

# PREDICTIONS FOR HEALTHCARE IN A TRUMP ERA

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Healthcare has been *the* talking point for generations, but its presence has been even more pronounced since President Obama's election in 2008. Such discussions have revolved around passing comprehensive healthcare reform, passing the Affordable Care Act (ACA or "Obamacare"), repealing the ACA and replacing it with the American Health Care Act of 2017 (H.R. 1628) (AHCA) and failing to secure the votes to pass the AHCA in the House of Representatives. There have also been discussions regarding the future of healthcare enforcement, information technology security and transgender health protections. The common thread passing through each of these issues today is: what's next?

## DEFEAT OF THE AMERICAN HEALTHCARE ACT

When President Trump was elected, industry stakeholders predicted the ACA would be repealed and replaced (many predicting in the first 100 days of Presi-



dent Trump's administration). However, the House of Representatives Republicans were unable to pass their healthcare reform bill—the AHCA. In his remarks, Speaker Ryan said, "we will be living with Obamacare for the foreseeable future." While President Trump says he has not put healthcare completely to the side, he said he will focus on his next

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# ON CONGRESS, CARVEOUTS AND CRAFTING A RESILIENT PROFESSIONAL IDENTITY

Much has happened on the healthcare legislative front since our last issue of *Communiqué*, published not long after the presidential election. Notably, the American Health Care Act of 2017 (H.R. 1628) (AHCA)—the House bill that would have repealed and replaced key provisions of the Affordable Care Act (ACA)—was withdrawn after failing to receive sufficient support. Just days after the defeat, however, House Speaker Paul D. Ryan [signed new determination](#), indicating plans to pursue a “two-track” effort to change the healthcare system, with White House press secretary Sean Spicer stating “We’re at the beginning of a process.”

As this issue of *Communiqué* goes to press, we don’t know what that process will look like or how it will unfold. But in *Predictions for Healthcare in a Trump Era*, Neda Ryan, Esq. compliance counsel for ABC, offers thoughts on some of the healthcare issues that will continue to matter to anesthesia practitioners during the next few years, with an emphasis on compliance and information technology security.

In *Why Your Compliance Efforts May Be Worthless*, frequent contributor Mark F. Weiss, JD tackles compliance from another angle, namely, the legal difficulties anesthesiologists and other physicians can find themselves in if they make certain kinds of deals and arrangements believing they are protected from federal scrutiny. “Federal prosecutors are demonstrating their willingness to charge healthcare providers and other scheme participants with federal crimes related to underlying state law violations, including those in respect of state laws that have nothing in particular to do with healthcare fraud and abuse,” writes Weiss. “For a variety of reasons, not the least of which is that the federal government collects huge multiples in settlements and fines for every dollar put into investigating and prosecuting physicians

and others for healthcare-related crimes, physicians, other providers and facilities now have targets painted on their backs.”

Compliance headaches of all kinds, including the time and effort required to meet healthcare’s stringent and occasionally unfathomable regulatory requirements, are often cited as key contributors to physician burnout. But, as anesthesia providers know, compliance issues are only one of a constellation of factors that can leave physicians feeling empty and drained.

In her first article for *Communiqué*, organizational psychologist Brianna Barker Caza, PhD of the University of Manitoba contends that professional identity also plays a role, especially when that identity is idealized and reality doesn’t match expectations. The more idealized the image, the shakier the ability to bounce back from stress and the higher the burnout risk, argue Dr. Caza and co-author M. Teresa Cardador, PhD, MPH of the University of Illinois at Urbana-Champaign. Anesthesiologists can boost their resilience by cultivating a broader, more flexible professional identity that breaks free of the highly specialized and narrow sense of professional role and duties often wrought by medical training and socialization, they suggest.

While broadening their professional identities, anesthesiologists might consider exploring new ways to broaden their responsibilities in the hospitals they serve. One relatively untried possibility is leadership of the intensive care unit. As ABC Vice President Jody Locke, MA suggests, “In the current environment where the focus of payment reform is on bundled payment arrangements, it may be time to review what were once considered core competencies of anesthesiologists and reassess the strategic opportunity to enhance the scope of the relationship between the anesthesia practice and the facility.” The

goal of an anesthesiologist-led ICU is not to generate revenue, he asserts, but rather, for anesthesiologists to enhance the quality of critical care medicine and to position themselves favorably for the future of hospital contracting by applying their clinical skills in different ways to support their organizations’ strategic and financial goals.

Also in this issue, ABC Vice President Gregory Zinser provides a strategy to help anesthesiologists achieve their personal financial goals for retirement. The model he presents can be used to answer such key financial planning and retirement questions as “How long do I need to continue income-producing activities?” and “What average annual investment return is needed to cover all anticipated expenses between now and the end of life expectancy?”

Finally, we welcome back consultant Will Latham, MBA who probes the fundamentals of effective governance, including the differences between governance and management, the importance of delegating authority and determining when a supermajority vote is and is not warranted.

This year’s Advanced Institute for Anesthesia Practice Management in Las Vegas promises to enlighten participants with sessions on group practice strategy issues, compliance, billing, coding and more. We look forward to seeing many of you there.

With best wishes,

Tony Mira  
President and CEO



# BUILDING PROFESSIONAL RESILIENCE: STRATEGIES FOR ANESTHESIA PRACTITIONERS

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It is becoming all too common for physicians to report feeling overwhelmed by the demands of their jobs, and, at times, even emotionally, psychologically and physically depleted. In fact, occupational burnout, a syndrome characterized by emotional exhaustion, depersonalization and lack of personal accomplishment,<sup>1</sup> is hitting near-epidemic rates across the medical community.<sup>2</sup>

This is alarming on numerous levels. For instance, such feelings can contribute to increased turnover, absenteeism, medical errors and decreased patient and worker satisfaction.<sup>3,4</sup> In addition, the direct and indirect costs associated with physician occupational stress, including lost productivity, employee replacement costs, physical illness and psychological illness may even begin to threaten the financial viability of healthcare organizations.<sup>5</sup>

Stress and burnout have been linked to patient safety as well. It has been esti-



mated that the top 10 most common workplace stressors are responsible for at least 120,000 deaths and between \$125-190 billion in healthcare costs annually in the U.S. alone.<sup>6</sup>

## BURNOUT: WHEN, WHERE AND WHY

Distressingly, symptoms of burnout do not appear to be reserved for those

with job longevity, but rather, are starting to be noticed in early career medical professionals too, leading to a high potential for talent flight from hospitals. In fact, one study showed that approximately half of all residents showed signs of burnout.<sup>7</sup> In another study, 22 percent of anesthesiologists screened positive for depression and reported associated medical errors and less attention to patients.<sup>8</sup>

Physician burnout has been blamed on everything from aspects of the organizational structure (e.g., bureaucracy, changing productivity requirements, increased workload), to characteristics of the work itself (e.g., unforgiving hours, constant cognitive overload, lack of sleep) and even the emotional tenor of medical work (e.g., interprofessional conflict, high levels of unpredictability, consistent exposure to trauma).

In addition to these chronic, constant stressors, medical professionals are often exposed to sudden and acute instances of trauma and adversity that can take a toll. Medical workers feel a strong sense of responsibility for negative healthcare outcomes when they occur, regardless of whether their professional behavior was causative. Noting this, growing literature suggests that medical professionals often become “second victims” in acute, traumatic medical events involving their patients.<sup>9</sup>

<sup>1</sup> Maslach, C. (1982). *Burnout: The Cost of Caring*. Englewood Cliffs, NJ: Prentice Hall.

<sup>2</sup> Shanafelt T, Sloan J, Habermann T (2003). The well-being of physicians. *American Journal of Medicine*, 114, 513-59.

<sup>3</sup> Aiken, L. H., Clarke, S. P. and Sloane, D. M. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *Journal of the American Medical Association*, 288, 1987-1993

<sup>4</sup> Leiter M. P., Harvie P. and Frizzell C. (1998). The correspondence of patient satisfaction and nurse burnout. *Social Science and Medicine*, 47, 1611-1617.

<sup>5</sup> Morrell, K. (2005). Towards a typology of nursing turnover: the role of shocks in nurses' decisions to leave. *Journal of Advanced Nursing*, 49, 315-322.

<sup>6</sup> Goh, J., Pfeffer, J., and Zenios, S.A. (2014). Workplace practices and health outcomes: Focusing Health Policy on the Workplace. *Harvard University Working Paper Series*.

<sup>7</sup> Martini, S., Arfken, C. L., Chirchill, A. and Balon, R. (2004). Burnout comparison among residents in different medical specialties. *Academic Psychiatry*, 28, 240-242.

<sup>8</sup> de Oliveira Jr, G. S., Chang, R., Fitzgerald, P. C., Almeida, M. D., Castro-Alves, L. S., Ahmad, S., & McCarthy, R. J. (2013). The prevalence of burnout and depression and their association with adherence to safety and practice standards: a survey of United States anesthesiology trainees. *Anesthesia & Analgesia*, 117(1), 182-193.

<sup>9</sup> Dekker, S. (2013). *Second Victim: Error, Guilt, Trauma, and Resilience*. New York: CRC Press.





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priority: tax reform. So, with all of these shocking developments, many are left to wonder whether the ACA will, in fact, be comprehensively replaced. The answer: it is unlikely.

According to most Republicans, and as stated by President Trump, Obamacare “is imploding and soon will explode.” In the *Wall Street Journal*, Aetna’s CEO said the ACA was in a “death spiral.” As it stands, it is expected that insurance premiums will continue to increase and many of the larger insurance companies will pull out of the exchanges in 2018, thereby creating fewer healthcare coverage options for many Americans from which to choose.

Unfortunately, Congress is stuck in its own death spiral: the blame game over who will own the fate of the ACA. Republicans will continue to blame Democrats for passing the law seven years ago, while Democrats will blame Republicans for failing to come up with a viable alternative, all while knowing the law’s fate. What we do know is that this was a huge loss for Republicans and whether they will muster the courage (and votes) to propose another bill is yet to be seen.

### HEALTHCARE ENFORCEMENT

Healthcare enforcement has been on a steady and steep rise over the years, especially in light of the government’s expanded enforcement power under the ACA. In its most recent Semiannual Report to Congress, the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) sought to recover \$5.66 billion in investigative and audit receivables. This is \$2.31 billion more than was recovered in 2015. Some question whether President Trump’s recent hiring freeze and focus on enforcement elsewhere (think: immigra-



tion) will impact healthcare enforcement. The answer: it is unlikely.

Although on January 23, 2017 President Trump issued a memorandum instituting a hiring freeze, the impact of it on healthcare enforcement is debatable. The statement of the hiring freeze was immediately followed by numerous exceptions, including those positions deemed by the head of the executive department or agency as “necessary to meet...public safety responsibilities,” as well as “those exemptions [that] are otherwise necessary” as deemed by the director of the Office of Personnel Management. Moreover, the memorandum “does not prohibit making reallocations to meet the highest priority needs...” In other words, so long as the positions are deemed necessary and/or agencies reallocate their resources to meet their highest priority needs, this hiring freeze will have limited impact on various agencies, including those that enforce healthcare-related laws and regulations.

On the campaign trail, then-candidate Trump was vociferous about

his concerns with our current immigration system, vehemently expressing his desire to deport “bad hombres.” In fact, it was on this platform that he rose to such prominence and popularity in the early days of his campaign and, ultimately, won the election. Many question whether his public focus on our country’s immigration system will limit the Administration’s focus on healthcare enforcement. Although we expect to see a sharp spike in immigration-related enforcement, because of the great revenue generated by the OIG in recent years (and the rate at which such revenue generation has increased), the healthcare industry should expect the Trump Administration to continue the Obama Administration’s fervent enforcement of healthcare-related laws regulations.

Accordingly, anesthesiologists should continue to remain vigilant in their efforts to achieve, and remain, compliant with all laws and regulations affecting their practices, and to develop and improve their compliance plans furthering those efforts.

### INFORMATION TECHNOLOGY SECURITY

Hack. It has become the new buzzword in recent years. From repeated hacks of Yahoo’s and other companies’ email platforms and hacks during the 2016 presidential election to recent hacks of the CIA, one thing is clear: hacking is at an all-time high. And the healthcare industry is more exposed than ever.

Historically, healthcare entities have been most vulnerable for attacks because they have spent the least on IT security. Put bluntly, despite the Health Insurance Portability and Accountability Act of 1996 (HIPAA), IT security has not generally been a priority in the healthcare space. While hacking and IT security are



not matters of high priority to President Trump (though some may argue the jury is still out on that point), this is still an issue facing the Trump Administration. It is estimated that \$1 billion was extorted from individuals and companies through ransomware attacks in 2016 alone, with this number growing rapidly each year. Therefore, it is imperative that all healthcare providers, anesthesia providers included, at a minimum, take the following steps:

- Understand which laws and regulations affect their practices' information (e.g., HIPAA, state data privacy and security laws, etc.);
- Conduct a risk assessment; adopt and/or update existing policies and procedures addressing deficiencies found during the risk assessment that are consistent with current law, regulations and industry standards;
- Conduct penetration tests to determine the IT system's susceptibility to attacks;
- Regularly educate employees and staff regarding safe IT and email habits; and
- Ensure all anti-virus and malware software is up-to-date.

## TRANSGENDER HEALTH ISSUES

President Obama made it clear that transgender issues, including health issues, were an area of focus for his Administration, an area believed best to be addressed by the federal government. Through actions such as the joint guidance issued by the U.S. Departments of Education and Justice and Section 1557 of the ACA, the Obama Administration made known its position on transgender discrimination issues. The Trump Administration views these issues, and the role of the federal government in them, differently, stating, in part, that

these issues are best left for the states to address on a case-by-case basis.

In May 2016, the Departments of Education and Justice issued a joint statement directing public schools to permit students to use the bathrooms matching their gender identities (Joint Statement).<sup>1</sup> In response, 12 states filed suit and were granted an injunction, which prevented the federal government from taking adverse action against those schools that refused to follow the directives in the Joint Statement. President Obama's Justice Department appealed the injunction. In February 2017, the Trump Administration both rescinded the Joint Statement<sup>2</sup> and elected to withdraw the government's challenge to the injunction. While perceived as a victory for opponents of President Obama's actions, proponents of the effort saw this as a step backward in our nation's efforts toward equality for all people regardless of gender or gender identity.


When enacted, Section 1557 of the ACA made it impermissible for federally funded healthcare programs and activities to discriminate against patients and members of the public on the basis of race, color, national origin, sex, age or disability. In issuing its regulations in May 2016, the HHS Office of Civil Rights (OCR) defined "sex" to include gender identity and sex stereotyping. In other words, the regulations prohibit sex-specific services from being denied because an individual identifies with a gender other than their biological gender. The regulations also prohibit the "categorical exclusion" of health services related to gender transition.

On December 31, 2016, the U.S. District Court for the Northern District of Texas issued an opinion in *Franciscan Alliance, Inc., et al v. Burwell* enjoining

HHS from enforcing the portions of Section 1557 that prohibit discrimination on the basis of gender identity or termination of pregnancy. Although this opinion was issued during President Obama's presidency, even if it was appealed during President Obama's term, it would be likely that the Trump Administration would withdraw the government's defense of the action as it did in the case involving the Joint Statement.

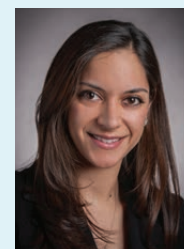
Though unlikely to change or encourage changing existing law that specifically affords certain gender and gender identity-related protections, it is clear that keeping in place Obama-era efforts is not a Trump Administration priority.

## CONCLUSION

Healthcare in 2017 continues to evolve aggressively, showing no signs of relief. In both politically charged and non-politically charged arenas, it is clear that healthcare will continue to be one of the government's focuses. Whether the political stakeholders can take action is yet to be seen. However, political disputes notwithstanding, anesthesiologists can best position themselves by keeping abreast of rapid changes as well as ensuring they are currently compliant and meeting the standards for best practices in both compliance and IT security. 

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<sup>1</sup> <https://www2.ed.gov/about/offices/list/ocr/letters/colleague-201605-title-ix-transgender.pdf>

<sup>2</sup> <http://www2.ed.gov/about/offices/list/ocr/letters/colleague-201702-title-ix.docx>



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In addition to these constant stressors derived from the nature and structure of the work, our own research has revealed a somewhat surprising culprit: meaningful work.<sup>10</sup> It is rare to see a medical or nursing student lacking passion for the medical profession. Typically, these students report a drive to do work that has a positive, often life-changing impact on others.

As a result of the high degree of meaning they subscribe to their work, medical professionals often become highly identified with it. Essentially, this means that they think of themselves as a medical professional first and foremost. While, generally speaking, this is seen as positive, and perhaps even a goal for medical organizations to be filled with highly invested and identified employees, it adds substantial pressure for the work to continue to be a source of positive meaning for these employees.

### THE BURDEN OF MEANINGFUL WORK

Unfortunately, while there are very positive aspects to medical work, and moments where individuals see their profound positive impact on others, there are also moments of devastation and uncertainty. The more identified individuals are with an idealized image of their profession, the more precarious their ability to understand and cope with the rough times.

Another example of how modern medical workers are feeling burdened by the weight of their meaningful and impactful professional identities is with the growing amount of professional moral distress being reported. One of



the authors' research with coauthors<sup>11</sup> found that physicians and nurses across a range of specialties reported struggling to determine the moral "rightness" of their day-to-day professional decisions. Moral questions of "right" and "wrong" are rarely clear-cut. But changes in the modern healthcare system have amplified the uncertainty.

For instance, in the neonatal intensive care unit (NICU), while medical technology has increased physicians' ability to sustain life, it has opened the door to questions regarding whether this is the "right" thing to do given the quality of life it is sustaining. Similarly, there is growing debate over physicians' responsibilities and duties in end-of-life care. Anesthesiologists often report struggling to determine how to honor patients' wishes when they may not necessarily be aligned with their own and/or their colleagues' medical judgements.

On a number of fronts, the moral grey area is expanding in healthcare. And the constant moral distress is having a substantial impact on the lives of healthcare practitioners at all levels. In fact,

the physicians and nurses in our study reported that their days were punctuated by moral disruptions—moments in which, during the course of caring for patients, they struggled to assess whether a specific professional action was aligned with a moral standard to which they ascribed.

### COMPETING PRESCRIPTIVE MORAL FRAMEWORKS

Moral disruptions come at a cognitive and emotional cost, one that modern physicians struggle to afford. Our findings indicate that both nurses and doctors often consider three different competing moral frameworks when trying to decipher "rightness."

- First, they strive to uphold the moral virtues, duties and principles central to their profession.
- Second, they may draw on organizational policies and guidelines to determine the best action.
- Third, they often find themselves responding to these moral disruptions not just as a physician or a hospital employee, but also as an individual who often has strong moral values.

Given these contrasting sets of moral guidelines, many physicians flounder. And though the disruptions may occur on a regular basis—weekly, daily or perhaps even multiple times a day—the moral distress caused by these disruptions can have significant implications.

### FEELING ENTRENCHED: IDENTITY RIGIDITY AND IDENTITY FLEXIBILITY

Our research suggests that both the high identity investment associated with meaningful work and the moral distress

<sup>10</sup> Cardador, M. T., & Caza, B. B. (2012). Relational and identity perspectives on healthy versus unhealthy pursuit of callings. *Journal of Career Assessment*, 20(3), 338-353.

<sup>11</sup> Caza, B.B., Vogus, T., Avgar, A., & Stansbury, J. (2015). Ethical dilemmas and identity work in the hospital. 2015 Annual Meeting of the Academy of Management, Vancouver, Canada. August 7-11, 2015.



inherent in the medical profession may pose particular challenges to physician well-being when individuals have work identity rigidity—an inability to consider other work identity possibilities and/or to initiate change or demonstrate plasticity in response to events and circumstances.<sup>12,13</sup> When medical professionals view their work as highly meaningful, yet lack identity flexibility, they are less able to respond adaptively when work fails to meet their expectations and/or when they experience challenges and stressors in the work environment.

For example, if a nurse with a rigid professional identity experiences a moral disruption in the course of their work—perhaps from performing a “necessary evil,”<sup>14</sup> such as causing a patient significant distress in the process of administering a potentially life-saving diagnostic test—they may be more likely to experience causing patient distress as a role identity violation, and, thus, more likely to experience this even as stressful and potentially traumatizing.

In contrast, identity flexibility aids in an adaptive response, because the greater the flexibility, the smaller the proportion of the self that is affected when a negative event occurs.<sup>15</sup> This minimizes the perceived role violation. Further, when an individual is flexible in their identity orientation, and subscribes to a broader professional identity orientation, such as one of a medical professional, they



are likely to be better able to understand contrasting perspectives on an issue and feel more comfortable with the ambivalence that it creates. Identity flexibility allows individuals to “bounce back” from challenges, and even to experience growth from such setbacks.<sup>16</sup>

Despite exposure to stressors and adversities, a good portion of the physician population still does not succumb to burnout. This variance in professional well-being despite similar exposure to adversities suggests that some individuals are more effective in dealing with these demands in ways that do not reduce their professional well-being. In fact, growing research suggests that some may even thrive amid extremely high levels of adversity in the workplace.<sup>17,18,19</sup>

In psychology, resilience is thought of generally as individuals’ ability to bounce back after experiencing serious life stressors. Resilience indicates that someone is “doing well” developmentally despite exposure to setbacks. Thus, *resilience at work* is demonstrated when individuals show competence and perhaps even increased capabilities in the context of adverse experiences at work, feeling able to handle future adversities.<sup>20</sup> Given the critical difference in outcomes between a physician succumbing to burnout and one demonstrating resilience, an important question facing researchers and healthcare managers alike is: what influences levels of professional well-being in complex and turbulent healthcare environments?

## RESILIENCE-BUILDING STRATEGIES

Research in organizational behavior has begun to identify a number of possible interventions to boost resilience at work. This includes aspects of the organizational environment, such as social support, organizational mindfulness practices and adverse event debriefing protocols. Additionally, psychological research has demonstrated the impor-

<sup>12</sup> Cardador & Caza (2012).

<sup>13</sup> Grotevant, H. D., Thorbecke, W., & Meyer, M. L. (1982). An extension of Marcia’s identity status interview into interpersonal domain. *Journal of Youth and Adolescence*, 11, 33–47.

<sup>14</sup> Margolis, J. D., & Molinsky, A. (2008). Navigating the bind of necessary evils: Psychological engagement and the production of interpersonally sensitive behavior. *Academy of Management Journal*, 51(5), 847–872.

<sup>15</sup> Linville, P. W. (1987). Self-complexity as a cognitive buffer against stress-related illness and depression. *Journal of Personality and Social Psychology*, 52, 663–676.

<sup>16</sup> Caza, B. and Wilson, M. G. (2009). Me, myself, and I: The benefits of multiple work identities. In Roberts, L. M. and Dutton, J. E. (Eds), *Positive identities and organizations*. NY: Psychology Press.

<sup>17</sup> Caza, B. & Bagozzi, R. (2017). Working through adversity: The effects of professional identity on emotional exhaustion and resilience. *Working paper series*.

<sup>18</sup> Sutcliffe, K. M. and Vogus, T. J. (2003). Organizing for resilience. In Cameron, K. S., Dutton, J.E. and Quinn R. E. (Eds), *Positive Organizational Scholarship*. Oakland, CA: Berrett Kohler, 94–110.

<sup>19</sup> Weick, K. E. and Sutcliffe, K. M. (2007). *Managing the Unexpected: Resilient Performance in an Age of Uncertainty*. San Francisco, CA: Jossey-Bass.

<sup>20</sup> Caza, B. and Milton, L. (2011). Resilience at work. In Cameron, K. and Spreitzer, G. (Eds), *Handbook of Positive Organizational Scholarship*. Oxford: Oxford University Press (Sage Publications), 808–908.

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tance of psychological fitness, personality traits and self-care practices. While all of these undoubtedly play important roles in helping individuals to minimize the negative impact of work adversity on health and performance, we draw on the concept of identity flexibility to offer another prospective, individual-level resource that can be cultivated in health-care organizations: healthy professional identification.

An individual's professional identity is a cognitive schema that provides individuals with affective, psychological and behavioral resources that they can draw on in times of uncertainty and stress at work. Specifically, drawing on our own and others' research into the dynamics of resilience at work, we propose three ways that medical professionals and practice managers can leverage healthy professional identification to increase resilience at work.

- First, medical training programs, healthcare organizations and practice managers should pay attention to and invest resources in helping medical professionals develop a healthy identification with their work. The internalization of the norms and expectations of one's profession become the standards they attempt to achieve and uphold on a day-in, day-out basis when working. Medical educators, mentors and practice managers should find ways to help young medical professionals form strong but complex and agile work identities that can provide both affective and instrumental support during periods of work stressors and work adversity.



Group discussions with peers and role models, as well as role playing exercises, might serve to foster healthy professional identities. Specifically, we suggest that these programs help medical professionals to create flexible identity orientations that emphasize growth and learning. When we feel threatened, our psychological tendency is often to retreat and entrench in positions that feel comfortable. Medical professionals need to learn ways of combatting this tendency and becoming more agile.

- Second, organizational leaders should encourage medical professionals to broaden their base for identification. Often, the result of the medical socialization process is a highly specialized and narrow

sense of one's professional self, role and duties. This may be limiting in the dynamic modern health-care environment. Instead, it may be more adaptive for individuals to identify with the nature and meaning of medicine on a more general, broader level. This may be facilitated by encouraging medical professionals to take on additional roles or responsibilities.

Ironically, adding a layer onto one's professional identity may actually buffer them from the adversity inherent in their work. Specifically, having a broader sense of one's self in a professional capacity enables identity flexibility. Such flexibility in how one views their professional capabilities is linked to an ability to respond more effectively to different and changing circumstances and roles, and to experience violations of role expectations.<sup>21</sup>

Broadening one's base for identification may be accomplished through strategies such as job rotation (e.g., giving medical professionals a chance to rotate through different jobs or departments in the organization), interdepartmental or interprofessional team building and project-based work teams. Such practices may help medical professionals break free from a specialized and soiled mentality, and allow them to identify with other professionals and broader aspects of the medical role. Further, these practices might allow individuals to capitalize on a

<sup>21</sup> Cardador and Caza (2012).





broader base for social support because they can identify with other medical professionals and the medical community more generally, rather than only with a specific subgroup. This broader base of identification may foster more positive interprofessional relationships and expand healthcare providers' access to relational resources, both of which should foster resilience.<sup>22</sup>


- Third, medical training institutions and practice managers should create an open forum to discuss the growing burden of moral uncertainty, which poses a threat to positive professional identification. Medical professionals should be introduced to the nature of the moral distress they are likely to experience early on in their training. Further, they should be encouraged to craft their own *professional moral identities*, a personalized professional moral code, that will help guide their experiences with and responses to moral distress. They should consider professional standards, organizational policies and personal beliefs in creating this document. By thinking through where these standards converge, as well as where they diverge, medical professionals will be able to identify the types of situations and practices in which they do and do not feel comfortable being involved.

These strategies promote greater professional identity flexibility by helping

medical professionals to clarify and develop more informed expectations about work processes and outcomes, and to deal with unmet expectations. When individuals are better prepared to manage expectations, they are less likely to become stressed by events and actions that challenge expectations<sup>23</sup> or to become disillusioned with organizations that they perceive to be failing their ideals.<sup>24</sup> It is important to note, however, that this does not mean giving up on ideals, but rather adopting a growth mindset whereby expectations are positioned as opportunities for personal and organizational learning, growth and development.<sup>25</sup> In other words, the unexpected moral grey areas become conduits for further understanding and developing one's professional moral standards.

## CONCLUSION

If healthcare professionals' feelings of exhaustion and reduced personal accomplishment can be decreased, and their perceived resilience can be increased, they can perform and thrive amid the inevitable and growing stress of doing highly important and meaningful work in a dynamic and unpredictable work environment. Resilience is now seen as essential for success at all levels of the healthcare organization.<sup>26</sup> Resilient medical professionals face the same adversities as their non-resilient colleagues, but they are able to regain their equilibrium faster, maintain a higher standard of work and sustain a higher level of well-being. This is what we, the medical community at large, and practice managers in particular, should be striving to facilitate. The

identity-based strategies we have outlined will help individuals build the psychological and social resources they need to become resilient. 

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# WHY YOUR COMPLIANCE EFFORTS MAY BE WORTHLESS

Mark F. Weiss, JD

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It's a riddle almost as inscrutable as that of the Sphinx: How can a physician or pharmacist or facility owner be convicted of a federal crime for violating a state law? The answer is, unfortunately, quite simple, quite questionable and quite dangerous. It turns what many think about federal healthcare law compliance on its head.

It signals that many compliance efforts and, probably, most attempts to skirt the bounds of federal law, have been in vain, and must immediately be reinvestigated, re-planned and, in many cases, retired.

## CONTEXT

To put things into context, let's use the concept of a kickback and the federal Anti-Kickback Statute (AKS) to frame the discussion.

In everyday terms, the AKS prohibits the offer, solicitation, payment or acceptance of remuneration—that is, the transfer of anything of value—for referrals of federal healthcare program patients. The affected programs include Medicare, Medicaid, TRICARE and about a dozen others.

The AKS is a criminal statute. Violation can lead to fines and prison time. Physicians and hospital administrators are serving time in federal penitentiaries right now for their violation of the AKS.

## CARVEOUTS

Many physicians, healthcare business owners and facilities have turned to what they think is a solution: the so-called “carveout” to avoid federal scrutiny. In large part, that's because they saw their state's law, and sometimes their state's

enforcement of state law, as either permissive or lacking in “teeth.”

As a result, they have structured deals in which no federal healthcare program patients are treated or served.

For example, anesthesiologists practicing as chronic pain management specialists in states that permit physicians to own interests in retail pharmacies are often approached by pharmacists to do rather interesting pharmacy deals.

They'll propose that the physician become one of the owners of a pharmacy that will fill prescriptions only for commercially insured patients; that is, only for those who are not participants in any federal healthcare program.

They believe that any issue of remuneration to referral sources (that is, inside of the relationship between the pharmacy and the physician), is outside of federal scrutiny.

Or, as a second type of arrangement, they structure deals in which all sorts of patients are treated but in which payments that might be challenged as remuneration in violation of the AKS are limited to being in respect of nonfederal healthcare program patients only.

For example, consider a deal in which an ambulatory surgery center (ASC) charges the anesthesiologists or nurse anesthetists practicing at the facility a management fee only in connection with commercially insured patients.

Note, as an aside, that this sort of carveout has never been viewed as valid by the Inspector General, as the management fee paid on the commercial part of the anesthesia providers' practice induces not only the referral by the ASC of those patients, but of the federal healthcare program patients (e.g., Medicare patients) as well. However, those planning these



sorts of deals generally have turned a blind eye to that fact.

## CARVEOUTS CARVED OUT

Despite these planning “best practices” (yes, that’s meant to be tongue-in-cheek), federal prosecutors are demonstrating their willingness to charge healthcare providers and other scheme participants with federal crimes related to underlying state law violations, including those implicating state laws that have nothing in particular to do with healthcare fraud and abuse.

For instance, in a current case in the Northern District of Texas (*United States v. Beauchamp, et al*) prosecutors obtained an indictment under 18 U.S. Code § 1952 – Interstate and foreign travel or transportation in aid of racketeering enterprises—commonly known as the Travel Act, a law that can be used to “federalize” underlying state law violations.

The *Beauchamp* case is the second federal court prosecution related to a now defunct chain of physician-owned hospitals in Texas known as “Forest Park.” Among other things, the prosecutors in this ongoing case allege the payment of approximately \$40 million in kickbacks to physicians, including at least one anesthesiologist, consultants and others in connection with a half-billion dollars of kickback-tainted claims.

The Forest Park founders established the hospitals as both out-of-network facilities and, as a result of their physician ownership, non-Medicare facilities. In fact, their model was not to treat any federal healthcare program patients. Nonetheless, the membrane blocking patients from the plethora of federal healthcare programs turned out to be merely semi-permeable, and Tricare patients leaked in.

In pertinent part, the Travel Act makes it a crime to use the mail or any facility in interstate commerce (e.g., email, the phone) with the intent to



further any “unlawful activity.” As defined in the Travel Act, unlawful activity includes, among other things, bribery in violation of the laws of the State in which it is committed.

In the *Beauchamp* case, Texas’s broad commercial bribery statute was the hook into the Travel Act allegation.

That Texas law defines a number of professionals (including physicians, attorneys and corporate officers, among others) as “fiduciaries” owing duties to their “beneficiary,” the person or entity on behalf of whom they are acting. In lay terms applicable to the indicted physicians, the law makes it a felony for a physician to accept any benefit from a third party pursuant to an understanding that it will influence the physician’s conduct in relation to his or her patients.


Depending on how a particular state law defines bribery, conduct in a carved out healthcare deal can (and did in *Beauchamp*) trigger federal prosecution under the Travel Act.

## THE BOTTOM LINE FOR YOU

For a variety of reasons, not the least of which is that the federal government collects huge multiples in settlements and fines for every dollar put into investigating and prosecuting physicians and others

for healthcare-related crimes, physicians, other providers and facilities now have targets painted on their backs.

Deal planning, deal vetting and ongoing compliance efforts that consider only federal healthcare laws, or only federal *and* state healthcare laws, are no longer sufficient.

Getting paid and staying out of jail now requires careful scrutiny of conduct against a filter of a wide range of federal and state laws that transcend application to any one industry, from statutes relating to commercial bribery, wire and mail fraud, to, as mentioned above, the Travel Act. 

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# EFFECTIVE GOVERNANCE: WHO DECIDES WHAT?

**Will Latham, MBA**

*President, Latham Consulting Group, Inc., Chattanooga, TN*

Over the years, you may have heard the old saying that “Nothing happens until someone sells something.” With regard to anesthesia groups, we have found that “Nothing (good) happens until the group has effective governance.”

Without effective governance:

- The group lacks the ability to develop and focus on a vision. Unanimity is required in every decision.
- Issues are discussed *ad nauseam*.
- There is an over-emphasis on protecting the rights of every individual.
- Responsibility is given, but without the needed authority to carry out the responsibility.
- There is confusion over the difference between governance and management.
- Only unimportant issues are resolved, and the group spends little (if any) time focusing on issues of strategic importance.

## MODES OF MEDICAL GROUP GOVERNANCE

One of the more important aspects of effective medical group governance is determining who has the authority to make decisions about various issues.

We have found that a medical group's system of governance can be categorized by one of seven modes (see Exhibit 1). Each of these modes has positives and negatives, but many groups are finding that it is counter-productive to include all shareholders in all decisions.

A group may miss capitalizing on important opportunities or avoiding



significant threats because of the challenges of getting everyone together to work through an issue. Or, the group might be of such a size that it is no longer feasible to expect all shareholders to become sufficiently knowledgeable about all of the issues to make well-informed decisions.

## DELEGATING AUTHORITY

Whatever the reason, the most effective anesthesia groups find that it makes sense to empower a subset of the group to make certain decisions for the entire group. Depending on your corporate structure, this subset might be called the “board,” the “executive committee” or the “management committee.” (We will use the term “board” in this article.) The board is often assigned a number of governance responsibilities, but is often not provided the needed level of authority to carry out those responsibilities.

Every group has to choose the level of authority it will extend to the board. Exhibit 2 provides a checklist of issues that: 1) might be reserved for the

shareholders, or 2) can be decided by the board, president or manager without coming back to the next higher level for approval.

## SUPERMAJORITY ISSUES

Many groups require supermajority votes on certain (sometimes all!) issues shown in Exhibit 2. Supermajority votes could require a vote of two-thirds or three-fourths of the shareholders (although we have seen supermajority thresholds as low as 60 percent and as high as 100 percent).

What is often not recognized is that supermajority votes tend to protect the individual rather than the group. Accordingly, many groups are stymied in moving forward even when a significant majority of the group wants to pursue a given initiative.

Our belief is that supermajority votes have their place, but that: 1) they should be limited to a small set of extremely important issues; and 2) the supermajority threshold should be fairly low (two-thirds rather than three-fourths).

Which issues might require a supermajority? Typically, they include:

- Amending the shareholders' (buy/sell) agreement.
- Amending the shareholders' employment agreement.
- Amending the group's bylaws.
- Decision to sell the entity and/or the assets of the entity.
- Decision to dissolve the entity.
- Decision to merge the entity with another entity or any other business.
- Discharging a shareholder physician.



### Exhibit 1 — Modes of Medical Group Governance

	<b>Mode 1</b>	<b>Mode 2</b>	<b>Mode 3</b>	<b>Mode 4</b>	<b>Mode 5</b>	<b>Mode 6</b>	<b>Mode 7</b>
Stage Name	<b>Chaos/ Dictatorship</b>	<b>Unanimity</b>	<b>Full Democracy</b>	<b>"Advisory" Board</b>	<b>"Weak" Board</b>	<b>Board</b>	<b>"Strong" Board</b>
Description	Actually not a stage of "governance" but a way many groups operate.  Groups in "chaos" don't know how they make decisions, or do their best to avoid working together. "Avoidance" is the key word.  In "dictatorships" group members allow someone to make essentially all decisions.	All shareholders participate in all group decisions. Group does not act until it reaches unanimity (they may say "consensus" but really mean unanimity).  Unanimity is actually a dictatorship — it's just a different dictator on every issue!	All shareholders participate in all group decisions.  Shareholders vote on all issues.  Hopefully, all agree to support group decisions.	Group forms a board and lets it handle insignificant issues. Board "pre-processes" most issues for consideration by shareholders.  All shareholders participate in all group decisions.  Shareholders vote on all issues.  Hopefully, all agree to support group decisions.	Group forms a board and gives it specific and <u>limited</u> powers.  "The board can decide the following specific issues..."  Shareholders vote on all <u>significant</u> decisions.  Hopefully, all agree to support group decisions whether made by board or shareholders.	Group forms board and gives it broad powers with a few exceptions where shareholder votes are needed (e.g., group mergers, firing owners, making physician shareholders).  "The board can decide everything except..."  Hopefully, all agree to support group decisions whether made by board or shareholders.	Shareholders elect board members.  Board members empowered to make all decisions for the group.  "The board can decide everything."  Hopefully, all agree to support board decisions.
Shareholder's Role	Essentially none.	Every shareholder is a potential dictator.	Has a vote on all issues.	Has a vote on all issues.	Elect board members.  Typically votes on any issue that is close to being significant.	Elect board members.  Votes on identified issues.	Elect board members.
Variations				Board is sometimes asked to make recommendations. In other groups, boards are expected to provide objective pros and cons of each issue without providing a recommendation.		Issues decided by board require supermajority to overturn.	Board may include outsiders (rare).

Other important and controversial issues might affect shareholders' lifestyle, such as changes in the compensation system, adding or deleting a site of service or making a physician a shareholder that could be considered for supermajority status. Every group needs to decide which issues should be supermajority issues, but in general, we believe the fewer issues, the better.

### GOVERNANCE VERSUS MANAGEMENT

As a board tries to do its work, it's often tempted to move from "governance/

oversight" to micromanagement of the organization. The best way to avoid this is to focus the board on setting policy rather than on making decisions.

A policy is a statement that guides and constrains the subsequent decision-making. The goal of setting policy is to *specify the ends rather than the means*.

In setting policy, the board should *identify what is to be accomplished and determine a range of acceptable and unacceptable means for achieving these objectives*. This could include a set of directives for how the group will operate in the future, or instructions to management.

To help the board avoid micromanagement, it's often helpful to remind them that they don't have to (and shouldn't) make each and every decision. The board has options, which include:

- Requesting proposals and recommendations from management (or a committee) prior to making a decision. Example: "We need to avoid problem X. Management: develop a set of alternative methods to achieve this end."

*Continued on page 14*



## EFFECTIVE GOVERNANCE: WHO DECIDES WHAT?

Continued from page 13

### Exhibit 2 — Decision-Making Grid

Who should approve what? Supermajority should be \_\_\_\_%

	Shareholders	Board	President	Manager	Supermajority?
<b>GOVERNANCE APPOINTMENTS:</b>					
Selection/election/replacement of board members.					
Designation of executive committee.					
Election of officers.					
Committee appointments.					
<b>PHYSICIAN CONTRACTS:</b>					
Amend buy/sell (shareholder) agreement.					
Amend shareholder employment agreements.					
Amend associate employment agreements.					
Change physician compensation system.					
Amend the by-laws.					
<b>OVERALL STRATEGY:</b>					
Approve strategic/long-range plan.					
Decision to sell the entity and/or the assets of the entity.					
Decision to dissolve the entity.					
Decision to merge the entity with another entity or any other business.					
Adding or deleting a site of service.					
<b>PHYSICIAN MANAGEMENT:</b>					
Changes in physician fringe benefits, including retirement plans.					
Physician scheduling – office.					
Physician scheduling – call structure.					
Approve new shareholder-track physician positions.					
Hiring a particular employed, shareholder-track physician.					
Approve new employed physician positions.					
Hiring a particular employed physician.					
Approve a physician extender position.					
Hiring a particular physician extender.					
Evaluate performance of physicians.					
Evaluate performance of physician extender.					
Discharging a shareholder physician.					
Discharging an employed shareholder-track physician.					
Discharging an employed physician.					
Discharging a physician extender.					
<b>MANAGEMENT:</b>					
Hiring of manager.					
Evaluate performance of manager.					
Firing of manager.					
Hiring of new legal and/or accounting representation.					
<b>OPERATIONS:</b>					
Approving new non-physician positions.					
Hiring/firing all staff.					
Oversight of administrative/management personnel.					
Approval of staff policies and procedures.					
Approval of staff job descriptions.					





## Exhibit 2 — Decision-Making Grid

Who should approve what? Supermajority should be \_\_\_\_%

	Shareholders	Board	President	Manager	Supermajority?
Approval of staff wage scale.					
Evaluate staff performance.					
Approval of marketing plan and budget.					
<b>FINANCIAL:</b>					
Approval of budgets – operating and capital.					
Monitoring of budget.					
Non-budgeted capital expenditures to \$_____ or less.					
Non-budgeted capital expenditures \$_____ to \$_____.					
Non-budgeted capital expenditures \$_____ or more.					
Enter into contractual agreements such as leases.					
Approve debt requiring personal guarantees.					
Approve corporate debt up to \$_____.					
Approve corporate debt over \$_____.					
Approved managed care contracts.					
<b>OTHER:</b>					

- Delegating decision-making authority with constraints. Example: “We need to avoid problem X. Management: develop a set of alternative methods to achieve this end, but it must cost less than \$50,000.”
- Delegating decisions with exceptions. Example: “We need to avoid problem X. Management: develop a set of alternative methods to achieve this end, but it must be a process solution rather than a technology solution.”
- Retaining authority and making decisions itself.


The most effective boards always think: “Is this something that management should decide once we’ve provided guidelines?” The best boards spend most of their time setting policy and then delegating responsibility to others to carry out tasks rather than trying to do everything themselves.

### KEY QUESTIONS FOR THE BOARD

The following is a checklist of questions that the board should ask as it processes individual issues.

1. Has this issue been processed yet by a committee?

2. Is this issue strategic or operational/tactical?
3. Is this issue related to one of the key responsibilities of governance?
  - a. Set mission, vision and values
  - b. Move group toward strategic goals
  - c. Oversight
  - d. Deal with disruptive physicians
  - e. Evaluate management
  - f. Evaluate board performance
  - g. Over-communicate with constituents
4. Is this within the board’s authority to decide?
5. Is this something that management should decide on once we’ve provided guidelines, constraints, exceptions?
6. When the decision is being made:
  - a. What is the board’s expectation with regard to timing?
  - b. Does management have sufficient resources to meet those expectations?
7. Periodically – Do the board’s priorities and management’s priorities match?

Careful thought in assigning responsibility and authority for various types of decisions will help your organization develop the structure it needs to function more efficiently and effectively. 

**Will Latham, MBA** is President of Latham Consulting Group, Inc., which helps medical group physicians make decisions, resolve conflict and move forward. For more than 25 years



Mr. Latham has assisted medical groups in the areas of strategy and planning, governance and organizational effectiveness, and mergers, alliances and networks. During this time he has facilitated over 900 meetings or retreats for medical groups; helped hundreds of medical groups develop strategic plans to guide their growth and development; helped over 130 medical groups improve their governance systems and change their compensation plans; and advised and facilitated the mergers of over 120 medical practices representing over 1,200 physicians. Mr. Latham has an MBA from the University of North Carolina in Charlotte. He is a frequent speaker at local, state, national and specialty-specific healthcare conferences. Mr. Latham can be reached at (704) 365-8889 or [wlatham@lathamconsulting.com](mailto:wlatham@lathamconsulting.com).

# ANESTHESIOLOGISTS IN THE ICU: ECONOMICS AND OTHER CONSIDERATIONS

Jody Locke, MA

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Very few private anesthesia practices provide services in their hospitals' intensive care units (ICUs). The lack of enthusiasm for staffing the ICU relates directly to a perception that ICU coverage is not as profitable as operating room (OR) coverage. The entire Anesthesia Business Consultants client database only yields a few examples of private anesthesia practices covering the ICU. Are these outliers visionary or just clinical exceptions? In the current environment where a principle focus of payment reform is on bundled payment arrangements, it may be time to review what were once considered core competencies of anesthesiologists and reassess the strategic opportunity to enhance the scope of the relationship between the anesthesia practice and the facility.

Quite different from anesthesia billing, ICU billing involves some unique compliance considerations. Conceptually, all patients must be triaged based on acuity of care. If a new patient introduced into the unit receives a full workup that takes an hour or more, the work would probably be billed with CPT Code 99291 (CPT Code 99291 – **critical care, evaluation and management** of the critically ill or critically injured patient; first 30-74 minutes), but specific criteria have to be met. If the acuity of care does not meet the CPT criteria, then the workup must be down-coded to a subsequent hospital visit, which is paid at a considerably lower rate. Table 1 indicates average rates for the most commonly billed codes. Obviously, the overall yield per workup will depend on the mix of patients and the conditions they present.



Most patients brought from the OR to the ICU will be stabilized on the first day, resulting in diminished acuity of care over time. A high-level initial workup would normally lead to one or more low-level hospital visits before the

patient is released to the floor. As such, the revenue opportunity diminishes.

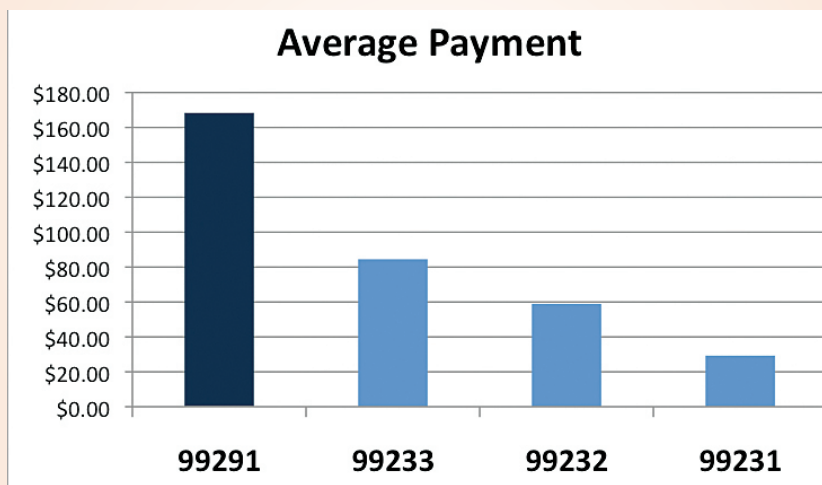
Most of the ICU codes include all the intensivist's usual services, but some other services may be billed in addition to these as evaluation and management (E&M). The placement of invasive monitoring (arterial lines, central venous pressure (CVP) and Swan-Ganz catheters) may be inserted and paid separately. It is also possible that a patient might need an intubation only, which would be payable as a stand-alone service.

## ECONOMIC REALITIES

The economics of ICU coverage hinges on three factors: the volume of patient encounters, the acuity of care provided as assessed on a case-by-case basis and the payer mix of the patient population. A large hospital will typically

TABLE 1

### Average Rates for the Most Commonly Billed Codes



have multiple types of ICUs and step-down units. It is the cardiac critical care units (CCUs) and the surgical intensive care units (SICUs) that are of the most potential value. The clinical opportunity stems from the concept of providing a continuum of care from OR to ICU. A good example is the service at Lutheran General Hospital in Park Ridge, Illinois. For years, a team of critical care certified anesthesiologists have provided effective coverage to critically ill patients passing from the OR into the unit.

With regard to the volume potential of an ICU practice, it is unlikely that the unit will generate levels of payment that even come close to what the same physicians could generate in the OR. Generating these payments would require more patients than come from the OR. Busy practices might see eight to 10 new patients per day in the ICU.

The revenue potential is determined by the combination of coding and payer mix. Since ICU services are paid based on a general medical fee schedule, the level of the code and the fee schedule from which the services will be paid can make a huge difference. For example, Code 99291 has a Medicare allowable in one region of \$244.61, while the Blue



Cross Blue Shield allowable is \$263.81. The Medicaid allowable is only \$84.

With regard to coding, the importance of clear and complete documentation cannot be overstated. Coders of ICU services review provider documentation for a variety of factors, including diagnosis, the details of the patient's evaluation, and treatment and the amount of time spent face to face with the patient. Code 99291 covers the first 74 minutes of care in a given day.

Code 99292 (CPT Code 99292 – **critical care, evaluation and management** of the critically ill or critically injured patient; each additional 30 minutes) is used for additional 30-minute increments.

There has been considerable focus in recent years on the use of Code 99291. Many a practice has had to review its documentation patterns after a careful audit when it was revealed that the necessary criteria were not being met. The financial implications of such a development can be significant, sometimes reducing the revenue potential by 60 percent, the payment difference between codes 99291 and 99233 (CPT Code 99233 – **subsequent hospital care**, per day, for the evaluation and management of a patient).

## THE ICU AND HEALTH REFORM

Anesthesiologists have lost interest in covering the ICU for many reasons. The lack of comparable revenue potential is just one. In many facilities, the ICU is the domain of surgeons or cardiologists and primary care physicians who have claimed responsibility for the patients. Often, the result of this evolution is a



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## ANESTHESIOLOGISTS IN THE ICU: ECONOMICS AND OTHER CONSIDERATIONS

*Continued from page 17*



domain where standards of care and provider availability are somewhat the luck of the draw. To avoid this, some hospitals have hired intensivists for their ICUs, but turf wars persist.

There are two types of ICUs: closed and open. In a closed ICU, the hospital has either contracted with or hired a staff of trained intensivists to manage all patients. In the open ICU, various providers, including cardiologists and surgeons, come and go as they manage “their patients.” The data suggests that the incidence of mortality is lower in closed units.


An anesthesia ICU solution in which one team of providers manages the patient through the entire continuum of surgical and postoperative care offers a more appropriate alternative. In most facilities, the introduction of such a model would represent a dramatic cultural change, and, yet, one that is probably more consistent with where reimbursement mechanisms are heading than where they are now. The current model reflects a fee-for-service environment, which fosters competition between providers for payment.

Although the recent Republican effort to replace Obamacare failed, other market changes, including the move to value-based payment through MACRA’s (Medicare Access and CHIP Reauthorization Act) Quality Payment Program (QPP), are likely to go forward. Most observers believe that bundled payment programs will be expanded. For one thing, Medicare is clearly focused on exploring ways to reduce the overall cost of cardiac care. It is also reasonable to assume that plans will also be developed to address all expensive surgical procedures that involve multiple specialties such as total joint replacements. Such arrangements will ultimately require reducing overlaps and coordinating providers involved in package rate negotiation and distribution.

Anesthesia has an opportunity to pre-empt this process and position itself to be a player in the negotiation of a reasonable rate structure. The key point is that the era of fee-for-service medicine, in which providers get paid to perform services, irrespective of the outcome, is evolving into an era of cost reduction, where providers are incentivized to help drive down the cost of care.

The same concepts are being explored on the quality side. The Merit-Based Incentive Program (MIPS) arm of the QPP includes a measure related to transfer of care to the ICU. Payment incentives could be developed to explore ways to better coordinate care between the OR and the ICU. It is not clear how this would work, but that might be the opportunity.

### CONCLUSION

The concept of taking on responsibility for the ICU represents out-of-the-box thinking. It is a paradigm shift. It makes no sense if the objective is to enhance practice revenue by adding a new line of business. In fact, most coverage arrangements require hospital support. What it also speaks to is a desire to broaden the relationship with the facility in an effort to better align the anesthesia practice’s and hospital’s incentives. What it also speaks to is the future of hospital contracting in which anesthesia looks for ways to apply its core competencies in ways that better support hospital administration’s strategic and financial objectives. The critical next step will be finding a way to make such arrangements financially viable for all parties. 

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# PREPARING FOR THE FINANCIAL AFTER-LIFE

**Gregory R. Zinser, CPA**

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Depending on how much fun you're having in the OR each day, at some point, you may decide to "discontinue full time professional engagement." Please note that I did not use the "R" word or the "W" word. With so many negative connotations, including declining physical and mental abilities and boredom, retirement, in the traditional sense of the word, is not something to look forward to, but rather, to be dreaded for most of us.

Regarding the "W" word, I would suggest that to call what you do "work," it must meet certain criteria. You may currently depend to some degree on the income stream produced by your "job," but if you would choose to spend your time engaged in a profession or activity even if you were independently wealthy and did not need the money, then it's not work and it's not a job. It is a calling, and you are among the lucky few who will want to continue doing it until you are no longer able. If there are other things you would prefer to be doing if



you were independently wealthy and not dependent on the income stream, then it is important to take a closer look at your current situation and predict the future as best you can to determine when you will reach that point of financial independence. You won't necessarily choose to stop working at that precise time, but knowing when you have the choice will likely affect your decision-making as life events occur, and your bucket list becomes longer and more important.

## YOUR PERSONAL FINANCIAL PROJECTION

While financial planners use many tools to project life after income production, one approach I have found to be most helpful is a model designed to "solve for" any one of the primary variables, or more specifically, answer the following typical financial planning questions:

1. If fixed variables are:
  - a. Current level of assets
  - b. Life expectancy
  - c. Average annual return on investments
  - d. Level of essential expenses and non-recurring cash needs
  - e. Desired discretionary expense levels
  - f. Average annual inflation rate and estimated federal and state income tax rates

### How long do I need to continue income-producing activities?

2. If fixed variables are:
  - a. Current level of assets
  - b. Life expectancy



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## PREPARING FOR THE FINANCIAL AFTER-LIFE

*Continued from page 19*

- c. End Date of Income-Producing Activities (EDIPA)
- d. Level of essential expenses and non-recurring cash needs
- e. Desired discretionary expense levels
- f. Average annual inflation rate and estimated federal and state income tax rates

**What average annual investment return is needed to cover all anticipated expenses between now and the end of life expectancy?**

- 3. If fixed variables are:
  - a. Current level of assets
  - b. Life expectancy
  - c. EDIPA
  - d. Average annual return on investments
  - e. Level of essential expenses and non-recurring cash needs
  - f. Desired discretionary expense levels
  - g. Average annual inflation rate and estimated federal and state income tax rates

**What is the date of full asset depletion?**

- 4. If fixed variables are:
  - a. Current level of assets
  - b. Life expectancy
  - c. EDIPA
  - d. Average annual return on investments
  - e. Level of essential expenses and non-recurring cash needs
  - f. Average annual inflation rate and estimated federal and state income tax rates



**What is the average level of discretionary funds available after EDIPA up to the end of life expectancy?**

This model is a mathematical calculation using inputs you provide to show how things would turn out if all of the assumptions you made proved to be true. It is a departure from the traditional “Monte Carlo” risk assessment analysis that most financial planners will run for you unless you direct otherwise. So, while ideally this model should be built by someone with financial planning experience, you will need to describe it and request specifically that it be run either in lieu of or in addition to the traditional models.

The process starts with providing the following information:

- 1. Current age
- 2. Targeted EDIPA
- 3. Estimated life expectancy
- 4. After tax assets:
  - a. Current balance
  - b. Estimated annual additions

(after tax savings over and above essential, discretionary and non-recurring expenses) between now and EDIPA

- c. Estimated average annual investment return between now and EDIPA
- 5. Pre-tax assets (401k/IRA)
  - a. Current balance
  - b. Estimated annual contributions between now and EDIPA
  - c. Estimated average annual investment return between now and EDIPA

The following information is then provided relating to the period between EDIPA and end of life expectancy:

- 1. Annual after-tax cash flow needs in today's dollars (by year):
  - a. Essential living expenses. This would include mortgage debt, utilities, annual home maintenance items, food, in-



surance, medical care transportation-related expenses and all other things that you could not live without. They will change from year to year as mortgages get paid off, dependent education costs are incurred, etc. This is also the category where you would estimate cost of post-employment healthcare coverage and some form of nursing home care (or the cost of a long-term care policy) if you so choose.

- b. Discretionary expenses. Discretionary expenses are non-essential things like travel, entertainment, gifts, donations, etc. This category is the source of funding for all of the fun things you are doing now and would like to continue doing to some degree when you discontinue full-time employment.
- c. Non-recurring cash needs. Non-recurring expenses are major one-time expenditures

such as major home maintenance expenditures, funding your daughter's wedding, putting a new roof on the house, etc.

2. Estimated inflation rate
3. Estimated annual income (by year):
  - a. Part-time employment or consulting
  - b. Social Security
4. Estimated average annual investment return (net of all fees):
  - a. On after-tax funds
  - b. On pre-tax funds
5. Estimated federal and state income tax rates:
  - a. On Social Security income
  - b. On all other income and IRA withdrawals

With these assumptions, a mathematical model can be built that will solve for any one of the primary variables described above. The sample calculation



in Exhibit 1 is solving for the level of annual discretionary, after-tax cash flow between the EDIPA and the end of life expectancy. In addition to those assumptions listed in the exhibit, it also assumes:

- Current age is 57
- EDIPA is age 70
- Life expectancy is age 88
- Expenses in all three of the major categories between now and the EDIPA are covered, with enough remaining to contribute \$30,000 per year to your IRA during that 13-year period
- Essential annual expenses of \$70,000 (after tax) between EDIPA and end of life expectancy
- A "terminal portfolio value" (i.e., amount remaining in the portfolio at end of life expectancy) of \$1,000,000

While the only thing that is certain about any version of this model is that reality will never match your assumptions, knowing how things would turn out using your best estimates will prove to be a very useful tool for planning your



## PREPARING FOR THE FINANCIAL AFTER-LIFE

*Continued from page 21*



future, whether it be choosing an EDIPA, developing an investment strategy necessary for you to reach your goals, or level of discretionary spending during your post-EDIPA years.

One of the most useful purposes of this model is to guide decisions about portfolio diversification both before and after EDIPA. In one sample of the model, every 0.5 percent increase in average

return on investments changed the portfolio depletion date by three years. If you kept the portfolio depletion date the same, you could also solve for how much more after-tax discretionary income you would have each year (post EDIPA) with each 0.5 percent increase in the average investment return. Knowing that sensitivity in your own model can help you decide how much risk you need to take in the market to achieve your goals.

If you can diversify your portfolio in a manner that will result in a very low probability of average annual returns that are less than your investment return goal, you will also have a portfolio that minimizes the downside risk in the market to the greatest degree possible. This is just one example of how information provided by this model can influence your decisions regarding investments, major purchases and all types of discretionary spending. Also, when reality proves to be different than your assumptions, you will be able to change the applicable variables, and see exactly how it affects your results

and what course changes you might need to make to keep things on track.

The thought process required to make these assumptions causes each of us to examine our beliefs and attitudes about lifestyle, future tax rates, long-term investment returns, future cost of healthcare, and many other difficult and very personal matters. There are no right or wrong answers; only personal comfort levels. Accordingly, this model has potential risk areas and also potential positive impact items that will vary with the individual.

Possible negative impact variables not covered in the model include:

1. Major medical expenses above and beyond those covered by Medicare and that exceed amounts you budgeted for healthcare.
2. Other non-discretionary expenses higher than budgeted.
3. Unexpected large non-recurring costs related to house or family.
4. Tax rates higher than assumed.



5. Inflation higher than assumed.
6. Investment returns lower than assumed.
7. Sequence of investment returns could have a negative impact on long-term results (e.g., poor market returns in five years immediately following EDIPA affect income more than poor returns 20 years after EDIPA).
8. Social Security payments reduced or eliminated by federal government.

Possible positive impact variables not covered in the model include:

1. Investment returns higher than assumed.
2. Tax or inflation rates lower than assumed.
3. Post-EDIPA income higher than assumed.
4. If there is equity in your home:
  - a. Reverse mortgage could increase cash flow.
  - b. Option of selling current home; purchasing less expensive home (either in current location or moving to another location with a lower cost of living); and adding some of the equity to available assets.
5. Inheritance not included in assumptions.

With all of the negative things to worry about, it is understandable that the most conservative among us may never get to the point where we're comfortable enough to stop working. On the other hand, we all know that when the end is near, no one ever said that they wish they would have worked longer. The death of loved ones, especially those who pass "before their time," and other high-profile



catastrophic events, remind us that life is short and unpredictable. At those times, many of us re-examine our path and our personal goals, and sometimes make changes in how we're planning to spend the rest of our lives. The purpose of this model is only to assist in that thought process by quantifying the financial implications of various possible scenarios using certain assumptions.

It is said that there is a time to accumulate wealth and a time to stop and enjoy it. While the timing of that decision is a very personal one that has both financial and personal considerations, this article has been devoted to describing a financial planning tool that can help in achieving some degree of peace of mind when faced with what can sometimes seem like an overwhelming number of variables and uncertainties.

If the model and underlying assumptions are updated as circumstances change, it can be used as a basis for important decisions about spending levels, when to discontinue or curtail income-producing activities, and investment diversification strategies.

Regardless of how you choose to act on the results, the process will provide a valuable frame of reference for many years to come. ▲

**Gregory R. Zinser,** CPA Vice President at Anesthesia Business Consultants, has a broad range of experience in healthcare finance and administration. Mr. Zinser's recent experience includes four years as CEO of one of the nation's largest anesthesia billing and practice management companies, and CEO of the management company for one of the nation's largest anesthesia groups. With experience in all facets of anesthesia practice management, Zinser adds strength and depth to an ABC management team that has become the industry standard in responsiveness and quality of resources. He is a licensed CPA with an undergraduate degree in accounting with honors from the Ohio State University. Mr. Zinser can be reached at [Greg.Zinser@AnesthesiaLLC.com](mailto:Greg.Zinser@AnesthesiaLLC.com).







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## What You Don't Know Can Hurt You.... Understand and Meet the QPP Requirements

The Medicare Access & Chip Reauthorization Act of 2015 (MACRA) marked the end of Medicare payment's fee-for-service model and the beginning of a performance-based payment system, the Quality Payment Program (QPP). The QPP offers the choice of two tracks: the Advanced Alternative Payment Models (APMs) or the Merit-Based Incentive Payment System (MIPS). Most anesthesia practitioners participating in the QPP in 2017 will utilize MIPS.

As CMS transitions to a pay-for-performance methodology, it is easy to get lost in the acronyms and the policy. The co-sourced **MACRA MadeEasy** certified Qualified Clinical Data Registry (QCDR) platform guides clients through these changes and provides a structured and practice-specific

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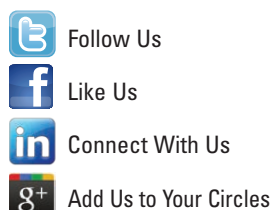
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Join the 2,000,000 patients and 6,000+ anesthesia clinicians already reporting their performance through the MiraMed QCQR, a MACRA-compliant registry. Call the MACRA Made Easy hotline today at (517) 962-7301.

## PROFESSIONAL EVENTS

Date	Event	Location	Contact Info
April 27-30, 2017	California Society of Anesthesiologists 2017 Annual Anesthesia Meeting	Hyatt Fisherman's Wharf San Francisco, CA	<a href="https://csahq.org/continuing-medical-education/events/details/2017/04/27/cme-events/2017-annual-meeting">https://csahq.org/continuing-medical-education/events/details/2017/04/27/cme-events/2017-annual-meeting</a>
April 29-May 1, 2017	Advanced Institute for Anesthesia Practice Management 2017 Conference	The Cosmopolitan of Las Vegas Las Vegas, NV	<a href="http://www.aiapmconference.com/">http://www.aiapmconference.com/</a>
May 5-9, 2017	International Anesthesia Research Society 2017 Annual Meeting and International Science Symposium	Grand Hyatt Washington Hotel Washington D.C.	<a href="http://www.iars.org/education/annual_meeting/">http://www.iars.org/education/annual_meeting/</a>
May 8-12, 2017	Harvard Medical School Anesthesiology Update 2017	The Fairmont Copley Plaza Hotel Boston, MA	<a href="http://anesthesiology.hmscme.com/">http://anesthesiology.hmscme.com/</a>
May 15-17, 2017	American Society of Anesthesiologists Legislative Conference 2017	Hyatt Regency Washington on Capitol Hill Washington, D.C.	<a href="http://asahq.org/meetings/legislative-conference">http://asahq.org/meetings/legislative-conference</a>
June 9-11, 2017	Florida Society of Anesthesiologists 2017 Annual Meeting	The Breakers West Palm Beach, FL	<a href="https://www.fsahq.org/meeting/">https://www.fsahq.org/meeting/</a>
June 9-11, 2017	Perioperative Surgical Home Perioperative Care Boot Camp	Marriott Marquis Houston, TX	<a href="https://periopmed.org/">https://periopmed.org/</a>
September 7-10, 2017	Texas Society of Anesthesiologists 2017 Annual Meeting	JW Marriott San Antonio, TX	<a href="http://www.tsa.org/professional/meetings.php">http://www.tsa.org/professional/meetings.php</a>



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