virginia society of anesthesiologists

UPDATE

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SPRING 2022: **ETHICS, LAW & THE BUSINESS OF MEDICINE**

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Introducing the Issue Editor, Jack Craven

By Brooke Albright-Trainer, MD, FASA
Editor, VSA Update

VSA welcomes Jack Craven, MD, JD, MBA, a second clinical year anesthesiology resident at VCU Health System in Richmond Virginia, as this edition's Issue Editor of the *VSA Update.*

Jack Craven, JD, MD, MBA

Dr. Craven was also recently elected Vice President of the VSA Resident & Fellow Section. He brings to our organization a magnitude of experience as he entered medical school later in life, after an extensive and fulfilling career in law.

He has previously written about legislative advocacy, the changing landscape of opiate regulations relating to chronic pain practices, acute pain practice billing, and is featured in this issue discussing laws related to physicians.

Prior to entering medical school, Dr. Craven worked as a magistrate holding hearings for the Commonwealth of Virginia. Before and during medical school, he served as a Reserve Judge Advocate in the Army's JAG Corps, attaining the rank of Major. He resides in Henrico with his wife and daughters.

Feature Article

The Business of Anesthesia

By Martha Kelley, MS, CMPE
CEO Innovation Management Services
Administrator
ACV/VAPCS

Martha Kelley, MS, CMPE

It seems there is constantly something new we need to do for our anesthesia business to stay compliant; work more efficiently, meet facility expectations, govern our group, and produce revenue to pay the bills. We are increasingly consumed with the business of running our practice rather than anesthesia. Do we have a choice?

The management company proliferation over the past fifteen years was successful in part, due to the ever-changing tides of anesthesia administration. Anesthesiologists were tired of keeping up with CMS changing MIPS requirements every year, increasing costs, billing problems, and decreasing reimbursements from payers. Not to mention negotiating with hospitals and ASCs on staffing, utilization, and justifying the need for stipends with a 60+ percentage of government payors. Being managed by a company took the headache out of running a group. But those administrative burdens are global and experienced within management companies, academic, and privately owned groups.

Having a practice administrator and a dedicated business office decreases the need for anesthesiologists to have day-to-day direct administrative responsibilities. However,

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Inside This Edition:

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vsa virginia society of anesthesiologists UPDATE

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The ***VSA Update*** newsletter is the publication of the Virginia Society of Anesthesiologists, Inc. It is published quarterly. The VSA encourages physicians to submit announcements of changes in professional status including name changes, mergers, retirements, and additions to their groups, as well as notices of illness or death. Anecdotes of experiences with carriers, hospital administration, patient complaints, or risk management issues may be useful to share with your colleagues. Editorial comment in italics may, on occasion, accompany articles. Letters to the editor, news and comments are welcome and should be directed to: Brooke Trainer, MD • brooke@vsahq.org.

SAVE THE DATES

RESIDENT/FELLOW MEET AND GREET

Random Row Brewing Company
608 Preston Ave A
Charlottesville, VA 22903
Saturday, May 21
1-3 pm
RSVP by May 13 to:
angela@societyhq.com
(Please include Random Row in the subject line)

ASA LEGISLATIVE CONFERENCE 2022

May 9 - 11, 2022
Hyatt Regency on Capitol Hill,
Washington, DC

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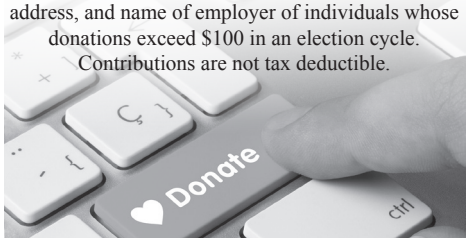

President's Message

Our Perspective on the Business of Medicine

By Marie Sankaran Raval, MD
VSA President

Dr. Marie Sankaran Raval

As anesthesiologists, we have a unique perspective on the business of medicine. We are active as anesthesiologists and as practice leaders within our individual practice groups.

Patient safety is, and always will be, our primary focus while simultaneously decreasing costs. As a specialty, we should continue to make our voices and ideas heard and work with hospital leadership to achieve this goal.

In addition to taking on leadership roles, we should also participate in advocacy so that we can effect change at the level of government. As President of the Virginia Society of Anesthesiologists, I have seen firsthand how advocacy can shape our future as a specialty.

Throughout the summer and fall, the members of the VSA executive board had numerous opportunities to meet with members of the Virginia General Assembly to discuss the practice of Anesthesiology in the Commonwealth. We were able to have meaningful discussions and were successful in having them understand what we do and how we keep our patients safe.

In this issue, we will further explore ethics, law and the business of medicine as it pertains to anesthesia. I will touch on a few of this quarter's contributions.

One article explores the idea of introducing a public policy and advocacy curriculum to our residents. This early exposure would teach them about the legislative process and the importance of legislation in the practice of medicine. As previously mentioned, advocacy is a huge part of protecting our patients.

We also discuss the concept of "green anesthesia" as inhalational anesthetics contribute significantly to environmental pollution. This article explores current practices aimed at reducing the anesthesiologists' carbon footprint. The main focus is on low-flow anesthesia delivery, which one anesthesiologist has been able to teach systematically within his practice group. He also highlights that regional anesthesia itself helps to reduce our carbon footprint.

In addition, we discuss the ins and out of starting your own pain practice, as discussed by an anesthesiologist with firsthand experience. This article discusses various aspects such as choosing your practice setting, completing startup tasks (obtaining malpractice insurance, opening a bank account, etc.) and the importance of marketing. This is pertinent for any physicians hoping to open their own private practice.

We are fortunate as anesthesiologists to have a very active national group that works to further our understanding of the business of medicine through a seminar called ADVANCE. We have a review of this year's conference and encourage all who are interested to attend next year.

I hope you enjoy this issue and I encourage you all to contribute to the VSA newsletter. We enjoy all contributions and look forward to your participation.

The ASA will also hold its Annual Legislative Conference in May and I encourage you all to attend to see advocacy at the national level.

As always, feel free to reach out me at marie.sankaranraval@vcuhealth.org or any member of our board with any issues or ideas you would like to share.

Incorporate Advocacy and Healthcare Policy Education into Anesthesiology Trainee Curriculum

By Brooke Trainer, MD
Editor, VSA Newsletter Update

Dr. Brooke Albright-Trainer

The time has come to formally incorporate and mandate advocacy and healthcare policy curriculum into our residency anesthesiology trainee programs.

Some theorists will argue that anesthesiology trainee education should be focused solely on concepts related to the practice of medicine, anesthesiology, and patient disease management. They will argue that four years is barely enough time to cover all there is to know about the medicine of anesthesiology, and certainly not enough time to debate healthcare policy implications.

However, when one considers our current political landscape, is more education centered solely on medicine, science, and research really the answer to safer anesthesia practice? We are facing unprecedented times where an alarming number of non-physician interest groups are successfully advocating for legislation to expand their scope of practice and manage patients independently without increasing their education to the level of physicians. Moreover, state legislators who are blind to the dangerous medical implications of such policy are given authority to approve and adopt measures.

In a world where medical education, research, and science seem to matter less than "fairness", costs, and efficiency, perhaps a more effective solution to safeguarding our patients would be for anesthesia trainees to learn how to monitor and advocate for appropriate legislation which prevents harm.

The reality is, whether you like it or not, the practice of medicine is largely dependent upon the political landscape and current healthcare policy. If physicians continue to sit on the sidelines arguing the ethics of getting involved in politics, we will slowly be replaced and patients will ultimately suffer the consequences. It is time to put aside our ethical dilemmas of getting involved in politics, learn about relevant healthcare policy implications, and teach our aspiring physician anesthesiologists how to safeguard their patients through effective legislative action.

ACGME core curriculum requirements for anesthesiology does not include legislative activities

Currently, the American College of Graduate Medical Education (ACGME) mandates a core set of curriculum requirements and activities for anesthesiology residents that largely emphasizes academics, scholarly activity, and research. They mandate that residents complete a mandatory 36 months of direct perioperative clinical care and participate in at least one scholarly and/or academic assignment, under faculty supervision.

Though professional development is a core requirement, there exists no mandate for resident participation or mentorship in legislative activities. A degree of flexibility is granted to programs placing emphasis on areas outside of the core requirements, which could allow for some healthcare policy curriculum to be taught.

However, this is dependent on the interests of the residency program director and staff involved in resident trainee education. There is currently no ACGME expectation that any curriculum surrounding healthcare policy or legislative affairs be taught throughout the duration of resident training.

Why make advocacy education an ACGME core requirement, rather than just an elective?

Approved ACGME core didactic activities allow for protected time in which residents may be excused from clinical work to attend lectures, conferences, courses, and other forms of teaching, and education related to the approved topics.

By formally incorporating legislative curriculum in the ACGME core requirements for graduation, residents will be provided protected time to participate in didactic activities related to learning about relevant legislation, politics, as well as how to effectively advocate and communicate with key stakeholders.

This could translate into residents being excused to attend their state or national societies "Legislative Day", where the entire conference is devoted to teaching these

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concepts and putting them into action.

Healthcare policy is a core component of nurse anesthesia training curriculums.

To some degree, all nurse anesthesia training curriculums incorporate education in advocacy and healthcare policy as a requirement towards attaining a 36-month "Doctors of Nurse Anesthesia Program" (DNP) degree.

A brief review of the curriculum advertised online for some of the top nurse anesthesia programs report a large percentage of credits geared towards advocacy and healthcare policy. (Table 1) Advanced nursing degree programs consider healthcare policy one of the most important core requirements of their training program.

The Council on Accreditation of Nurse Anesthesia Educational Programs (COA) lists the 7th most important course and activity specific to the profession of nurse anesthesia as "professional advocacy, practice standards and regulations (non-governmental, governmental)". It should come as no surprise that several non-physician national organizations are having more success in pursuing their political agendas with state legislatures.

Formally adopting "advocacy of healthcare policy" as a core curriculum goal for ACGME anesthesia residency training programs would allow for future physicians to more fully understand healthcare policy decision making and its implications, as well as provide protected and dedicated time towards current legislative activities.

Familiarity with the legislative process and remaining apprised on healthcare related legislative issues should be a priority for all physicians. But it is ever more important in this political landscape where some of our non-physician colleagues are moving away from physician-led care teams and towards autonomous practice.

If anesthesiologists are truly keen on safeguarding their patients, then consideration must be given to modernizing our residency training curriculum in order to keep pace with the current political landscape shaping healthcare.

Table 1: Examples of top CRNA DNP schools' curriculum related to advocacy and policy

CRNA DNP/DNAP School	Relevant Course Curriculum Objectives
University of North Florida	• Public Policy Implication of Advanced Practice
Rush University	• Provide leadership in influencing policies on the financing, regulation and delivery of healthcare • Healthcare economics, policy, finance
Baylor College of Medicine	• Leading and Managing Healthcare Systems • Influencing Healthcare Policy
Baylor Louise Herrington School/ US Army and VA affiliated Program (USAGPAN)	• Advocate for evidence-based health policy to improve local, national, and/or global patient and health population outcomes. • Healthcare Management • Health Policy and Law • Policy Implications for Healthcare • Leadership in Advanced Practice Nursing
Georgetown University	• Healthcare Systems • Healthcare Policy
Northeastern University	• Healthcare Finance and Marketing • Health Policy and Law
Columbia	• Health and Social Policy in the Context of Practice • Health Policy and Advocacy
Duke University	• Employ strategic leadership skills to influence health policy; implement ethical, cost effective, and evidence-based changes in healthcare systems; advance the profession,
Mayo Clinic College of Medicine & Science	• Organizational and systems leadership • Health Policy/Quality Health Delivery
Villanova University	• Transformational Leadership • Ethics and Law • Healthcare Finance • Health Policy
University of Cincinnati	• Healthcare Policy for the Doctoral Prepared Nurse • Professional aspects/role development in nurse anesthesia • DNP Leadership Seminar: Synthesis of the Leadership Role

** The CRNA DNP degree curriculum course objectives that are relevant to advocacy and health policy, taken directly from the programs' website.*

References:

1. https://www.acgme.org/globalassets/pfassets/programrequirements/040_anesthesiology_2021.pdf
2. https://www.coacrna.org/wp-content/uploads/2020/01/2004-Standards-for-Accreditation-of-Nurse-Anesthesia-Educational-Programs-revised-October-2019.pdf

Pearls and Pitfalls of Starting a Pain Practice

By Casey Fisher, MD
Pain Relief Solutions
and Chantelle Fisher, Esq.
Blackmar, Principe & Schmelter, APC
San Diego, CA

Dr. Casey Fisher

Chantelle Fisher, Esq.

Whether you are finishing up residency, fellowship, or you have been in practice for some time, starting a pain practice can be a daunting, yet exciting, decision. There are many benefits as well as risks to starting a practice. If you are considering taking that leap, it is important to do your research and understand the pros and cons.

After completing a residency and fellowship in pain management about eight years ago, I started out my career in private practice. Initially, I began as an employee for a pain management office that had been in business for twenty-five years. Then, a couple years ago, after working at other practices, I decided to start my own pain practice. Below are some pearls of wisdom and pitfalls that I experienced in making that initial decision and then beginning the practice.

Choose the Practice Setting That Fits You Best

You have many options when deciding the type of setting in which to practice pain medicine. You can choose to be in education, be an employee, join a group practice, or start your own practice. In making these decisions, it is crucial to consider what is important to you, your strengths and weaknesses, what will fit your personality and needs, and the market you want to work in.

If education and research are important to you, you may want to consider being employed in an academic institution. If you prefer to step into a job with a set pay structure and without worrying about overhead, startup costs, and running a business, you may want to consider being an employee. If you are interested in exploring other interests, such as providing consulting services, speaker services, and medical services for other companies, you may need to find out whether those other interests are allowed when working for others. If you have an interest in running a business, want to be your own boss, want access and control, including over your location, financials and the services you provide, you may want to consider starting your own practice. When deciding to start your own practice, you may also want to consider whether it will fit your personality and goals to partner with another physician.

You should also evaluate the market you want to work in, as that may affect your decision. For instance, my practice is located in a very competitive pain market. It has two major hospital systems, with more than 60% of patients coming from HMOs, meaning that many of my referrals come from HMOs. In these markets, it can be more difficult to obtain hospital credentials and join HMO contracts. In fact, it can take several years to do so. You may even need to be an employee for a pain practice before starting your own practice in order to join certain HMO contracts.

Understanding your personality, interests, skills, and the market you want to join, and reevaluating these and what setting fits you best throughout your career, should help you succeed.

Complete Start Up Tasks

Once you have made the decision to start your own pain practice, but before you can even open the doors, there are numerous considerations and tasks to complete, some of which are costly and many of which are business related. Since many physicians, including myself, do not have any training or experience in starting a business, surrounding yourself with the right people, including lawyers, consultants, certified public accountants and insurance agents, especially ones who have experience with the healthcare industry, is one of the most crucial first steps.

Once you have your advisors in place, you can begin to work on the following long, although not exhaustive, list to start your practice:

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- Determine the type of practice you want to open;
- Choose which business entity is right for you and properly form and maintain the entity;
- Decide whether you want to use a fictitious business name and obtain the necessary permits and licenses, including from the state medical board and the counties and cities in which you have an office, if required;
- Obtain malpractice insurance, if you do not have it already;
- Research and maintain compliance with the laws and regulations of the appropriate federal, state, local agencies and boards;
- Obtain your group National Provider Identifier (NPI). A group NPI will allow your practice to accept payment from Medicare and other insurance providers;
- Obtain your DEA license, if you don't have one already. You will need a DEA license to prescribe scheduled medication in a pain practice;
- Begin the credentialing process;
- Obtain an Employer Identification Number (EIN), also known as a federal tax identification number;
- Purchase appropriate insurance;
- Determine your location;
- Open a bank account solely for your business;
- Secure financing, if necessary;
- Setup an accounting system;
- Setup payroll; and
- Understand and ensure compliance with healthcare and pain practice regulations, as the healthcare industry and pain practices are highly regulated.

Throughout this process and your practice, you will find that you need to negotiate, prepare, review and sign several contracts. This is another reason why it is imperative that you have the appropriate advisors and lawyers.

As you can imagine, these startup tasks can be time consuming, lengthy and costly. But failure to take the appropriate steps can expose you to significant risk and liability.

Select Your Setting for Procedures

When starting a pain practice, it is important to decide the setting in which you will perform procedures. You can perform procedures in office, in hospitals and/or in outpatient surgery centers.

Performing procedures in your office requires you to have the necessary and appropriate supplies, equipment and staff. As you can imagine, this results in larger overhead for your practice.

For example, to perform in-office epidurals or medial branch blocks, you will need a fluoroscopy machine. To perform radiofrequency ablations, you will need an RFA machine. Both are expensive types of equipment and require staff. Whereas, if you perform procedures in a hospital or surgery center, the hospital and surgery center provide the equipment, supplies and staff.

As a side note on surgery centers, you may also have the option to establish ownership in the surgery center, which in turn may provide another source of income. In addition to accounting for overhead, you may want to consider the types of insurance accepted and the market in which you are practicing. Using any or all of these settings can be viable and successful options for a pain practice.

For example, given the location, the competitive market and the types of insurance accepted at my practice, it made the most sense to perform the majority of the interventional pain procedures in a procedure suite in my office, and the only time I use hospitals or surgery centers are for larger procedures, such as spinal cord stimulator implants and intrathecal pain pumps.

Establish Day to Day Operations

Many pain physicians choose to run their own practice and have control over the day-to-day operations and staff. Others choose to engage a management services organization ("MSO") to support the practice.

MSOs are designed to manage the administrative and non-medical aspects in a practice including, but not limited to, operational issues, human resources, personnel management, credentialing and contract management, providing and managing office space and equipment, and coding, billing and collection services.

Deciding whether to engage an MSO will entail its own list of pros and cons, but it is an option to consider if you want to start your own practice and are amenable to limitations on your autonomy. Based on my experience and the difficulties I saw when physicians managed their own offices, and because I wanted to focus on being a physician and treating patients, I chose to engage an MSO.

Whether you use an MSO or not, your practice will need a front office and a back office. The front office will consist of clinical staff, including medical assistants. The back office will include management, billing, collections, human resources and authorizations. You will want to ensure that hiring is not rushed and results in finding the right people. There are a few pitfalls I have encountered with certain positions in a private pain practice. The first pitfall can occur in billing. In your own practice, you can choose to outsource billing or handle it in-house.

Generally, collections for a pain practice are optimized with in-house billing or billing services provided by an MSO. The second pitfall is when medical assistants do too much administrative work or make too many business decisions. This may stunt the efficiency and growth of the practice.

The third pitfall is adding mid-levels at the wrong time or for the wrong reason. Whoever is responsible for hiring should evaluate your practice monthly to determine if and when to add a mid-level.

For instance, when your number of new patient visits and referrals increase, it may be a good time to add a mid-level. You do not want to add a mid-level for the sole purpose of avoiding seeing patients for medication follow-up.

Avoid Unnecessary Debt

Starting a pain practice generally requires significant startup costs. Besides the costs to set up the business side of the practice, you may need to fund salaries, buy or lease office space, and buy or lease equipment. Be mindful of your costs, try to avoid expensive rent and purchasing unnecessary equipment and supplies, and try to be as efficient as you can with the supplies you have. For example, if you are performing in-office procedures, you will need a fluoroscopy and/or an ultrasound machine, both of which are expensive. But those costs may be mitigated by finding a company that will allow you to lease, lease to own, or buy used ones for less. And you

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Pearls and Pitfalls, *from page 7*

can always upgrade as the practice grows.

Get Paid

As discussed above, there are several steps to take before you open your new practice. A couple that may directly impact how you are paid involve the credentialing process and joining insurance contracts. You may need both to start collecting for your services.

Regarding insurance contracts, you do not want to be locked in to one type of insurance that you accept, as that may impact who you can treat as well as collections. It is also important to accept different insurances, including Medicare, to try to increase the frequency with which you are paid and stabilize your monthly collections.

Additionally, there will probably be a lag in collecting for your services from insurance companies. How long may depend on your location and the type of insurance. As a result, you may want to prepare for not being able to take home a paycheck for several months after the opening of your practice.

Avoid Medical Fads

When you start your practice, you will likely have salespersons reach out to you or come in to your office to try to sell you on new products. You should research the products and avoid any that do not have any research or data to support them. Fads come and go, including in pain management, and when there is a change in billing or reimbursement for a fad that makes up a majority of your services, it can impact the revenue of your practice.

Market Yourself

The majority of patients in a private pain practice will come from referrals. As a result, you should come up with a marketing plan and spend time marketing. In marketing to physicians, you may want to consider meeting with major primary care groups in your area to discuss your practice and the services provided. In marketing to patients, an online presence helps, but word of mouth seems to bring in the most patients.

Starting a pain practice can be very challenging and requires a significant investment of time and money, but it can also be very rewarding. Hopefully, sharing my experience and the pitfalls I have encountered will help you in making your decision to start, and with the starting of, a successful pain practice.

The content of this article is for informational purposes only, and does not, and is not intended to, constitute legal advice. This information is not intended to create, and receipt of it does not constitute, an attorney-client relationship. You should not rely on the information as a basis for making any business, legal, or other decisions. You should seek appropriate counsel for advice regarding your individual situation.

Business of Anesthesia, *from page 1*

this is their business to run and knowledgeable involvement is crucial to success.

Let's look at a few of the main non-clinical components to running and growing a prosperous/thriving anesthesia business.

- Strategic Plan – It is no longer enough to show up at 6:30 for a 7:30 start, give excellent patient care all day, then go home. What is next? What is our vision? Do we remain static or seek opportunities for growth? Developing a long and short-term strategic plan gives the group focus on the future.
- Governance – Have an operating agreement along with an employee handbook that outlines policies and procedures such as board authority, dealing with disruptive colleagues, harassment, benefits, etc. This is imperative in establishing rules and guidelines that apply to everyone in the group.
- Developing and Sustaining Relationships – Make sure you are not just friendly, but become partners with hospital administration, surgeons, nursing, and medical staff. Work together to promote the mission, vision, values, and strategic plan of the facilities where you provide care.
- Administrative and billing teams – Whether you have your billing in-house or you outsource, it is crucial to stay informed on days in A/R, net collection percentages, managed care negotiations, to name a few metrics. Quality data and communication is imperative in keeping track of the financial health of your group. If you are not informed you could experience drastic declines in revenue and compensation.
- Data – Your EMR and billing software can provide invaluable data to help quantify and qualify your day-to-day operations. Having accurate data while negotiating with hospital administration is the key to legitimizing often discussed issues plaguing staffing, scheduling, and utilization. Know what data is available and how to use it.

> *Everyone not only needs to have their superpower anesthesia skills, but also have leaders who focus on the intricacies of running a business.*

Everyone not only needs to have their superpower anesthesia skills, but also have leaders who focus on the intricacies of running a business. Partnering with a knowledgeable and experienced administrative team is a definite recipe for success.

Legislative Update

By Lauren Schmitt
Commonwealth Strategy Group

The 2022 General Assembly session adjourned Saturday March 12th, as scheduled, but without reaching agreement on the budget. Instead, they passed a joint resolution that will carry the budget into a special session. Governor Youngkin will call the legislators back into a Special Session, but we do not know the date at this time.

The budget conferees need to reach a resolution on the final budget before the Governor will call the legislators back to Richmond. The main area of disagreement is regarding tax cuts.

The House of Delegates wants to include more tax cuts than the Senate, which leaves a significant difference in the amount of revenue they have to spend on other priorities. In addition, any bills that were still in conference will be carried over to the special session.

This was an eventful session with a lot of new faces and shifts in power. The elections in November resulted in the Republicans winning all three statewide offices and the majority of the House of Delegates. The Democrats still maintain the majority in the Senate. Governor Glenn Youngkin was sworn into office on January 15th and has been setting up his new administration.

VSA worked closely with our colleagues in the House of Medicine to advocate for our patients and profession. Our biggest victory this year was the defeat of legislation that would have made major changes to the current medical malpractice cap.

If passed, this bill would've been very harmful for physicians and resulted in malpractice insurance rates skyrocketing. We have now defeated this bill two years in a row.

Scope of practice bills continue to be introduced at the legislature every year. This year, we saw legislation to permanently change the law to allow nurse practitioners to practice autonomously after two years of clinical practice and legislation to allow optometrists to perform certain laser surgical procedures.

HB 1245, introduced by Delegate Adams, will allow Nurse Practitioners to practice autonomously after only two years of clinical experience. The current law required five years, but during the pandemic an emergency order was issued allowing for only two years.

The bill passed the House of Delegates, but was amended heavily in the Senate. The Senate version maintained the five year requirement, but grandfathered in any NPs that received their license during the emergency period. We support the Senate version, and at this time, a conference committee has been appointed to come up with a compromise on the bill.

As of adjournment, the conference committee had still not reached a decision on the bill. It will be continued into the Special Session.

SB 375 and HB 213, introduced by Senator Petersen and Delegate Robinson, will allow optometrists to perform three specific laser surgeries.

The Medical Society of Virginia and the entire House of Medicine opposed this bill, but unfortunately, there was widespread bipartisan support for it. The bills passed and it demonstrates that the legislature's top concern regarding health care is increasing access.

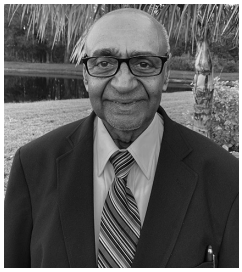
Many mistakenly believe that expanding scope of practice will increase access. We will continue to work over the next year to educate legislators on the importance of a physician-led patient care team.

We were anticipating legislation this year that would have allowed Certified Registered Nurse Anesthetists to practice independently. We were pleased it was not introduced this session but know we will likely see it in 2023.

The best way for the VSA to be successful at the legislature is to build and maintain relationships with your local Delegate and Senator.

If you are interested in helping, we will work over the spring and summer to set up in-district meetings for you. It is critical that legislators know and trust the physician anesthesiologists in their districts!

The Arts



Jaikumar Rangappa, MD, LTC, DABA, FACA
Retired US Army, Hampton, VA

Doctors Day

Doctors are not ready born,
Study hard, go through thorn
Work, watch, practice to grow,
Into expert, to the world show.

They do openly care & prevent
Many diseases cure and treat,
Aware of professional liability,
Care for the depressed family.
Profession can be satisfactory,
And toil hard to keep all happy.

Thank your own doctors today,
Bring a smile to them anyway,
Appreciate all they try to do,
Do toil to make a healthy you.

Good Intentions: How well-meaning regulation can pave the road to terrifying consequences for physicians

By Jack Craven, JD, MD, MBA
Issue Editor
VCU Health System
Keith May, MD and Shilen Thakrar, MD
VCU Health System

Dr. Jack Craven

Dr. Keith May

Dr. Shilen Thakrar

"No person shall be… deprived of life, liberty, or property, without due process of law."

The text of the Fifth Amendment seems straightforward. However, as institutions and governance have become more complex, so too has the application of regulation.

The following article highlights three areas of Federal Law which have been criticized by physicians for lacking due process under the Fifth Amendment, both in terms of property rights and criminal liability.

A Prime Example:

Dr. S is dual-boarded in both anesthesiology and chronic pain, and has been practicing for over 25 years . He volunteered his story for this article on the condition of anonymity.

In 2017, he received a letter from CMS (Centers for Medicare and Medicaid Services). Inside was a request for approximately 10 charts. He promptly prepared each record, and submitted per the identified instructions. Months passed, and eventually he received a follow-up letter. It explained that he had 30 days until his right to bill CMS would be revoked. Included were instructions on how to file an appeal.

Although Dr. S had been following the training he learned during fellowship, CMS took issue with several patient outcomes. Dr. S hired an attorney and discovered his options were limited. Together, they drafted an appeal letter. The letter led to a curt review and his concerns were dismissed.

His attorney explained that he had few remaining options. He could file for an appeal hearing, during the pendency of which his right to bill CMS would be suspended. It would be around 18 months from the date of the request. If the hearing was not successful, he would face a possible 3-year suspension.

Alternatively, he could accept the decision, and reapply in 18 months. Since the wait for a hearing was approximately the same length as the suspension, there was effectively no upside to arguing his case. As a result, Dr. S accepted both the decision and his lack of recourse.

Unfortunately for Dr. S, losing the privilege to bill CMS can also result in the inability to submit claims to certain insurance companies. Moreover, it often causes the revocation of hospital privileges and may affect DEA licensing. It devastated his practice for two years.

This article explores revocation of enrollment by CMS, as well as Stark Law and the Anti-Kickback Statute (three areas which have been criticized for their surprising effect on physicians).

42 CFR § 424.535 - Revocation of enrollment in the Medicare program

The list of requirements for continued enrollment in Medicare is long. As expected, non-compliance with Medicare documentation, provider misconduct, improper billing, felonies by staff or providers, submission of misleading claims, loss of medical licensing, or failing an onsite review can lead to revocation.

However, there are more nuanced factors such as patient harm (as determined by state licensing boards or independent review organizations) and improper prescribing. The difficulty lies in the fact that patient harm

Continued on page 11

can occur to varying degrees even when proper care has been provided, and improper prescribing can be subjective.

One intriguing aspect of Dr. S's case is that CMS commissioned three non-chronic pain reviewers to investigate his patient care—which he believes affected the decision (the exact details cannot be shared due to HIPAA). Bolstering his viewpoint, is the fact that two of the three reviewers were non-physicians.

Ultimately, he was also investigated by his state licensing board, and cleared of any wrongdoing in terms of patient care. That process did involve a chronic pain physician. However, the state investigation lagged behind and was independent of CMS's swift revocation. By that point, his practice had already been devastated.

As a result of the inability to file for a quick appeal hearing or to have his case reviewed by a specialist in chronic pain, he was effectively deprived of due process.

Federal Anti-kickback Statute- 42 U.S. Code § 1320a–7b

The Federal Anti-Kickback Statute was similarly passed with good intentions. As gatekeepers to medication, supplies, and testing; physicians can effectively send large numbers of patients to businesses which stand to gain substantial revenue.

Examples include: physical therapy, durable medical equipment, pharmaceuticals, laboratory tests, and radiological exams. If left unchecked, CMS believes that kickbacks will lead to overutilization, increased costs, and corruption of medical decision making. Their viewpoint is not without merit.

In the past, companies developed creative referral fees, rebates, and complex contractual arrangements which sent money back to physicians as compensation for referrals. This statute broadly prohibits those arrangements. The law applies to anyone receiving federal healthcare funds, and it can look at the overall effect of contracts to see if an illegal payment has been made.

The penalties included range from up to $25,000 and/or five years in jail per occurrence, and mandate return of the initial reimbursement. The statute also provides penalties, for willfully or knowingly making a misrepresentation of a material fact in connection with a benefit or payment under a federal healthcare program.

Fig. 1 - Common Safe Harbor Provisions to the Anti-Kickback Statute

- **Investors: Only 40% of a practice's revenue can come from referrals generated by investors**
  - o Investors in a position to generate referrals or revenue for a practice, can only own up to 40% of the practice.
  - o Terms offered for investors and the practice must bear no relation to the revenue generated (In other words, they must be fair market value). Moreover, there can be no requirement for a referral. There are also limitations on marketing.
- **Leases:**
  - o Leases must be in writing, consistent with fair market value, and take no account of the revenue generated between the parties.
- **Equipment Rental:**
  - o Must be in writing, consistent with fair market value, and take no account of the revenue generated between the parties.
- **Personal Services and Management Contracts:**
  - o Cannot consider the volume or value of referrals generated by the parties covered by CMS.
- **Sale of Practices between Covered Entities:**
  - o Must be completed within one year of the first agreement
  - o The practitioner selling his/her practice must not be in a position to make referrals to the practice within one year
  - o The selling provider must not be in a position to influence referrals or generate business for the purchasing entity

A classic example of a kickback would be a physician receiving a referral fee from a radiology or laboratory services provider. A more complex example would be if the referring physician owned and leased the MRI building to the MRI company at an above market rate (thus receiving an indirect form of compensation).

Due to the nature of the current healthcare environment and sheer number of contracts, services, and individuals involved- it is easy to inadvertently violate the anti-kickback statute. Moreover, although the statute requires that a physician have the intent to receive money from a federal healthcare program in order to be charged, that can often seem like innocuous behavior.

For example, if a patient requires a device for a legitimate illness—it is not obvious that a physician would face jail time for receiving a referral fee from a device company. In such an example, the amount paid by the federal healthcare program would be identical, regardless of the referral fee. As a result, providers may not believe they are committing a crime, as no increase in federal spending has occurred.

Interestingly, Congress seems to have anticipated that physicians may not know such behavior is illegal. The text of the statute explicitly states, "a person need not have actual knowledge of this section or specific intent to commit a violation of this section". In other words, the crime occurs regardless of a physician's intent to violate the law. Such a prospect is terrifying and poses a trap for unwary providers.

The text of the statute explicitly excepts certain discounts, payments to bona fide employees, waiver of coinsurance, and certain risk-sharing agreements (for example where a lump-sum payment is made for a knee replacement, division of reimbursement may be made accordingly and then payment

Continued on page 12

revised if an infection occurs).

There are also exceptions for ACO's, home health agencies, and other programs. As payment structures grew more complex, it became necessary for regulators to clarify what was violative of the law. Therefore, they created the safe harbor provisions shown in Fig. 1.

There are other provisions related to referral services, ambulatory surgery centers, health centers, warranties for equipment, discounts, renumeration to employees, waivers of coinsurance/deductibles, price reductions, practitioner recruitment, and investment in group practices.

Recent safe harbor provisions have been put in place to protect those engaged in care-coordination agreements (which improve quality, outcomes, and efficiency), value-based arrangements (which must include substantial downside risk in order to qualify), CMS sponsored models, telehealth for in-home dialysis, and local transportation costs.

Stark Law (AKA, Physician Self-Referral Law), 42 U.S. Code § 1395nn

Another such example of a federal law which has surprising effects on physicians is the so called "Stark Law". It was designed to prevent physicians from referring Medicaid or Medicare patients to anyone with whom the physician (or the physician's family) has a financial interest [See fig. 2].

The law itself has an illustrious history, and was first advocated for by Congressman Pete Stark in the 1980's. The original scope only covered lab work, but it has since grown to cover many commonly ordered services. The statute gives the name "designated health services" to those areas where referral is prohibited.

Designated health services include: physical therapy, occupational therapy, laboratory services, radiology services, home health services, hospital services, durable medical equipment, and prescription drugs. Having a financial interest in designated health services can include: ownership, investment, holding debt, and compensation agreements (such as referral fees, rebates, etc.). The rules dictate that neither the provider nor the provider's immediate family can have a financial interest in such companies.

The penalties covered by this statute are civil in nature (non-criminal). However, they are strict liability offenses. Strict liability means there is no requirement that the government prove an improper intent (It is only necessary for them to show an improper relationship and transaction). The fines involved can range from repayment of three times the CMS reimbursement, $15,000 per occurrence, and up to $100,000 per identified arrangement. It can also result in exclusion of the provider from all federal healthcare programs.

Fig 2 - Stark Law Defined Immediate Family Members:

Spouse	Sibling or stepsibling	Grandparent, grandchild, or the spouse of a grandparent or grandchild
Birth, step or adoptive parent	Mother or father-in law	
Child or stepchild	Son or daughter-in-law	
	Brother or sister-in-law	

Similar to the Anti-Kickback Statute, exceptions are made for leases at fair market value, provided they are over 1 year, in writing, and subject to certain requirements. There are also exceptions for qualifying employment relationships, physician incentive plans (provided unrelated to the referral volume/value), physician recruitment (similarly if unrelated to the referral volume/value), and certain group practice arrangements.

There are a large number of other exceptions, and a multitude of intricacies. As a result, Stark Law has often been criticized for creating unfair traps for unwary providers. Recent rule revisions were made in December of 2020, resulting in a 191-page update that creates a number of new exceptions.

Providers of DHS, are required to make reports regarding their ownership, investment, and compensation- subject to civil penalties of up to $10,000 per day for failure to comply. Physicians are not held to have an ownership interest in a DHS provider if that provider is publicly traded (for example on the New York Stock Exchange), or if it is a corporation that has stockholder equity exceeding $75,000,000, provided the investment is purchased at terms generally available to the public.

Conclusion

The intent of CMS enrollment revocation, the Anti-Kickback statute, and Stark Law are benevolent. As stakeholders, physicians have an interest in maintaining the viability and trust of the current system. However, these laws are notable for their heavy-handed penalties, which take little account of the expenditure of time, effort, and goodwill that physicians devote to their profession. Moreover, Stark Law enforces strict liability, and the Anti-Kickback Statute requires nominal intent. As a result, well-meaning physicians are unlikely to benefit by claiming a lack of knowledge that they were violating the law.

Therefore, it is highly advisable for practitioners to educate themselves about specific provisions in order to understand when and where each law may be implicated. The provisions may come into play when negotiating contracts, leasing space, hiring employees, providing care, and when referring patients to services.

Due to the sheer complexity of the laws, exceptions, safe harbor provisions, and recent updates, it is recommended to consult an attorney whenever a potential concern arises. Even seemingly benign arrangements can result in a violation, and legal fees spent in advance are likely to be far cheaper than potential penalties. By being vigilant and seeking legal advice before issues arise, physicians can work to minimize the prospect of unintentional consequences and maximize their chances of avoiding the implications of each law.

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Green Anesthesia: Beyond a concept, shaping of a movement!

"We must be the change we want to see in the world." -Mahatma Gandhi

By Nirvik Pal, MD, FASE
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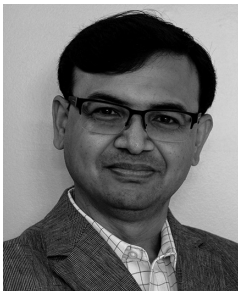

Dr. Nirvik Pal

The three principles of ecology state 1) everything is connected to everything, 2) everything must go somewhere, and 3) nature knows best.

Universally, there is increasing awareness, eagerness, and interest on sustainability in anesthesia practice, but there is still room for acceptance and adaptation[1].

One of the unique contributors to environmental pollution in anesthesia has been inhalational anesthetics[2,1]. Since these vapors and gases undergo minimal metabolism, they are vented directly into the atmosphere. Common terminologies to measure the effect on the atmosphere are: greenhouse gases (GHG), global warming potential (GWP), and life cycle assessment (LCA). While LCA evaluates the period gasses last in the atmosphere, the GWP assesses how these GHG (anesthetic) gases will contribute to global warming over a period of time (Table).

The way for anesthesiologists to reduce our carbon footprint is to 1) sparingly use inhalational agents, 2) curb spillage and waste of these agents, and 3) be cognizant and conscientious of one's own practice pattern and willingness to change. On average, a normal adult needs 350ml/minute of oxygen, for a basal metabolic rate of oxygen consumption of 5ml/kg/minute. So technically, this is the amount of FGF needed, and anything over is wasted and released into the atmosphere.

Assuming a margin of safety and compensating for leaks, FGF during maintenance can be reduced to 500 ml to 1 liter/minute ('Low-flow anesthesia'). The downside to running such low flows is an increase in the usage of carbon dioxide (CO2) absorbers.

In a recent VSA newsletter, Dr. Meyer from the University of Virginia discussed this concept eloquently in great detail, which was recognized and appreciated in a follow-up correspondence as well[4,5].

This may be common knowledge to many of us. However, implementing knowledge effectively and translating to outcomes is always a challenge. Dr. Varun Dixit, MD, a practicing cardiac anesthesiologist with NAPA group in Richmond, has successfully achieved this in his career. Under his guidance, he has been able to implement a low-flow anesthesia practice systematically, as well as several other initiatives to recycle, reduce, and reuse operative wastes at several hospitals. The author had a chance to interview Dr. Dixit on his initiatives and endeavors.

Table: Indicating the type of anesthetic agent, it's corresponding LCA, 100-year global warming potential, and its translation to comparative global warming potential from equivalent miles driven in an average automobile.

Agent	Atmospheric LCA (years)	GWP (100-year)	Automobile miles equivalent
CO2	5-200	1	
Sevoflurane 2%@ 2L FGF	1.1	130	8
Isoflurane 1.2%@ 2L FGF	3.2	510	18
Desflurane 6%@ 2L FGF	14	2540	400

(Adapted from ASA practice guideline and Gordon et al 3) (FGF: Fresh gas flow; CO2: carbon dioxide)

Q (Dr. Pal): How much do we contribute as anesthesia practitioners to pollution, global warming, and climate

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change?

A (Dr. Dixit): Healthcare is a very energy intensive industry. The issue has many aspects. Thinking of every product we use, from a simple intravenous (IV) start-kit to a complex fiberoptic scope, they require energy to be manufactured and then shipped to healthcare facilities. Most energy sources to date come from fossil fuels.

Another aspect is waste. Hospitals in general, and operating rooms in particular, generate enormous quantities of waste, a large proportion of which is regulated medical waste, which leads to pollution and contamination of waterways, soil and air. The anesthetic gases we use have powerful greenhouse gas effects.

Q (Dr. Pal): What change has your practice adapted towards Green Anesthesia practice?

A (Dr. Dixit): I strongly believe we can provide excellent patient care with fewer resources. Low-flow anesthesia techniques reduce the anesthetic gas used, saves the environment, reduces pharmacy bills, and conserves heat and moisture for patients.

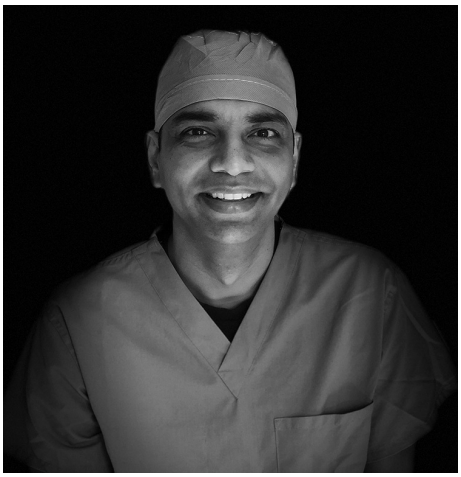
I joined Henrico Doctor's Hospital in 2017. I explained the technique to my group. I am proud that my group of CRNA's enthusiastically adopted that technique. They were willing to change their old habits based on evidence-based practice.

We hardly use desflurane or nitrous oxide. More importantly, I work with North Atlantic Partners in Anesthesia (NAPA), which is one of the largest single specialty anesthesia providing companies. NAPA clinicians give over two million anesthetics per year. NAPA has adopted low-flow as a quality metric this year and will provide awareness to their clinicians about this technique.

In my quest to reduce our carbon footprint, I have been very fortunate to find a few willing partners in the hospital administration. Everyone from the CEO of the hospital to the environmental staff were willing to make changes.

With their help I was able to start a recycling initiative in the Operating Rooms in 2019. I found a local company which processes this material in Richmond. The idea is to separate recyclable material in separate bags, and at the end of the surgery collect them at the loading dock.

A recycling company then processes the material. This supports local manufacturing jobs. Moreover this material can be made into new products and saves virgin resources.



Dr. Varun Dixit

Apart from these measures, we use commonsense processes like only opening equipment which is needed, turning off the suction and the anesthesia machines at the end of the day, avoiding disposing of medications in the sink, turning off unnecessary lights, etc.

Q (Dr. Pal): So what have you accomplished with these changes?

A (Dr. Dixit): By implementing the 'Low gas flow' initiative, we have attained a 23% reduction in total sevoflurane use in six months. Not only does this avert pollution, it also translates to saving thousands of dollars in pharmacy bills. This is also helpful for patient's physiology, since it reduces heat and moisture loss. So, as you can see, it's a win-win. In ecological terms this means roughly 75,000 less miles driven, just in six months' time!

There is so much more that can be done. We have made a modest but positive start. We are recycling about 13,000 pounds of waste every month, which is trash diverted from landfills. This is equivalent to planting 800 trees every year!

Q (Dr. Pal): Tell me more about Low Flow Anesthesia? Can it harm the patient? What about Compound A?

A (Dr. Dixit): The oxygen requirement for a patient under anesthesia is 4-5 mg/kg/min. Gas which is not used to anesthetize a patient is scavenged into the environment. Even considering the sampling line and leakage, we can use about 1 L/min in an average patient and still be safe.

In our practice we use sevoflurane as our primary anesthetic. After induction the flow can be safely reduced to 1 L/min with 2% sevoflurane. At the end of anesthesia, the flows are increased and patient is extubated. We avoid using Desflurane and Nitrous oxide, which are very potent greenhouse gases and responsible for ozone layer depletion[6].

As I mentioned earlier, there is wide margin of safety and, in fact, in most of the world it is standard practice. We can give safe anesthesia just by avoiding the waste. With newer generation carbon dioxide absorbers there is hardly any concern for Compound A production.

Q (Dr. Pal): Doesn't the hospital have to pay the county to recycle cardboard boxes? Isn't it an added expense?

A (Dr. Dixit): It's true that hospitals have to pay for recycling. But there are other aspects of sustainability which payoff in the long run. Reducing the anesthetic gases and eliminating desflurane have tremendous cost benefits. Energy expenditure can be reduced by turning off lights, machines and suction. By opening only equipment which is needed, purchasing costs are reduced.

All these practices put together have huge cost savings and pay for themselves. Moreover, these days patients, shareholders and employees are all concerned about the carbon foot print of their practices. These measures add immense value not just in monetary terms, but also marketing value for the organization.

People who work in these organizations want to be associated with institutions who care about the environment. So there are multiple benefits.

Q (Dr. Pal): What about the landfill, and extra CO2 absorbers; more lithium batteries; so on and so forth?

A (Dr. Dixit): Very valid concerns. Low flow initiatives lead to an increase in CO2 absorber consumption, but the studies have shown that even with increased CO2 absorbers, the environmental benefits of low anesthetic flows far exceed the costs.

There is ongoing research about scrubbers installed in anesthesia machines which can absorb and retrieve extra anesthetic gases. There is a certain systematic way to recycle batteries, but yes, a better solution needs to be found.

Q (Dr. Pal): Do you think there is more

of a role for regional anesthesia in reducing our carbon footprint? How about the growing use of inhalational agents in ICU? What are your thoughts?

A (Dr. Dixit): Any time we don't use inhalational gases there is environmental benefit. Regional anesthesia, even with the cost of equipment, has a much smaller carbon footprint. Anytime we can replace inhalational gases with total intravenous anesthesia, it has environmental benefits.

Q (Dr. Pal): ASA has taken an initiative of anesthesia and sustainability. Can you fill us in on that?

A (Dr. Dixit): ASA has taken several initiatives to encourage and educate practitioners to be aware of preventable pollution from inhalational anesthetics.

They have adopted four principles: 1) Utilize low FGF, 2) avoid desflurane and nitrous oxide usage, 3) consider IV and regional techniques, and 4) invest in waste gas trapping and destroying technology.

They have introduced a "Inhaled Anesthetic 2020 Challenge" with a goal to reduce your facility inhaled anesthetic carbon emission by 50% by 2020. "Project Drawdown" is another collaborative initiative to compare and inspire facility-level performance improvement.

All details are available on the ASA website for those who are interested. (There is talk about changing this to the 2022 challenge)

Q (Dr. Pal): Personally, I am a big user of inhalational anesthetics for my CHF patients, as the onset is quick, less chances of overdose, and it does not depend on circulation time. Now, I feel guilty.

A (Dr. Dixit): My efforts are not to make anyone feel guilty. We are all here to take care of patients, which is our first and foremost priority. My goal is to avoid waste and make providers aware of environmental costs. As I mentioned earlier, we can reduce our carbon footprint without compromising the quality of patient care. And that is not difficult at all! It is all about a conscientious practice.

Q (Dr. Pal): Playing the devil's advocate:

i) Q: Earth's climate has always changed, what's new?

A: Climate is always changing, but the speed at which change is happening does not give mankind or other species time to adapt. Even without the concern for environmental costs, it makes more business sense if we can provide the same care with fewer resources.

ii) Q: Plants always need CO2, right?

A: But we are cutting the existing trees, and reforestation efforts are not even close to the devastating deforestation worldwide. By using fewer supplies we are saving virgin resources.

iii) Q: Isn't it still cold in the winter?

A: Climate change is a much wider problem than simple global warming. It means changing precipitation patterns, more intense rains followed by prolonged periods of drought, more intense hurricanes, depleting water table, plastics and medications in our food supply, pollution etc.

iv) Q: Climate change is a future problem!

A: If you look around, it is not the problem of tomorrow or the next century. It is happening all around us. Western US, which is our fruit and vegetable basket, is facing a once in a millennial drought, rainfall patterns are changing, landfills are overflowing, in our lifetimes oceans will have more plastic than fish, and we are eating almost a credit card worth of micro plastic every week!

Dr. Dixit, I truly appreciate all your arduous efforts and success. You have evolved to be a change that we all would like to see in ourselves. I have already started paying attention consciously to the gas flow rates of my anesthetics in the operating rooms and draw attention to that fact for my trainees. I hope this encourages our fellow Virginia anesthesia practitioners to make an effort to adapt to sustainable practices in anesthesia[7]. Wish you all the very best in your future endeavors!

Anesthesiologists pride themselves as champions of safety and patient advocates, and truly so. It is not uncommon that, in our pursuit of taking care of individual patients, we sometimes overlook the larger impact we have on the environment, which may have significant adverse health impacts on all of us.

The time is ripe for us to expand our thoughts more globally, and widen our vision further, beyond our patients, to global humankind. As has been demonstrated by Dr. Dixit, who achieved 23% reduction of sevoflurane usage over six months in his fairly large practice, it is not impossible. All it needs is a little more attention to our day-to-day practice. A little effort, however small, will add up in the end yielding big results.

For all those interested, at the level of the ASA, Dr. Jodi Sherman from Yale School of Medicine, and locally, Dr. Matthew Meyer from UVA, who serves at the "Virginia Clinicians for Climate Change", are always available and approachable with ideas, initiatives, and help.

You may also contact Dr. Dixit in Richmond to share in his experience and implementation of these changes. As enumerated in the article, the following may be a few notable organizations in this area: Virginia Clinicians for Climate Action (virginiaclinicians.org), Practice Green health (practicegreenhealth.org), and Healthcare Without Harm (noharm.org)[4].

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MSV Physician Advocacy: A reminder about the importance of a handshake

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It's the small meetings that count. Only a few people could make the appointment as we packed into the small offices in Richmond, shoulder-to-shoulder, to meet with a delegate, then a senator, then another delegate representative, and so on. We split up the talking points beforehand, so each person had a task as we rushed from office to office.

For several of us, it was our first time participating in support of our specialties; and not just our own, but for physicians as a whole. Others had participated in these events year after year. We took a breath after all of the meetings and reflected on our unassuming appearances and roles in the day's events.

Even though our interactions were brief, we couldn't shake the feeling that it is meetings like this that play a critical role in protecting the integrity of physician-led care and our patients.

Bill SB 672 had been introduced with the aim to allow pharmacists to treat UTI's, certain URI's, tobacco cessation therapy, etc. If passed, one could imagine the permanent impact this would have on primary care physician practice.

Physicians visiting members of the General Assembly in Richmond

> *In spite of the massive amount of time devoted to learning medicine, we are massively underprepared as a profession to engage with the community at large in regards to healthcare issues and policy.*

The lines would become blurred on what it means for a patient to see his or her doctor, receive a physical exam, have a thoughtful differential diagnosis developed, receive appropriate treatment and follow up—a process that pharmacists are not trained to perform—and yet, patients would be led to believe these factors had all been considered in their best interest.

Unfortunately, this is only one of many bills being crafted and sent to the legislature in an attempt to expand non-physician-based practice.

Our jobs are not absolute. Without a face, a handshake, a reminder to our representatives of who we are, how do we expect our careers and patients to be protected?

In medical school we are indoctrinated with the virtues of physicians' past, focused on the treatment of disease and alleviation of suffering. Taking and abiding by the Hippocratic oath to do no harm, be just, and respect patient autonomy.

We intensely study the pathology, physiology, and ethics behind treatment of our patients. In spite of the massive amount of time devoted to learning medicine, we are massively underprepared as a profession to engage with the community at large in regards to healthcare issues and policy.

While our degrees, education, and experience undoubtedly make us the leaders of clinical medicine, there is a strong effort to remove physicians from the care of our patients.

Physicians of the past were considered the experts in their respective specialties, gatekeepers to practicing medicine and maintaining patient care. The whitecoat,

Continued on page 17

APRN Compact: Be on the lookout

With lawmakers heading back to the legislatures for 2022 legislative sessions, State Affairs strongly urges state component societies to be on the lookout for legislation seeking to adopt the dangerous APRN Compact.

Unlike other healthcare-related compacts, the APRN Compact is highly concerning because once effective, any advanced practice registered nurse (APRN) who holds a multistate license under the Compact will be authorized to practice without physician involvement, using the Compact language to bypass and supersede state law.

In fall 2020, the National Council of State Boards of Nursing (NCSBN) adopted amendments to the APRN Compact. Instead of 10 states now being required to enact the compact, seven states are now required.

The APRN Compact is based on NCSBN's review of other compacts, looking for the compact that requires the least number of states to enact the language – the PSYPACT Compact (applicable to psychologists). The rationale for this change was NCSBN's recognition that state lawmakers are extremely hesitant to enact this Compact – which State Affairs believes is because it supersedes state law with respect to physician involvement requirements for APRNs, including nurse anesthetists.

Although NCSBN likely recognizes this as a barrier to adoption, it has not altered this concerning language and stands firm that the Compact must supersede state law because, according to NCSBN, the laws are "so different in every state, and with a compact, you need that uniformity."

Thus, to address the challenge faced by lawmakers' hesitation, NCSBN lowered the state adoption requirement rather than address the core issue of superseding state law.

In 2021, two states (Delaware and North Dakota) introduced and adopted the APRN Compact. Only five more are needed before the Compact becomes effective.

It is clear from NCSBN's amendments that it will continue to push the APRN Compact in other states, and physician anesthesiologists should be extremely vigilant for its introduction in their state legislatures. For questions, please contact State Affairs Manager, Erin Mahrt, JD at e.mahrt@asahq.org.

Physician Advocacy, *from page 16*

Hippocratic oath, and integrity of the field of medicine had largely been unchallenged by non-physician providers. The practice of medicine has improved dramatically in areas of patient care, technology, and respect of patient autonomy.

However, we will ultimately fail our patients as gatekeepers of best practice and patient safety if we allow unrestricted, unsupervised patient care. Patients deserve to know who is treating them, what their education is, and ultimately who is responsible for their care in the event of adversity.

It is our duty to engage the public and the government to protect the millennia-long patient-physician relationship from being compromised. Medical schools and residencies must better prepare physicians to engage the community on healthcare policy and ethics.

Additionally, residents and medical students must be educated on how to be advocates for their profession to legislators. We work tirelessly to provide the utmost care for our patients, and that duty does not end when we leave the hospital doors.

The realization that we risk doing too little too late is what inspired this group of physicians to assemble on that cold morning. Yet many go about their jobs each day unaware; unaware that their careers may be changed entirely without their consent.

Our silence on these important issues implies indifference toward others who are taking actions that will permanently shape our future and diminish our leadership in healthcare.

We can influence decisions and decision-makers. With our careers potentially on the line, we would like to posit that we have an obligation to advocate.

Once famously put, "if you don't have a seat at the table, you're probably on the menu."

Anesthesia in the News: A new lens on common provisions . . . and more

By Judith Jurin Semo, Esq.

Judith Jurin Semo

Exclusive contracts with hospitals and ASCs. Non-competes with anesthesiologists. "Everyone" has them. Of course, they're permissible, right? Well, maybe not.

Originally, this article was intended to provide an update on recent developments relating to exclusive contracts, non-competes, and no-poaching agreements and how commonplace arrangements may be viewed as illegal, depending on the facts. The scope of this article expanded following a November 9, 2021, Department of Justice ("DOJ") press release announcing a major settlement relating to alleged kickback arrangements between anesthesia groups, and ASCs and their referring physician-owners.

The goal of this article is to sensitize readers to the risks associated with commonplace arrangements, and to remind them of the enforcement risks associated with kickbacks, so that they are not caught by surprise if the government – or a whistleblower – comes knocking.

Bellingham Anesthesia Associates Settlement with Washington State Attorney General's Office

On August 26, 2021, the Washington State Attorney General ("WSAG") announced an antitrust consent decree with Bellingham Anesthesia Associates ("BAA"), under which BAA "must end its illegal dominance of the local healthcare market" and pay $110,000 in costs and fees.

According to the Attorney General, "BAA used unlawful non-compete clauses and exclusive contracts with area medical providers to take about 90 percent of the market share for physician-administered anesthesia services in Whatcom and Skagit counties.

This legally enforceable agreement requires BAA to cease illegally requiring physicians to sign three-year non-compete contracts." https://www.atg.wa.gov/news/news-releases/bellingham-medical-providers-must-end-illegal-non-compete-contracts-pay-110k/.

It first should be noted that BAA did not admit to the allegations in the WSAG complaint, there has been no finding that the WSAG allegations are true, and that the discussion in this article is based on the settlement negotiated by BAA and the WSAG.

The consent decree filed with the court (https://agportal-s3bucket.s3.amazonaws.com/BAA_ConsentDecree_Conformed.pdf) provides some factual details, but does not provide context as to why the WSAG pursued this matter.

The settlement cites that BAA used exclusive agreements with healthcare facilities and "overbroad and restrictive non-compete agreements with its employed and shareholder physicians." Both such arrangements are common. In fact, exclusive contracts and internal non-competes are more the rule than the exception.

Often it is the facilities – the hospitals and ASCs – that insist on exclusive contracts. Anesthesia practices similarly tend to want exclusivity, as they do not want to find others cherry-picking cases if the practice is obligated to provide full coverage. Post-termination non-competes for physicians in an anesthesia practice also are quite common.

The BAA settlement is of note because exclusive contracts and internal non-competes are commonplace among anesthesia practices, at least in those states such as Virginia in which non-competes are permissible. In fact, in some cases it is the hospitals that mandate that the anesthesia group have a noncompete with its physicians. So what led the WSAG to conclude that in the facts of the BAA case, BAA's use of those arrangements "foreclosed the market to new competition"?

The one factor that may distinguish BAA is its location in Bellingham, Washington, which is a city of about 50,000 people located about 90 miles north of Seattle and twenty-one miles south of the U.S.-Canada border. The settlement agreement recites that BAA is the exclusive provider of anesthesia services to a number of acute care hospitals in four Washington counties, as well as two ASCs in Bellingham, and one ASC in the adjoining county to the south of Bellingham. BAA had three-year non-compete agreements with all of its anesthesiologists, employees and shareholders. Following enactment of a Washington State law limiting the permissible length of non-competes, BSA reduced the time from three years to eighteen months for its employed physicians, while retaining the three-year restriction for shareholders. The WSAG concluded that, in that market, the combination of the multiple exclusive contracts and the internal non-competes was problematic.

How the BAA situation became known to the WSAG is not known, though this author speculates that perhaps a competitor in the market or a current or former employee of BAA raised the issue.

The remedy to which BAA agreed was that it would not include or agree to any exclusivity provision in any facility contract with a non-acute care facility, such as ASCs. It also may not enforce any exclusivity provision in any existing facility agreement. As for non-competes, BAA agreed that it would not require any employed physician to sign a noncompete that applied for longer than nine months and that non-competes with shareholder physicians would not be longer than twelve months.

The Takeaway from the BAA Settlement

The lesson for anesthesia groups in Virginia is that, especially if they are not in large urban areas, they should consider their "footprint" in the market and reconsider the implications of their growth and expansion to new sites.

Second, they should revisit their restrictive covenants with their anesthesiologists and nonphysician anesthetists, to assess

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whether those covenants are narrowly tailored to address each group's legitimate interests. (Doing so is a good idea in any event, as Virginia courts enforce noncompete only as written. If they are overbroad, they are not enforceable.)

Scrutiny of non-competes and no-poaching agreements at the federal level

The BAA consent agreement comes in the context of federal scrutiny of restrictions on employees and whether they violate the federal antitrust laws.

On July 9, 2021, President Biden issued an Executive Order on Promoting Compensation in the American Economy (https://www.whitehouse.gov/briefing-room/presidential-actions/2021/07/09/executive-order-on-promoting-competition-in-the-american-economy/).

In that order, President Biden expressed concern with consolidation, which has often led to "excessive market concentration," and he singled out noncompete and "other clauses or agreements that may unfairly limit worker mobility."

In particular, he directed the Federal Trade Commission ("FTC") to consider exercising the FTC's authority "to curtail the unfair use of non-compete clauses and other clauses or agreements that may unfairly limit worker mobility."

He also encouraged the FTC and the Attorney General to consider whether to revise the October 2016 "Antitrust Guidance for Human Resources Professionals" (https://www.justice.gov/atr/file/903511/download) to protect workers from wage collusion.

In that 2016 guidance, the DOJ and FTC announced that they would investigate on a criminal basis, allegations that employers have agreed on employee compensation or have agreed not to solicit or hire each others' employees. Anesthesia practices must consider the DOJ/FTC guidance in connection with any "nonsolicitation" or "no-poaching" agreement in their hospital and ASC services agreements. Anesthesia practices often want to include no-poaching language in such services agreements with hospitals and ASCs in order to protect against fragmentation of their practices, and to strengthen their negotiating positions vis-à-vis the facility. The 2016 guidance is a reminder of the potential risks associated with such no-poaching agreements, depending upon the context.

The bottom line is that there will be a continued focus on non-competes and no-poaching agreements and possible action on the federal and state levels.

Class action lawsuit relating to a no-poaching agreement

In a separate development on this same topic, a CRNA employee of Traverse Anesthesia Associates ("TAA") in Traverse City, Michigan, filed a class action lawsuit on August 2, 2021 against TAA and Munson Healthcare alleging that Munson had agreed not to solicit or hire TAA's anesthesia personnel and that the agreement was to suppress the compensation paid to such personnel.

This lawsuit is in the very early stages, but it points to the potential for anesthesia group personnel to file suit to challenge no-poach agreements between their employer practices and the facilities at which they practice. https://www.record-eagle.com/news/lawsuit-accuses-munson-traverse-anesthesia-associates-of-no-poach-agreement/article_3c9d-cd94-fee1-11eb-8216-4781e05fb0e9.html

$28 Million Settlement by Anesthesia Providers, ASCs, and Referring Physicians

This next topic is conceptually separate, in that it relates to kickback issues. In essence, this development illustrates the focus of federal fraud and abuse enforcement efforts on ridding the healthcare system of improper influences and on promoting fair and free competition.

On November 9, 2021, DOJ announced that three anesthesia providers – Ambulatory Anesthesia of Atlanta, LLC, Northside Anesthesiology Consultants, LLC, and Stanford Plavin, M.D. – and several ASCs and their physician-owners, and an administrator agreed to pay more than $28 million to resolve kickback allegations.

The allegations were that the two anesthesia groups had made payments for drugs, supplies, equipment, and labor, and had provided free staffing to the ASCs, to induce the ASCs to select the two anesthesia groups as their exclusive anesthesia providers, and that Stanford Plavin, M.D. negotiated these arrangements on behalf of the two groups.

DOJ alleged that these arrangements violated the Anti-Kickback Statute and caused the submission of false claims in violation of the False Claims Act. See https://www.justice.gov/usao-ndga/pr/anesthesia-providers-and-outpatient-surgery-centers-pay-more-28-million-resolve.

This settlement resolved a whistleblower (or qui tam) lawsuit that led to the DOJ settlement. The three whistleblowers ("Relators"), an anesthesiologist (Kathleen Hartney-Velazco, M.D.), anesthesia group (Capitol Anesthesiology, P.C.), and the vice-president of the anesthesia group (Jan Kersey) reportedly received over $4.7 million from the settlement.

Conclusion

The law is not static. In the case of non-competes and exclusive agreements, commonplace arrangements need to be examined in the context of the facts and circumstances in which they were negotiated and presently exist to assess their legality.

In the case of kickbacks, which depend on a finding of intent, anesthesiologists need to be mindful of the very high stakes and risks associated with arrangements with referring physicians and facilities.

Heed the adage – Proceed with Caution – or proceed at your peril.

Member Spotlight: On the opioid crisis, pain expert Dr. Denise Lester is "Silent No More"

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Dr. Denise Lester

When she isn't researching new, non-opioid treatments for pain, Denise Lester, MD, is raising awareness and prevention of opioid use among hundreds of at-risk teens.

In this ASA Member Spotlight, she shares how she got involved on both sides of this important issue and the impact she's having in her local community and beyond.

You're a double-boarded anesthesiologist and chronic pain physician with a certification in addiction medicine. Can you tell us a bit more about the focus of your practice and how it's changed over the years, especially given the opioid crisis?

I have been a chronic pain physician at the Central Virginia VA Health Services Center in Richmond for more than 25 years. During most of those years I focused primarily on training our pain management fellows from an academic standpoint and clinically treating a large variety of complex painful conditions including cancer pain, perioperative pain and palliative care–related pain.

We provided our veterans state-of-the-art pain care ranging from minimally invasive complementary alternatives (examples include acupuncture, tai chi and mindfulness training) to more invasive techniques such as implantable drug delivery systems, spinal cord stimulation, Kyphoplasty, Osteocool, intradiscal procedures and many other procedures for pain.

Over the years my practice has changed significantly thanks to the opioid epidemic, as well as a "perfect storm" of other factors. First, the opioid crisis.

About ten years ago the primary care service, which typically relied on the pain service for its complicated patients, began to steer away from an opioid management fallback in refractory pain. With the buy-in of the hospital we were granted the resources to try new and novel alternatives to opioid therapies.

At the same time, our regional amputation center was struggling to keep up. Several VHA hospitals funneled all of their amputations our way, making us one of the largest amputation centers on the East Coast. Suddenly we were seeing not only a very large number of amputations but also a combination of new amputation patients with pain coupled with severe chronic postamputation debilitating disorders.

We now had to manage a large group of amputations who had been quite suddenly taken off all analgesics except their acetaminophen and maybe some low-dose NSAIDS.

That really spurred us to try new things. For example, we already had a strong background in our pain training using electricity to assist pain. We had many years of placing and managing spinal cord stimulators and other topical and implantable electrical devices to manage pain, and we understood that electricity applied to a patient's nerves, spinal cord, skin or even parts of the brain can be more effective in some situations—especially for neuropathic pain. So we were not fearful of trying new methods of instilling electricity as a primary analgesic.

When innovation for electrical implantable analgesia entered the market (such as the temporary peripheral nerve stimulating implant and even the permanent peripheral nerve stimulator) we were ready.

Also, ultrasound guidance has become so very much more available to us over the past ten to 15 years. Once it became commonplace in our pain center we were able to implant the peripheral nerve stimulators in our clinic procedure rooms without having to delay cases awaiting operating rooms.

Lastly, we were primed to create a brand-new interventional pain research program at our facility. We had wanted to take on more research for quite some time over the years, but with clinical duties a priority and our busy administrative schedules on local, regional and national VHA committees, research just seemed like a goal without a plan.

Then in 2017 our facility was looking to award five startup grants of 50,000 each to incentivize physicians to begin research projects on their service. Several of my colleagues, including anesthesiologists Dr. Brooke Trainer, Dr. Rob Trainer and Dr. Erik Baker and physiatrists Dr. Doug Murphy, Dr. Thomas Phan and Dr. Meenu Bindal got together and said, "How can we use this 'perfect storm' to benefit our veterans?" We applied for the grant and our interventional pain research team was born.

Dr. Rob Trainer and I are the co-directors of the interventional pain research team housing about 20 investigators and we have been the primary investigators of several studies since that time, including our four-year "Perioperative Temporary Peripheral Nerve Stimulation Implant Post Amputation" study, which Dr. Brooke Trainer will be publishing this year, our "Temporary Peripheral Nerve Stimulation Implant for Chronic Low Back Pain" study, which will be ongoing for the next four years under Dr. Meenu Bindal, and our retrospective review by Dr. Rob Trainer of several hundred temporary peripheral nerve stimulating implants for neuropathic pain since 2017.

We feel that this research benefits not only our veterans currently but also their future as well as the future of our pain fellows, residents and ACGME approved pain programs at CVHSC.

What would you most like your fellow physicians to know about non-opioid alternatives to analgesic modalities?

It is a very exciting time for both electricity-induced analgesia and also regenerative medicine for pain control. It's so easy and quick to place peripheral nerve stimulating implants at the source of pain. It doesn't require a prolonged surgery or recovery time and the skill set is easily achieved using ultrasound guidance.

Also, with the new temporary leads on the market it is less committal when compared to life-long implants - as patients can have their providers remove them at 60 days and achieve a "hangover" pain relieving effect sometimes past one year or longer.

Regenerative medicine is also an up-and-coming alternative to opioids There are many new studies introducing the concepts of using cellular materials (such as plasma, and even amniotic tissues) to promote pain control. The future is vast with non-opioid therapies.

You're also a well-known advocate and educator to increase opioid-abuse awareness and prevention in your community. What are some of the

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programs you work with?

The list of opioid awareness and prevention projects that I work on is quite long, but my primary project involves working in the community in a program called Silent No More.

This program is an opioid awareness immersion program in Virginia middle schools and high schools. Since 2019 I have been traveling throughout middle schools and high schools in the Richmond Virginia area monthly teaching a two-hour "neurobiology of addition" program as part of a team including Dr. Robert Trainer as well as two mothers that share their experience with high school sons who suffered with opioid use disorder and succumbed to the disease.

There are also presentations by the DEA, the federal prosecutor, and slideshows and videos that demonstrate the impact of not only the decision to start opioids but also the biological, domestic and legal consequences of the same.

We are very excited to be one of the exceptions to the rule where we have a speaker who understands and lectures on the connection between mental health disorders and overuse disorders.

Our last presenter on the team is a survivor voice who discusses hope in recovery. We engage with the kids right in the aisles of their high school auditorium! We have them do interactive challenges on stage demonstrating the activity of the Prefrontal Cortex versus the Nucleus Accumbens. Yes, sledgehammers are part of the skit!

According to post education student surveys this interaction helps them remember the target points. We touch on treatment and especially being "silent no more" as evidenced by their "chanting" that slogan loudly and emphatically as I end my lecture.

Many of the kids have thanked us and most of the kids report knowing someone who is suffering with the disorder. Kids have rushed down to the front of the auditorium post-lecture to tell us they have been using substances since they were 10 or 12 and they want to stop. Kids have said they wish they knew the brain pleasure center was being "hijacked" and that's one of the reasons their dad had such difficulty with relapses before they lost him.

It has indeed been an emotional rollercoaster teaching the kids and hearing their stories, but it has also been an immense pleasure working on the mission. I believe it makes a difference.

Our team is also partnering with the board of education for state of Virginia to align teaching with the standard of care discussions on substance use disorder. We are also starting a new project where we are trying to facilitate a partnership with emergency medicine walk in overdose and peer support recovery. We are all very thankful to Kim Ulmet and Olivia Norman from the United States Attorney's office for their vision and consistent hard work for this program since 2019.

In addition to Silent No More, I'm also a member of the Central Virginia Overdose Working Group (CVOWG), a group of experts from a variety of disciplines that work together toward preventing overdose in Virginia, among other initiatives and projects.

What can others do if they'd like to get involved with these types of efforts?

There are many ways to help and volunteer time or donations to the opioid awareness campaigns. With the rise of Stimulant Overuse Disorder many more resources are needed, and physicians can play a major role in assisting their communities.

A large organization ASAM (American Society of Addiction Medicine) consistently has information on their website on how to become and advocate of prevention and recovery in overuse disorders.

Additional organizations include Voices for Non-Opioid Choices and SAMSHA (Substance Abuse and Mental Health Services Administration). Local hospitals are always appreciative for physicians as well as your local and state school boards and departments of education.

Of course, if you live near the Richmond area and you'd like to hear more about working with me on Silent No More please feel free to contact me.

Is there anything we haven't discussed that you'd like to talk about here?

I don't often talk about all aspects of my life publicly but today I will talk about another healthy community activity I've done for more than half of my life: fitness instruction.

I'll tell you why. We all know that being a doctor and "doctoring" your patients involves more than just knowing their MRI results, knowing their lab values or the results of their flexion/extension films in pain management. It truly is about connecting. You only have about 10-15 minutes in your clinic visit despite what it says on your clinic schedule. During that time you have to decide not just what's going on in their spine or in their knee joint but just…"what's going on," period.

Depression, suicidal ideation, anxiety, domestic violence, substance use disorder, divorce, abandonment, homelessness, court dates…some of our veterans are going through things we have only ever seen on the big screen.

You need to develop the connection with your patients that they can trust you. So, in that 15-minute visit you can not only decide what's next for their spine pain but also what's next for their life experience.

One of the ways that I've become such a skilled "connector" is by serving the community as a community fitness instructor for over 20 years.

It started out as a (really really) fun hobby—in fact, I have now accumulated over 40 current mixed fitness certifications (yoga, spin, boxing, lifting, etc. and teach fitness daily). I soon realized that when I connected with my fitness students something felt very familiar.

My fitness students had similar goals. They wanted a feeling. They were interested in just being better than yesterday. They wanted to move better and emotionally feel better and live better—and that's exactly what my pain patients wanted, too. Fitness exercise drills involve the expression of dopamine at the CNS and so does pain relief after years of chronic pain.

My pain patients wanted me to look at them and not judge. To choose to look but not judge them for their obesity or their anxiety or substance use disorder behaviors. They wanted me to listen to them and not quickly give my opinions. They wanted me to guide and not direct.

So, I say all of this to inspire all of you to remember to remain the best connector that you can be with your patients, so that they can help you help them.

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Update!

Since this article was first published in October 2021, Dr. Lester has been busy building an expanding her partnership initiatives.

Here's the latest (as of February 2022):

In addition to my role in the high school opioid submersion program Silent No More, I'm also a member of the Central Virginia Overdose Working Group (CVOWG).

This group of nearly 350 experts from a variety of 14 disciplines work together toward preventing overdose in Virginia, among other initiatives and projects. Through routine meetings, the CVOWG members bring ideas, concerns and gaps to the attention of the working group. The Group has since de-

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ASA ADVANCE Meeting Recap

By Casey Dowling, DO, FASA
Treasurer/Delegate, VSA
Winchester Anesthesiologists, Inc.


Dr. Casey Dowling

I had the pleasure of attending the ASA rebranded business meeting ADVANCE. This meeting caters to anesthesia administrators and executives (AAE) as well as to physician anesthesiologists interested in the business aspect of running a practice.

For many years the ASA business meeting has had "tracks" e.g., AAE and Essentials of Anesthesiology Practice. The tracks for ADVANCE have remained, but for this year's conference attendees could attend any of the meetings in any of the tracks.

I took full advantage of this ability and chose my lectures by topic alone. This worked well for me with only one unintended consequence.

At an AAE lecture, the moderators spoke about physician anesthesiologists almost as if we weren't there. "Don't bother the doctors with lots of numbers. Just give them a simple chart". And while it hurt just a little, I'm sure they meant well, and I did gain a very interesting perspective!

Speaking of perspective, I attended a lecture on "Nudge Theory". You know that EMR bubble that asks if you have given an antibiotic? Yup, that a 'nudge'. Not at all new apparently, but new to me and I found it fascinating. I encourage practice leaders to investigate this method when looking for a benign method to encourage a certain behavior.

A consistent theme to all the lectures was that physician anesthesiologists can no longer operate under our historic M.O. of being "under the radar". We need to be seen, and we need to be seen as invaluable. We need to be an active partner aligned with the goals of our hospital system. And the system is certainly not going to see us as we want unless we show them.

I would be remiss if I did not mention that this meeting was not without an episode of drama. The Main Conference on Saturday morning had an Ask the Expert session. The experts were our President, Randall Clark, Chief Advocacy and Practice Officer, Manny Bonilla, and ASA CEP, Paul Pomerantz.

An attendee stood and told the story of how his group was ousted from one of its practice sites after being given only a very short time to generate a Request For Proposal. What upset this attendee the most, was when his group sat down at the negotiating table, the representative of the soon to be new anesthesia group, was one of his own ASA officers.

He felt truly betrayed. This attendee then demanded from the experts that this officer resign from his position due to conflict of interest.

It should be noted that said officer was present and stood to say that all facts were not in evidence, and that events did not go down quite as stated.

Dr. Clark also clarified that the ASA stands neutral on public equity anesthesia companies, as many members are employed by them. But I must be honest when I say, that I too feel this attendee's fear and anger. I too feel the larger companies breathing down my small-to-medium group's neck. I know that for the survival of our specialty we need a unified ASA. But I worry, and I wonder, if we have met the enemy and he is us.

Denise Lester, *from page 21*

veloped eight targeted committees to develop solutions to the Working Group's ideas.

One gap realized was the need for more peer support in the community; particularly in the immediate aftermath of an overdose. As such, members of the Working Group applied for and received over $300,000 in discretionary funding through the Washington/Baltimore High Intensity Drug Trafficking Area (HIDTA), for subgrantee Substance Abuse and Addiction Recovery Alliance of Virginia (SAARA) to fund Project RECOVER.

The purpose of Project RECOVER is to bridge the gap between emergency responders, law enforcement, medical, treatment and recovery communities in Central Virginia, and leverage a continuum of services to the community following emergency and law enforcement responses in drug trafficking operations.

The overall goal of Project RECOVER is to reduce overdoses, death and the stigma associated with substance use disorder ("SUD") through the use of Peer Recovery Specialists ("PRS") in the aftermath of emergency response and drug trafficking enforcement operations.

Four certified peer recovery specialists and a certified supervisory peer recovery specialist will be dispatched with Richmond City Police Department, Richmond Ambulance Authority, Chesterfield County Police Department and Henrico County Fire/EMS. They will assist overdose victims in getting into treatment and recovery programs immediately following resuscitation and will provide a continuum of follow-up services and support.

The peers will also provide similar services and support after receiving dispatch calls from Bon Secours Medical Center Emergency Departments in Central Virginia after walk-in and drop-off overdose victims are resuscitated.

And, lastly, they will provide services and support to federal witnesses who are in need of treatment and recovery services.

All of the peers have been hired and the peers began working the last week of January 2022. On their first day on the job with Richmond Police Department, they received a referral from a police officer and they were able to get the overdose victim into treatment. Exciting times!

Denise Lester, MD, is a Board-Certified Anesthesiologist and Pain Management physician. She also holds a certification in Addiction Medicine from the American Board of Preventive Medicine.

She's the director of Peripheral Nerve Stimulation Implant Program and Co-Director of Interventional Pain Research at the Central Virginia VA Health Services Center.

She obtained her MD degree at the New Jersey Medical School and completed her anesthesiology residency and Pain Management training at Thomas Jefferson University Hospital.

Dr. Lester has held academic and clinical interventional pain physician positions for the past 24 years. She has served as teaching staff for the Virginia Commonwealth University Pain Fellowship since 1998.

She has extensive experience in the use of central and peripheral neuromodulation for peri-operative, chronic and cancer pain.

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