American Society of Anesthesiologists™

Residents In a Room
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VOICE OVER:

Welcome to ASA's Central Line, the official podcast series of the American Society of Anesthesiologists edited by Dr. Adam Striker. Slides and a video recording of this April 2nd Town Hall are available at asahq.org/covid19info.

DR. ADAM STRIKER, HOST:

Welcome to another episode of Central Line. I'm Adam Striker. Today, we're sharing more information from ASA's most recent COVID-19 Town Hall bringing you up-to-date information from our experts in the field. Here's what they said…

DR. MARY DALE PETERSON:

Tonight, we want to welcome not only our ASA members, but also members of the anesthesia care team, anesthesiologist assistants, nurse anesthetists, anesthesia techs, as well as our administrators and executives. We also welcome and value our relationships with attendees from across a number of specialties and other organizations that have worked collaboratively with us through this pandemic.

Before we begin, I want to address what happened on Monday, which was, ironically enough, Doctors' Day. Many of you are wondering why President Trump eliminated all scope-of-practice rules in hospitals, essentially stating that no doctors are needed. As many of you have told me, there are anesthesiologists who are currently out of work, with the cancellation of elective surgeries. So there is not a work force shortage currently in the anesthesia community. My understanding is that the federal government does not want to impede any flexibility that states may need to handle this crisis. State laws and your hospital by-laws will still prevail, and should be used to ensure timely and safe patient care, which will be dependent on your surge and your work force. We should not be discouraged.

This is an unprecedented period of time that we must all work through. The Medicare waiver is temporary. Once the emergency declaration expires, so too does the waiver.

I have already conveyed my disappointment and concerns to senior administration officials. I will continue those conversations, and at the right time, ASA as an organization, will respond more fully. So please stay tuned.

I also want to briefly update you on new statements ASA has posted this week, in response to the concerns that you have shared with me. I charged Dr. Beverly Philip with updating our statements. I want to thank her, and all the volunteers, for their expeditious work.

First, we have a statement that supports anesthesia professionals having appropriate PPE. And, if the hospital can't provide it, allowing us to bring our own commercial grade PPE to wear. Second, I heard from many of you that some hospitals and other professionals were interpreting, or misinterpreting, our statement on who should intubate COVID patients. Please see our updated guidance. Anesthesiologists are not required to intubate all COVID patients. Experienced ER and ICU physicians are capable of doing this, just like they have been doing in the past. Some hospitals and anesthesia groups may choose to provide this service. But, it is a local decision. The intent of the original statement was to discourage these procedures as training opportunities because of the complexity of more people having to wear PPE, and the potentially unstable nature of these patients in respiratory failure.

I also want to alert you to new guidance as of April the 1st, related to converting anesthesia gas machines and fresh gas flows, as well as the resources you need to take care of COVID patients in the ICU. These resources are on both the ASA and APSF websites. Those critical care resources are under the acronym CAESAR.

Finally, we know that this crisis has the time, has limited the time available for clinical instruction of residents. Anesthesia, ASA is helping to bridge this potential gap by creating a catalogue of free education for resident members that is available during this pandemic. Resident members can find these resources at asahq.org/resident-courses, or by visiting the ASA education center on the ASA website.

Now, I would like to bring in our wonderful speakers for our first panel, who will give their first-hand viewpoints from the front lines of New York City, where we've seen 40% of the total cases in the US, with more than 85,000 confirmed cases of COVID-19. I'm so grateful that they have taken the time to share the lessons that they have learned with us.

Some of you are on the front lines, working really long hours in ICUs. And some of you are furloughed and worried about your livelihood. We don't know what's next regarding the economy. We worry about our families, friends and colleagues.

I want you to know that the ASA leadership and staff are here to support you. Please, please take care of yourselves and support each other. Take some time to exercise and disconnect from the barrage of bad news, and recharge.

Our nation and our people have been through wars and depressions before. Our upcoming holy days of Easter and Passover are times of celebration after suffering. I know you are suffering now, but we will get through this. There will be a brighter day. Keep the faith.

Our speakers from New York tonight are Dr. Andy Rosenberg our ASA Vice President of Scientific Affairs and Chair of the Department of Anesthesiology Perioperative Care and Pain Medicine at NYU's Langone Medical Center.

And we also have Dr. Stephen Schulman, Associate Medical Director and anesthesiologist at St. Francis Hospital in Roslyn, New York. Andy?

DR. ANDREW ROSENBERG:

Thank you very much, Mary Dale. Tonight, I'm going to be speaking about organizing an Academic Anesthesia Department to respond to the COVID pandemic.

And I really don't have anything to disclose. So, I want to outline the organizational issues that need to be addressed when planning to respond to the COVID pandemic. I also want to, uh, have you understand the vital value that our skill-set provides as members of the anesthesia care team in helping to fight this pandemic and discuss the care team, equipment, and supplies needed to help the institutional response to the COVID pandemic.

So, we're in the midst of a devastating pandemic or actually if you look at this graph, which was prepared by The Institute for Health Metrics and Evaluations, we're really at the beginning of this. On this graph, you can see April 1st or April 2nd, and actually the one that I had prepared yesterday, um, had to be redone because of the increased projections, but, uh, you can see that we're really not peaking until about April 14th. And originally the suggestion was that we have to have about 18,000 ventilators available for today. That was changed yesterday to 21,000 on April 2nd. And, we're going to be peaking at about, uh, 32,000 ventilators about April, about April 14th, with 39,000 ICU

beds. So this is really a pandemic that's coming. And is, it's going to hit us harder as it comes along, and we're going to really be stressed. A lot of Institutions are already having problems getting enough ventilators, and that's just going to be compounded as this situation moves along.

But I think that, I think that if you're approaching this you really have to approach it from an organized fashion, and that's going to really help you as an institution, especially academic medical centers and private groups as well, smaller hospitals. You have to really be organized. We've had some experience in New York City. We've experienced both 9/11 and Super Storm Sandy. So we would have had a couple of times where are institutions were shut down and we have to deal with it. And while those were unprecedented situations, we really went to a recovery phase and had to get ourselves back into gear. COVID is different. It's a pandemic with many different issues and it's just presenting, and is going to be here for a while. So we really need to get our skill set together. As a department, we really were well organized and we've learned a lot from our experiences during the 9/11 and Sandy, Super Storm Sandy time period.

Um, we realized that we have to be organized and we had to be nimble and keep changing, um, and addressing challenges as they occurred. And I was lucky in my department to have so many skilled people who can actually help me from the organizational level.

So what's our role in the Academic Medical Center? Listen, as anesthesiologists, we're really on the front lines. And that's what we're good at. We care for sick patients. We do intubations, we do ventilator management, ICU care, we put in lines and we prone proposition patients. All of these are really crucial during this COVID pandemic. So it makes sense that, for us as department, to define our role because we know what we're best at, instead of letting the institution tell us what you, we should be doing. So really you want to define your role and show exactly what you could do to help the institution. And I'm very humbled at the conviction, determination, and dedication of our physician anesthesiologists, our nurse anesthetists, our residents, and our anesthesia techs, um, staff. Everybody's been pitching in and working really hard and it's a real big good team effort, and it's really been organized well. We're collaborating with others in our institution as well as we do this.

So what are the organizational issues that we're faced? First, at the leadership level we have to make sure that the department is working well. It's important to disseminate information to the entire department. There are workforce issues that have to be addressed, how to reschedule people, where should they be, what team should we be using, what's our approach to the teams, and equipment and supplies. Everybody's

talking about PPE, using anesthesia machines, um, what happens in the operating rooms? These are all things that need to be considered and thought about ahead of time, so you're not, really not making decisions at the last minute.

So, the way I'm looking at this COVID pandemic right now, and we all say it's a marathon because we look how long this is going to be lasting. It's a marathon not a sprint, but at the beginning this really seems like it's a marathon that's going to be run at a sprint pace. So we have to sort of pace ourselves and keep moving and figure out what's going on. I, I have daily leadership conversations over video, video conferencing with the leaders at the four different hospitals that we have in our system, as well as other key leaders in my department that I need to get input from. And I do get input from these multiple locations. People are providing information about the COVID care that they're giving, and that helps the rest of us determine the needs, share our experience and determine the next steps that we're going to be taking in care of our patients. This meeting is, uh, the video conferencing, takes about a half an hour to an hour and I get everybody to weight in and we've really learned a lot from each other. We have a, the tertiary care hospital, we have a city hospital, we have a freestanding orthopaedic hospital and then we have another tertiary care private hospital that's out in the, uh, in the suburbs. And everybody's having different experiences, but we're all learning together and I think organizationally, that's very important.

Then I, I put together a daily update that I disseminate to the department members. So everybody can keep knowledgeable and engaged as far as what's going on, because people, in your department, you'll see, there's a lot of variability, but a lot of people are scared. They don't know what's going on, and it's important for them to get information because they feel connected. And the feedback on that has been very positive. I try and address each of the individual locations, um, and what's going on in those locations and, um, make suggestions to the rest of the people about what's going on at specific locations. And I also think it's an important opportunity to express gratitude to the members of the department for working so hard.

It's also important to consider the emotional state of our personnel. Some of the people are fragile, they had, they need support. And other people, as well, like to hear that, about the great job they're doing, so we, we give references for people where they can check in for support, uh, and other wellness, uh, opportunities.

So, the first thing is important is that you have to account for all your staff. Um, and as you're organizing your staff, include downtime early on because you can really going to need everybody working together later as this really hits. Um, and, we've been trying to do that even in New York when we've been getting hammered right away. We discuss

issues such as scheduling, vacation, the call schedules, how to handle that, overtime. And basically we came to the decision as an organization to move into shifts. We no longer have weekends or weekdays. There's no call, and we just do shifts, and that's to organize that way. We collaborate with all the locations to return to determine, determine who's assigned to each of the locations, um, as we doing our scheduling.

Um, and we've centralized our overall schedule so that one person is actually the lead schedule for all the, um, anesthesiologists, nurse anesthetists and, uh, residents in our organization. So we're organizing hundreds of people. That person's a very, very critical resource. But we do have redundancy, because one of the things you're going to find that, is all of a sudden somebody gets sick and they're out for a week at least and they have to be out after for 72 hours of having no fever. If those overlap that's fine, but you're going to be losing people for a while. So, it's very important to get redundancy. So you want to define your teams and your team leaders and let the team leaders, um, help make their schedule. As I said you want to take into consideration that you going to be losing staff for varying amounts of time. Um, we have a resident COVID tracker, we follow our attendings, and then before anybody comes back, we wanted them to meet with, uh, have a conversation with, uh, one of our leaders to actually understand are they ready to come back or not. And you have to be flexible with your staffing needs as different staff needs increase in different teams, for example in the intubating team, uh, need more people.

So what staff are we dealing with an academic medical center? We have our physician anesthesiologists, those are anesthesiologists that work in the operating room as well as our intensivists. We have nurse anesthetists, who are a critical part of the team. We have residents who are a critical part of our team. They all play an important role, so you make sure, we want to make sure that they are not deployed elsewhere in the institution. One of the things that we heard right away is that they want to be pulling the nurse anesthetists the way to another area. I think it's important to keep them on the team because everybody's valuable to you. Um, schedules should be organized on an, uh, level and fed into the team schedules and you also want to make sure that if you're deploying your anesthesia machines to different areas that you have anesthesia techs there as well to help keep up with their supplies and equipment.

So, the first thing is what happens to your OR teams? There a lot of anesthesiologists who aren't working, and we certainly are doing less cases and we're doing only emergencies. But I would maintain some of these, uh, call teams or these OR teams in the shifts, because they're really good for on-site backup. We've had a few nights already where we've had some surges we needed some extra people, bringing some machines around, helping us through the intubations. So, it's good to have that on-site

back up. The ICU attendings, early on, it was probably 3 weeks ago, I took all the anesthesia intensivists off of the OR call schedule and freed them up to be 100% intensive care physicians. And, uh, they're being used because every day we're opening new COVID ICU floors, and they're really helping out a lot.

We have a second pool of anesthesiologists, so you should think of your organization. Who is doing the really difficult um, complicated cases, like your transplant anesthesiologists, who may be able to serve as ICU positions as well, even though they're not certified, because it's all hands on deck. And the anesthesia care team in general is really helping out with vent management and other issues. We have excellent collaboration among our attendings, our nurse anesthetists, our residents, and our anesthesia techs because we have to educate the floor nurses about some of the important things because we're bringing up anesthesia machines and they've never seen them before. There's a big learning curve to this, so it's worth spending the time.

So we've developed some teams called the AVPP teams. So the AVPP teams, AVPP stands for: Airways, Ventilation, Procedures and Prone Positioning. And these are really the important areas that were involved with. Obviously airways, we're doing the intubations, ventilation management, we're managing the ventilator settings and uh, making sure we have enough supplies and equipment necessary. We're doing procedures, replacing a lot of lines. On the intensivists, and uh, all the floor people are really, really appreciative of the a-lines and central lines we put in. In one of our locations we're even offering to put in regular IVs, because there are no, there is not enough staff to help do all this time, all this work positioning.

Prone positioning. So I hope everyone saw the excellent talk that uh, Dr. George Williams gave at the last webinar, where he was describing the benefits of prone positioning. We're excellent at prone positioning, we've done it for years, and we really know how to do that. Um, we have both our attendings and residents as part of these teams and that's one of the things that we can get an advantage of at an academic medical center. And these teams are really appreciated by the, the clinicians and the hospital leadership. As you develop your prone positioning teams, though, I would suggest that you just don't have it be the anesthesiologists. There are a lot of people around the hospital. You have the scrub techs to have been helpful in positioning patients and you have some of the surgeons who are helpful. So get them, get the nursing staff to help move the patient into the prone position.

I think that one of the key things we could do as anesthesiologists, is collaborate with others. We personally work in a very large organization. So it's important to let people know what's going on, and what your department is doing. I'm lucky at NYU. We have

phenomenal leadership at the, uh, administrative level, and the Dean's office staff. They're very interested in patient care, they're very interested in the, uh, the employees the physicians, the nurses, and all the staff of work in the hospital. So it's important to have them understand what's going on in, from your department, what you're doing, what your roles are and that way you having a conversation and they can ask what can I do to help you, um, get done what you need to get done.

We also, I also have a couple of leaders in our department participate in daily briefings. So we understand what new floors are opening, what units are opening, what the staffing models are for those units and whose ventilation, ventilators they'll be using. I've been working with ID a lot. The infectious disease people are really good. We had frequent conversations, I actually had a webinar with one of our ID physicians to the department and that enabled our department people to ask a lot of questions about managing, um, patients who are COVID-positive, PPE and gave them a little bit more reassurance and understanding that people were there to back them up. Because this is a constantly changing landscape, the definition of who should be wearing PPE, who should be wearing masks, what should be happening in the perioperative area. And I think it's really important to have that good collaboration with the infectious disease specialists.

The ICU personnel are really important to talk to as well. I'm, you want to really define where to best deploy your people. The emergency management, okay, I have a really good relationship with the emergency management people, which is important. Those are the ones who make sure you get your needed PPE and the other supplies and equipment you need. Um, and I think that that's really, really helpful in a large organization.

Respiratory therapy. How many events are there? Where are they going? Which, which machines are going to, being used on which floor? Are the Servos better than the LTVs and where do the anesthesia machines fit within this whole scheme of caring for patients. So you can know where your anesthesia machines are, you know where you going to be deploying them, and you have an organized approach to managing and maintaining them as well.

As far as your equipment is concerned, you should have all your supplies and equipment. Have somebody in charge of that. Centralize your anesthesia machines from all your ambulatory and offsite locations. Get those trucks out there and bring them in. There a lot of anesthesia machines out there that, that can, that, we don't know when the surge comes, we may be using all of them. Keep a daily tally of the anesthesia machines and their locations, all those in use and your spares. And it's, I think it's

important to let the people who were working overnight know those numbers, know where the machines are. So in case there's a surge, they can run and get the machines. And if you think you're going to need something down the line, get it now, or plan how you'll get it and procure it later on, because they're going to be, we will be running into, into a lot of shortages. So, and also know where your supplies and equipment are stored.

I think it's important to talk to your, um, operating room personnel and the people who run the environmental areas, and understand which of your operating rooms can be negative pressure. We have a new pavilion, so basically every operating room could be negative pressure. We've already established which operating rooms are going to be capped at negative pressure, so we don't have to ask that to be changed at different times. So we have two operating rooms on each of our three floors in our new building that are negative pressure rooms. And I think that's really important to do. If you're going to use your anesthesia machines, there's a lot written about that on the on, uh, on the web. So take a look at that.

Gain experience. Try and cohort your anesthesia machines. I think we've done that nicely. We're using them on one floor so that we can have our anesthesiologists or nurse anesthetists, everybody who's helping out with the management, be there and understand it. I think that it's also very important, if you do have anesthesia intensivists, try to have them work on the same floor as where your anesthesia machines are. It's really, really valuable. We got our institutions to buy into that because you can have good discussions about what's going on and the, uh, how much PEEP your putting on a patient, how much flow is, thinking about your CO2 absorbers, the water traps, the filters, they're speaking the same language as you are, and it's a little, it's very, very different from having a medical intensivist discussing your anesthesia machines with you.

The other thing to think about with your anesthesia machines, is that, how many machines can you put in an operating room? Cuz they're talking about, we've heard the discussion about, two, uh one person, two people put, being placed on one ventilator. Um, I think you can get enough anesthesia machines and bring people into these negative pressure operating rooms. You can think about all your different oxygen sources in your operating room. In some of the new operating rooms, we have, uh, double sources for oxygen and I actually on the … area there's also a third source. So we can run at least two ventilators in those rooms and sometimes three. So just take some time to think about that, and get the anesthesia machines if you need them.

So I think I just wanted to, uh, summarize by saying I hope I told, gave you some ideas about developing an organized approach to this crisis. I think each crisis is different, but as anesthesiologists, we're used to being flexible and we need to use that ability to help our institutions and the country fight this issue. As anesthesiologists, we certainly have the skillset to play an important role in this, uh, in this disease process. I think good leadership and organization sends a positive message to the institution and to your staff, so they know that things are under as much control as possible. So be safe out there and thank you.

And now I would like to introduce Dr. Steve Schulman, who's going to talk about small private practice. Steve?

DR. STEVEN SCHULMAN:

Thank you Andy. So my name is Steven Schulman. I'm the Associate Medical Director at St. Francis Hospital in Roslyn, New York, and I'm also the President of New York Cardiovascular Anesthesiologists.

So tonight I'm going to talk to you about my hospital, where we are, what we do, uh, give you a perspective on a suburban community hospital response, right next to this pandemic, and also talk particularly about what we're doing as private practice. So on Long Island, we have the number of different Hospital Systems. St. Francis is a part of the Catholic Health System of Long Island. We also have a big presence from Northwell, NYU Winthrop, Mount Sinai South, South Nassau, Stony Brook and Nassau County Medical Center. So we have a mix of private and public hospitals. St. Francis is located in northwestern Long Island. And as you can see, we're really right adjacent to Queens and the Bronx, which is really some of the biggest hot spots in the country right now.

So we have, we had, 224 med-surg beds, 60 ICU beds, 20 operating rooms, and of these 20 operating rooms, 6 for cardiac, 14 general and we had 60 ventilators available. And we also have an association with an ASC that has five rooms.

I'm going to talk about what we did as a community hospital next, starting with the timeline. So on March 1st, that was only a month ago, but seems like a really long time ago, uh, the first Coronavirus patient was identified in New York. On March 6th, the first patient was identified on Long Island. On March 7th the Governor declared a state of emergency and on March 22nd, the Governor mandated cancellation of all elective surgery, which was to go into effect March 25th. On March 23rd, my hospital canceled all elective procedures and that same day, Governor Cuomo mandated every New York

Hospital increase our capacity of beds by 50%. On March 30th, we closed all of our general ORs, 14 ORs, such that all emergency surgeries were relocated to the Heart Center OR, so all of our cases were going to only 6 ORs, and are still. So, as a result of the Governor's mandate, we have increased our med-surg beds to 336, we've increased our ICU beds to 94, we only have 6 operating rooms now as mentioned, and this slide has been updated every day. This just gives you an idea of how many patients are positive, uh, every day. And even as of tonight, these numbers are significantly higher, in that, just what we had yesterday. Yesterday we had 147 COVID-positive patients, 66 PUI. Our ventilators available, again, we started with 60 and then we're down to 14, then 8, 6 as of this morning, but we've just been told we're getting 15 anesthesia, excuse me, ventilators coming from New York state. So as of yet we, we don't have to use anesthesia machines, but we are prepared to do that. In addition, because of the cancellation of all elective surgery, uh, we took our ASC down to two rooms, which are only for emergent cases, but we'll talk more about that later.

So, communication with regional anesthesia leadership. What we're talking about is talking to other private practices in the area. Uh, our group's private practices traditional exist in silos, but it's so important to communicate with the other anesthesiologists and other hospitals to really find out what's going on there and to compare notes. And we've done this through a number of hospitals in Long Island by group text, conference calls, video conference, and some of the information that we share regularly, our, our clinical experience, what we're seeing and how we're doing it. Uh, what kind of PPE is available at each hospital, uh, what we doing with our work force. Our work force has totally changed now with the cancellation of all surgeries, so what are we doing with our manpower? And also reimbursement strategies is really important in the private practice.

So, we also have to have internal communication as well as external communication. Very early on, we spoke to the Chairman of the Emergency Room, Director of Critical Care and also respiratory therapy. We talked to the group numerous times and the shareholders, CRNAs, employed physicians, everybody, just to talk about what was coming.

The plan for intubations is different, different in a small community hospital as it is in the major academic Medical Center like Andy's. In our hospital, we don't traditionally do the intubations on the floor. They've always been done by respiratory therapy and we get involved perhaps for a very difficult intubation. So with the recommendations from some societies and maybe some misinterpretations, uh, we had early conversations, and we had to talk about who would be doing these intubations, and if we were going to be involved would we be involved 24 hours? And I'd really say that we had very successful

talks, we had, we had a multidisciplinary approach to intubations now, where critical care, ER, respiratory therapy and anesthesia are all involved and we all share the burden and share the risk equally.

The other issue is critical care coverage. Uh, as Andy mentioned in NYU, there's a number of critical care trained physicians, and we have several. We have two in my group who are critical care fellowship trained and we work towards getting them rotated in with the intensivists.

We also established a surgical case review committee. Uh, Governor Cuomo mandated us to suspend elective surgery, but elective surgery is frankly, in the eye of the beholder. Uh, so we put together a team made up of the Surgical Chiefs organized by the Chief of General Surgery with representatives from anesthesia, nursing and OR scheduling, and this team needs daily at, at noon and they discuss the cases that are booked for the following day and they triage these cases based on the urgency. Whether they are believed to be true emergencies or they could wait potentially three months, which is the landmark that we're saying for an emergent case vs. a non-emergent case, and then the logistics. Uh, how long is the length of stay is this patient going to need if they come in? Do they need critical care? Do they need resources which are in short supply? And then we also look at options. We really never did breast cancer surgery at our ASC before, but now these patients really shouldn't be waiting three months. We've explored using our ASC for some of these urgent, but not emergent, but not truly elective cases. And so that's an option is to look towards your ASCs for some of these cases.

Now let’s talk about specific concerns for a private practice. Again, the name of my group is New York Cardiovascular Anesthesiologists, and I'm going to talk about a number of issues that we taste. So my group has 50 total employees, we’re made up of 28 shareholders, 31 call-taking positions, 4 non call-taking positions, and we have 16 CRNAs, 8 of which are full-time, 8 are per diem, and we have an office staff of 7, and we outsource our revenue cycle management.

Very early on it's still crucial to talk to all of your key external support systems. We very early on, as soon as we realized what was coming, we talked to out lawyer, we talked to our accountant, and we talked to our banker, and we talked to our billers. In many instances, we had them talk to each other because everybody needed to be aligned. I heard a great quote today that what we're facing isn't the game of checkers where you just look one at a time. It’s really a game of chess, and you have to think several moves ahead and you have to anticipate what's going to be happening, not just next week, but several months from now.

With frequent, uh, emails within the department, and we really use video conferencing. I frankly have never really used video conferencing at all, and now I find myself on multiple meeting a day. It's a great way for us to communicate with the CRNAs and it was a great way to have shareholder meetings, and we have weekly shareholder meetings now, and we have a greater attendance than we ever had in our regular face-to-face meetings.

So what are the financial considerations, uh, with a private practice group? Well first thing you have to look at it are, what are your accounts receivable? What is your cash flow look like over the coming months when we have canceled all elective cases and when I had this discussion a couple days ago with Dr. Rosenberg, I'll give him credit and he said, you know what your revenues you have to flatten the curve also. You have to do what you can to make your revenues last as long as you possibly can and that's, that's really what we've done.

You have to look at your staff and you per diems. Frankly, our per diem CRNAs were the first to be told that we wouldn't be needing the services anymore. And then you have to look at your full-time employees, CRNAs and your, uh, full-time positions and you have to look at the contracts and you have to make some decisions about how you will allocate these resources. There's a consideration, uh, to use your CRNAs as ICU nurses and there certainly is a shortage and it certainly is a need, and it's certainly a direction that we looked at, and, uh, frankly, we really thought that we were going to have nurses working as, in the ICU. But the truth is that lot of these nurses are not comfortable with the charting requirements, they're not comfortable with some of the responsibilities that come with an ICU nurse. And, excuse me, and not all nurses are willing to embrace this possibility, and transparency is really important with everybody you're dealing with.

So, some of your financial options you need to consider, again, I mentioned, um, critical care coverage and our hospital and most hospitals in Long Island have been very supportive of having help in the ICU. They're really, have been very generous, very forthcoming with reimbursement to having our nurses work in the ICU and to compensate us, uh, at least at what they're getting paid now, if not full per diem rates. They also are, there's been a lot of communication with the hospitals regarding using anesthesiologists as critical care physicians and the use of anesthesiologists in critical care, you have to decide whether it's better to do that as a fee-for-service or with direct hospital support, and that's kind of an individual decision and you have to look at your own payer mix and what the hospital's willing to offer.

Many hospitals including, uh, at NYU, have teams that are out there to do intubations, line, lines coverage, maybe assist the intensivist 24/7 and again, this is hospital by hospital. At St. Francis Hospital, literally, we just started this last evening, was the first time that we had anesthesiologists in-house as another set of hands and we expect this to expand going forward and again talk to your hospital leadership proactively, before you need this, because the hospitals have been very, very supportive of this.

The other thing to consider are the SBA loans, Medicare Advances and potential line of credits with your bank and this will be talked about in the later presentations.

So what are some of the key lessons that we've learned through this process? Remember when you talk to your lawyers, you're getting legal advice. And the lawyers will often push you in a direction saying well, this is what the contract says and this is really what you need to do. They're working for you. Remember that the lawyers are giving you advice and as shareholders, as owners of you corporation, you really need to evaluate that advice and see is that the best path for you to take, cuz it, it might not be. And you have to understand your risks if you don't take their advice, but often times there's a better direction for the corporation to go.

You have to remember your responsibilities as business owners. Uh, when talking to your employees, you have to share the pain. You have to make sure that everybody knows that we're in this together and we're taking a financial hit, and if you're going to take a financial hit we're really all doing this together. I think it's great to crowdsource ideas. When you talk to your employee physicians, your CRNAs, even your shareholders. Everybody knows what's happening with volume and the decreased revenue with a decrease in elective surgeries. So, talk to everybody. See if there is some interesting ideas if people are willing to take unpaid leave for a period of time. Explore all options that don't lead you down towards termination, or just making a relationship something that you're not going to recover from long-term.

And, most importantly, empathy. None of us have ever been in this situation before. The nurse anesthetists have never been in this situation before, your employee physicians, your shareholders. Really lead with compassion. Start the conversations off with compassion, we're all in this together, and I think that will lead to the best outcomes.

Uh, in conclusion, I just really want to thank all the physicians at St. Francis Hospital and especially all the physicians and nurses at, in my department of anesthesiology with a special shout-out to Robert Gates, my clinical chairman. Thank you.

DR. MARY DALE PETERSON:

Thank you, Steve and thank you, Andy. I really appreciate all the hard work that you've done. We got a few minutes for Q&A. Um, I know we've had a number of questions tonight on the use of N95s, and um, and provided updated guidance a couple of weeks ago that, that the ASA along with double ANA really believe that N95s should be used, um, by our providers and all aerosolized generating procedures. So what is that? That would be at intubation and at extubation, um, and that's regardless of whether you know the patient has a COVID-positive status or not, um, because really it is in most of our communities now and we do know there's about a 6 to 13% either pre-symptomatic or are asymptomatic, uh, patient that you just don't know based on symptoms.

Now, to our panelists, um, I, I think that, um, the question I have from Jim Kelly is we have some physicians in the Midwest who do not believe that this pandemic will impact us. Can you please describe the New York experience to help us explain to our non-believers how serious this is? So maybe, Andy, if you would start with that, and then Steve, you can chime in as well.

DR. ANDREW ROSENBERG:

Okay, so I, I think that we have to consider that every single patient that we're taking care of is COVID-positive. I think that all our anesthesiologists and the nurse anesthetists, anesthesia assistants should be wearing PPE, N95s when they're taking care of patients in the operating room. I think that, um, the way to explain that to, um, anybody who says you shouldn't be getting this, is just look at the progression that we've been doing a lot of hospitals in New York. At the beginning, nobody was really wearing any N95s. People were walking around the hospital. Now everybody's in the hospital wearing masks most of the people, there are some of the people walking around wearing N95s all day long, and that's really where we're going. So if they want to protect themselves, if they want to protect the hospital staff, if they want to protect the patients and then people at home start being smart about this.

STEVEN SCHULMAN:

And, and I'll address the second part about, uh, physicians in the Midwest potentially not thinking that this is real or going to become a true pandemic. So, I was off for a couple of days, again, elective surgery was canceled, there was no clinical need for me, and I worked last evening and when I left the operating room to just walk through the PACU to, to go to the floor, I was very unsettled because that's my PACU, that's where I bring out my patients, my total hip replacements, my thoracotomies and walking through and seeing a complete COVID ward, that every patient there was on a non-rebreather or on a, a CPAP machine. Every patient was very ill. All the nurses were in their full PPE

gear, uh. This is my home, this is where I've worked for all these years, and it's changed that dramatically in two days. You go up to the floors, every door is closed. All the nurses have a high level of anxiety. This is real. And day-to-day it changes so quickly, I can't begin to tell you.

DR. MARY DALE PETERSON:

Thank you both. So, another question that's come up, and this has probably been a subject of the most media requests I have gotten, and that has to do with splitting ventilators. And I know ASA, and five other organizations, um, really believe that this should be the very, very, very last choice, um because of not the technical issues of, of putting a Y or T connector and putting it to two different patients, but the fact the patients need to be around the same size and at the same stage of disease or have the same area, or type of lung compliance. So I wanna ask Andy first. Are you splitting ventilators? And do you know if anybody's doing this and how are you managing your ventilator supply? And then I'll go to Steve.

DR. ANDREW ROSENBERG:

So, we're not splitting ventilators. Um, I know there's a lot of people say that you shouldn't. I don't really know what's going to happen down at the end of the line, so I can't say that we shouldn't do that. I don't think we want to let patients die rather than split ventilators. So I'll leave that is an open question. Um, we've had our respiratory therapist doing modeling, um, to get an idea of how they going to be using the ventilators, and which ventilators to use to do that. So I think it's an open question. I think there's a lot of discussion. I think it's like the PPE question. Once you understand that you have to wear that, you can do that and you move on, and that may be the same situation when splitting ventilators. We're not doing it now. We can spend a lot of time discussing it, and then you can go in the rooms and do what you have to do.

DR. STEVEN SCHULMAN:

Right, and, and we will have a lot of, uh, extra ventilators. We have all of our anesthesia machines. Uh, we've heard anecdotal reports around New York City about people doing it, but I haven't heard any direct confirmations or had any conversations.

DR. MARY DALE PETERSON:

All right. Well, thank you very much. I've got a question here about, uh, medical licensure and what if doctors want to go and help out, um, our colleagues in New York? Um, will the Governor or the hospital allow them to come and practice there? Andy?

DR. ANDREW ROSENBERG:

So, they're, they're working, they keep asking for physicians to come. Um, we've had some people who have actually asked us if they can come, so we've started working on some credentialing. Um, I do believe they're going to make it fairly easy for people to get credentialed. I am not very versed in the details of that, though.

DR. MARY DALE PETERSON:

All right, and what are, what you do when your intubating patients in the operating room? Do you have other staff leave the room? Or stand three to six feet away? Or what do you do with that? Steve?

DR. STEVEN SCHULMAN:

Staff is typically it's, it's pretty much as typical as it was before. Uh, I'll have somebody at the airway, one person at the airway helping me but what we'll do is on all cases we'll wear an N95 and again just to conserve resources, is we'll put a disposable surgical mask over on top of the N95 for all of our airway procedures.

DR. MARY DALE PETERSON:

So, but it's just the people participating in those airway procedures that are wearing the N95? Not on every single person in the operating room. Is that correct?

DR. STEVEN SCHULMAN:

That's generally correct, yes.

DR. MARY DALE PETERSON:

Okay, great. And then I know we've had some questions on… go ahead, Andy.

DR. ANDREW ROSENBERG:

They're moving on to having more people wear them. So, I think everything changes, day-to-day.

DR. MARY DALE PETERSON:

Got it. Of course, we're, we're dealing, right, with a critical supply issue and so are you all, um, reusing your N95s or using them for extended use, or using some of the sterilization processes that have come online recently? Andy?

DR. ANDREW ROSENBERG:

All of the above.

DR. MARY DALE PETERSON:

(laughter) OK, can you talk a little bit more about that? So do you like issue, one a day or what?

DR. ANDREW ROSENBERG:

No, you know, we got, early on, we were able to get PPEs and you just have to be, um, take good care of them, you know, and the whole thing has progressed over time to, uh, having them last for a while and reusing them, and now we're instituting a re-processing program. So hopefully that'll be really good in getting more fresh PPEs as we need them. But clearly, if you're operating, if you're taking care of somebody and it's an aerosolizing event, you have to really consider, should you be reusing that, or will you get rid of it? If it's obviously contaminated, you're not going to keep it again. So…

DR. MARY DALE PETERSON:

Right, and I know recently and this should be in our FAQs on our website but, um, Steris which is a lot of the way you sterilize a lot of your instruments in your OR, came out with guidance on how to re-process N95 masks in sterilizers, really that you already have, so that might be a choice for, um, some institutions to be able to re-sterilize their N95s if they're short of it.

DR. ANDREW ROSENBERG:

Right and I think, but, that's where I commented to the point that where I was talking about working with your um, your emergency management people, because we've been

really lucking in getting the supplies and the PPE equipment we need, so connect with them early on and have a good relationship, you get what you want. And, um, that's what I was saying, our leadership is very good on helping us with that.

Thank you so much. I think our panelists have done a fabulous job. And for the second part of this Town Hall, which will last about an hour, um, we have, um, Stephen, uh, Comess, and Genie Blough, leaders within the ASA Anesthesia Administrators and Executives membership category, and they're going to facilitate a discussion on how COVID-19 has affected practice administration and finances. That discussion will also include Sharon Merrick, Nora Matus, James Kim, and Manny Bonilla, our ASA Chief Advocacy and Privacy Officer. Steve, can you lead us off?

STEPHEN COMESS:

Thanks so much, Dr. Peterson, and good evening everyone. Uh, it's, uh, I would like to say it's a pleasure being with you, but unfortunately under the circumstances, I think everyone is being tested. We're all working in uncharted territory and the community of ASA, uh, is rising to the challenge. It's there for all of us as we navigate them. And if ever there was a time for your manager, your administrator, your executive, to be a member of the Anesthesia Administrators and Executives section of the ASA, it is now. Uh, our partnership is bringing together clinical and administrative resources, which together are critical. All hands are on deck in meeting the needs of this crisis.

As you can see, uh, in this slide, everyone is feeling the squeeze in healthcare. And that squeeze is not just in your chest, it's in your pocketbook. What we're going to be talking about tonight is some of the resources available to you and some of the practice plans that you might want to engage in to deal with this. First, it's important to establish, as I think you've heard from our New York colleagues, that conditions and resources are all local. And so your plans need to reflect this. Uh, every state has not been impacted equally and so the timeline for your strategies will change, from locale to locale. If you're not hit hard at this time, it's an excellent opportunity to plan. If you have been hit hard then you're constantly adapting your plans to meet those current needs. This is a hard time for everyone, but we can, and will get through this.

Step one. It's important for you and your practice leadership to establish priorities, first and foremost, the safety of your anesthesia personnel. The service is to your patients, and identify those resources that are available to ensure the ongoing operation, not only during this event, but for what is going to be needed to ensure a viable organization or anesthesia department after this event. And this event will be over, and then, based on these priorities establishing an action plan. None of us have a crystal ball. We don't

know when our communities will begin to flatten the curve and the out of it, but based on what we do know today, it's important to establish a plan of action, one that probably looks at a 4 to 6 months horizon.

Uh, resource assessments during that time, personnel needs that you have for full- and part-time. As mentioned before, understanding your cash flow, your accounts receivable. What are the sources of your stipends? And what's the likelihood of them to be ongoing? What are your collections?

It's also important for you to take stock of your current expenses, what's variable, what's fixed and what can be modified. One area for exploration is your malpractice expense. You can look at negotiating with your carrier. If your caseload has been reduced and your staff time demands have been accordingly reduced, you may be able to reduce their coverage to part-time and save your practice significant dollars. But in looking at your plan, you also need to figure out, as it has been discussed before, how you can fairly and sustainably implement this plan. What would be the impact on shareholders and partners? Who will be expected to shoulder the lion's share of the burden?

What about non-MDS and CRNAs? What will be their impacts as a result of this plan? Benefits impact, you need to assess essential vs. non-essential. Health insurance vs. CME, PTO and the like, and then as operations return to normal all staff will share in the benefits. If every one of the people can have confidence in the transparency and the quality of your organization's caring, it is helping them to understand that as you return to recovery and good health, everyone will benefit.

Some of the practice issues that you will face, you want to create expectations of modifications as demands change. This is a very fluid situation, both locally for your practice, and nationally, with constantly having to adapt and adjust to the current information that we have available to us and our practice.

Your relationship with your facilities will be tested. If you had a great relationship going into this, that is going to get cashed at this time. But you're also going to be able to utilize the quality of those relationships with your facilities, not only in terms of stipend support, and personnel transfer, but also perhaps as equipment is needed. As ASCs and ambulatory facilities are being shut down or reduced, they may be available sources of supplies, personnel, and anesthesia equipment. It's important to work with all of your professionals to explore what federal, state, and local resources with support are available.

Prepare and submit those applications and supporting documentation as soon as possible. Jump on it. But again, you'll be hearing from Nora and Sharon later on this evening about those resources and the policies around them, and the regulations are being updated daily, if not hourly. So you want to stay tuned to that and you want to act on them as quickly as those resources are available to you.

Explore and pursue the support of staff safety equipment, PPE supplies, aerosol boxes, or anything that might actually help support your staff. You have a role in acquiring. It's not just hospitals, it's not just surgeries. But you as practice administrators can also access supplies and equipment with sister staff.

Another key point that is important to remember and has been brought up before, is communicate, communicate, communicate. Everyone is looking forward to the clinical administrative leadership to help guide this process as we both go into this event, through it, and exit from it. You cannot over-communicate with your staff about clinical and safety policies, about staffing, about variations in case load, impacts on compensation, PTO, benefits. It's important to hold, as has been discussed before, regular conference calls using GoToMeeting resources, Zoom sessions, being as transparent and informative as possible. Because in the absence of this, this kind of regular communication your staff will fill in the gaps and those will be fueled by their anxieties and pressures and stressors that they are experiencing, both professionally and personally. So, anything you can do to convey the care that leadership is providing is critically important.

Finally, we're all in this together, and it's important to remember that your staff knows that leadership cares, that we're planning and executing strategies to support them, and that we remain open to change as new issues and opportunities arise. We can overcome this.

Now, it's my pleasure to introduce Genie Blough, who's going to help facilitate our discussion. Genie?

GENIE BLOUGH:

Thank you. Steve. Like many of you, I'm very concerned about our anesthesia groups and practices that were already operating on thin margins pressed by surprise medical bills and production pressures. And as Dr. Peterson mentioned, I would suspect that most anesthesiologists share that concern and want to know what's on the horizon for their groups. What can they do? How can they take advantage of the federal resources available? And when you think about it, with nearly 50% of the anesthesiologists

working in small to medium groups of 50 or less, the strain on resources both financial and human are amplified. The COVID battle will stress these practices to unimaginable limits and we are already hearing of proactive planning from the ranks. As all practices are working to provide services, the human toll of stress and burnout should be recognized and addressed. Be aware of your partners, your staff, your colleagues and pay close attention to any changes in communication and behavior. It's going to take a cohesive team of the anesthesiologists, CRNAs, AAs, schedulers, accountants, administrators and more to guide your practice through this crisis. But as you said Steve, we are all in this together.

So our first speaker from Washington DC's ASA office, is Sharon Merrick. Sharon, as many of you know, is the Director of Payment and Practice Management. She will be discussing billing for critical care, tele-health regulations, and accelerated payments. Sharon?

SHARON MERRICK:

Thank you so much, Genie. So, right now, your practices are facing truly steep, steep economic challenges while you guys are on the front lines of the COVID battle. So in my short time with you this evening, I just want to take it, make you aware of some options you have right now for some immediate cash flow into your practices. I realize that the amounts of some of this cash might seem small in scale and scope compared to the catastrophes that we're facing, but at this point you just want to, you know, to stop the bleeding and you keep cash moving just as much as you can. So in these next few slides, we're going to talk a little bit about critical care, tele-health as an option and Medicare's Accelerated Advanced Payment Program.

So, critical care, this slide gives you the two codes, the CPT codes that describe critical care for adults and notice that one is an add-on code, always reported in conjunction with the, uh, the 1st one. 99292 gets reported with 99211. Um, the criteria, these codes, when you report them, the patient and the care have to meet certain criteria. The patient has to have a critical illness or injury, so that there's a high probability of eminent, or life-threatening deterioration in his or her condition, which would certainly be the case for a COVID patient that requires critical care. And the treatment has to involve medical decision-making that is so complex because you are assessing, manipulating and supporting all those vital life functions. It doesn't mean that the patient needs to be in an ICU. The patient could be anywhere but as long as the patient meets the criteria and the care meets the criteria, you can report critical care services.

These are time-based codes, and just like anesthesia there's rules about what's included in your time and what's not included in your time. The timely topic in the more information link on this slide gives you more information about that. Um, anesthesiologists may not provide, it may not be providing critical care per se but you may be providing ventilation management. If you are providing vent management and not critical care, report that event management code. If you are reporting critical care the vent management would not be separately reported, it's bundled in there. Um, payment amount is what Medicare allows for the fee schedule right now. And, as you know, ASA has been promoting and it, advocating for, advanced payment for services such as critical care, um that anesthesiologists are providing right now, um, and, to COVID patients in this environment, so hopefully we'll be able to reports some success for that.

Tele-health. Um, in this challenging environment where so many of us are under stay-at-home orders and where hopefully all of us are, are, practicing social distancing, tele-health could be a real option for some practices, and also think about it for pain practices where you can continue to provide the care your patients need while mitigating the risks of exposure to them and to yourselves. In this past week or so, there have been changes announced about tele-health a rate and a frequency that I don't believe I've ever seen before in all my years of doing this. Um, the patient does not need to be, the patient can be anywhere in the country, anywhere, any patient anywhere, is now eligible for tele-health services. The origin, originating site, which is where the patient is, can be at the patient's home. They don't have to go to a special designated site, and the distance site can actually be the provider's home as well.

Um, the list of services that CMS allows to be performed via tele-health has been expanded, 80 more services, I believe, have been added to this.

You may even want to consider a pain practice continuing to do tele-health after the crisis is over as another way to sort of be able to enhance revenue, enhance patient care, and get yourselves back on the field after uh, this crisis is over. If you remember, many of the loosened restrictions may tighten up again after the public health emergency does end, so you want to make sure that you stay aware of that. Information is in the, uh split here on your slide as well. Uh, anesthesiologists may even want to consider tele-health. If you're working as an intensivist, because of those 80 codes that have been added to the list, critical care with two codes 99291 and 99292 are now on the list of services that can be performed via tele-health.

I want to talk about CMS' Accelerated and Advanced Payment Program. This program has been in existence for many, many years. Typically, it's used like for hurricanes,

floods, things like that, anytime that there is a disruption into the claims submission and the claims processing systems. It has been expanded a little bit for the duration of the PHE to include um, more providers are now eligible to make the request. The amount of money, um, that you can request has been increased. Right now, you can request up to 100% of your Medicare payments for a 3-month period, and what they're using for that 3-month period is the fourth quarter of 2019. And also the recoupment as changed a little bit as well, um, starts at 90, it starts at 120 days. You will make the request through, um, your MAC, you Medicare Administrative Contractor. The uh, fact sheet that is linked to this slide includes step-by-step instructions that you can follow to make that request. This could be a way to get cash in your door quickly because the MACs are committed to reviewing and approving those requests within 7 days of the receipt. However, do remember that this is not a grant, um, it is, you do have to pay it back, and the way it works is 120 days after you've received the money, CMS will then start when you, when they receive your claims, rather than issuing payment for those claims just take, they withhold your money, and they will continue to do that until the amount that you have been advanced has been paid. And, if it is not repaid within 210 days from date of issue, then they will ask you to write them a check and if you are unable to do that, interest may accrue at the rate of, I believe, 10.25%. Um, again lots of information on that fact sheet as well. And with that, I'm going to turn this over to Genie and look forward to your questions at the end of the panel.

GENIE BLOUGH:

Thank you, Sharon. That's some very valuable information. Next I'd like to introduce Nora Matus, ASA's director of Congressional and Political Affairs, and Nora's going to discuss features of the recent Cares Act as it relates to anesthesiologists and their practices. Nora?

NORA MATUS:

Thank you, Genie. And good evening, everyone. I hope this finds everyone well. In recent weeks Congress has passed and President Trump has signed into law three large bills to address the Covid-19 pandemic. The first bill allocated 8.3 billion dollars in emergency funding for Covid-19 prevention, preparation and response efforts. Phase two expanded Covid-19 testing and provided paid sick leave and unemployment benefits for workers and their families. Tonight, we're going to be focusing on the economic relief provisions of phase three - The Coronavirus Aid Relief and Economic Security Act or the CARES Act, which was passed unanimously by Congress and signed into law by President Trump last Friday.

The CARES Act will not solve all the problems that you and your practices are facing. It will provide you with some tools to help you maintain your practices through the challenges posed by the pandemic.

In sum, the CARES Act provides 2 trillion dollars in overall federal assistance to families and businesses.

Following this webinar you can access links to the agency websites, and where available, directly to a loan and grant applications from the ASA website. And I'd encourage everyone to check back frequently, as Sharon noted in her presentation, regulations are changing and updating frequently and we try to keep that site updated for you.

So, with funding of a hundred billion dollars the Public Health and Social Services Emergency Fund is probably the most eye-catching provision of the CARES Act. It's designated to provide immediate relief to eligible healthcare providers for healthcare related expenses or lost revenues attributed to the Covid-19 pandemic. All health care entities that provide health care, diagnose or tests are eligible for funding. And make no mistake, competition for this funding is going to be fierce.

Non-reimbursable expenses attributed to Covid-19 for funding, including among other things personal protective equipment and revenue foregone from cancelled procedures, all qualify. This fund is designed to be immediately responsive to needs and the Secretary of Health and Human Services will release the funds to healthcare entities on a rolling basis as qualified applications are received. The Secretary is expected to release guidance on the application process very shortly.

We've heard many concerns from physicians about being able to maintain their practices as a result of the pandemic and cancellation of elective surgeries. The Small Business Administration is offering loan programs, often with loan forgiveness.

The SBA Payroll Protection Program provides loans up to 10 million dollars to help retain employees on payroll. Through the Payroll Protection Program a physician practice can apply for a loan of up to 250% of their average monthly payroll cost to cover payroll as well as rent, mortgage payments and utilities. This loan can be forgiven based on the number of employees retained on payroll up to 100%. Forgiveness is not available for income above $100,000 per employee on an annual salary basis. The program is retroactive to February 15th in order to help bring workers who may have been laid off back on to payrolls and loans are available through June 30th of 2020 and

payments deferred for 6 months. Applications for the Paycheck Protection Program open tomorrow, April 3rd.

The SBA provides financial assistance in the form of loan guarantees and subsidies to small businesses through the 7(a) guarantee program. The CARES Act increases the maximum 7(a) loan from 5 million to 10 million dollars and experience eligible uses to include payroll support, employee salaries, mortgage payments, insurance premiums and other obligations

The Emergency Economic Injury grants provide an emergency advance of up to $10,000 for practices experiencing an unexpected drop in revenue due to Covid-19. Advances are paid within 3 days of applying for an SBA economic injury disaster loan or EIDL, and these advances do not need to be repaid. You do not have to accept an EIDL Loan in order to accept the $10,000 Grant.

Economic Injury Disaster loans make up a 10 billion dollar program to provide small businesses and practices with working capital loans of up to two million dollars to overcome temporary revenue loss due to the pandemic.

The CARES Act also includes an employee retention tax credit. For practices that aren't eligible for the paycheck Protection Program or didn't participate didn't choose to participate. Any business that's been forced to fully or partially suspend operations or has seen a significant drop in revenue is eligible for a 50% credit of wages paid to furloughed or reduced-hour employees. The credit can be claimed against the businesses quarterly payroll tax liability and is fully refundable. There are also options to receive advance payments.

The CARES Act allows employers and self-employed individuals to defer payment of their employer share of the Social Security tax until December 31st. The deferred amounts would be paid over the following two years, with half of the amount required to be paid by December 31st of 2021 and the remaining half by December 31st of 2022.

The CARES Act also provides an economic impact payment or tax rebate to anyone who filed a tax return this year or last year. Individuals are eligible to receive $1,200, married couples, $2,400, and dependents under the age of 17 $500. The rebates phase out at a 5% rate above adjusted gross incomes of $75,000 for single filers and $150,000 for joint filers. The CARES Act also allows for a withdrawal of funds from retirement accounts of up to $100,000 in 2020 without paying any tax penalty. If the position, spouse or dependent is diagnosed with SARS, COV-2 to or COVID-19 or experience

adverse financial consequences, as a result of being quarantined, furloughed, laid off or having work hours reduced due to the viruses.

Finally, interest on student loans held by the US Department of Education has been waived through September 30th 2020. Borrowers with commercially or privately held loans, unfortunately are not eligible. No interest will accrue on these loans for the same time period. And any payments made during this time will be applied to the principal and previously accrued interest.

This concludes my overview of The CARES Act, and Genie I'll hand this back to you.

GENIE BLOUGH:

Thank you, Nora.

James Kim is our next speaker and he's not ASA staff. Rather, he's from the DC law firm McDermott, Will & Emery, and James is going to discuss how to access small business loans and some other features of federal aid to take care of your practices in these difficult times. James?

JAMES KIM:

Thank you very much. I really appreciate the introduction and I applaud the summary that Nora just provided. What I'm going to go through here are a number of slides that are repetitive for much of it. I will not focus on the sections that were discussed but rather focus my discussion on the nuances related to the interpretation and application of the definitions in the Payment Protection Program or what was discussed as the expanded 7A loan program that includes forgiveness.

In this case, first of all, I want to thank everyone for joining me on the call. I am in the legal community, but I am, first and foremost, I was the, I spent two years in disaster relief post 911, the 911 Fund. I got my degree from Mailman in Columbia in public health policy and epidemiology. And I appreciate the fact that everyone being on the call here, it is absolutely appreciated what you do on a day-to-day basis.

What, and just to turn to the topic here the CARES Act here. We're going to be moving over to the actual provisions of the Paycheck Protection Program that were discussed before right. So expanded 7A loan program allows for, as mentioned, a 10 million dollar loan maximum value based upon a historical 12-month average payroll. You take your payroll according to the application, it is for calendar year 2019. You take that payroll

over 12 month period, get the average monthly amount, multiply that by 2.5 and that is your payroll maximum. Overhears listen to the description of the organizations and eligible recipients. Most often practices of this type will be in the small business, fewer than 500 category. I will note however, one thing to consider, that is of much debate in my community, is the application of the rule of affiliation, managed practices. For example, there is a specific rule in certain circumstances that will require you to aggregate your employee headcount.

Again, I don't suggest this for the people on the call, but this is not just counting the number of people in your entity. The rule is found in Title 13 of the code of federal regulations. It is very specifically applied. Generally speaking it means there is common control between two different organizations, they are considered affiliated and combined for employee threshold, and revenue threshold, qualification purposes. In that case, for companies that are in group situations, again … it is possible, that you would have to aggregate that across multiple levels of the organization. I don't think it's probably applicable to the people on the call here for the most part, but I do reference it. If you look at the application form, it states on question 3, "you must provide whether or not you have common ownership or management with another business and if so, list an addendum A that lists capital A affiliates." That is what is being requested on the form. What other entities are in common interest, common control, with the entity being applying for aid, right? So the owner is the practice, for example, that would be the concern. There are a couple of exemptions here listed in the state, in the statute, not really applicable for the most part here.

We've already discussed, briefly, the application period but I will reference to specific here. Starting April 3rd, 2020, that being in two and a half hours that, as of midnight, this application goes live to a small number of organizations. There are banks that are refusing to roll this practice, to roll this program out immediately, and allowing additional time for this to be developed. However, it is starting technically tonight in about 2-1/2 hours, two hours and 37 minutes according to my clock. There is a list of SBA lenders. However, my understanding is based on the intelligence that I received from the various banks, banks are very much targeting existing lending and banking relationships. Go to your bank first. Ask them if they have a 7A affiliate. If it is, if that is the case, you may get an opportunity to apply earlier than others. I am the under the understanding that certain banks are refusing to open up applications for the first few days.

Employee. So this is actually a critical definition. If you want to see how to calculate this correctly, it's not an FTE basis. It is all employees whether full time, part-time or other. Count that number, aggregate that over the average monthly period in terms of numbers for calculation purposes.

One of the questions that we have received quite a bit on is, what about it independent contractor? What about interns, temporary to permanent hire employees? There are specific pieces of guidance on how those are treated by the SBA. Don't make an assumption. The rule applied by the SBA is often different than the rule applied by the IRS or other authorities. You must be cautious, look to the actual SBA definitions themselves. Unfortunately, because of the interest of time here, it is a fact specific decision. I can't go through the details there. But I would suggest you should look to at the SBA definitions there.

One more thing to say. You have to certify that one, the uncertainty of the economic conditions make the loan request necessary to support ongoing operations. That's a critical piece. You are certifying to a federal government official in the receipt of assistance. The potential penalties for getting this incorrect are very broad. And in fact the application recites a litany of absolutely terrible statutes, the worst of which, and I will quote from the application itself. It states that I further certify that I am providing all supporting documentation and forms is true and accurate. I realize that knowingly making a false statement to obtain a guaranteed loan from SBA is punishable under, and I will get to the last one, a 18 USA 1014 by imprisonment of not more than thirty years and a fine of not more than 1 million dollars. It is one of the highest standards in the criminal statutes. I do not suggest that there is any concern here. However, it is important to understand that when you sign this application it is not just the business, it is the 20% or greater owner and for the majority of people I would guess, these physicians, will have an ownership interest in their practices, they will have to sign on the dotted line, personally. Know what you're signing. Read the application carefully. Fill the documents out with a CPA. Go to your professional advisors. Get this correct. The value is obvious. They are going to give you two months essentially eight weeks of salary for your personnel at near full complement. You will in addition to that, get up to 25% of loan value, of forgiveness value, which would you be one-third of your salary payroll amount, inclusive of health benefits, including group health insurance and insurance premiums. You will allow to have 25% dedicated to rent, utility payments, leases and previously and previously incurred mortgages, mortgage interest. This is only for items that were previously existing prior to 2/15/20. So if you calculated correctly, you should have a forgiveness value that covers approximately two months worth of salary plus those additional expenses. Your loan forgiveness should be near to the full value of your loan if you do this, correctly.

The obligations are several. The two critical ones, well, the three critical ones are first you may only use funds for permitted purposes. It says and describes them in the vault itself in an application, but they are self-payroll including group health insurance and group insurance premiums, rent, utility, mortgage interest, and other debt interest that is

pre-existing. You may not use it for other purposes. You must only use the loan for those purposes. Number one. Number two, as mentioned on the forgiveness side, if you think about it, the differences between eligible expenses and what you get forgiven for are different. A payment of interest on other debt obligations is not included. You will want to be careful and structure the, how you use those expenses properly. You are also required to average, over the period time in the covered period, until June 30th, a number of employees by a headcount, it's actually defined as full-time employee headcount in the regulation, in the statute. You must recover 100% of that number. You can reduce salaries by up to 75% and it's a running average over the covered period, as long as you meet those two goals, your forgiveness value is 100% and is reduced proportionally based on your failure to meet those two standards.

The key here, is really understanding that you have to meet those obligations. And because it is a running average over the period you cannot simply not be thoughtful about maximizing that number and ensuring you get the forgiveness value. You should be cautious. And remember this. One, the application is quite simplified but very detailed. There is a lot of information that you are writing in there and you are certifying to the accuracy of it. You won't need to collect 941 payroll tax statements to attach to the form for calendar year 2019. You will need to prepare a list and description of the 20% or greater owners of the organization, prepared to have those owners signed the form as well as the business representative, and get the certifications drafted, and looked at carefully.

Once that's done, the application is submitted. The processing is very quick. We are expecting money to roll out within days for the first applicants. Weeks will follow before the real bulk of the money will go out. Once that occurs, the problem, the issue is, is that on the back end in order to obtain the greatest amount of forgiveness, which is the form of rent, it is actually required for you to send payroll tax receipts, rent receipts, utility statements. There is an enormous, there a much greater documentation requirement on the back end.

Getting the load is easy. Making sure you live up to those requirement is more difficult. Be careful, read the requirements. Make sure you do the calculations right, and use your professional advisors to help you through that process. You do it right, you will have two months of salary, rent and utilities paid for by the government.

It is a fantastic program and I do encourage everyone here who is eligible to take serious consideration of application to it. We have on our website at the law firm, a coronavirus Resource Center that has detailed summaries of each of these requirements. We have recorded webinars that are walking through each of those

obligations. And we expect to have one Tuesday of next, as early as Tuesday of next week that we targeted towards non-profit organizations and small businesses. It is not targeted toward our ordinary client base, but towards the greater community and anyone who is interested is more than welcome to attend.

Thank you very much. I'm here to entertain any questions at all.

GENIE BLOUGH:

Thank you, James. I think you got all of our attention on that one. Um, if we weren't paying attention part of this we definitely did on that. The penalties are pretty audacious.

Um, our last speaker for tonight is Manny Bonilla and as many of you know, Manny has been the leading voice for anesthesiology on the Hill for years. He's here tonight to discuss future federal relief and ASA priorities in the days and the weeks ahead. Manny?

MANNY BONILLA:

Thank you, Genie.

Um, I, I am going to serve as a bookend to the previous discussion, up from James Kim and Nora Matus. This, the situation with these funds is a dynamic situation. And that is constantly changing. The CARES Act created some basic structures that are in place, uh, and will be in place.

We're going to take a three-pronged approach moving forward. Number one, looking at the CARES Act, looking at the processes that James has set, has referenced, and that Nora has referenced. Are they working for anesthesiologists? Is the federal government getting cash out the door to anesthesiologists' practices? Are there changes that ASA needs to seek, either at the regulatory level or the legislative level, to make the process easier, uh, and to make this these funds more accessible to our practices.

I've noticed on the chat lines are number folks who have indicated they are preparing, or have applied for the SBA loans. We would certainly welcome your feedback if that was a, if that's a reasonable process to go through and if they're changes that ASA can advocate for to help, uh, make it easier for future applicants.

Our second uh, prong is going to be preparing for what we expect to be a forth phase of relief legislation. The CARES Act was the third major package that the government had

taken up. We do expect a fourth package to be worked on by Congress. The House of Representatives, expected back in 8, on April 20th, either to work on the legislation or perhaps even to pass what is being worked on behind the scenes now.

One of our primary goals is going to be that hundred billion dollar fund. We do expect that to go quickly since hospitals are also in that fund. We don't think a hundred billion dollars is sufficient. We will be asking for more dollars to be included in that and to the degree possible, trying to identify a fund specifically for physician practices. We also want to continue to monitor the small business loan process that was referenced, make sure that their dollars will continue to be available there. As James mentioned, that money is going to likely go fast. We need to make sure that there are opportunities for anesthesiologists to access those dollars. Also we're going to look at liability relief. That's an increasingly important issue for many of our members, especially folks who may be moving beyond their scope of usual practice. Typically folks doing anesthesia may be doing critical care. The governor of New York had a very expansive immunity liability, immunity that he put in place through an executive order. We want to see if there are options to mirror that in federal action whether by legislation or action by the administration. We think it's very important to try to provide those liability protections to our members.

We're also going to be looking at what private payers are doing. Certainly the government is, is ahead of the game and trying to keep up to date on payments for Medicare and Medicaid. But what about commercial payers? Is there an opportunity for Congress to engage some oversight over the commercial payers to make sure they are appropriately paying for anesthesia and critical care services?

And finally we're going to continue to work with HHS and CMS on enhancing existing payment, Medicare payments. Sharon mentioned some of those opportunities. Obviously those are not going to make anesthesiologists whole, but we want to continue to seek increases where possible. As part of our formal correspondence with the administration, we did ask for 20% bump up add-on code for a, for anesthesia and critical care services for COVID patients because they are no longer a typical patients as of those payment rates are typically sat at. And that would mirror what the hospitals got. The hospital hospice got a 20% add on to their COVID related DRGs. So we thought the same should be applicable to physicians.

And they're also going to continue to look at new payment models. Are there opportunities for us to make anesthesia practices whole and make physicians whole about their work that they are doing. We're certainly hearing a lot about anesthesiologist, that are doing a lot of work in hospitals, demonstrating leadership in

the critical-care space, helping to organize systems within the hospital that aren't necessarily being paid for those services. Are there opportunities for us to work with the government to have those services paid for?

And that's the conclusion of my comments. Thank you very much and I certainly think all the ASA members for their work out there.

GENIE BLOUGH:

I think now we want to bring back all of our panelists, and Manny, I just want to say, the way this is all progressing, it's just, just dizzying where we are now vs. a month ago and you're definitely dealing with a moving platform as there, all those that are in practices. It’s gonna take quite a while to get back to where we were just a month ago or a couple weeks ago financially.

I found in several of the groups that I work with a lot of concern about their financial futures, and so here are just a couple of questions, um, I've encountered. I want to put these questions to the panelists. This is when inquiring minds really want to know, what are some of the strategies that practices have had to maintain clinical and support staff through these financially uncertain times? I'm thinking about how anesthesia practices might be able to ramp up with elective cases once this event passes. You know, the hospital thinks we're like a, a faucet, you turn it on and you get anesthesia.

STEPHEN COMESS:

It's a great question. As I said before there is how we're adapting to the event and how we're going to adapt after the event. And it's important that people feel the kind of support and flexibility to get them through this. We are having people use PTO, we're having people use unpaid time off. We're going to be flexible if that's been consumed, and as the event, which we anticipate is a surge of activities, 7 days a week 24 hours a day to catch up that backlog of elective cases. We want to engender their goodwill to help support that. Uh, that's going to be the use of additional time, additional pay, our facilities being flexible with their support, uh, in, in the, the economics of it. Though we are going to have to work together because different people will be able to contribute in different ways during his time. Some people have personal demands that will take them out of the loop or that are at higher risk it so they cannot participate at this time. But those people can be begged for the future when they can return for the work force. Some people were just, you know, and again fairness and transparency is important, asking everybody to sacrifice proportionately. As I said before shareholders and partners, the lion's share of the burden falls on them. And that doesn't mean that

everybody else is not participating in the sacrifice. And as long as they feel that they've been treated fairly, their, their individual concerns are being listened to, and their employment is being sustained, then they are going to be have confidence in the organization and want to be a part of the solution after this event.

GENIE BLOUGH:

Thank you, Steve. I think that, um, one of our previous speakers talked about the compassion and honesty and transparency with this. Thank you for that. Nora and James, what are the best ways that practices can seek and receive financial help today? What avenues would be best for them to consider? And start with James.

JAMES KIM:

Sure, so, I think it's an, and, answer with looking a lot of, it is a puzzle, and Nora outlined a lot of the key levers you'd be looking at it in organizing that puzzle. There are unemployment benefits that are available for people who are going to be put on, if you have to at least, and there are ways, depending on jurisdiction and state rules, to allow for unemployment to be collected when they're furloughed. You can furlough an employee, pay their group health benefits and insurance premiums, and still get unemployment in the right jurisdictions. That lends itself to a certain favorable analysis with regard to Payment Protection Program. It's a balance.

It does not, it does not really mean one-size-fits-all. It really depends on your circumstances. You have to look at the pieces that are available for people who don't look, look at some of the payroll tax deferrals are a way of advancing capital now, but that bill is due in the future. That is not actually adding funds to you right now. And the other programs out there, generally, appear to be advances. The program that will actually most effectively put money and capital in your pocket, truthfully, to extend the opportunity for salary to be paid to your employees during the next few months is Paycheck Protection Program. The other programs have been EIDL other ones they are absolutely valid as well. They are good ways to access immediate capital. I would be cautious. Everyone sees the EIDL program and sees loans of up to two million dollars.

That is factually true. If you take the average origination value of a set, of an EIDL loan by the SBA over the last few years, the average value is, median value is around $20,000 to $50,000. They are not meant to be multimillion-dollar loans. EIDL is just for a brief period of time that may get you, with a $10,000 emergency grant to the Paycheck Protection Program, that gets you two months forward into the future. The one thing I've heard, I think people are a little mistaken about is this. If you get EIDL money and you

apply for the Paycheck Protection Program, you can apply for both, but you only get a salary equal to the Paycheck Protection Program amount. It is my, in my understanding from SBA folks in the lending industry that they are going to re-fi in the EIDL amounts into your PPP, so you don't get to get extra. It's the same amount right? The calculation cap is the same in the end. You are not going to look for additional amounts.

Um, that's my initial suggestion. There are things you can strategically do for those in, with, with Medicare Advanced Payment and the like, but again, be cautious. Those bills are due in a very short period of time. They are significant payments, but they are not for, that's not new money. That is just moving money from the future into your pocket now. It will be due. Just understand that in the reality of this, in this environment, my understanding, my guess is, your services will be well needed. You are essential to everything that we are doing here and getting by the next few months of what's happening may be what you need to be on your feet and ready to go when the new normal comes back, whatever that might be. Right? July 1st is when the Paycheck Protection Program more or less expires.

On that day, the worker retention worker, … worker hiring, re-hiring requirements will expire. I am aware of many large organizations saying when that money runs out, we are stopping, we are not going to continue to pay the employees. We will make hard decisions at that point. Be forthright with your people. Be open with them, have a frank discussion about this, because truthfully there are a lot of things that can be done to the benefit of them, should the answer is that these programs are intended to put money in people's pockets, in workers pockets, not in corporate pockets. And that is important for you to deliver that message to your people, to understand that, look, what we're doing everything we can to make this work. Let's be honest, this will allow you to pay people to stay home.

If they have valid reasons for doing so you can continue them on salary with different duties that don't require them to be around. You can pay someone to do less work. It's hard for you to pay someone, to not pay someone to do work. Right? It goes that way. That would be my suggestion and thoughtful about that. Try and think about your people. I think the business model is there down in future for you, from, from a supply and demand standpoint. Just, it's important for you to do that. I see a lot of questions on the bottom about 1099 contractors. The answer is, SBA typically treats independent contractors as non-employee, that it is a fact and circumstances determination how the payroll taxes are paid, the structure, all those pieces are relevant. However, on the other hand owners are fully covered, qualified to be paid under payment protection, but you must work a prop, you must do a full time position to get full salary.

And are you qualified? You should qualify, you should be spending 40 hours a week with that business, honestly. I don't think that's much of an issue from any of the practitioners here, but you cannot claim employment if you are not actually working at that practice. You can draw a salary, but count it once, thank you very much, and two, you cannot add it in today. It is historical salary, 2019 calendar year payroll is what they're going to look at. You can't simply make an adjustment today to make that different. I apologize for taking up time, but I think that's an important message to deliver. Thanks.

GENIE BLOUGH:

Thank you, James. So, at this point, I'd like to thank everyone for their questions, um for the panelists here, and I'll turn it back over to Dr. Peterson.

DR. MARY DALE PETERSON:

Thank you so much, Genie. Um, as we wrap up, ASA would like to know how COVID-19 has changed your daily life and practice. Share your stories with us, and each other. Jot an email to our communications team at pr@asahq.org. So, I want to again thank you for being with us. Um, keep the faith.

DR. ADAM STRIKER:

Thanks for joining us. We'll continue to keep you updated here at Central Line. And for more information, you can find video of the original town hall at asahq.org/covid19info where additional COVID-19 resources can also be found. Stay safe and join us again soon.