residents because of his caustic demeanor;

Dr. M is a pleasure to work with because she takes care seriously and treats her residents with respect;

Dr. N gives residents an appropriate amount of autonomy;

He is a better academic anesthesiologist than many of our faculty. Methodical, knowledgeable, friendly… actively involved in teaching; Dr. O takes his teaching responsibilities seriously and discusses current topics in his subspecialty;

Adds a very humanistic aspect to the picture;

Excellent Dr. P has the confidence to allow me to work independently;

Excellent teacher. Dr. Q is great to work with; Excellent;

Dr. R is a role model for practice, career, and motivation;

Dr. S uses residents in her clinic, doesn't teach residents in her clinic. Very condescending;

Great teacher. Good physician; Dr. T is very premature in taking procedures from residents;

Things simply go well when Dr. U is my attending. She teaches efficiency and focus with natural ease;

Excellent! Dr. V needs to drink less coffee; One of the best; What an outstanding resource - knowledgeable, enthusiastic; Clearly an outstanding educator and role model; He teaches valuable lessons in the conduct of anesthesia. He should talk less – he has a lot to teach, but would do it better in deliberate language. (This does not mean he should stop talking - just teach one point at a time and construct his talk carefully - he is so eager, he often is teaching several things at once, and confusing his pupils);

One of the best; A joy - even when things are not going well; I hope Dr. W stays as he is. He is one of the most pleasant attendings to work with, and a masterful teacher;

Dr. X is one of the best; Great to work with; He is an asset and a pleasure to work with;

Dr. Y style suits senior residents well, and helps sharpen ideas and tendencies that lead to good patient care;

Always showing residents something new to learn or try; Dr. Z has successfully improved on her already excellent teaching skills by becoming a less-intrusive overseer, and a more effective mentor and manager;

Dr. 1 is a brilliant lecturer;

Clearly distracted. Dr. 2 is more interested in residents doing work for her than educating them;

Dr. 3 is an excellent teacher. Good to work with;

Young and enthusiastic. Dr. 4 enjoys teaching and obviously has the knowledge base to do it. A pleasure from start to finish; Always excellent. She goes out of her way to educate allowing residents a great deal of independence in appropriate settings. She is the most considerate attending in terms of work sharing;

My limited exposure to her teaching has been something to cherish; Sometimes seems extremely busy but extremely willing to teach. Dr. 5 is never above any job in patient care; One of a kind;

Dr. 6 is an excellent addition to our faculty;

Excellent coordinator. Extremely just. Extremely fair; Dr. 7 is fair when running the schedule board;

Dr. 8 backs up idiosyncrasies with reason;

Dr. 9 is the quintessential educator;

Dr. 10 does not foster a great deal of independence;

Dr. 11's criticism is rarely constructive and is often condescending and disproportionately negative;

Fun to work with, even if not always the greatest teacher. Dr. 12 allows residents extreme amounts of independence;

She is so oblivious to the pressures of time that my educational experience is marred by frustrations of patients, residents, and surgical team; Has trouble listening to presentations. Often will need information repeated; Very inefficient and slow in OR and clinic. It is absolutely inconsiderate to make clinic patients wait 3-4 hours.

Dr. 14 is a danger to patients - forces the resident to be the attending. This is not a good thing

Notes:

ASA Structure

Jane C.K. Fitch, M.D.

Objectives

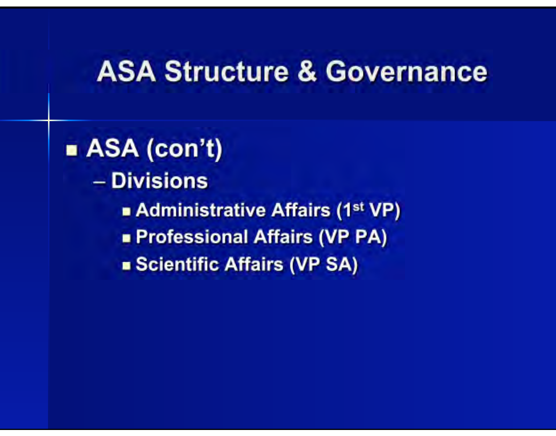
1. Audience will learn about the structure and governance of the ASA.
2. Audience will learn about how an individual SAAA member can affect ASA policy.
3. Audience will learn about SAAA representatives within ASA.

ASA Structure & Governance

Jane C.K. Fitch, MD
SAAA General Session 5
Saturday, November 5, 2001

ASA Structure & Governance

- ASA
  - House of Delegates
    - Reference Committees
  - Board of Directors
    - *Director & Alternate Director for Academic Anesthesiology*
    - Review Committees
      - Administrative Affairs
      - Professional Affairs
      - Scientific Affairs
      - Finance
  - Administrative Council
  - Executive Committee



ASA Structure & Governance

- ASA (con't)
  - Sections
    - Administration
    - Representation
    - Professional Standards
    - Professional Practice
    - Clinical Care
    - Subspecialties
    - Education and Research
    - Annual Meeting
    - Journals
    - Professional Education Oversight

ASA Structure & Governance

- ASA (con't)
  - Committees
    - *Academic Anesthesiology*
- Related Organizations
  - ASAPAC
  - Anesthesia Foundation
  - APSF
  - FAER
  - Wood Library-Museum
  - Anesthesia Quality Institute

ASA Structure & Governance

- ASA (con't)
  - Bylaws
  - Administrative Procedures
  - Offices
    - Park Ridge, IL
    - Washington, DC

Steven J. Barker, Ph.D., M.D.

Notes:

ASA

Board of Directors -- House of Delegates

PROGRESS REPORT

2011

Steven J. Barker, PhD, MD
ASA Director, Academics

ASA Board of Directors & House of Delegates

- Officers: 10 *(12 total)*
- States: 50
- D of C 1
- Puerto Rico 1
- Residents 1
- Military 1
- *Academic* 1

Total: 65

HOD has 359 voting members:
- *Directors*
- *Delegates from states*
- *Affiliates (APSF, FAER)*

ASA Committees of the Board *2012*

Administrative Affairs
- Steven J. Barker, Ph.D., M.D.
- Steven J. Hattamer, M.D.
- Joel Mumford, M.D.
- Chris Yeakel, M.D.
- Chris A. Kittle, M.D.

Finance
- Claude D. Brunson, M.D.
- Stephen P. Long, M.D.
- Jeffrey S. Plagenhoef, M.D.
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- Donald E. Arnold, M.D.

Professional Affairs
- Gerard T. Costello, M.D. 20
- Peter J. Dunbar, M.D. 21
- Jane C.K. Fitch, M.D. *
- Sheila J. Ellis, M.D. 23
- Donald Martin, M.D. 24
- (Alternate) Daniel J. Cole, MD

Scientific Affairs
- James M. West, M.D.
- John Wills, M.D.
- William H. Montgomery, M.D.
- P. Alex Skaff, MD
- Kenneth J. Tuman, MD

Deep Sedation

for non-anesthesiologists

- *Report:* Oct. 2011 HOD Handbook 411-2.2.
  - Committee on Quality Management & Dept Admin (QMDA).
- Committee wrote a "how-to-do-it" manual for procedural sedation, including "deep."

FROM: Committee on Quality Management and Departmental Administration 411-2.2
SUBJECT: Deep Sedation for Non-Anesthesiologists Education Program
DATE: August 21, 2011

1. EXECUTIVE OVERVIEW
A. Background

Under the revised December 2009 Centers for Medicare & Medicaid Services (CMS) Conditions of Participation, the anesthesia service and its physician Director were given ***responsibility and authority to provide oversight of all providers delivering all sedation/analgesia and anesthesia services anywhere in the facility***. This responsibility includes establishing criteria for granting privileges to providers across the entire range of anesthesia services, from topical/local anesthesia ***through moderate and deep sedation***. Procedural sedation is the fastest growing component of sedation services in all facilities, and to meet this new "market opportunity", various individuals and ***groups with varying knowledge have sprung up to "educate" non-anesthesia professionals to perform procedural sedation***.

So, we're going to teach them to 'do it right'?

"Deep Sedation for Amateurs"?

- Philosophy: *"They are going to do it anyway, so it is our responsibility to make them do it safely."* Good point, but…
- SJB Question: If you were an airline pilot, would you write a manual called "Flying the B-747, for Non-Pilots"?
- I don't have the answer, but I believe SAAA needs to weigh in on this debate.
- "Deep Sedation" ***is*** general anesthesia, without a protected airway.
- Ask Dr. Conrad Murray (Michael Jackson's MD).

Action by House of Delegates

October 19, 2011

- Vigorous debate on both sides.
- Report was "referred to a committee of the President's choice" by the full HOD.
- This means there were very mixed feelings, but not enough "no" to kill it. It will be back, perhaps in a modified form.
- There is an opportunity to change or stop this. *SAAA recommends?*

"Surgical Home"

- *Concept:* A "bundling" of entire perioperative experience -- pre-op evaluation to post-op care.
- *Opportunity (?):* Anesthesiology is the logical discipline to coordinate and lead this initiative.
- *Threat:* This sounds a lot like "bundling" and reminds me of DRG's. Does this bring "time-based billing" back onto the table???
- If so, how do we (again) defend the academics from the obvious problem?

From Last Year's SJB Report: Recent Developments on CRNA's and "Independent Practitioner"

- Number of "opt-out" states has gone from 8 to 15 in last four years! CA and CO have joined.
- New York Times – Editorial, 9/6/10:
  - "Two studies ...... essentially concluded that there is no significant difference in the quality of care when the anesthetic is delivered by a certified registered nurse anesthetist or by an anesthesiologist."

Well, there's new news....

New York Times

10/18/11

- **U.S. Moves to Cut Back Regulations on Hospitals**
- **By ROBERT PEAR**
- **Published: October 18, 2011**
- WASHINGTON — The Obama administration moved Tuesday to roll back numerous rules that apply to hospitals and other health care providers after concluding that the standards were obsolete or overly burdensome to the industry.
- Kathleen Sebelius, the secretary of health and human services, said the proposed changes, which would apply to more than 6,000 hospitals, would save providers nearly $1.1 billion a year without creating any "consequential risks for patients."
- Under the proposals, issued with a view to "impending physician shortages," it would be ***easier for hospitals to use "advanced practice nurse practitioners and physician assistants in lieu of higher-paid physicians."*** This change alone "could provide immediate savings to hospitals," the administration said.

They will be back!

Your ASA-PAC wins again!

- CMS was recently considering a new ruling that abolished all physician supervision requirements for *all* APRN's. That would include CRNA's – a U.S. "opt-out."
- ASA – BOD developed strategies; DC Office mobilized: "All hands on-deck!"
- CMS issued new regs last week: *Nothing* on MD supervision.
- Major victory for ASA-PAC!

One more reason to join and support the ASA-PAC!

Join now, at the "Chairman's Council" level

Ad Hoc Committee on Quality Practice Recognition

- Report 675-2.1: Recommends a new "ASA Seal of Quality" status.
- Would require a site visit to all O.R.'s.
- Cost to department > $10,000.
- "SQ matrix tool" subject to interpretation by site visitors.
- *RESULT*: Overwhelmingly voted DOWN by full HOD. *Watch out* – may come back.

SUMMARY

- We need to weigh in on "Deep Sedation."
- "Surgical Home": Opportunity or threat?
  - Lead, follow, or get out of way.
- ASA – PAC won another round at CMS.
  - Support our PAC, or?
  - There is *definitely* more coming on this!
- ASA "Seal of Quality"
  - Caution: Bad ideas keep coming back.
- Congrats to **Jane Fitch** – new First VP!

THE END

Thank You!

Notes:

American Society of Anesthesiologists

ASA Update
SAAA
Do we need to teach
the “unscientific” curriculum?

Jerry A. Cohen, M.D.
ASA President

November 5, 2011

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After the science, what else?

- Healthcare policy – emerging issues
- Healthcare regulatory issues – CMS IG’s, accreditation
- Emerging models of healthcare delivery
- Role of the anesthesiologist in coordination of care
- Medical staff/hospital political activities
- Contracting

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Why don’t residents learn this

- Clinical education is more important than political, regulatory and professional practice issues
- Time is limited enough for clinical training
- Insufficient faculty experts
- Its too political
- Consequence – residents may be poorly prepared to take part in controlling their future locally and nationally

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3 big areas – in some detail

- Healthcare finance reform
- Future models of anesthesiology practice
- Preserving Scope of practice and the economics of anesthesia extenders

- And mention of one – Joint Commission

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Healthcare reform driving forces

- Taxes are approaching 20% of GDP – may be the absolute maximum before growth slows
- Cost of supporting Medicare is unsustainable
- Medicare continues to grow limiting discretionary spending
- Illusion that physicians (12% of cost) can fix this by controlling outcome and utilization
- Shortfall of revenue versus expenses

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June 2009– get'er done

- One moment in time or narrow window of opportunity
- Public plan – much like Medicare on steroids & a false choice
- Threat to private insurance rather than reform
- Need for real insurance reform not a public plan bludgeon
- CBO: 1.5 gigabucks to cover 16 of 46 million Americans
- Pressure to cut services to avoid unsustainable costs
- No effective tort reform

What ASA advocated

- Healthcare coverage for all Americans
- Medicare/Medicaid pays true cost of care – not financed on the backs of healthcare providers
- Medical liability reform
- Incentives for quality improvement and prevention
- Repeal of Medicare payment formula
- Streamlined claims process with less administrative costs

What ASA advocated

private insurance reform

- Real competition among insurance companies
- Patient in control of their healthcare decisions
- Affordable coverage
- Portability
- Reduced denials or restrictions for pre-existing conditions
- Choice of plans across state lines

What ASA advocated

- Identified the so-called “non-discrimination” language as a potential problem for scope of practice
- Truth and transparency – defining who is a physician and
- Regulate scope of practice issues on the state level – including advocacy for pain therapy as a medical practice
- Careful analysis of alternative payment systems – ACOs

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- House passed the Senate bill (3590) as is, blocking further change – the Scott Brown out-maneuver
- Paired with reconciliation bill – merry Christmas
- HR 4872 sent to Senate March 21
- HR 4872 passes Senate March 25
- Signed by President March 30 to become Public Law Nº 111-152

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Post-reform watch list

- Proliferation of Medicare Payment rate model
- SGR fix is still not fixed – temporary fix until 21/31
- Medicare financing – still a Ponzi scheme
- PQRI still mandatory with 1.5-2% payment penalty
- Medicaid expanded (15M new covered lives) without adequate funding
- Scope of practice is still ill-defined
- Tort reform insufficient
- IPAB, Support for specialty education, HER/HIT

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FUTURE MODELS OF ANESTHESIOLOGY PRACTICE

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ACO's & other shared savings

- Notice of proposed rule making – April 1 – 465 pages
- ASA ACO task force met April 6 to review the NPRM
- TF sent comments to CMS in late April
- Multiple problems make it difficult for anesthesiologists to have a key role in ACOs
- ASAs role will be to comment on the NPRM and assist members in practices adopting the ACO model

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ACO NPRM Problems

- Very little applies to anesthesia practices; more for PCPs
- Will be hard for members not in well integrated groups
- The language is idealistic, the bureaucracy staggering and prescriptive
- Adding members to the ACO is difficult
- 16 grounds for termination
- Final rule may not be under CMS control – OMB inserted fiscal requirements it is not likely to remove

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ACO NPRM cont…

- Bright note: Non PCPs can participate in multiple ACOs
- Payment is withheld and returned according to compliance with quality measures (few for anesthesia)
- Very difficult for systems not already well integrated
- Upside and downside risk bearing choices are problematic; selecting the wrong one could be catastrophic
- Audits may occur at any time

ACO assessments:

- 10 large groups (Mayo, Geisinger) letter to Berwick – "As currently proposed, ACOs have a greater potential for incurring losses … than for generating savings. This risk-reward imbalance makes it difficult, if not impossible, for internal decision makers to accept the financial design."
- Gail Wilensky – "If you really thought this was going to be '**the**' major driver of change in health care — not '**a**' major driver of change in health care — people are saying, '**are you crazy**,' who would want to play this game?"

Shared savings alternatives

- CMS did not mandate ACOs –PPACA did
- CMS will accept other shared savings models
- Bundled payment models may become attractive and are a better basis for the perioperative home concept
- Perioperative home model expands and defines the role of anesthesiologists; places them in a key position in revenue generation, safety and efficiency
- More practical less complex hybrid healthcare collaboratives may develop on the state level

Defining boundaries: The Meaning and Preservation of Scope of Practice

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NURSE ANESTHESIA • SAFE ANESTHESIA

Which ones are the anesthesiologists and which are the nurse anesthetists?

CAN'T TELL?

It's *just as hard* to tell the difference between their anesthesia education, the way they administer anesthesia, and their safety records.

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Out of the mouths of babes

Originally Posted by **Mbrickle**

I just graduated from college and decided i'd like to be a nurse. It wasn't a sudden decision, but rather one that was thought out. **I also decided that i'd love to be a CRNA. The job, the pay, etc. I feel like i'd be just like a doctor, making a comparable amount to doctors, without all the schooling.** Granted I know there is alot involved in becoming a CRNA, however it isnt the gruelling 4 years of med school + all years of internship, residency, etc.

http://allnurses.com/pre-crna-inquiry/associates-degrees-nursing-142014.html

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A very sort timeline of SOP

- Scope of Practice has smoldered for decades
- BoNs have pushed for expanded scope
- Dulisse and Cromwell write in *Health Affairs*, "No harm Found when NAs work without supervision"
- Major defect of Dulisse – use of QZ modifier to show independence

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What does the data show

- Hospitals without physician anesthesia have:
  - 33% higher postoperative mortality rate
  - 16% higher inpatient postoperative complication rate
  - 14% higher failure to rescue rate
- A growing public health issue – similar to outcomes associated with lack of critical care
- Physicians drive anesthesia safety – presence of anesthesiologist prevents 6 excess deaths per 10,000 procedures

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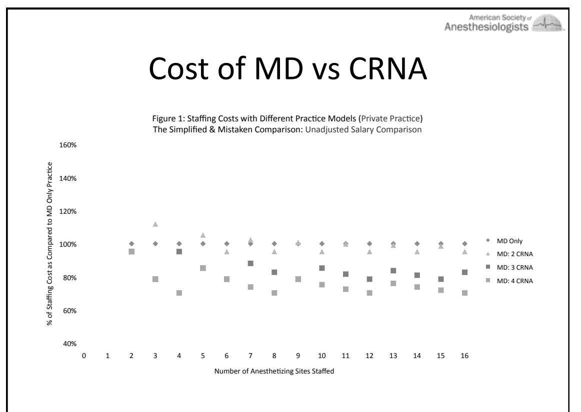
Cost of MD vs CRNA



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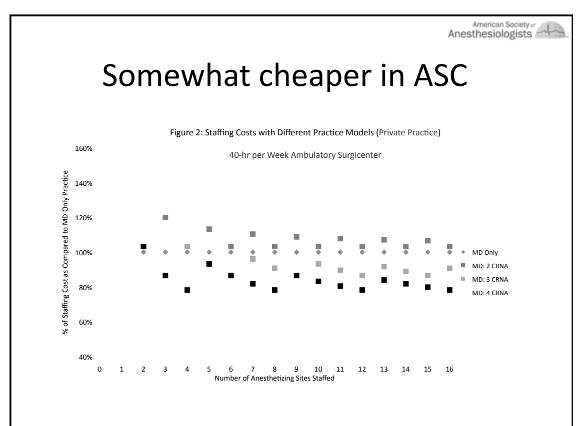
Somewhat cheaper in ASC



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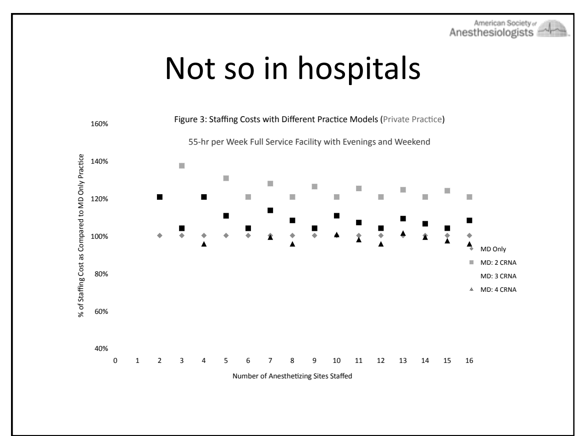
Not so in hospitals



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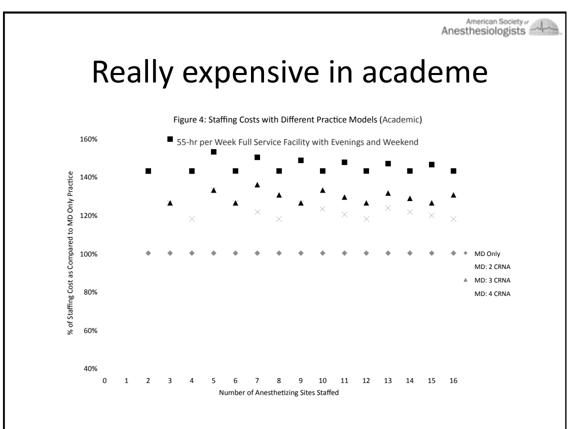
Really expensive in academe



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Public advocacy message

- Anesthesia is safe because we made/keep it safe
- To keep it safe, you need a physician involved
- Medicine is not nursing
- Nursing ed is not the same as medical ed – curriculum directed at different aims
- Premed is different than pre nursing
- Blurring the boundaries is counterproductive

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HEALTH POLICY
EDUCATIONAL OPPORTUNITIES

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ASA policy research rotation in political affairs

- ABA approved 4 weeks in ASA DC office
- CA 2 and 3 can apply
- Provides experience in political, legislative and regulatory factors that affect the delivery of patient care
- Emphasis on how healthcare policy affects anesthesiology practice
- Requires approval of Program Director

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Local action

- Develop a curriculum for heathcare policy and professionalism
- Get residents involved in your state component
- Nominate residents to ASA committees
- Provide time and support for attending meetings about healthcare policy and regulation
- Encourage research in healthcare policy, quality and coordination of care

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If your are not at the table

You are on the menu

Presentaion Material - *General Session 6: Updates*

Update from the ACGME
Thomas Nasca, M.D., M.A.C.P.

Anesthesiology RRC Update
Neal H. Cohen, M.D., M.P.H., M.S.

FAER Update
Denham S. Ward, M.D., Ph.D.

ABA Update
David L. Brown, M.D.

In-Training Exam Update
Cynthia A. Lien, M.D.

Update from the ACGME

Thomas Nasca, M.D., M.A.C.P.

Notes:

Anesthesiology RRC Update

Neal H. Cohen, M.D., M.P.H., M.S.

The RRC for Anesthesiology provides oversight of all anesthesiology training programs, incorporating ACGME policies and procedures with the program requirements for each of the core residency programs and subspecialty fellowship programs. In addition to providing regular review of all programs, the RRC addresses other issues related to program accreditation, duty hour requirements, and new approaches to education in order to ensure continuous quality improvement of its own processes and resident training. Dr. Cohen will report on the RRC's recent activity and, following Dr. Nasca's presentation, will provide perspective on how the next accreditation system will have a positive impact on anesthesiology training programs.

Participants will:

- Review the RRC's activity for the past year
- Recognize common areas of concern regarding interpretation of the specialty-specific and Common Program Requirements by the RRC
- Address questions to Dr. Cohen and the RRC staff to clarify RRC expectations and processes

Notes:

Notes:

THE AMERICAN BOARD OF ANESTHESIOLOGY

ANNUAL UPDATE

David L. Brown, M.D.
Secretary, ABA
November 6, 2011

ABA BOARD OF DIRECTORS

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Administrative Affairs:
Mary Post, M.B.A., C.A.E.
Professional Affairs:
David Chestnut, M.D.

COMMUNICATING WITH THE ABA

- Address all correspondence to the ABA Secretary
- Communications Service Center: (866) 999-7501
- **Email:** communications@theABA.org
- **Fax:** (866) 999-7503
- **Address:** 4208 Six Forks Rd, Suite 900, Raleigh, NC 27609-5735
- **Feedback via RTID** (Record of Training Information Database)

COMMUNICATING WITH THE ABA

- The ABA corresponds officially about training matters only with the Department Chair.
- When notified by the Chair, the ABA will correspond with the Program Director about training matters with a copy to the Department Chair.

HELP US HELP YOU

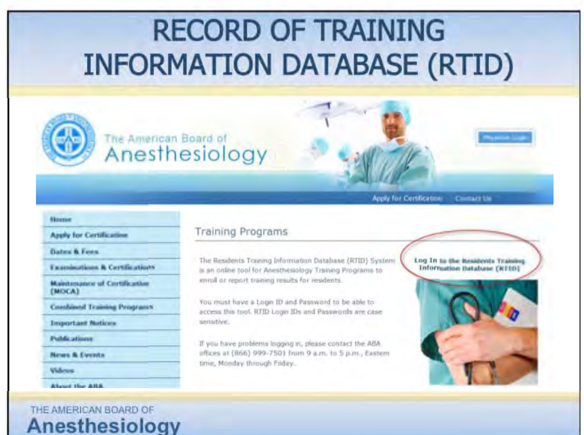
- **Timely completion** of Resident Enrollment forms every 6 months by January 31 and July 31
- **Assess and report** Clinical Competence every 6 months by January 31 and July 31
- **Thorough** performance assessment of resident's clinical competence; attestation of **7 Essential Attributes**
- **Assess** whether resident is capable of **performing independently** the entire scope of practice in the specialty or subspecialty without accommodation or with reasonable accommodation.

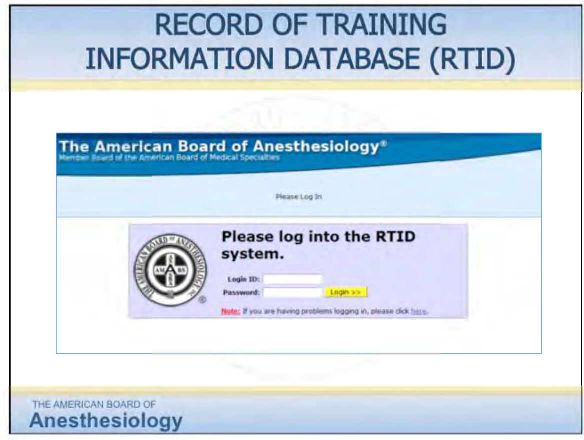
TIME-SENSITIVE COMMUNICATIONS

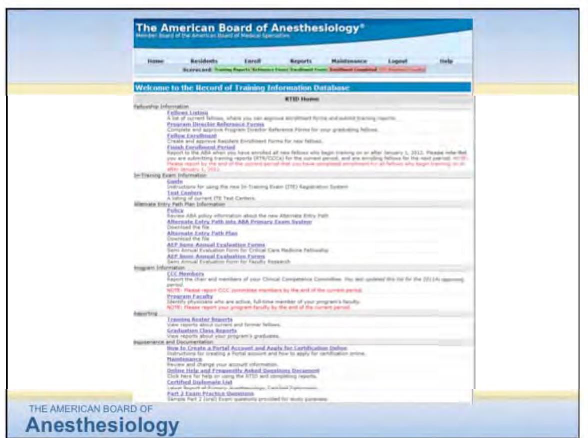
- Gap in Training
- Leave of Absence
- Requests that must be received 4 months in advance:
  - Training Away
  - Variation in Curriculum

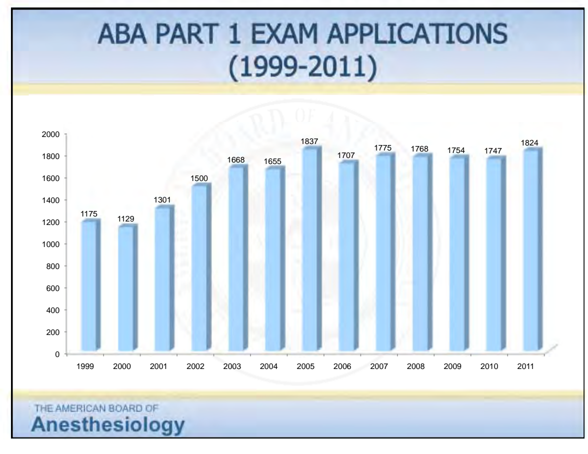
RECORD OF TRAINING INFORMATION DATABASE (RTID)

- RTID System is an online tool for Anesthesiology Training Programs to enroll or report training results for residents.
- RTID is point of reference for questions and information
- Log-in via the ABA website at www.theABA.org

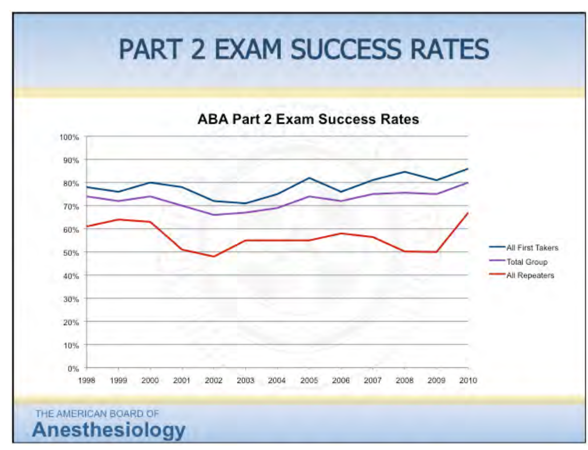




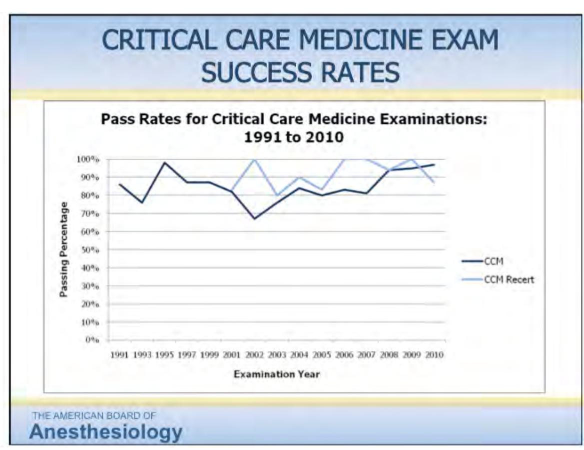




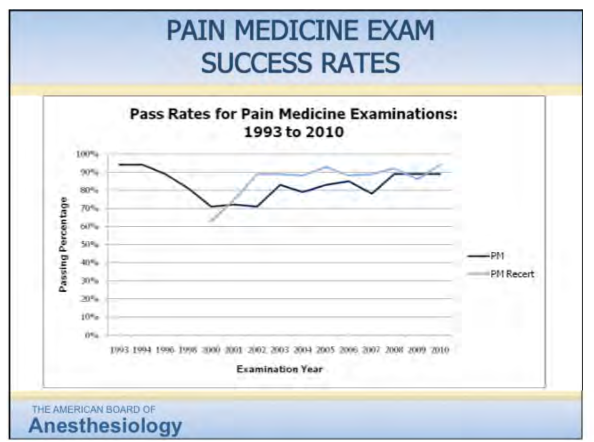
PART 2 EXAM SUCCESS RATES



CRITICAL CARE MEDICINE EXAM SUCCESS RATES



PAIN MEDICINE EXAM SUCCESS RATES



MAINTENANCE OF CERTIFICATION (MOCA)

- MOCA is the only option for recertification.
- All ABA certificates issued in or after the year 2000 are time-limited.
- MOCA program is the only option for ABA diplomates certified in or after 2000 to maintain their certification.
- Time-limited certificate holders are automatically enrolled in MOCA.
- For Non time-limited certificate holders participation in MOCA is voluntary.

MOCA REQUIREMENTS

- Part I - Professional Standing
- Part II - Lifelong Learning and Self-Assessment (LLSA)
  - Patient Safety Modules
  - ASA's ACE/SEE Programs
- Part III - Cognitive Examination
- Part IV - Practice Performance Assessment and Improvement (PPAI)
  - Simulation Course
  - Case Evaluation
    - Collect
    - Compare
    - Implement
    - Evaluate
  - Attestation
    - ABA verifies clinical activity

MOCA FOR SUBSPECIALTIES (MOCA-SUBS)

- For information about the ABA's MOCA-SUBS Program visit the ABA website at www.theABA.org

ABA INITIATIVES

- Pediatric Anesthesiology Subspecialty Certification
- Integrated Anesthesiology and Pain Medicine Training Program
- Combined Training in Internal Medicine and Anesthesiology
- Staged Part 1 Examinations

ABA INITIATIVES

- Curriculum development CA2-CA3 years
  - Leadership; PI; Practice Management; Safety
- Health system and hospital specialty alignment
  - Adding value focus
- ABMS relationship
- ACGME relationship

THANK YOU!

David L. Brown, M.D.
Secretary, ABA
November 6, 2011

Notes: