



the AnesthesiaRecord

AAAA[®] American Academy of Anesthesiologist Assistants

Third Quarter 2016



NEW DAYS DAWNING IN CAA PRACTICE

- Follow the money for clarity
- Decision: shift worker or value-added pro
- The power of coalescing
- Group practice change impacts AAs



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Cuffe's legacy built on coalition strength

I write to you from a cracked and weathered—but sincerely loved—back porch of an old family cottage on the coast of Massachusetts. Unfortunately, a line of thunderheads is directly approaching, threatening to end my efforts at writing. I am in a state where CAAs currently do not hold state licensure and are consequently restricted from work. The combination of the impending weather, and the realization that I cannot work in a state where I sincerely want to (and of what opposes me if I try to change that) can make for a frustrating outlook indeed. Some perspective is needed.

"Cuffe's strategic and bold fight against significant opposition should inspire... our own efforts in the greater healthcare community."

The little coastal village I am visiting is famous for just one individual, for it is truly not big enough to support any more fame. Still, the story of Captain Paul Cuffe is truly inspiring. Born in 1759, the son of a freed Ashanti slave and a Wampanoag Native American, Paul Cuffe grew up opposing the existing conditions of inequality and disparity, the menace of slavery, to become a sea captain and a leader in the whaling industry. He eventually became one of the most influential and wealthiest individuals in the region. Yet, he always surrounded himself with those who shared his Quaker beliefs in the equality of all men, and his advocacy for equality was constant. He refused to pay taxes when he was not allowed to vote and then brought petitions that led to statewide voting right changes in 1783. He used his fortune to found and build one of the first schoolhouses open to all races in Massachusetts. Rather than rising alone as an outlier, he partnered with likeminded individuals and leveraged his position of leadership to bolster the successes of his community. He was incredibly effective and resourceful, yet always professional, at a time when the larger governmental and institutional environment was often in direct opposition to him and the efforts of his community. While it is impossible to compare our causes, Cuffe's strategic and bold fight against significant opposition should inspire—as they do for me—our own efforts in the greater healthcare community for anesthetist provider equality and representation.

It is foolish to deny that our profession faces significant hurdles. Unequal and unfavorable payment models exist within CMS. Certain organizations promote ethically questionable actions and policies against CAA providers and the CAA profession. Groups and health care organizations continue to limit practice and responsibilities of CAAs without base or reason. These are just a few examples of some obstacles we face as proverbial underdogs. Our job as members of the AAAA®, and leaders in the CAA profession, is to find and produce success in times of a nationwide struggle. When faced with adversity, the AAAA® is the only national organization dedicated first and foremost to the CAA profession and should be a focus for efforts in the fight against those that oppose and limit CAA practice. The fuel for these tireless efforts is manufactured by continued membership in and donations to the AAAA®.

"AAAA® is the only national organization dedicated first and foremost to the CAA profession."

Rays of sunlight do shine through the clouds. The support of the ASA is steadfast; AAAA is increasing its cross-institutional support working with the ASA. The new CAA membership category within the ASA is available to all CAAs and provides a multitude of ASA resources to AAAA® members. More states are seeing the benefits of increasing competition within the marketplace of mid-level anesthesia providers and are introducing CAA license legislation. Membership within the AAAA® continues to increase, as do the incredibly valuable donations to the AAAA® Legislative Fund. And, yesterday I heard one of the most significant practice threats within a major CAA employer has been successfully addressed (with effort and powerful help from all corners of the medical community). As a greater community that sticks together, we have proven to be successful despite overwhelming, yet illegitimate opposition.

"We have proven to be successful despite overwhelming, yet illegitimate opposition."

Later, I'll walk up the road to the local general store, to submit this article on the only local and available wifi. Along that road, the rain has stopped and the skies beyond the clouds look clear and blue. As in life and in our profession, there is sunshine after the rain. Storms are a fact of life, but the AAAA® is dedicated to working for the success of the CAA profession and allow us all to shine in the sun.

¹Thomas, Lamont D. Paul Cuffe: Black Entrepreneur and Pan-Africanist (Urbana and Chicago: University of Illinois Press, 1988)

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Calendar of Events

October 2016

4th Quarter AAAA[®] Board of Directors Meeting | October 23 | Chicago, Ill

ASA Annual Meeting | October 22 - 26 | Chicago, Ill

November 2016

NCCAA June Certification Exam and CDQ Exam Applications Open | November 1

4th Quarter Newsletter Article Submission Deadline | November 14

December 2016

Membership Renewal Period Begins | December 1

Post Graduate Assembly Meeting | December 9 - 13 | New York, NY

January 2017

NCCAA June Certification Exam and CDQ Exam Applications Close | January 15

ASA Practice Management 2017 | Gaylord Texan Resort | January 27-29 | Grapevine, Texas

February 2017

NCCAA Certification Exam and CDQ Exam | February 18

New Horizons in Anesthesia Conference | Emory University's Department of Anesthesiology
February 19th - 24th | Vail, Colorado | Visit emoryanesthesiaconference.com



Set to go in San Antonio!

La Cantera Resort and Spa, San Antonio, TX -- Texas Academy leaders and AA students staffed the TXAAA exhibit booth at the Texas Society of Anesthesiologists annual conference September 8-11, 2016. Physician attendees asked for more information on hiring CAAs and how to integrate AAs into practice.

AAAA and state academy leaders also staffed exhibit booths at the Indiana Society of Anesthesiologists' Practice Management Meeting and the combined North Carolina/South Carolina societies joint meeting in Charleston, SC in September.



Follow the money



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Many CAAs wonder why nurse anesthetists are dominating the workforce in places where CAAs are qualified and desire to work. Almost everywhere CAAs work, with the possible exception of metro Atlanta, CAAs have experienced anti-competitive business practices. CAAs attuned to professional news have either experienced or been made aware of anti-AA literature, CRNA testimony against CAAs, discriminatory hiring practices, and even subversive attempts to get rid of CAAs where they are already employed. Because of this, it's easy to simply blame nurse anesthetists or their professional organization...but this simple laying of blame at the feet of the nurses is a mistake. **CAAs need to think bigger. Why does the opportunity for monopoly in the non-physician anesthesia provider industry exist at all?** There's a famous line you may have heard before: follow the money.

A groundswell of support exists among CAAs for advocacy that, not coincidentally, parallels the increase in practice and payment challenges that affect the bottom line for CAAs: their employability. It is no surprise that in a time of the notorious 1% and of the greatest pay inequality in history that Americans are educating themselves about how our economy works. CEO to worker pay gap is now 350:1, a 1000% increase since 1950. Citizens and government agencies alike are

"It's time to stop tolerating monopolies in the market of non-physician anesthesia providers."

following the money trail in the effort to avert economic crises, one of which is rapidly rising healthcare costs. Money in healthcare is multifaceted and complex and every CAA should understand where their paycheck comes from.

The money trail in our situation leads us to a growing effort by nurse anesthetists to monopolize the anesthesia provider industry even though monopolies and anti-competitive business practices hurt us all. Competition in any industry improves quality and contains costs. One should consider why CAAs are being shut out of employment opportunities. Rather than just crying "not fair!" or blaming physician anesthesiologists for skirting medical direction of patients under their care, follow the money. **It comes down to Centers for Medicare and Medicaid Services (CMS) and other insurers making CRNAs more profitable (and logistically easier to use) than CAAs through the use of the QZ payment modifier.**

The bottom line for any anesthesia practice is full payment for anesthesia services rendered. The choices for full payment of services are "medical direction" (QK/QX) or "independent nurse practice" (QZ). Medical direction

(QK/QX) requires documentation of a seven step criteria defining physician anesthesiologist oversight of CAA or CRNA. There are modifiers that exist for failed medical direction or physician oversight without meeting the seven steps for both CAAs and CRNAs (AD/QX) also known as "medical supervision", but these are generally not used since they result in a reduction in payment for services. The QZ payment modifier, originally specifying independent nurse anesthesia delivery, was altered in 2013 to cover any nurse anesthetist billing that is not medical direction. This means the QZ modifier is now used for independent nurse practice, care team model practiced by physicians other than anesthesiologists, and care team model where the 7 steps of medical direction have not been performed or, in many cases, simply have not been documented and/or billed for. The altered QZ modifier ensures maximum reimbursement regardless of how a CRNA is utilized in practice. QZ billing and practice not only lessens the workload of anesthesiologists or supervising physicians but also lessens the chance of inadvertent fraudulent claims, without sacrificing payment for services. Insurers need not look for documentation of the seven steps or any variation of supervision requirements if physician oversight is never billed.

QZ billing is a common practice even among ardent care team supporters and is often considered practical even when physician anesthesiologists provide comprehensive oversight of their anesthesiologists. As CMS tightens rules for payment of anesthesia services, it's far easier and less risky financially for a department or group practice to avoid potential penalties by using the QZ modifier rather than diligently performing and documenting the necessary criteria to meet medical direction. If the QZ modifier were less lucrative, that would solve part of the problem, but not all of it. Even if CMS experiences disruptive innovation with alternative payment models or accountable care organizations which might lead to a change in modifier use, many CAA work states have medical direction mandated in their practice statute.

Unless CMS revises tight requirements on CAAs, CAAs will have an uphill battle. It's very unlikely that CMS is going to relax its standards to make medical direction billing more conducive to anesthesiologists providing oversight to anesthesiologists. We need to advocate for CMS to tighten requirements on certain modifiers that would make them less appealing, in particular the QZ modifier. In a world focused on patient safety and quality of care, there would be billing for care team model or independent practice, with higher payment for services when the provider is a physician anesthesiologist practicing in the care team or independently. This would reflect specialized physician-led care as the highest level of patient care safety and quality. In an ideal billing world, CAAs, like CRNAs, would have a modifier that is used for any services they provide, since anesthesiologist oversight is already a requirement by state medical boards, facility bylaws, and even some practice statutes.

The distinction in billing between CAAs and CRNAs implies inferiority in CAA care and effectively keeps CAAs off the playing field even if they make the team. Whenever I find a practice that refuses to employ CAAs in states where CAAs are licensed providers, I find either a department where hiring is controlled by CRNAs or anesthesiologists that bill QZ.

It's time to stop tolerating monopolies in the market of non-physician anesthesia providers. Basing anesthesiologist payment and employment on educational pathway neither improves patient safety nor lowers cost to the consumer. Payment and employment opportunity restrictions are rarely seen between providers of same service anywhere else. Neither MDs and DOs nor physician assistants and nurse practitioners have CMS sanctioned anti competitive business practices determining their opportunities. Omitting CAAs from the revised QZ modifier proves arbitrary when it is permitted to be used in cases where there is indeed physician oversight of anesthesiologist delivered care. The distinction bears no relationship to skills, ability, or quality of care. CAAs do not advocate for working independently (nor do the majority of practicing NAs, evidenced by the fact that 80-90% of CRNA care is delivered in the care team model); we just don't want to be unfairly penalized.

"CAAs should not be disadvantaged by CMS payment policy."

These reimbursement policies deserve judicial scrutiny. CAAs should not be disadvantaged by CMS payment policy when delivering equivalent anesthesia services to patients. The national conscience has been awakened to the correlation of high cost of healthcare and disparate quality of care. Business practices that contribute to high cost of care and decreased care access have no place in the future. Policies that limit opportunities for CAAs are often labeled "protective" and "beneficial" (history has seen this before with race and gender) but if those same policies were applied to religion, race, sex, age, they would be readily recognized as invidious and impermissible. Let the medical boards, which control all licensure of CAAs, regulate and reassure physicians that CAAs cannot, nor do CAAs want to, practice independently. Billing modifiers should permit anesthesiologists to conduct oversight of their staff and care for their patients based on patient acuity and provider skill level rather

than checking boxes to ensure fair payment. The financial handcuffs on CAAs, and the anesthesiologists who employ them, should be removed. CAAs should be reimbursed as the highly trained, capable, and safe anesthesiologists they are.

"The financial handcuffs on CAAs, should be removed."

Many practicing CAAs remember a time when CAAs had two work states and limited practices within those states. Fast forward to 2016 and this limitation is as illogical as a time when gender or race were considered determinants of opportunity. CAAs and CRNAs deserve the same standing in healthcare payment and practice. If nurse anesthetists want practice and payment equality with physician anesthesiologists, they should and can attend medical school to become physicians, but that's another topic all together. If insurers, hospitals, and patients want nurses to practice anesthesia delivery independently, without a board certified anesthesiologist, then let them do so, but not for the same payment as a physician anesthesiologist delivering care directly. Those nurse anesthetists practicing independently should also be required to pay for and carry the same level of malpractice coverage as an anesthesiologist since they have assumed the same level of responsibility physician anesthesiologists carry. There are no doctorates of anesthesiology, only physician anesthesiologists with medical or osteopathic degrees and multi-year specialized training in anesthesiology (MD/DO) and non-physician anesthetists with either nursing practice degrees (CRNA) or masters level medical degrees (CAA). **Nurses aren't succeeding because they are better educated, better trained, or safer, or even more politically savvy. They are dominating the anesthesia workforce because they have an unfair billing advantage and more political power in numbers.**

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Nikki Block, CAA, MMSA

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In the ever-changing environment of health care, it is of utmost importance for CAAs to understand their role within the care team. As hospital expectations of anesthesia groups evolve over time, so do their expectations of CAAs. A global understanding of your role in the grand scheme of healthcare is absolutely necessary to maximize your value to anesthesiologists and practice managers.

“You are part of a growing profession where everything you do and don't do makes a significant impact. Your performance... representation of our profession as a whole.”

The absolute necessity for CAAs to position themselves as vital assets in the workplace is strikingly apparent when taking into account our relatively limited exposure in the anesthesia and larger healthcare industries. As of 2015 there were 115 CRNA programs in comparison to 10 CAA programs. The NCCAA reported just over 2,000 CAAs as of June 2016. In 2015, AANA reported a 90% membership rate with approximately 47,000 CRNA and SRNA members. AAAA® membership is currently at one of its highest levels with a mere 55% membership rate among our practitioners.

You may be asking yourself, “So, what's the point?” The point is we are a small group of professionals. We are really, really small in comparison to the CRNA profession. This means, whether you are aware of it or not, *you* are part of a growing profession where everything you do and don't do makes a significant impact. Your performance in the workplace is not only a representation of your abilities as a provider, but also a representation of our profession as a whole. Every day you are in the operating room, your actions show nursing and hospital staff, attending anesthesiologists, surgeons, and most importantly, your patients, what level of care CAAs provide.

What is your value, image?



Our profession has much ground to cover in the anesthesia market that has proven to favor the reimbursement and hiring of CRNAs over CAAs. CAAs must showcase their value and excellence as providers to employers and patients to keep and expand their foothold in the anesthesia provider market. If some of you have pondered your workplace value or more importantly, how to show your value, the following list may expand your understanding of the expectations that your value as an employee and provider are based on. Several anesthesiology department chairs and clinical directors were asked to share the top traits they look for in an anesthesiologist. Specifically, what do anesthesia groups expect of their anesthesiologists? Their answers are ranked below from most to least important.

1. Understand the group you practice in. Specifically, who are the anesthesiologists (or company employing the anesthesiologists) accountable to and how can you help them reach their goals? What is your anesthesia group's mission? This will vary depending on if you work for a large academic institution or a private, for-profit practice. Understanding the mission of the department will help you find your role within the group. What can you offer to further that mission? If you work in academics, they likely need help with staffing so their anesthesiologists, fellows or residents get much needed non-clinical time to focus on research or quality improvement initiatives. If you work for a private group, you will likely be held most accountable to the hospital—primarily surgeons. Are they happy with the care your group is giving? Are you efficient? Do your patients do well both during and after anesthesia? Are you a team player? Are you there to get the work done or are you watching the clock?

2. Professionalism. This is difficult to define, but you can spot unprofessionalism from a mile away. There are so many components of professionalism that it deserves its own article, but let's at least discuss a few essential components. In a nutshell, be dedicated to your profession, your group, and your patient outcomes.

- Respect your patients and the group you work for by providing the highest quality patient care and customer service. It's not enough to just provide safe anesthesia care. Safe care is the minimum expectation. As service providers, we should be focused on providing a positive customer experience while providing appropriate, tailored care. What makes you different? Do you take the extra time to ask for and listen to your patient's concerns before surgery? Do you anticipate and cater to every aspect of your patients' perioperative stay? Do you check on your patient an hour after you left them in PACU if you are available? Do you visit your ICU patients the next day to see how they're doing simply because you care or to understand what you may have done differently to improve their outcome? What do you think your surgeons or attending anesthesiologists would think if they noticed progress notes on your patient the day after surgery from the anesthetist? You might just be surprised at how gratifying our profession truly is when you see how much effect a little compassion and dedication has on your patients and their families.

- Make your presence and impact known to your group and hospital community when possible. Join committees, attend faculty or staff meetings, volunteer to help achieve department goals, learn about the challenges other staff and specialties are facing, and understand the decisions that impact your role within the team! Have a distinct voice within your group if you want to remain a part of the group.

- Belong to your societies and support them. It's a no-brainer and employers look for memberships to national and state organizations on your CV. One doesn't have to run for office and dedicate all free time to the organization—just be a member. There's really no excuse not to be. If you do not care enough about your profession (a.k.a. your livelihood) to be a member of your national and state organization, then why should anyone else care about your profession?

“Safe care is the minimum expectation.”

3. Teamwork—By far one of the largest complaints voiced by anesthesiologists was the “shift worker” mentality. While our employers truly respect our work-life balance, they also require flexibility from their staff anesthetists to get the work done. Our occupation is not one where the work consistently ends at a certain time, and if that is your expectation, then you chose the wrong career. The OR can be extremely unpredictable and when cases get added or procedures run long, the last thing your employer or attending physician of the day needs to worry about is making an anesthetist upset because they're held late. We need to keep the patient's welfare first and foremost in our minds.

“You can spot unprofessionalism from a mile away.”

4. Work ethic and reliability. Everyone understands that life can be demanding and sometimes you just cannot make it into work. However, we also have a professional responsibility to take care of our patients and cannot take missing an assigned shift lightly. When you're at work, show up ready to work hard. Put a smile on your face and take care of your patients the way you want to be taken care of. Resist voicing undirected complaints and criticisms to your colleagues and OR staff. Instead, well-articulated concerns should be shared directly with your chief anesthetist, which greatly increases the chances that the issue will be promptly addressed.

5. Efficiency. Time is money. Period. Go above and beyond to increase efficiency in your room. Look up your patient history the night before if you have access to your schedule and medical histories. This will speed up your preoperative assessments in between cases and free up time for your patient's to share undocumented health history or questions about their anesthesia care. Prepare for your cases ahead of time. Help with room turnover. We all know how to change linens and mop the floor. A lot of this may seem obvious, but I can't tell you how many times I've passed someone in the hall complaining about room turnover yet they're doing nothing to help. It's everyone's responsibility and it takes great teamwork to perform at the highest level.

“Employers look for memberships to national and state organizations on your CV.”

With the stark differences in the number of training programs between CAAs and CRNAs, it's not hard to believe we are outnumbered 25 to 1. During my time as a chief anesthetist and now program director, I have been greatly involved in student acceptance and anesthetist hiring. When seeking employment at a practice that employs both CAAs and CRNAs, CRNA candidates will grossly outnumber you. Your potential employer will sift through hundreds of CVs just to weed people out for interviews. If you are fortunate enough to obtain an interview, I challenge you to take a different approach to the opportunity. Instead of focusing on what this group can bring to you, ask yourself, “What can I bring to this group?” So, I'll ask you again: “What is your value?”



Watch CAA video @

<http://www.anesthetist.org/about-the-profession>

Mergers and Buyouts



John Kimbell, CAA

Administrative Chief Anesthetist
Northside Anesthesiology Consultants/Atlanta
Director, ARC-AA
Past Director, AAAA

Not many weeks go by without hearing of the acquisition, merger, or replacement of an anesthesia group with an Anesthesia Management Company (AMC). Whether it's Sheridan, NAPA, TeamHealth, American Anesthesiology, or a number of other smaller players, these types of shakeups are becoming quite common. Each year, the number of independent anesthesia groups dwindle.

"Everything else related to your schedule, compensation, and benefits are fair game."

Traditionally, anesthesia practice groups have been the long-standing exclusive provider of anesthesia services to a facility or hospital system. However, anesthesia group management has changed hands significantly in recent years, favoring more ownership by large corporate entities. Indeed, most of the large non-academic anesthesia groups in the Atlanta area are now owned by an AMC. The reasons are quite varied. Sometimes it is the group partners who seek to align with an AMC in search of a better financial or reimbursement position. A frequently cited reason is that the hospital seeks to decrease its own costs, particularly those related to subsidizing an anesthesia department or running its own department. In others, a group has not responded adequately to the needs of the hospital, and the hospital looks for alternatives. Sometimes the AMC itself

courts the hospital administration, attempting to offer better services. These negotiations are often conducted with significant secrecy, with the first clue that a contract is in jeopardy being hospital's announcement of a change in provider contract.

"All will be looked at and examined by the new group."

In groups where the practice negotiates being acquired, the financial incentives to partners in the group may be significant. In more hostile takeovers, incumbent groups may simply be pushed aside as their contract expires. Partners in these groups may be left out in the cold, with no purchase of the "equity" in their group since the group dissolves.

"Pay very close attention to everything that is said and read everything that is provided to you by your new employer."

One result is certain with these differences in ownership structure – things are going to change. You may hear it will be "business as usual" or some variation of the "if it ain't broke don't fix it" concept. That is largely a myth. While your actual day-to-day care of the patient is not likely to change, just about everything else related to your schedule, compensation, and benefits are fair game. Literally everything is on the table: salary, retirement, insurance benefits and your share of the costs of those benefits, overtime, vacation and sick time, etc. All will be looked at and examined by the new group. Things that make sense to them may remain untouched – things that are foreign to them or don't fit into their corporate culture are frequently adapted or discarded.

"You may think your services are irreplaceable."

Particularly with private anesthesia groups, the largest single financial change for anesthesiologists is likely to be to a pension/profit-sharing retirement plan. Many groups in the past contributed as much as 15% or more annually to an employee's pension plan. While that level of contribution was

slowly eroding in many practices, the pension plans of AMCs are rarely at anything that would be considered a generous level. A 4-5% contribution or match to a 401k seems to be quite common – others only contribute a flat dollar amount, totally independent of the amount of compensation.

What can or should you do if you find out your group has been sold or has lost its contract? First – take a deep breath. Although sometimes things happen very quickly (a matter of days between announcement and sale) it is more common that a change will occur with several months notice.

"Your best move is to stay as informed as possible"

The most important thing to do is to pay very close attention to everything that is said and read everything that is provided to you by your new employer. There may be terms that you feel are non-negotiable, and you may decide you can't stay. These new groups understand that, but they also plan for it. When AMCs consider these acquisitions, they come up with an "attrition factor". They actually recognize and plan for the fact that a certain number of anesthesiologists or physicians will leave the practice. And, although you may think your services are irreplaceable, or that if enough of your band together you can somehow derail things, that option is fatally flawed. Things will continue without you, even if the surgery schedule is disrupted for a short period of time.

Working for corporate America is quite different than working for a close-knit and tightly managed group. Changes take place far more slowly. Where one person in your group likely had the power to affect certain changes and could understand everything that was going on, now it is done through several layers of corporate management (that you have not and will likely never meet). Corporate managers are rarely positioned to see the whole picture, and indeed, may be responsible only for their small line item of the overall budget. Salaries are the responsibility of one manager – overtime may be considered

entirely separately – and benefits are another area altogether. Even things like recruiting may be done on more of a corporate level. Rather than a recruiter for a single anesthesia group at an AAAA® meeting, you may see a recruiter from an AMC that represents a number of groups, and has openings available at different locations.

Change is coming. It's almost inevitable. Constant changes in insurance reimbursement and government regulations is troubling even for large well-managed groups. Your best move is to stay as informed as possible, both about your own group, and the general environment of the reimbursement and regulatory side of anesthesia practice. If you don't know about MACRA or MIPS, you need to learn about it. It's an area about which many of us are woefully uninformed. And, that's something all of us need to change.



Follow The Money - From Page 4 & 5

With this in mind, what protections may exist against majority rule or even just aggressive rule, by those whom oppose the CAA profession? The answer may lie in the specialized field of antitrust law. Trusts and monopolies are concentrations of economic power in the hands of the few. Economists believe that such control injures both individuals and the public because it leads to anticompetitive practices in the effort to either obtain or maintain total control of the industry. Anticompetitive practices can then lead to price controls and diminished individual initiative. This may result in stagnation of markets and may depress economic growth. In 1890, the United States Congress passed the Sherman Antitrust Act in order to reduce market domination by individual corporations and to preserve unfettered competition as the rule of trade. The Sherman Antitrust Act is the foundation for most federal antitrust litigation. Given that congressional jurisdiction does not reach purely intrastate commerce, many states have adopted laws that parallel the Sherman Antitrust Act in order to avoid having local economies depressed by anticompetitive behavior.

Another economic injury to consider is restraint of trade. Antitrust laws address restraint of trade, but the topic covers a wider range of activities. In short, a “restraint of trade” is any activity that hinders another person from doing business in the way that he would normally do it, if there were no restraints. While federal, state and local governments may pass laws and regulations that create obstacles for certain kinds of businesses, it is generally considered improper for individuals to restrain another's trade in certain ways. One who loses business or suffers injury may have a cause of action in tort law against the individual whose trade-restraining behavior caused the injury.

Following the enactment of the Sherman Antitrust Act, the Federal Trade Commission Act of 1914 bolstered the terms of the Sherman Act by providing that the Federal Trade Commission (FTC) could proactively and directly protect consumers, rather than offering only indirect protection afforded by the Sherman Act which provided protection for business competition. Congress granted the FTC the power to fill gaps remaining in the antitrust laws by identifying and coping with new threats to the competitive

free market. The FTC is already involved in healthcare provider disputes in several states. **Recent rulings by the FTC give CAAs reason to think anti-competitive business practices will not be tolerated in the healthcare industry as the government tries to contain costs and improve quality.**

“But if those same policies were applied to religion, race, sex, age, they would be readily recognized as invidious and impermissible.”

I'm sure you have heard it from a family member, co-worker, neighbor, or even surgeon at some time during your career: “Why can't you work there? Why can't you get reimbursed like a nurse? Why is there so much objection to you by the nurses? How can untruthful anti-CAA propaganda and testimony be legal?” There's a long list of questions like these with little variation, but the answers all come back to following the money trail, the precariousness of our future, and whether CAAs will be able to affect a change.

The APRN Compact: APRN Independent Practice Imposed on All Adopting States

Jeffrey S. Plagenhoef, M.D.

ASA President-Elect

Erin Berry Philp, M.A., J.D.

Those of us who are involved in state advocacy have witnessed numerous advocacy attempts by nurse anesthetists and advanced practice registered nurses (APRNs) in general to eliminate existing requirements for patient-centered, physician-led care. Many times, legislation or proposed regulatory language is obvious in its attempt to abandon the care team model, but sometimes... well, sometimes an incremental approach takes such a long time to implement, the last steps in the process can be downright shocking. This is the case with the so-called APRN Compact.

We have been aware of the APRN Consensus Model for several years and have tried to inform ASA members about this dangerous trend. In a nutshell, the APRN Consensus Model is 2008 draft state legislative language developed by the National Council of State Boards of Nursing (NCSBN) that gives the APRN title to four roles of advanced practice nurses: nurse anesthetists, nurse practitioners, nurse specialists, and nurse midwives. Although it is usually touted by APRNs as simple name change legislation, nothing could be further from the truth. If you Google “APRN Consensus Model,” you can read the draft language yourself; the language increases scope of practice for APRNs – including nurse anesthetists – and makes them independent practitioners. The Consensus Model toolkit on the NCSBN website clearly states that APRNs are to be licensed as “independent practitioners with no regulatory requirements for collaboration, direction or supervision.¹”

Many states have enacted parts of the APRN Consensus Model, with most of them picking and choosing language and not changing their already-standing statutes or regulations regarding the team care model. A majority of states now lump

all advanced practice nurses into the “APRN” categorization. You may be asking, “why does a name matter? What does it matter what we call advanced practice nurses?” It matters because even a small name change is a huge step in an incremental plan by APRNs to remove physicians as leaders of the care team.

Last year, the NCSBN approved draft legislation titled the “APRN Compact.” The compact would allow APRNs who hold a multistate license to practice in other compact states. The NCSBN says that in order to be considered a compact state, a state must pass the draft legislation without “any material differences.”² Unlike the Federation of State Medical Boards’ Interstate Medical Licensure Compact, the APRN Compact seeks to automatically eliminate physician involvement requirements for APRNs who practice under a multistate license. Additionally, if one reads the entirety of the legislation, you’ll see that the term “APRN” is never defined. All the “simple name change” bills states have passed means that nurse anesthetists automatically fall under the term “APRN” for the purpose of this compact.

Article III, Section (h) of the legislation says:

“An APRN issued a multistate license is authorized to assume responsibility and accountability for patient care independent of a supervisory or collaborative relationship with a physician. This authority may be exercised in the home state and in any remote state in which the APRN exercises a multistate licensure privilege.”

This means if an APRN (including a nurse anesthetist) receives a multistate license under the compact, he or she would be able to function independently, *regardless of what the party state’s law says.*



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Forty-six states and the District of Columbia, by statute or regulation, require nurse anesthetists to work in a team-based relationship with a physician (not necessarily a physician anesthesiologist), whether through physician supervision, collaboration, direction, consultation, agreement or other arrangement for the delivery of anesthesia services. The APRN Compact would completely usurp these states' laws and regulations. Words matter. Legislators and regulators carefully chose language to indicate that nurse anesthetists must work in those kinds of relationships with physicians when providing anesthesia care within their state lines.

“Nurse anesthetists are a valued member of the anesthesia team, but removing physician involvement from anesthesia care makes no more sense than removing it from any other critical care location. We are not trying to keep advanced practice nurses from obtaining a multistate license, but we are opposed to it when the mechanism to do so usurps state laws pertaining to patient safety.”

Other sections of the draft legislation say that the APRN Compact will govern licensing. This takes many decisions away from state boards of nursing and puts it in the hands of the NCSBN, who will govern the APRN Compact. An outside organization will have authority to say who should or should not receive an APRN license. The APRN Compact carelessly brushes aside laws and regulations crafted by states' democratically elected legislators or executive-appointed regulatory boards, all in the interest of gaining independent practice by any means necessary.

The APRN Compact fails to recognize the crucial difference between primary care and surgical anesthesia/critical care. Removing physician involvement (any physician, not just physician anesthesiologists) from anesthesia compromises patient safety. Nurse anesthetists are a valued member of the anesthesia team, but removing physician involvement from anesthesia care makes no more sense than removing it from any other critical care location. We are not trying to keep advanced practice nurses from obtaining a multistate license, but we are opposed to it when the mechanism to do so usurps state laws pertaining to patient safety. This is an underhanded attempt to eliminate the physician-led care team patients rely on in states where advanced practice nurses have not been able to do so via obvious legislative means.

The APRN Compact language states that only 10 states have to enact the compact into law to have it go into limited effect. So far during the 2016 legislative session, Idaho, Iowa and Wyoming saw the APRN Compact introduced, and Idaho and Wyoming signed it into law. Some have said “my state is one of the four states that has independent practice for nurse anesthetists. What does it matter if we pass the Compact?” Please do your part to keep the APRN Compact from going into effect! With Idaho and Wyoming now party states, only eight states stand between APRNs gaining automatic independent practice in every party state under a multistate license. Even some state boards of nursing are acknowledging that the APRN Compact is over-the-top. During an April 2015 Texas Board of Nursing meeting, the board discussed the APRN Licensure Compact and noted their board should abstain from accepting Article III (h) “since such provision is not authorized under Texas law.³” Article III, Section (h) is not authorized under 46 state laws and regulations!

For the remainder of this legislative session, and in preparation for the 2017 legislative session, determine the definition of “APRN” in your state. It's also important to monitor regulatory boards to make sure they are not unilaterally changing definitions in state regulations, as well. We must vigorously oppose the APRN Compact in its current format in order to prevent the usurpation of state laws regarding patient safety. For more information about the APRN Compact and what you can do in your state, contact Jason Hansen at j.hansen@asahq.org, Erin Philp at e.philp@asahq.org or Ashli Eastwood at a.eastwood@asahq.org.

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2. APRN Compact. NCSBN: National Council of State Boards of Nursing website. <https://www.ncsbn.org/aprn-compact.htm>. Approved May 4, 2015. Accessed on April 7, 2016.
3. Consideration of approval of new nurse licensure compacts. Texas Board of Nursing website. https://www.bon.texas.gov/pdfs/board_meetings_pdfs/2015/April/7-6.pdf. Published April, 2015. Accessed April 7, 2016.

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Staff enjoying 3rd Anniversary

October marks the 3rd Anniversary of the association of staff at Cornerstone Communications Group and the AAAA. The Atlanta-based association management and government relations firm began receiving materials, files and databases in October 2013 in preparation for the January 1, 2014 hand-off. Since, both AAAA and Cornerstone have enjoyed growth and new levels of energy and production.

Cornerstone's team of association, communication and advocacy professionals state they feel privileged to be a part of an organization that is on the move, led by capable and intentional leaders and paving new pathways for expanded AA practice. According to James E. "Jet" Toney, a Cornerstone principal and AAAA Executive Director, the attraction of working daily to benefit AAAA members and the profession is seeing so many CAAs and AA students engaged in the dynamic growth of the organization and the profession.

"I admire the commitment of AAAA members to the Anesthesia Care Team, first, and the AAAA, closely following," Toney said. "The ACT is clearly the most effective and efficient perioperative delivery system, and the AAAA is the only national organization exclusively dedicated to the AA profession."

Headquarters staff provide year-round service to AAAA members 7:30 a.m. to 5:30 p.m. EST. Of course, through technology, staff often respond after business week office hours and on weekends. And, there's always the excellent AAAA Annual Meeting and other opportunities to convene.

The Cornerstone team includes the following professionals:



Stephanie Bowen
Director, Member Services

Stephanie Bowen leads efforts in the area of member services and is often the first contact for AAAA members. Stephanie is a political science graduate from the University of West Georgia and a former state and federal government employee which provide AAAA with additional sensitivities to the nuances of political action.



Brooke Cain
Director, Communication and Events

Brooke Cain joined Cornerstone when former Associate Director Devon Bacon accepted an outstanding career opportunity with the state nursing home association. Brooke's skills in communication and event planning are already paying dividends to the AAAA, especially in the area of fulfilling the exhibit opportunities AAAA is enjoying at state and national meetings. A University of Alabama grad in Communication, Brooke is responsible for the e-Record newsletters which provide valuable, relevant information to members on a timely basis.



Mike Holiman
Cornerstone Principal

Mike Holiman is the other Cornerstone principal. He is responsible for providing the necessary monthly financial reconciliation which assures AAAA's recording of revenue and expenditures match what the monthly bank statement shows. Additionally, from more than 25 years of state government lobbying experience, he provides a valuable "devil's advocate" perspective on AAAA's state licensure and practice initiatives and federal level advocacy. Mike earned a bachelor's degree in political science from the University of Georgia.



LeAnn Johnston
Director, Financial Services

LeAnn Johnston, an accountant, has served Cornerstone clients in the areas of budgeting, bookkeeping and pre-tax preparation for more than 10 years. As Director of Financial Services, LeAnn assists the AAAA Treasurer in budget preparation, handles accounts receivable and payable, and provides valuable guidance and information to members of the Executive Committee and Board of Directors. One of her most appreciated skills is the efficient processing of members' expense reimbursements according to AAAA policies and procedures. LeAnn earned her undergraduate degree in accounting from DeVry University.



Felicia Kenan, CMP, MPA
Executive Support

Felicia Kenan joined Cornerstone in October. She provides executive support for Cornerstone’s principals and has already completed several special projects for the benefit of clients. Felicia is a Certified Meeting Planner (CMP) and holds a Master’s in Public Administration from South University. She will sit for her Certified Association Executive (CAE) exam soon. Many will know Felicia from her work as executive director of the National Commission for the Certification of Anesthesiologist Assistants (NCCAA).



Morgan Pitts
Grassroots Advocacy Intern

While she has returned to Augusta University to complete her undergraduate work in political science, summer intern Morgan Pitts deserves special mention. Morgan spearheaded AAAA’s successful grassroots advocacy on the important SafeVACare.org initiative. Morgan sent individual emails to AAAA members instructing how to contact key members of Congress and how to submit comments on to the Veterans Administration. Morgan will pursue a Master’s in Public Administration at Augusta University upon graduation.



Jet Toney
Executive Director

Executive Director Jet Toney has 41 years of experience in Georgia state government – 11 years as public information staff and 30 as a lobbyist for more than 25 clients over that period. He and business partner Mike Holiman consulted on more than 225 political campaigns at the local, state and federal levels from 1989 to 2004. Operating a direct mail processing business, the company processed 1.4 million pieces of political mail during one notable election cycle. Jet has served as the Executive Secretary of the Georgia Society of Anesthesiologists since 1997. He is the founding chair of the Georgia Professional Lobbyists Association, a position he has held since 2011.

Practice news and other good vibes

The Indiana University Board of Trustees has approved a new Master’s of Science in anesthesia program to be taught at the Indiana University School of Medicine on the Indianapolis campus.

The Georgia AAA joined with the GA Society of Anesthesiologists to advocate for clarification by the state Medicaid agency to assure payment for work done by anesthesiologists monitoring simultaneous epidural cases in the obstetrical suite.

In Texas, a health system has reversed its decision to block utilization of CAAs.

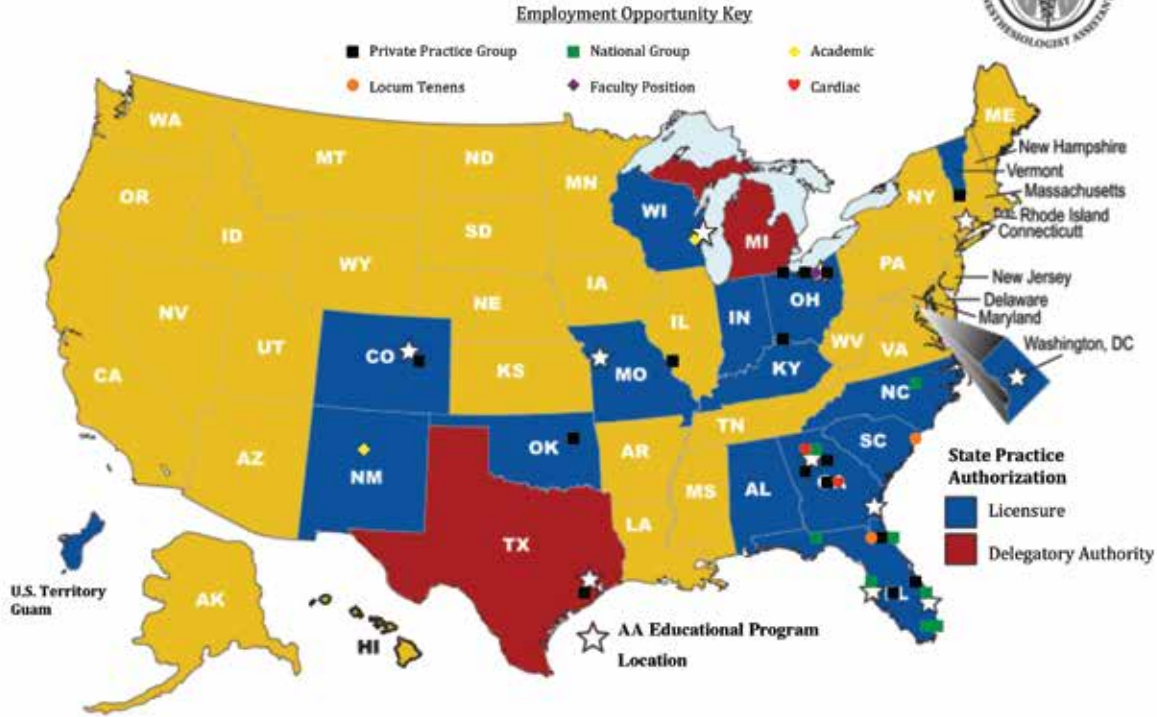
Anesthesiologists in several states are moving forward with the first phases of advocacy to expand AA licensure and practice.

AA exhibits and participation at state anesthesiology society meetings in North/South Carolina, Indiana and Texas in September.

The AAAA will once again staff an exhibit in the popular Resource Center at ANES2016, ASA’s annual meeting to be held October 22-26 in Chicago, IL.



Practice States and Employment Opportunities for Certified Anesthesiologist Assistants



*Graphic and Information current as of October 2016. For most up to date CAA employment opportunities, the AAAA recommends independent job market research via the AAAA website's Career Center, Gasworks.com or directly contacting HR departments.

CAA Employment Opportunities

| Practice Type | Position Description | Location | Company or Institution |
|-----------------------------|-----------------------|--------------------|--|
| Private Group | Full Time | Tulsa, OK | Associated Anesthesiologists, Inc. |
| Private Group | Full Time | Bennington, VT | Anesthesiology Associates of Bennington |
| Private Group | Full Time | Denver, CO | USAP CO/South Denver Anesthesiologists |
| Private Group | Full Time, Ambulatory | NW Ohio | SAS, LLC |
| Private Group | Full Time, Cardiac | Macon, GA | Anesthesia Associates of Macon, LLP |
| Private Group | Full Time | Macon, GA | Anesthesia Associates of Macon, LLP |
| Private Group | Full Time | Riverdale, GA | Riverdale Anesthesia Associates |
| Private Group | Full Time | Covington, GA | Riverdale Anesthesia Associates, PC |
| Private Group | Full Time | Lawrenceville, GA | American Anesthesiology |
| Private Group | Full Time | NE Ohio | |
| Private Group | Full Time | Cincinnati, OH | TeamHealth Anesthesia |
| Private Group | Full Time | Westlake, OH | Ohio Anesthesia Group Northcoast Division |
| Private Group | Full Time | Lake Wales, FL | Kanumuri Medical Group |
| Private Group | Full Time | Stuart, FL | Treasure Coast Anesthesia Group, P.A. |
| Locum Tenens | Full Time | Myrtle Beach, SC | Ambulatory Care Anesthesia |
| Private Group | Part Time | St. Louis, MO | Western Anesthesiology Associates, Inc. |
| National Group | Full Time | Jacksonville, FL | Sheridan Healthcare, Inc. |
| National Group | Full Time | Miami, FL | Sheridan Healthcare, Inc. |
| National Group | Full Time | Pembroke Pines, FL | Sheridan Healthcare, Inc. |
| National Group | Full Time | Tallahassee, FL | Sheridan Healthcare, Inc. |
| National Group | Full Time | Hollywood, FL | Sheridan Healthcare, Inc. |
| National Group | Full Time | Boca Raton, FL | Sheridan Healthcare, Inc. |
| National Group | Full Time | Tampa Bay, FL | American Anesthesiology |
| National Group | Full Time | Raleigh, NC | American Anesthesiology |
| National Group | Full Time, Cardiac | Atlanta, GA | American Anesthesiology |
| National Group | Full Time | Lawrenceville, GA | |
| Academic | Faculty Position | Cleveland, OH | CWRU |
| Academic | Full Time | Milwaukee, WI | Medical College of Wisconsin |
| Academic | Full Time | Albuquerque, NM | University of New Mexico, Department of Anesthesiology |
| Locum Tenens | | NE Florida | Tiva Healthcare, Inc. |
| Individual Anesthesiologist | Full Time | Houston, TX | US Pain and Spine |



American Society of
Anesthesiologists®

ASA® Membership Matters to your specialty

Join A Growing Community

In collaboration with the American Academy of Anesthesiologist Assistants (AAAA), ASA offers a new membership category that supports the CAAs valuable role on the anesthesia care team.

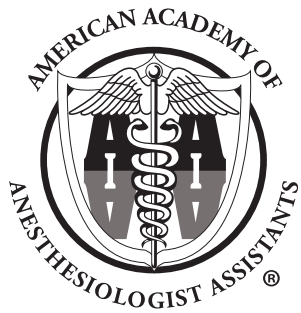
- **Powerful Advocacy Support:** ASA lobbies for states not currently licensing CAAs and solves payment issues for the anesthesia team model.
- **Quality Education:** ASA's educational products and meetings provide *AMA PRA Category 1 Credits™* which satisfy CAA maintenance of certification and licensure at special member pricing.
- **Leading-Edge Information:** Gain access to the latest clinical research, and new developments in the specialty with ASA publications including the *Anesthesiology®* journal, *ASA Monitor®* and *ASA®*, a weekly member e-newsletter.
- **Leadership Opportunities:** Become a leader in the specialty. Anesthesiologist Assistant members are eligible to participate in any of ASA's 90+ committees.

Join today
asahq.org/join



"CAAs play an important role in providing optimal patient care as part of the physician anesthesiologist-led care team. As leaders in patient safety, ASA is dedicated to serving the best interests of patients and strongly believes CAAs support this mission. We are pleased to implement the new membership category and further develop our relationship with the AAAA."

- Daniel J. Cole, M.D., ASA president



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