Critical Thinking – Part Three

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Tempting Response to Some Inquiries

I’d agree with you, but then we’d both be wrong

Concurrent Surgery

• Last year we reviewed activity related to concurrent surgery
• Since then, the American College of Surgeons and the Senate Finance Committee have issued policy statement and a report
• It is possible that there will be CMS activity related to these reports
Basic Overview of Overlapping Surgeries

- Overlapping surgeries generally occur when two surgical procedures under one attending surgeon overlap in part

- Overlapping surgeries may occur at:
  - Teaching hospitals (often with the assistance of residents)
  - Non-teaching hospitals (often with help from other surgical assistants)

- Over the past 1.5 years, we have seen a significant surge of attention surrounding these issues

Numerous Considerations and Stakeholders

- Hospital output
- Teaching effectiveness
- Surgeon production
- Patient care
- Billing and Compliance
- Patient informed consent
- Whistleblowers
- Media attention
- Political attention
- Government enforcement

Brief Overview of Medicare Rules for Teaching Surgeries

- Medicare billing rules for teaching surgical services permit certain parts of two surgical procedures, under the supervision of one attending surgeon, to overlap in certain circumstances
  - The teaching surgeon must personally document in the medical record that he/she was physically present during the key/critical portion(s) of both procedures
  - The teaching surgeon has discretion to define the key/critical portion(s)
  - When the key/critical portion of one procedure is over, the teaching surgeon may move to a second procedure. The teaching surgeon must designate another qualified surgeon to be immediately available for the first procedure, should the need arise

See 42 C.F.R. § 415.172; Medicare Claims Processing Manual, Ch. 12
Brief Overview of Medicare Rules for Teaching Surgeries

- Medicare does not pay for instances where the key/critical portions of both procedures overlap (others call this "concurrent" surgery)
- Three overlapping teaching surgical procedures are not billable to Medicare
  See 42 C.F.R. § 415.172; Medicare Claims Processing Manual, Ch. 12

Brief Overview of Authority for All Overlapping Surgeries, Including Non-Teaching Procedures

- No Medicare payment rules for non-teaching overlapping surgeries
- Medicare Conditions of Participation call for providers to deliver surgical services in accordance with acceptable standards of practice (See 42 C.F.R. § 482.51)
  - Consider guidelines from industry groups, such as the American College of Surgeons
- Consider State Law
- Consider State Medical Board requirements
- Consider Joint Commission and other accreditation requirements

Increased Media Attention: Boston Globe Investigative Report

"CLASH IN THE NAME OF CARE"
Political Interest Spurred by Media Attention

- In February 2016, a letter from the Senate Finance Committee was sent to 20 hospitals and health systems across the country.

December 6, 2016 Senate Finance Committee Report

The Senate Finance Committee released a report on concurrent and overlapping surgeries, highlighting areas of Congressional concern, including:
- Hospital policies, or lack thereof
- Ensuring compliance with policies
- Practice of “concurrent” surgeries where key/critical portions of two procedures overlap
- Patient safety
- Patient informed consent
- Improper payments and billing concerns
- Lack of Medicare payment regulations in non-teaching context
- Lack of government enforcement

Recent and Significant Qui Tam Enforcement Activity

- **January 2017**: Vanderbilt close to finalizing settlement to resolve False Claims Act suit brought by three physicians who allege the University’s medical center billed Medicare as if physicians were present for the key/critical portions of procedures when only residents were present.

- **August 2016**: A qui tam lawsuit filed by a former medical resident against an Advocate Health Care teaching hospital is unsealed.
  - Allegations include that surgeons improperly sued (and billed for) assistants at surgery (including PAs) when qualified residents were available to assist.
Recent and Significant Qui Tam Enforcement Activity

- July 27, 2016: DOJ announces a $2.5 million settlement with the University of Pittsburgh Medical Center and related organizations to resolve False Claims Act allegations in connection with a qui tam lawsuit
  - Complaint alleged neurosurgeons submitted claims for surgical procedures performed by other surgeons or practitioners, when the neurosurgeons did not participate in the surgeries to the degree necessary to bill for the claims
  - One of the whistleblowers was a neurosurgeon
- January 2014: Individual surgeons settled with whistleblowers (one whistleblower was an orthopedic surgeon) in a case against Rush University Medical Center
  - Allegations include that surgeons improperly billed for overlapping surgeries that did not meet Medicare rules

American College of Surgeons (ACS) Statements on Principles

Qualifications of the Responsible Surgeon
- Competencies
- Commitment to scientific knowledge and research
- Commitment to maintain fitness
- Eligibility to perform surgical procedures
- Educational requirements
- Continuing practice within a specialty
- Surgical assistants

Relation of the Surgeon to the Patient
- Informed consent
- Informed care
- Preoperative diagnosis and care
- The operation—Intraoperative responsibility of the primary surgeon
- Postoperative care
- Continuity of care
- Freedom of choice
- Confidentiality of medical records
- Conflict of interest
- Unnecessary operations
- Quality assurance
- Surgical fees

American College of Surgeons Statements on Principles

Interprofessional Relations
- Surgeons and colleagues
- Discrimination or harassment
- Consultations
- Payment
- Relationships to nonphysicians

Medical Education
- Continuous medical education and professional development
- Students/residents

Surgeons and Society
- Surgical research
- Scientific publications
- Public relations
- Advertising
- Expert testimony
- Impaired physicians
- Incompetent surgeons
- Maintenance of fellowship

References

Appendix
General Statement (ACS)

- The primary attending surgeon is personally responsible for the patient’s welfare throughout the operation
- In general, the patient’s primary attending surgeon should be in the operating suite or “immediately available” for the entire surgical procedure

Key Principles

- Concurrent or Simultaneous Operations
  - When critical or key components of the procedures, which the primary attending surgeon is responsible, occur all or in part at the same time
  - A primary attending surgeon’s involvement in concurrent or simultaneous surgeries on two different patients in two different rooms is inappropriate

Key Principles

- Overlapping Operations
  - The most common scenario is when the key or critical elements of the first operation have been completed, and there is no reasonable expectation that the primary attending surgeon will need to return to that operation
  - Another less common scenario is when the key or critical elements of the first operation have been completed and the primary attending surgeon is performing key or critical portions of a second operation in another room
  - Backup surgeon identified and immediately available

- Multidisciplinary Operations
  - Surgeons present only during the part of the operation that requires their surgical expertise
Other Related Circumstances

- Delegation to Qualified Practitioners
  - The surgeon may delegate part of the operation to qualified practitioners
  - The attending surgeon’s personal responsibility cannot be delegated
- Procedure-Related Tasks
  - The attending surgeon may have to leave the OR for a procedure-related task
  - The surgeon must be immediately available for recall during such absences
- Unanticipated Circumstances
  - During procedures the attending surgeon may be required to leave the OR before completion of the critical portion of the operation
  - A backup attending surgeon must be identified and available to come to the OR promptly

The Patient Needs to be Informed

- Surgeon-Patient Communication
  - Preoperative discussion
  - Patients informed of the different types of qualified health care professionals who will participate in their operation and their respective role
  - If a situation arises that requires the surgeon to leave the OR unexpectedly, the patient should be informed subsequently

Definitions (ACS)

- Concurrent or simultaneous operations
  - Surgical procedures when the critical or key components of the procedures for which the primary attending surgeon is responsible are occurring all or in part at the same time
- "Critical" or "Key" portions of an operation
  - The "critical" or "key" portions of an operation are those stages when essential technical expertise and surgical judgment are necessary to achieve an optimal patient outcome. The critical or key portions of an operation are determined by the primary attending surgeon.
- Immediately available
  - Reachable through a paging system or other electronic means, and able to return immediately to the operating room. This term should be defined more completely by the local institution.
- Informed consent
  - Described in American College of Surgeons Statements on Principles II.A.
- Multidisciplinary operations
  - An example of a multidisciplinary operation is a procedure in which a surgeon of one specialty provides the exposure required by a second surgeon who performs the main surgical intervention (such as a general or thoracic surgeon providing exposure for a neurosurgeon or orthopaedist to operate on the spine). Another example would be an operation that requires the involvement of two or more surgeons of different specialties (such as a chest wall or head and neck resection followed by plastic surgical reconstruction, face or hand transplantation, and repair of complex craniofacial defects).
Definitions

Overlapping or sequenced operations for surgeons
• The practice of the primary surgeon initiating and participating in another operation when he or she has completed the critical portions of the first procedure and is no longer an essential participant in the final phase of the first operation. These are by definition surgical procedures where key or critical portions of the procedure are occurring at different times.

Physically present
• Located in the same room as the patient.

Primary attending surgeon
• Considered the surgical attending of record or the principal surgeon involved in a specific operation. In addition to his or her technical and clinical responsibilities, the primary surgeon is responsible for the orchestration and progress of a procedure.

Qualified practitioner
• Any licensed practitioner with sufficient training to conduct a delegated portion of a procedure without the need for more experienced supervision and who is approved by the hospital for these operative or patient care responsibilities.

Recent Data

Outcomes of Concurrent Operations: Results from the American College of Surgeons’ National Quality Improvement Program
Jason B. Liu, Julia R. Berian, Kristn A. Ban, Yaoming Liu, Mark E. Cohen, Peter Angelos, Jeffrey B. Matthews, David B. Boyd, Bruce L. Hall, Clifford Y. Ko
• Annals of Surgery, submitted April 2017

Safety of Overlapping Surgery at a High Volume Referral Center
Hyder, Joseph A. MD, PhD; Hanson, Kristine T. MPH; Storlie, Curtis B. PhD, Glasgow, Amy MHA; Madde, Nageswar R. BS; Brown, Michael J. MD; Kor, Daryl J. MD, MSc; Cima, Robert R. MD, MA, FACS; Habermann, Elizabeth B. PhD, MPH
• Annals of Surgery, in press, 2017

No Safety Issues

Sample Policy: Surgeon Presence in the OR

• Must be present for the time out
• Must be present for all critical portions of case
• Must be immediately available for the duration of the procedure
• For overlapping surgeons, back up surgeon must be identified — must be qualified to do the procedure and not involved in another surgery
Sample Policy

- Back up surgeon will be identified in time out
- Critical portions of the case will be identified at time out
- Other limitations
- Violation of policy will result in loss of the ability to perform overlapping surgery

Do You Telehealth?

- Dr. Brainiac has a unique specialty in treating anorexia and other eating disorders
- Concerned parents and other physicians are calling him from other states and countries
- He wants to help using telehealth
- Can he give a consult to a patient in Alabama?
The Evolving World of Telehealth

- Started with written consent, onerous process; now verbal consent
- Possible solution to any concern about consent: include in terms and conditions of admission:
  - To facilitate my care, I consent to evaluation and examination by a physician or other health team professionals who may be physically distant from me via telehealth technologies, including but not limited to, two-way video, digital images, and other telehealth technologies as determined by my providers.

Legislative Intent

- It is the intent of the Legislature to create a parity of telehealth with other health care delivery modes, to actively promote telehealth as a tool to advance stakeholders’ goals regarding health status and health system improvement, and to create opportunities and flexibility for telehealth to be used in new models of care and system improvements

50 States, 50 Approaches

- You need a map to figure this out (and probably legal counsel). An interactive map can be found at http://www.telehealthpolicy.us/state-laws-and-reimbursement-policies
- You can click on the map as a starting point
- Either way, it is advisable to have a centralized clearing house to approve telehealth projects
Examples of Issues Addressed State by State

- Licensure requirements
- Frequency limitations on telehealth activity e.g., fewer than 10 consults per year
- Compensation or no compensation
- Peer-to-peer allowed with no patient contact?
- Can there be a written versus just verbal consult?

Issues Addressed State by State

- Can there be telephonic communication with an existing patient who has moved to another state?
- Prohibition against opening an office in a state where provider is not licensed
- Retention of medical decision making by the in-state physician
- Teaching ok; primary diagnosis or managing treatment not ok

Can you Relate?

I MADE A HUGE TO DO LIST FOR TODAY. I JUST CAN'T FIGURE OUT WHO'S GOING TO DO IT.
Dealing with Restraining Orders

- Baby Sarah is terminally ill and at the end of life; the parents are involved in domestic violence and there is a restraining order
- Both parents are grieving and want to visit together
- What do you do?

Dealing with Restraining Orders

- Little Johnny is here for heart surgery and is recovering nicely in the pediatric cardiac ICU. The mother told the staff that she has a restraining order, but she and her husband keep coming to the hospital together. Staff have overheard heated conversations
- Staff calls and asks for next steps

Dealing with Restraining Orders

- Ben is a patient in your primary care clinic. The parents are fighting and have a restraining order prohibiting them from being closer than 100 yards from each other
- The child’s mother is a behavior problem with your staff and insists that the father not be involved
- What do you do?
Restraining Orders

- The focus needs to remain on staff and patient safety
- It is not advisable to allow patients or parents to dictate whether the restraining order if followed
- Give clear direction on compliance — one visitor at a time or visitor restriction based on your visitation policy
- Involve security — escort or check in

Restraining Orders Against Patients

- After several warnings about his behavior, Mr. Stalk has repeatedly violated your terms and conditions of admission
- He received a written warning, too
- He began stalking members of the staff and showing up without an appointment
- Finally, the hospital wrote a letter, discontinuing his care and the police issued a stay away order

Terms and Conditions Related to Behavior

- [Redacted] has adopted a zero tolerance policy for violence in our facilities. As such, [Redacted] is committed to maintaining a safe workplace that is free from threats and acts of intimidation and violence. For the safety and security of our patients, visitors and staff, weapons, knives, alcohol, illegal drugs and other dangerous materials are not allowed in our facilities. It is the expectation of the Medical Center that you conduct yourself in a respectful, non-violent and non-abusive manner and that you do not leave the hospital at any time during your stay. It is against hospital policy for you to leave your assigned unit with property belonging to the hospital (example: gowns, IV machines, oxygen tanks, etc.). You may be discharged if you leave the hospital without informing your clinical team or if you repeatedly violate the hospital’s smoking policy.
Treatment in the Emergency Department

- After Mr. Stalk received his discontinuation of care letter, he shows up in your Emergency Department
- You are paged and the staff wants to know if they have to see him — they see the discontinuation of care in the medical record

EMTALA trumps the stay away order and discontinuation of care letter

- However, if the condition stabilizes and does not require hospitalization, there is no obligation to refer to patient to your own clinic
- You should have FYIs in your record to alert staff to these patient issues so that the risk of violent behavior can be managed (see Workplace Violence Prevention Act)

LGBTQ Patients: A Growing Community
Current Examples

- Jackie and Jane are a couple and decided to have a child, with Jane as the biological parent
- Jackie adopted their son, Ben
- Jackie and Jane break up and have joint custody of Ben
- However, after the break up, when they take Ben for medical treatment, the medical team deals only with Jane
- Jackie feels like she is the “emergency contact” only

Current Examples

- Steve and John have been together for many years; they are not married as they have never gotten around to it
- Steve is conflicted anyway because his family does not approve of his life style or John for religious reasons
- Steve is now in your hospital, without capacity, an Advance Directive or an Oral AD
- Steve’s parents are taking the position that they should make decisions as “next of kin”

Current Examples

- Julio presents to your Emergency Department, clearly in the midst of a psychiatric crisis — he is 18
- He has recently come to the United States, but is alienated from his family because he was “outed” as gay and his family has disowned him
- A review of some records thru Care Everywhere reveal some concerning history
Current Examples

- Julio is with Bob, who claims to have exclusive control over Julio as his “guardian, partner and attorney.” Bob is 30 years old.
- Bob wants to get a court order allowing him to remain the guardian until Julio turns 21.
- Bob presents an AD giving him decision making immediately and absolute right to be present and speak for Julio at all times — but Julio seems afraid of him.
- Bob does not want the physicians to ask Julio any questions — he is intimidating your staff.
- Some of the records reviewed question Bob’s motives.

LGBT Demographics

- Community is growing over time; difficult to know how much it is growing over time.
- As of 2011, 3.5% of population identified as lesbian, gay or bisexual.
- .3% identify as transgender.
- This approximates 9 million individuals.
- LGBTQ youth are at higher risk of sex trafficking and homelessness.

Health Care Bias

- While attitudes have improved over time, there is a long history of anti-LGBT bias in health care.
- This shapes health-seeking behavior and access to care for LGBT individuals despite increasing social acceptance.
- A comprehensive discussion of cultural competency is beyond the scope of today.
Resources

- California Domestic Partner Rights and Responsibilities Act of 2003 — Family Code section 297 et seq
- The Joint Commission Field Guide: “Advancing Effective Communication, Cultural Competence and Patient and Family Centered Care for the LGBT Community
  [http://www.jointcommission.org/lgbt/](http://www.jointcommission.org/lgbt/)

Resources

- Sex trafficking and LGBTQ Youth [http://polarisproject.org/children-youth](http://polarisproject.org/children-youth)
- Sex trafficking of LGBTQ individuals
  [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4204396](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4204396)
- Center for Transgender [http://transhealth.ucsf.edu](http://transhealth.ucsf.edu)

Some Basics — Policies

- Address anti-discrimination against LGBTQ community in policy:
  - Non-discrimination policy
  - Code of Ethical Behavior
  - Patient Complaints and Grievances
  - Patient Rights and Responsibilities
  - Inclusive Language
  - Visitation policy that ensures equal visitation
  - Policies defining “family” broadly
Some Basics

- Identify organizational initiatives to support the community and develop methods to measure
- Consistent with “Inclusive Language” policy, your forms should include inclusive gender-neutral language that allows self-identification
- Intake forms and patient interviews should be inclusive
- Waiting rooms, posters should include LGBT material

Health Care and Star Trek — The Next Frontier is Here

Chat Rooms, On-Line Education Apps, Health Care related Facebook pages

The e-World is Ever Expanding With …

- Social networking
- Professional networking
- Media sharing
- Content production blogs
- Knowledge/information chat rooms
- Virtual reality and gaming environments
Examples

- Teen Facebook group for cancer patients — to share their experience
- Web live nutritional classes with group discussion
- Patient and family blogs related to a certain disease
- Education about a new drug or treatment

Precautions

- Need confidentiality statements and agreements by participants
- Waivers
- Clear disclaimer that the health care provider does not control the conduct of the participants
- Discussion does not include medical consultation for emergency

Social Media Guidelines for Providers

- First: Ask for a risk assessment from your IT, Privacy, Risk, Legal teams
- Use credible sources only
- Remember content may be discoverable
- Comply with privacy laws
- Get consent as needed
- Know professional licensure for your state
- Do not contact patients with a request to join your network
Social Media Guidelines for Providers

- Avoid providing specific medical advice to non-patients
- Avoid writing about specific patients
- Keep personal and professional profiles separate to avoid stalking
- Disclose any in-kind or financial compensation received
- Do not make false or misleading claims

Remember … Once You Get Involved in Social Media …

- You have to be prepared to receive not only good feedback from participants, you may also receive negative feedback
- Generally, you have to be willing to take “the foam with the beer”

Questions?
Thank you

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