



Central Line
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(SOUNDBITE OF MUSIC)

VOICEOVER:

Welcome to ASA's Central Line, the official podcast of the American Society of Anesthesiologists, edited by Dr. Adam Striker.

DR. ADAM STRIKER:

Welcome to Central Line. I'm Dr. Adam Striker, your editor and host. Today, we're going to jump into the topic of practice management. We're fortunate to have Genie Blough, Principal for G. Blough Associates who does consulting work exclusively on anesthesia and pain management issues for a variety of groups and settings, as well as Dr. Patrick Allaire, Staff Anesthesiologist with McFarland Clinic in Ames, Iowa, and who currently serves on the ASA Board of Directors. Dr. Allaire has been engaged in long standing committee work, both at his institution in Ames, as well as at the ASA.

This past year has been tough because of the pandemic, many of us have been forced to deal in unprecedented ways with disaster management, practice disruption, mental health, stress management, even suicide awareness and prevention. It's certainly been a lot, so we're glad to have the point of view of both a physician and an executive here to give us the lay of the land and help us chart a path forward. Today I want to focus on the topic of disaster management and practice disruption. Just so our listeners know, we're going to record a second episode with the two of you dealing with the emotional fallout of disasters and disruptions, anxiety, stress, suicidal ideation and the COVID pandemic specifically.

Ms. Blough and Dr. Allaire, welcome to Central Line.

DR. PATRICK ALLAIRE:

Thank you.

MS. GENIE BLOUGH:

Thank you for having us.

DR. STRIKER:

No, absolutely. Do you mind both giving us a quick intro into your background and how you've come to practice management in these issues?

MS. BLOUGH:

Well, thank you, Dr. Striker.

Well, I actually came out of an academic program teaching computer science at the University and had an opportunity to start with an anesthesia group that was growing and expected to move someone into an administrative role. So the first day I showed up after having taught computer science at a University and I wanted to do three things. I learned how to operate the letter opener, how to run the postage machine, and somebody very quickly told me how to code Medicare. I didn't even know what code meant. And so obviously I failed at all three of those. And thankfully, I was able to move through every job position in the group, and in the billing operations and the, the practice operations until I was able to kind of at least understand what everybody was doing.

So, as an anesthesia administrator, I got involved with ASA along with a few of our physicians, and we were a care team at that point with five hospitals and three ambulatory surgery centers. And with about close to, we wound up close to 30 anesthesiologists and somewhere between 65 and 75 CRNAs. So we were a fairly good sized group and not that many of my physicians were members of ASA. Along with a handful of colleagues across the country, I attended the very first Practice Management Conference in, in Phoenix and I have not missed one since.

I have served on the Practice Management Committee for years and also developed an online education model. I've written articles for ASA and conducted surveys, and I'm a speaker at the ASA Annual Conference and Practice Management Conferences. I've been engaged in many areas of ASA, including committees, ad hoc committees and work groups, working with ASA and other administrators and executives, we all established the AAE category of membership a few years ago for ASA.

And now as a consultant, I consider myself an ASA ambassador, and I'm encouraging all the groups and all the physicians I've worked with to become, for the whole group, everybody in the group, to be an ASA member. And I think that's one of the great values of my role with the groups and with anesthesiologists and ASA, is that ASA really gets

the teamwork of working both on the business side and the, the clinic side. So that's how I came to be here.

DR. STRIKER:

Thanks very much, Ms. Blough. Dr. Allaire?

DR. ALLAIRE:

Dr. Striker, thank you for having me here today. I've been a staff anesthesiologist after completing my training at the Mayo Clinic in Ames, Iowa, for twenty-five years now. During that time, I founded and developed a pain medicine clinic. I served as Department Chair for many years. I've always been involved in committee work, including the Medical Executive Committee, and for the last several years now, I have Chaired the Physician Compensation Committee for the McFarland Clinic, as well as, I am the senior ranking member on the McFarland Clinic's Finance Committee.

Over the years, I became involved in state politics at the physician leadership level. So I've served in all of the offices for the Iowa Society of Anesthesiologists, which led me ultimately to becoming involved in Committee work with the ASA and being elected to the Board of Directors representing the State of Iowa, now.

For the last several years, I've been on the Practice Management Committee and recently, was very honored to be named Co-Chair of the Practice Operations Subcommittee with Genie. In addition to that, I serve as the Chairman of the ASA Board of Directors Committee on Finance.

DR STRIKER:

Excellent. Well, again, we are glad to have both of you here and let's get right to it. Let's start with the big picture. How should practices prepare for disasters or unexpected occurrences? Are there different types of disruptions practices should be prepping for? How do practices actually prepare? Ms. Blough, I'm throwing a big complex question at you, but I think you can speak to this.

MS. BLOUGH:

Well, people are often going to prepare for a disaster because they've been through one. And that's the best experience that you can have, whether it's fires, earthquakes, derechos, or as we have on the Gulf Coast, hurricanes. So for us being on the Gulf

Coast, we know they're coming. There may not get one this year. It may not be a direct hit, but past experiences have shown us really what we need to do to prepare.

So that kind of helps you prepare for something, if anything could have, for a pandemic. You need an action plan. So, who's going to cover? How are you going to cover the rooms? How are you going to make sure you can do all the cases that need to be done? And one of those things you'll need to know is, who can stay in the hospital? Like if, if we have a hurricane, you want to make sure you know who is most likely to be able to stay in a hospital. If you've got a lot of young children or children that are in school, that may not be the best arrangement. You can also make arrangements for the family to be with them. So if, if you're preparing for something that's going to be at least maybe two weeks duration, which there have been earthquakes and fires and things that would require you being in house quite a bit, you may not be able to swap out. So you kind of go there to live. You want to make sure that your family has an arrangement there as well. And our hospitals have always worked with us on that.

You also want to have a volunteer list so you know availability. During the pandemic, people would volunteer. It may be better for you to work nights because you have young children at home or there are other circumstances that you may have been a day working person, but maybe you want to switch or maybe you can volunteer for some extra nights. So you want to know that you have available. You need to identify your team and have a, a way to accommodate whatever this is going to be.

And what's going to trigger an action plan? So if you have a hurricane, you don't just immediately go into it, but you start thinking a day or so ahead. Now, that's the advantage of a hurricane as opposed to a tornado, or a derecho, or earthquake. You don't know those are coming. So when that happens, you have to be able to react quickly and, and know who's going to be in charge and, and how you're going to go about making sure that you've got a, a communication plan as much as anything planned. Just how is it going to work? What are you going to do if all the cell towers are out, or if the phones aren't working? How do you communicate? How do you, is there a relay system? Is there a backup plan for that?

Managing a, a pandemic like COVID is much different because it's long term. I think in March, we all might have thought it was not going to last that long. But of course, the longer we've been in this, it, it wasn't going to be a short term. So the short-term answers, you have to be able to take those short-term answers and come up with a, a longer-term plan. How are we going to manage this?

DR. STRIKER:

Right. I mean, it's certainly, the COVID pandemic is, is a great illustration of this point, which is you prep for these disasters, and then you have something like COVID, which is a much longer term disruption per se than the quintessential disaster we plan for. And it's obviously one thing to prepare for these things on paper and then real life happens. And so, Dr. Allaire, let me ask you, were the disruptions caused by COVID anticipated by your practice? Did they differ significantly from the plan that you guys had, had already formulated?

DR. ALLAIRE:

Well, I think the, the honest answer is that they differed, you know, fairly substantially. Certainly as anesthesiologists, we spend a lot of time contemplating, you know, what I call mass casualty disasters. And certainly there's been instances, you know, due to problems with people bringing weapons into public places over the years that have alerted all of us to what can happen in a very short order. But COVID creeps so deeply into our hospital systems that suddenly, you know, anesthesiologists found themselves, you know, contemplating scenarios that were not going to be a day long, not going to be a couple of days long, not going to be disruptive for a few hours. But, you know, something that was going to be disruptive for weeks and months and, you know, worst case scenario, years. And I guess that's kind of played out.

You know, a year ago, I don't think I would have known, you know, who my facilities manager was at our local hospital. Most of our disaster planning was pretty short term. You know, a storm comes in and you have to juggle the call schedules, people stay late. You have a big accident on the interstate and you need some people to sort of step up, but suddenly we found ourselves, you know, trying to stratify our groups into who was going to be the COVID worker, who was going to be the operating room worker. You know, do you do you try to platoon so that everybody isn't having the same exposures at the hospital in a given week, you know, as the workload went down? Do you go to a week on, a week off, so people have a chance to manifest a fever if they're going to get one?

So things changed a lot. We found, you know, that the entire institution was really rocked by COVID. It wasn't departmental and it wasn't like the emergency rooms getting swamped, or the operating room swamped. This is something that stressed people have to order supplies and medications. You know, suddenly you have hospitals, are having to do diagnostics on their own health as a, as a hospital system. Do they have to change their air handling or the way they clean rooms? So everybody became involved. And so I would say that was the, the one thing that was really novel over the past year.

COVID has caused us to build much deeper working relationships with really all departments that are required to run a hospital and or a clinic. You know, Homeland Security has, has been bringing out all of these disaster plans. But when you sit at those committees and participate in those, it's all pretty short-term stuff, you know, more like a tornado hitting. You're, you're going to clean it up in a few days or a few weeks. You can move people from one hospital to another if a hospital becomes damaged. COVID doesn't allow for that. So there certainly have been some disparities. I, I think we stepped into them pretty well. And, you know, certainly the learning curve on this has been steep, and at times painful.

DR. STRIKER:

Well, let me follow up with you a little bit about the responsibility during a disruption. Who is ultimately responsible during that in your practice? Is it, is the brunt of it shared by specific individuals, or is the whole group responsible? How do you manage that?

DR. ALLAIRE:

Yeah. Well, certainly there needs to be identified leadership in, in any disaster. And so having predetermined, you know, Department Chairs and people and certain leadership roles was very helpful. Our organization had that all well defined. And our organization, probably, like a lot of organizations, has what I would call certain divisional superheroes. These are people that for whatever reason or willingness, they do a lot of the heavy lifting and a lot of the day-to-day work. While, you know, many of the physicians and the mid-level providers and the nurses are content to take their assigned workflow and move on. But, you know, the duration of this, this COVID epidemic has, has taught us that you can't rely on your superheroes to carry the weight for a year or two. We saw them becoming visibly exhausted and stressed out, which led to a whole new level of collaboration. I think we've been fortunate in that our organization, people have embraced their responsibilities and their desire to, you know, help one another, help their neighbor, help our patients.

And so we've been very lucky in that when the ask has been made now of nearly everybody to do, to do more with less in the case of PPE, possibly with less, and in, in the case of having to make some income sacrifices in the short run, because of the shutdown, people have stepped up and responded to that. And, and from what I've heard from talking to physicians and, you know, virtually one hundred percent of the other practices, that's, that's true everywhere. You know, so you can certainly credit the medical community for having a, you know, a real esprit de corps during this.

DR. STRIKER:

Well, Ms. Blough, do you have advice on how practices should maximize human resources during crises or as they prepare to manage disruptions?

MS. BLOUGH:

Well, in short words, I'd say flexibility is the key. As Patrick said, the superheroes, kind of everybody has stepped up to different roles. We really need a great team of administrative and physician leaders that have experience and the ability to adapt. We can't do things the way we always did, so I think during a pandemic in particular, you have to be able to change roles, and as he indicated, kind of step up to the plate, work with new people that you might not normally have had the camaraderie with, such as the OR staff or the hospital, the surgeons. It really becomes an esprit de corps across the whole institution.

Establishing some real clear communication channels. Who can speak for the group? Who can speak under what circumstances? And that really goes back to what you might have had set up in years past and what your action plan was. But this one is going to be a lot more flexible in terms of if we find someone that, new to the practice that really has the skill set, that would be appropriate. You bring those people in. And you want to make sure you bring in as many people as possible to ensure that the group is financially sound and that we're looking out for, for everyone.

Additionally, so let's say you have somebody, as, as I mentioned earlier, that, that worked only days. Well, this has changed the landscape. And people, if they're flexible, can do things and maybe even change their availability long term because their situation at home or their, their desires have, have obviously been altered by this pandemic. It's also good to have a list of people that you can call, CRNs, locums, pre credentialed, anybody that has previously worked for a group. If you keep a list and you have good relationship with them, a lot of those people may be available to come back and fill in. If you've got a CRN list, it's meaning, you can call them as needed. A lot of groups have found that that's been very helpful during this pandemic.

When everything was cut off initially, a lot of elective surgeries or elective cases, the groups may have found that they had extra people because all of their ambulatory surgery center cases were, were canceled because those were more than likely the elective ones. So you may be able to, if you have those people credentialed, be able to transfer them to work a, in the main facility.

And as you hire people, make sure you establish a, what your culture is. Make sure that you've got people that understand that we're part of a team and that we function as a

team in this group, and hire to that culture so that you always have those kind of people. You really don't need any outliers when you go into a disaster situation.

DR. STRIKER:

Look, do you mind also commenting on how organizations have adapted and changed during the pandemic and maybe point out some strategies that have been successful?

MS. BLOUGH:

Well, certainly group governance and being able to the strategic planning, taking time to identify the roles that different people play and what their skill sets might be. You need to be able to identify the different work needs and, and what efforts are, are needed in this case. And in the short run, you want to be able to do whatever it takes. And if you've got a group where the members of your group can say, this is tough, we're going to survive this, we're going to do whatever it takes, and that works great in the short run. But in the long run, you have to have more of a strategic plan of, a lot of groups that I know, when they didn't need CRNAs, ones that work with CRNAs, they didn't need CRNAs when there were no elective cases, or a lot of the casework was being cut, but they kept them on so that they didn't get gobbled up by another nearby group because we plan to get through this pandemic. And we've done that from the very beginning, when ASA first became aware of this.

So we just want to get back to the basics of, you want to treat people fairly and make sure they're compensated fairly for the work that they're doing.

DR. STRIKER:

Well, Dr. Allaire, how did your group deal with it in terms of, were there failures, successes, anything that you can learn from?

DR. ALLAIRE:

I think we've, we've certainly learned a lot. In many ways, looking back, I think, you know, we sort of had a fairly major failure right out of the gate. You know, the East Coast was, was really getting slammed and, you know, their hospitals were overtaxed and understaffed. But in the Midwest, there was very little COVID. But we reacted here in Iowa by shutting down the hospitals to elective surgeries. And then we sat around and, you know, our COVID numbers were 40 for the whole state some of those days. So, so that overreaction nearly, you know, at least left us feeling as if we were going to financially bankrupt all of the health care organizations in the state, every hospital, every

clinic, elective patient visits, physicals, everything was canceled. The place was shuttered. And our organization, we had to actually lay off several hundred people, or at least I guess we furloughed several hundred people. There's, there is a bit of a difference there.

But, you know, we've struggled now with the, the damage from sort of that fiscal misstep. Now, certainly, if we'd had better information from the government, more of it, like we do now, you know, with daily reporting by the regions and states. You know, we may have tempered our reaction to this pandemic in the short run, and we wouldn't have found ourselves quite so fiscally strapped by the time patients started coming through the door with, with the virus. Now, during that time, you know, we, we didn't sit idle. We had much more preparation time from what was happening on the coast to sort of observe what was happening there, build up our infrastructure and our protocols and our health care pathways for when the pandemic, you know, really did strike home, which it certainly has now. We think we're in our second or third surge. And, and that time was well spent. People had time to get educated. We had some time to, you know, work on PPE acquisition and acquire supplies and, you know, retrofit anesthesia machines and sort of figure out how we would ventilate people with anesthesia machines.

So, the time was a blessing. But I think our reaction in the short run, you know, almost bankrupted us. I, I think there were certainly administrators in our local hospitals and clinics all within our system, who felt that if a shutdown, as it first came through, had gone on beyond six or eight weeks, you know, we would, we would have potentially had solvency problems. And that's kind of the nature of the beast in health care. There, there's not a lot of retained earnings for most health care organizations. You know, even though it seems like there's, there's a lot of money moving around, the margins are relatively small.

DR. STRIKER:

Well, let's talk some more about the finances. Many practices obviously took a financial hit in 2020, and I'm wondering, Ms. Blough, if you have financial advice for some of our listeners?

MS. BLOUGH:

Well, absolutely. The financial aspect is huge, and in larger groups, you're going to find more flexibility and smaller groups are going to have more limited options on how to survive financially without incurring debt. I think when this pandemic first started, it was early in the year and we, none of us, expected that this was going to run for very long.

But administrators made financial plans. And due to the length of the crisis, we've, we've seen exactly how this plays out. I know Dr. Allaire has mentioned several of these, but you don't, the people that acted quickly, groups that were really alert and were aware of what was happening when the money was rolled out, they were able to grab that first bundle of money, which definitely helped early on to get through those first, you know, probably the first month or so.

Every group needs a good line of credit and anesthesia groups don't really have much margin in their finances. So with every dollar that comes in to a group, somewhere between 90 and 92 cents goes to support a provider, provider salary, benefits, and the overhead is very small for anesthesia practices, historically. In recent years, you won't find very many practices that actually have brick and mortar. A lot of them work out of a hospital office and perhaps pay rent for that. And many groups have outsourced all of their, their overhead to a billing company or a billing and management services. So there's just not a lot of money left over. And most anesthesia prices have been cash basis, historically. And the larger groups, perhaps have a different financial arrangement.

But the problem is, is that where you going to get this money from? And there's not much in the revenue other than what goes to support providers and a lot of those finances, you really can't change if you're talking about your retirement plan and certain benefits and expenses, they're not negotiable. Those are fixed, hard expenses. So one of the things that you need to do is to let people know, to let the people that work for you, know that they're going to be taken care of. I know there was a lot of concern early on about how are we going to support the group. The doctors and the CRNAs obviously can be taken care of, but the staff, any staff that you have should be reassured. You don't want them concerned. They may be living paycheck to paycheck. And actually many of the professionals may be doing the same based on their expenses and their, their lifestyle.

So when it does come down to this, so you want to make sure that the shareholders understand that there may be a loss of income this year, we may not be giving bonuses. And as someone that would maybe advise you, you may want to withhold and not deliver quarterly bonuses or monthly bonuses. However, that may roll out and it's not necessarily a bonus. There's no more money than what you're going to be making or your revenue sources. So you don't want the physicians to expect that you're going to be whole at the end of the year, and the shareholders in particular will be taking the first hit. Beyond that, other employee physicians may share in some of that. But you need to make sure that people understand the staff believes they're going to be taking care. And it's not just the, the providers.

It's important also to compensate for committee work, because during this pandemic, you find that there are a lot of meetings that need to be held by the hospitals trying to figure out how they're going to cover the services, how maybe they're converting some of their space that was may have been elective cases into ICUs. They're going to be a lot of changes. And you need somebody, the right person, someone who speaks well and can step up to the plate to be on that committee and to be the ears and the participant in the decisions that the hospital will be making.

So in terms of compensation, you do want to make sure that that physician is compensated appropriately or whoever this is that's attending. You don't want an anesthesiologist stressed out because not only do they have to do all their regular OR work, but now they also have to then go to a committee meeting. You need to make sure that you're aware of that and not overly stress the person that's doing the conversations with the CEO at the hospital or the perioperative services or the surgeons. So it's my thought that, not only do you, you compensate them, but you ought to compensate them as if they were in an OR. An hour spent at the hospital is an hour spent, it may not be as stressful going to a committee meeting, but it depends on who the individual is. If you have people who are talented and can speak well, let them do the committee work and support them and help cover them in the ORs.

DR. STRIKER:

Dr. Allaire, how has your practice changed as we move through the pandemic and going forward, what kinds of changes do you expect to see?

DR. ALLAIRE:

Well, in short, I, I almost feel like saying what hasn't changed. Just about everything that I thought was normal is, is not the same as it would have been a year ago. So workflow is dramatically changed. From the moment I get out of my car in the parking lot, you know, to the, we mask up, somebody takes your temperature at the door, you get a certain badge with a sticker. To patients, who can have their families, can't have their families with us.

So workflow, I think, for everybody involved is felt cumbersome and new. And, you know, you, you've spent decades building a skill set and, and the only time the job has felt normal in the past year, or the same, is when the door of that operating room closes and you actually begin surgery. You know, every step of the way, from input to output and into the PACU, which is the post anesthesia care unit, all of the workflows have changed.

I do know that what we've learned about change is that, as clinicians, we've come to work far more closely with what I call the, the support personnel and the hospital administrators. It's been very enlightening for, you know every member of our anesthesia department, every member of our surgical staff to sort of realize how interdependent the entire organization is. Is facilities management, do they have rooms for us to put patients in? You know, what's happening with bed control? Is the nurse, nursing staffing adequate? Do we have a COVID outbreak amongst our workforce? I think that as physicians, we've become a lot more, I guess, acutely aware of how dependent we are on so many other people with so many other specialties. And I think, I think going forward that that probably will be, you know, will be helpful organizationally, that the entire organization, you know, has, has learned that we're very, very interdependent.

You know, kind of to pivot off of that, I think looking ahead to what changes do we need to make? I think at both, you know, for many hospitals and clinics, anesthesia groups, there may need to be some discussions about how do organizations financially, weather a direct hit that just shuts down for a month or two, and I mean, how is that weathered financially? Most anesthesia groups, when we started doing some polling, and I think Genie's committee with the AAE did that, were looking at, you know, taking pay cuts. That, that is the short-term solution because there's not much in the way of retained earnings and certainly the tax structure of professional organizations, you know, there is a penalty for retaining earnings.

But I think COVID, and the financial crisis that followed for hospitals and clinics showed maybe there needs to be some change in the tax law or the tax situation, or, or groups may need to consider that the burden of, of a tax burden for retaining some earnings may actually have some benefit to the group. And, and I don't profess to have those answers. I'm not a tax law expert, but I know that as we go into 2021, we're starting to, you know, have lots of discussions as a large organization with a very large budget that doesn't have a big foundation, doesn't have a University of, doesn't have the state government that's going to support us if we get another wave that leads to a shutdown. We, we've had to sort of soul search. How would we finance another round of this if, if it comes through? And I'm sure there'll be lots of discussion on that, you know, both at a governmental level and at every private organization in every state is probably having those discussions in their boardrooms right now.

DR. STRIKER:

Well, if you could share one single piece of advice to other practices dealing with COVID, what would it be?

DR. ALLAIRE:

I think what we, we discovered really comes down to a very personal human level. When you go into something, this, this sort of unknown, frightening for some, you don't, you don't, you don't know everybody's circumstance with regards to what is their ability to cope with the stress, what is their personal situation at home in terms of taking extra shifts or perhaps taking fewer shifts, which might mean making less money? And we had very good success by being willing to sort of individualize our organization's approach to every person's willingness or ability to work, or not work, to take a furlough.

And you know, so often anesthesia groups in particular, because they're single specialty and so everybody's sort of treated the same, quite often. But one size fits all is not a good way to make all of your employees happy. You know, we had older physicians who were, who were happy to step away, and, and just they had, they had a different level of personal assets and of course, they were at greater risk if they contract COVID of having a bad outcome, and you know, and sort of customizing our human resource response to COVID. It was probably one of our biggest successes. And I would encourage anybody to kind of you have to open up the playbook and realize for a, a while, one size isn't, isn't going to fit all to do your best to find that compromise for every individual and then, you know, to fully utilize that person's assets. You know, take what they're willing to give and those that feel the need to step away, if you can make that happen, as Genie said, through creative staffing or use of locums, then you do that.

DR. STRIKER:

Finally, Ms. Blough, before we go, I know it's been a tough year, but I'm wondering if you could identify some successes that we've had, even though it's been so tough.

MS. BLOUGH:

Certainly, and I do think it's important for us to look at this and keep this optimistic view and think of the things that we've benefited from through this, and, and there are times when it's very difficult to do that. I have to say, the single thing that stands out to me is the electronic communication platforms like Zoom and the other, the video format that you can use to communicate with people. I just think it's helped groups cross over and add personal touches. I think it breaks down some barriers. There's nothing that will break down the barriers than having a conversation with someone who's pretty high up in their organization and they are in a casual setting, casual format, with the dog barking in the background and a, a young child comes around the corner and peeks into the, the video. I just think it really brings us all a little bit closer to each other. It, it humanizes us.

And I think it has helped groups stay closer. I know a lot of operations people use this for their, their staff to have small group conversations. And I know we're going to be talking about this, some of this with another podcast.

I think the second thing, in addition to this electronic communications, is that I've been so proud to see the anesthesiologists step in and take care of patients. They are perioperative specialists and have led the way, coordinating departments, particularly in the ICU, and they have really come, you know, it's pretty interesting when you watch the evening news and there's, you know, most days, there's something that you can relate to, an anesthesiologist, you know. So I just think that the national disability and recognition has been a real bright spot.

DR. STRIKER:

Thanks, both of you. This is Adam Striker thanking everybody for joining us for this episode of Central Line. Please join us for part two with Ms. Blough and Dr. Allaire, and we'll see you next time. Thanks.

(SOUNDBITE OF MUSIC)

VOICEOVER:

Stay ahead in this all new environment. Attend Practice Management 2021, an all-virtual conference January 29-31. This year's program addresses shifts that were in play before the pandemic, as well as the massive management and economic changes brought on by COVID-19. Explore the full program and register now at asahq.org/pm21.

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