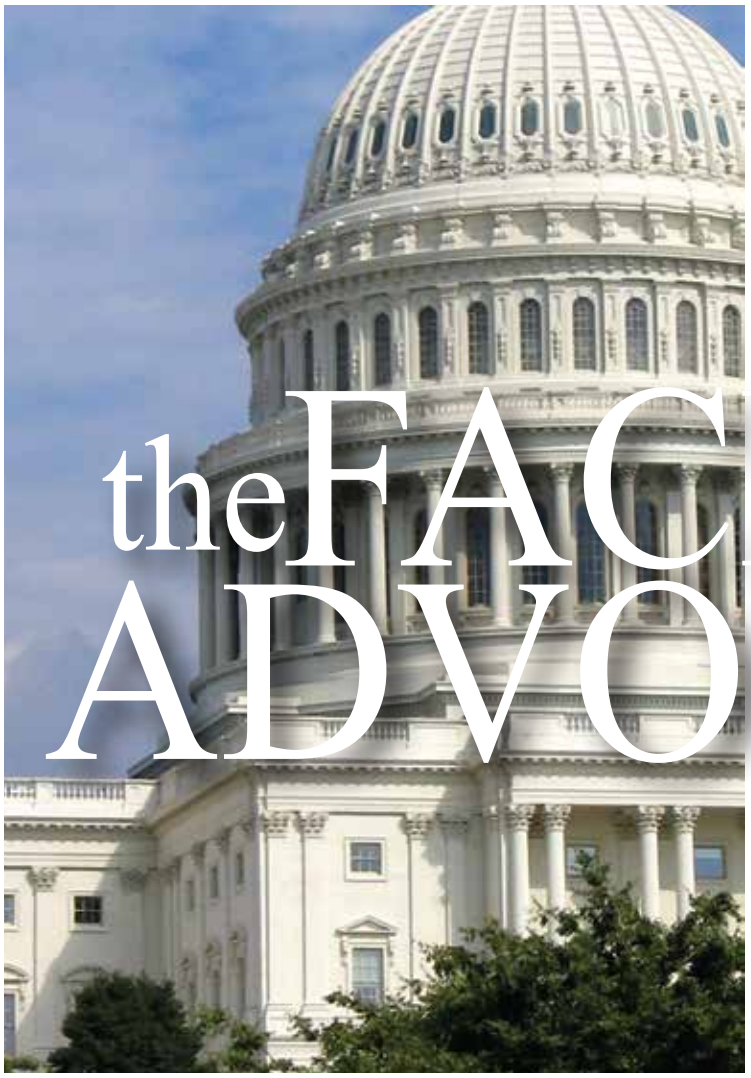
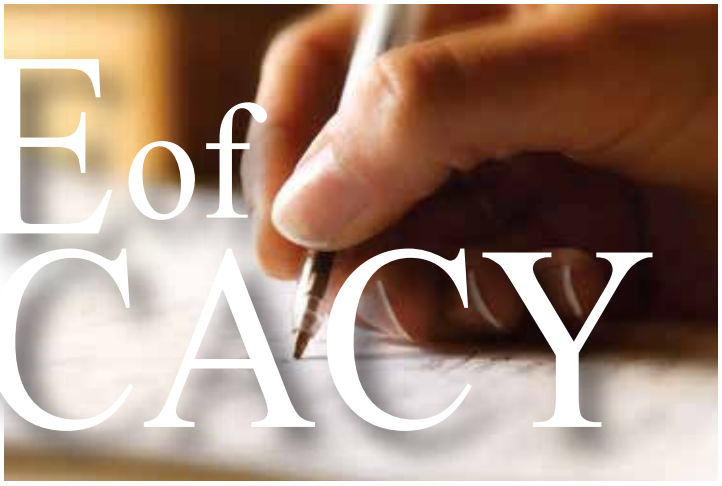
the AnesthesiaRecord

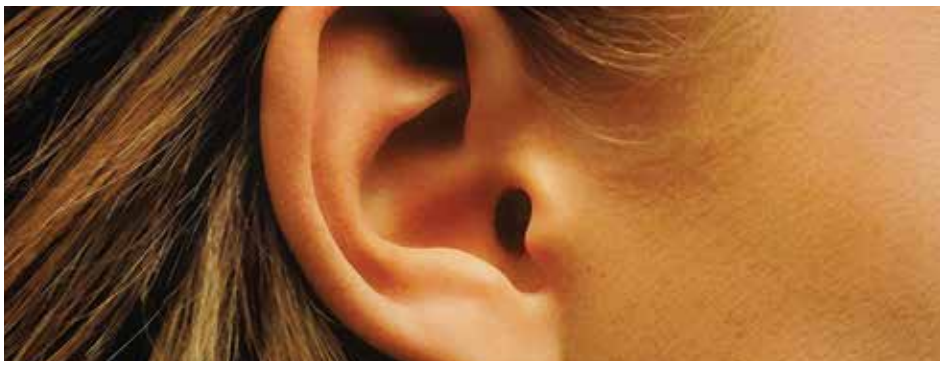
AAAA American Academy of Anesthesiologist Assistants — Second Quarter 2015





the FACE of ADVOCACY

Advocacy is a team sport. Passing laws and changing policy requires persistence, volume and resolve. Inside this issue, AAAA members demonstrate what must be done to expand AA practice and assure patient safety.



In The Media — View the NEW Promotional Video @ anesthetist.org!

AAAA
American Academy of Anesthesiologist Assistants

Officers and Directors

President
Megan Varellas, CAA

President-Elect
Tim Goodridge, CAA

Secretary
Ty Townsend, CAA

Treasurer
Jamie Taff, CAA

Immediate Past-President
Carie Twichell, CAA

Directors
William Paulsen, PhD, CAA
Gregg Mastropolo, CAA
Gina Scarboro, CAA
Patrick Bolger, CAA
Michael Nichols, CAA
Joy Rusmisell, CAA
Robert Wagner, CAA

ASA Representative
Howard Odom, MD

ASA AAAA Liaison
Michael C. Gosney, MD

Newsletter Editor
Christopher Wade, CAA

The Anesthesia Record
Published quarterly by the American Academy of Anesthesiologist Assistants, Inc. Please direct all general inquiries to AAAA management. Opinions expressed in this newsletter are those of individual authors and do not necessarily represent AAAA policy.

AAAA Executive Offices
1231-J Collier Rd. NW
Atlanta, GA 30318
Phone: 678-222-4233 Fax: 404-249-8831
www.anesthetist.org
info@anesthetist.org

Upcoming Events

Washington, DC (May 5, 2015) Case DC students Sam Lee (in focus left) and William Filbey (in focus right) absorb hours of public policy points and advocacy training at the ASA Washington Legislative Conference. Lee and Filbey joined more than 450 anesthesiologists, residents, AAAA reps and other CAAs in studying how to better advocate for the profession and for patient safety.

2015 Calendar of Events

June

NCCAA Certifying and CDQ Exams
June 13

Call for Nominations for Open AAAA Leadership Positions
June 8 – June 29

July

Member Voting for Open Leadership Elections
July 27 - August 10

August

AAAA 3rd Quarter Board of Directors Meeting, Strategic Planning Session
August 1 -2 | ASA headquarters, Park Ridge, Ill

3rd Quarter Newsletter Submission Deadline
August 10

September

APSF Sponsored Conference
Implementing and Using Emergency Manuals and Checklists to Improve Patient Safety
September 8-10 | Royal Palms Resort and Spa, Phoenix, AZ

North Carolina Society of Anesthesiologists
Annual Conference AA Lecture and Exhibit Booth
September 25 - 27 | Grove Park Inn, Asheville, NC

Voting period for AAAA leadership elections
September 19 – October 15

October

AAAA 4th Quarter Board Meeting
October 25 @ ASA Annual Meeting
October 24-28 | San Diego Convention Center, San Diego, CA

November

California Society of Anesthesiologists Fall Anesthesia Conference
November 2 - 6 | Grand Hyatt Resort & Spa, Kauai, HI

December

NYSSA Post Graduate Assembly Meeting
December 11 – 15 Marriott Marquis, New York, NY

2016 AAAA membership renewal begins
December 1

Telling our story, together

Megan Varellas CAA
AAAA President
Park Ridge Health
Hendersonville, NC
meganvarellas@gmail.com

This year at the annual conference opening ceremony, I shared a story written by the American author, David Foster Wallace, about a wise older fish swimming along and coming upon a group of younger inexperienced fish. The older fish greets the new fish and asks, "How is the water?" and the young fish look at one another perplexed and reply to the older fish "What is the water?"

The point of the fish story is that the most obvious and important realities around us are the hardest to see and talk about. Like water to the fish, advocacy is around us all the time and is necessary for our survival. In this issue of the AR, all of the feature articles relate to advocacy and you.

> "You don't have to be an expert in advocacy to be an advocate, you just have to be an expert on you."

The AAAA is here to advocate on behalf of the profession and its practitioners. The AAAA prioritizes knowing the position of AAs on the most urgent and influential matters related to your career and to comprehensively shape our message to reflect them. Advocacy is simply the telling of our story instead of allowing others to write the plot and do the telling. Perception is reality until it is either confirmed or corrected. Advocacy is the act of influencing that perception and should be a part of every certified anesthesiologist assistant's professional training. Every AA has the tools to change things that are critical to our professional success, from opening work states to correcting misinformation about our profession. You don't have to be an expert in advocacy to be an advocate, you just have to be an expert on you.

Groups can be powerful, even when small in number, and it's easy to be skeptical about your ability to change something by yourself or advocate for the whole profession. As a member of AAAA, our community can convince you to suspend that disbelief. Ask most practitioners, especially those practicing in states where AAs are the minority provider, and they will have a powerful story of advocacy and making a difference in their own way. Movements don't happen because everyone decides to face the same direction at once, they happen because of community, and habits within that community, that change the participation of the individual.

When you become a certified anesthesiologist assistant, you claim a responsibility of stewardship to the profession as a whole. If you don't become your own best advocate, someone will certainly do it for you....and you might not like the message delivered.

Your clinical credibility is at stake when others speak for your competence, but AAAA can only build and shape policies for your profession if you continue to support the work we do and recruit your coworkers to do the same. Advocacy isn't just expanding work states; it also includes working to make AAs the best anesthetists in the marketplace through education, working with other organizations to steer the future of the profession, and promoting AAs in the whole healthcare industry. It's not effective to organize around being AAs, but to organize around the issues that affect us disproportionately because we are AAs, such as restraint of trade, payment challenge, unfair practice policies, or slander. Like freedom, advocacy is the type of thing you aren't aware of until it's gone.

There is a saying attributed to Jesus in the Gospel of Luke: "For everyone to whom much is given, from him much will be required; and to whom much has been committed, of him they will ask the more." This truth is repeated "with great power comes great responsibility" by Voltaire, FDR, and even Peter Parker's Uncle Ben of Spider-Man comics. What is "given" or "great power" does not merely reflect wealth but all resources, whether it's skill, talent, time, or knowledge.

> "Your clinical credibility is at stake when others speak for your competence..."

I hope this issue will inspire some of you to take an interest in advocacy in its many forms of improving and promoting the AA profession. There are two primary choices in life: to accept conditions as they exist, or accept the responsibility for changing them. AAAA can't do it without you!

What Anesthesia Could Be in 2020

(If You Fail to Respond to the Proposed VA Nursing Handbook)

Jeffrey S. Plagenhoef, MD
ASA First Vice-President

Since cinema and television were introduced into our lives, a vision of another place and time conceived by others can capture our imaginations and carry us away, often to a place in the future. Creative genius allows us to experience fictional and fantastical situations, scenery and scripts. From "Star Trek" and "Space Odyssey," to "Back to the Future," time travel full of fantasy and fun captivates us and allows us to enter a possible future world as a form of entertainment. Key words here are *fiction, fantasy, fun, entertainment*, and yes... *very possible*!

Many of you have seen the American Association of Nurse Anesthetist's (AANA's) recent marketing script: "CRNAs: The Future of Anesthesia Care, Today."

Now jump into a time capsule and allow yourself to be transported into a new hypothetical movie – "The Future of Anesthesia Care." This movie is based upon the tragic, not-so-short story titled "Apathy Among Physician Anesthesiologists" - production and screenplay by VA nursing leadership and supporting cast comprising all nursing organizations, including the AANA. Focus your imagination on the following potential landscape for our patients that is not fantasy at all, and will not be fun or entertaining – not even for nurses!

How *We* Built the Foundation for This New Script

Imagine the following scenario: When the VA released its new "Nursing Handbook" in the *Federal Register*, the continual complacency among us, or just simple denial of reality, resulted in only a few thousand of ASA's approximately 52,000 members responding to an important call to action – this time to the VA's invitation for public comment in the *Federal Register*. VA officials were unconcerned by the minimal amount of objection they received from physician anesthesiologists, and instead acted in accordance with the dominant feedback they received from nurses supporting the proposal on the table for independent nurse practice. Comfortable that they would be pleasing the majority of stakeholders –based upon the balance of the responses they received – they implemented new policies mandating, in every VA, complete "independent" or solo practice of all advanced practice registered nurses (APRNs), including nurse anesthetists.

> "Our veterans and the future of our specialty literally depend upon you taking action!"

With this nurse-led care scenario implemented in the primary care setting for these least-healthy patients, serious concerns about the disruption of care are easily stirred. Think of this sickest subset of patients in America – our Veterans – receiving not just primary care, but acute, critical and complex perioperative care delivered without the involvement of a physician. Team-based care abandoned – with **no medical physicians involved** – through a policy that minimizes, marginalizes or eliminates coordination with, or oversight by, a medical doctor in the VA system.

Envision the ensuing disruption and confusion in VA. Nurses write orders that conflict with the physician's knowledge, judgment and orders, but the new handbook policy mandates – not just *allows*, but *mandates* – that the nurses must practice "independently." Who makes the decisions for the patient? How do Veterans benefit from this new model of care?

The trip to the future outlined above is not fantasy, and envisioning this potential reality is not entertaining. By ignoring the severity of our Veterans' health and abandoning the VA's team-based model of care, bad public policy has been advanced.

Summary of the Real Issue

ASA learned in May 2013 that the VHA had been working on developing a new Nursing Handbook mandating independent practice of all APRNs, nurse anesthetists included, and its introduction was imminent. VA nurses propose no physician-led team-based care anywhere in the VA system, including operating rooms, proposing instead solo nurse-led care.

Summary of Our Response

An unprecedented level of effort can be found in the organization and execution of our strategic response to this threat as lead by our Immediate Past President Jane C.K. Fitch, M.D. and our President J.P. Abenstein, M.S.E.E., M.D. ASA'S multi-pronged plan includes the following strategic accomplishments to date:

1. We established regular and direct dialogue with VA leadership regarding ASA's concerns with the handbook as proposed.

2. We earned the support of more than 80 U.S. senators and representatives resulting in continual communication from Congress to VA leaders expressing disagreement with the handbook as proposed. Our strong congressional support resulted in ASA-supported language in the recent government funding bill just passed by Congress that formally requests VA to seek the input of internal and external stakeholders in the development of the Nursing Handbook and asks the VA to work to ensure that the Nursing Handbook does not conflict with the other handbooks "already in place" – a reference to the Anesthesia Service Handbook, which contains the current team-based policy for VA.

3. We gained the support of Veteran Service Organizations (VSOs) resulting in continual communication from VSOs to VA leaders expressing disagreement with the handbook as proposed.

4. We supported our VA colleagues as they courageously presented a unified front of opposition to the proposal, particularly the VA's own chiefs of anesthesia.

Despite these accomplishments, the issue has not yet been resolved. Much work remains to be done.

This train to the future left the station several years ago, heading with great speed on a crash course with preexisting VA handbooks that outline physician-led, team-based care. The nursing-led goal: achieving unprecedentedly broad expansion of nursing scope of practice within the VA itself, and once done, to have the new VA policy add to the momentum of the national comprehensive effort to achieve APRN independent practice in every state. Although multifactorial in conception, do not overlook the reality that the proposed handbook initiative is a page taken directly from the "APRN Consensus Model's" playbook. (https://www.ncsbn.org/Consensus_Model_for_APRN_Regulation_July_2008.pdf)

What to Expect Next

In the near future, as part of the routine rulemaking process, VA will seek public input on its initiative. VA will place the draft Nursing Handbook in the *Federal Register* as a proposed regulation. The regulation will eliminate physician-led, team-based care throughout the VA, including in anesthesia, and will propose to put in place an APRN practice model that includes no physician involvement, oversight,supervision or direction.

After the expected 30-day comment period, the VA will weigh the balance of public comments – those for mandating nurses practicing medicine in the VA versus those opposing the same. Understand this: **inaction is action that will have severe consequences!** Not responding in the *Federal Register* to the proposed handbook equates to a vote in favor of mandated independent nurse anesthetist practice. Stakeholders' opinions will likely be the determinant of whether or not nurse anesthetists are mandated to practice independently within the VA.

Our veterans and the future of our specialty literally depend upon you taking action! If the nursing lobby is successful, this will have profound impact on subsequent evolving public sector attitudes on scope-of-practice debates. We have strong reason to believe that if each and every ASA member responds during this comment period, we can reverse what is proposed.

Much work needs to be done on this issue to have the team based anesthesia care model favorably positioned when the handbook is opened up for public comment. The ball cannot be carried across the goal line without you carrying it! The *final* regulation, the content of which is literally up to you, will be the next posting in the *Federal Register* after the public comments are weighed.

To be clear – the contents of the finalized new Nursing Handbook will shape "The Future of Anesthesia Care." Either way, the *final* regulation will have wide-reaching and significant implications and influences.

Our Ask of You

Please prepare yourself to receive the impending call to action from your state component society and ASA leaders to "respond now." The call may come today, next week or next month. The vagaries of the federal regulatory process make it difficult to discern the release date. However, once ASA announcesthe release of the document, please make sure your voice is heard by participating in the public comment period.

To those who take action, I thank you in advance for your leadership and professional citizenship. Together, if we make our voices heard, we will prevail in protecting those who have protected us. Take a stand for anesthesiologist-led, team-based anesthesia care in the VA system and for preservation of the current model of safe, high-quality care for our Veterans.

Reprinted with permission from the ASA Newsletter, April 2015 Volume 79 Number 4.

"I thank you in advance for your leadership and professional citizenship."

Nomination & Elections Notice

Carie Twichell, CAA
Chair, Governance Committee
Immediate Past President
MetroHealth Medical Center
Cleveland, Ohio
ctwichell1@gmail.com

The nominating period for AAAA leadership positions opens June 8 to all members in good standing. Multiple offices are open including President-Elect, Secretary, and Board of Director Seats 1, 2, and 3.

Each of these begins January 1, 2016 and vary in role and term by position. The Secretary serves for two years and may not exceed three consecutive terms, while each director position carries a three-year obligation limited to two consecutive terms. The President-Elect serves a one-year term after which the individual will accede to the role of President and then Immediate Past President, one year each.

> "This new system expands who may nominate for honor awards."

The AAAA Bylaws and handbook of policies and procedures, found under the resources section of the AAAA website, yield more inclusive information on the terms, descriptions of the duties for each role and the complete election and nomination process. This annual election period closes at the fourth quarter board of directors meeting in October. All election cycle dates are posted on the AAAA website calendar.

In addition to the early June nomination process for board and officer position, the honor award nominations will open later this summer. The Board has established five honor award categories and voted last October to change the policy and procedures regarding nomination for these awards. This new system expands who may nominate for honor awards. It allows for fellow AAAA members to nominate individuals within all five categories and opens the nomination process to student AAAA members for the Education Award. The categories are listed below with descriptions of each:

A. AAAA John E. Steinhaus, MD Memorial Award for Distinguished Service by a Physician: Awarded for exceptional contributions to the AA profession encompassing an entire career.

B. Meritorious Commitment by a Physician: Awarded for exceptional contributions to the AA profession within the past five years.

C. Distinguished Service by an AAAA Member: Awarded for exceptional contributions to the AAAA and to the AA profession.

D. Media Coverage Award (to include print, video, electronic and radio media): Awarded for exceptional contributions by media professionals to the AA profession.

E. Distinguished Service in Education by an AAAA Member: Awarded to an exceptional AA who has demonstrated excellence in preceptorship and has made notable contributions to the AA profession.

The executive committee has slated the voting of these honor awards for the third quarter board of directors meeting in October. Please stay tuned for announcements and email reminders to participate in the process. This is a great opportunity to recognize the positive impact many individuals have contributed to improving our profession.

> "it only takes a few minutes to nominate a future leader "

Watch for updates regarding the nomination and election process within AAAA announcements. Summer is a busy time but it only takes a few minutes to nominate a future leader and it takes mere seconds to vote for these future Board Directors and Officers who will represent our membership and guide our profession.

Thank you in advance for your participation.

2015 Nominations and Elections Timeline

June 8 - Call for nominations

June 29 - Nominating period closes

July 25 – Deadline to request paper ballot from Headquarters

July 27 - August 10 - Online voting period

August 15 - Election results announced

The Face of Advocacy | Strength in Numbers

William Buntin, CAA
AAAA Membership Chair
Phoebe Putney Hospital - Albany, GA
wpbuntin@bellsouth.net

The AA profession is advancing at an astounding rate! We are gaining new ground in state licensure and practice arenas each month. Student clinical sites are increasing and awesome career opportunities are available for the new grads. Thank you to the 706 fellow and 477 student AAAA members who continue to support our great profession.

The AAAA is leading our charge, and the membership is making it possible. The Fellows membership rate is **42%** of practicing AAs. Fellows, you should be embarrassed. Get out there and do some recruiting in your practice. The AA Student membership rate is almost **100%**. Students, great job!

New AAAA benefits abound!

Group practice discount
The 10% discount for group membership is very easy to attain. Register your group today! Contact Member Services Manager Stephanie Bowen at stephanie.bowen@politics.org.

New graduate discount
Sign up for AAAA membership renewal within 60 days after graduation and receive a $100 discount and *the next year free. (Only good for new graduates of an AA program)*

Enhance your CV
Professional association members demonstrate they are team players and support their profession. Take full advantage of your membership by attending annual conferences and earning CME credits. Committee members are leaders looking to make a greater impact and go the extra mile for their group. Employers look for leadership qualities on your CV.

Discounts for Certification renewal and CDQ exam
Fellow AAAA members who are renewing their certification or taking the CDQ exam receive a substantial discount from the NCCAA. Use your member number to apply the discount.

This table compares the number of CAAs to the number of AAAA members in each state. Note the winners.

State	CAAs	AAAA members
Georgia	820	255
Ohio	198	144
Florida	217	80
Texas	124	49
Missouri	76	39
Wisconsin	45	30
Colorado	39	21
DC	38	26
New Mexico	28	18
S.C.	25	16
Alabama	24	4
Vermont	18	4
N.C.	15	5
Michigan	6	7
Kentucky	2	5
Oklahoma	2	2
CT	1	1
Indiana	0	0
Totals:	**1678**	**706**

The Face of Advocacy | Collaboration

Michael S. Nichols, CAA
Chair, Legislative Committee
Member, Board of Directors
Emory St. Joseph's Hospital
Atlanta, Georgia

The American Society of Anesthesiologists held its annual Legislative Conference May 4-6 in Washington, DC. This event attracts the most politically engaged anesthesiologists who are actively involved in the legislative process, regulatory implications on the profession and advocacy for anesthesiology.

Each year, the AAAA sends a delegation to this meeting to not only foster our organizational relationship with the ASA, but also to meet with state component societies interested in CAA practice authority in their states. This year's delegation was Megan Varellas (President), Tim Goodridge (President-Elect), Soren Campbell (Vice Chair, Legislative Committee), Gary Jones, and Michael Nichols (Chair, Legislative Committee).

"These meetings proved very successful."

We met with physician representatives from California, Iowa, Oregon, Illinois, Indiana, and Nevada. These meetings proved very successful and informative as much of the discussion focused around how to strategically advance CAA practice in those states.

Washington, DC (May 6, 2015) – AAAA President Megan Varellas, CAA, and President-Elect Tim Goodridge, CAA, listen as ASA President Dr. John Abenstein outlines future models of online educational content for members of both organizations. Leaders of AAAA and ASA met at the ASA Legislative Conference to discuss collaborative efforts that will deliver more member benefit.

Washington, DC (May 4, 2015) – Case DC students joined Case Program Director Shane Angus, CAA, and AAAA officers Megan Varellas, CAA, and Tim Goodridge, CAA, at the ASA Legislative Conference where more than 450 anesthesia professionals developed advocacy skills and discussed AA licensure expansion.

Joint effort in Golden State effective

Shane Angus, CAA
Case Western Reserve University
MSA Program Director
Washington, D. C.
President California Academy of Anesthesiologist Assistants

In addition to the individual state component meetings, the delegation was privileged to attend many excellent presentations on state and national issues of importance to anesthesiology. Of note, Dr. Erin Sullivan (Chair, Committee on Governmental Affairs) moderated a panel on state affairs issues, including a prominent section on the politics of state licensure for CAAs, which was presented by Dr. Jay Mesrobian from Wisconsin. Our notable "CAA Friends", Drs. Elmassian (Michigan), Zerwas (Texas), Adams (Indiana), and Page (Missouri) all participated in a interactive advocacy training panel that offered pearls of wisdom and 'tricks-of-the-trade' on how to interact with legislators and make one's point efficiently and expertly. Additionally, conference participants welcomed many congressional legislators, including Senators Isakson (GA), Cassidy (LA) and Representative Andy Harris (MD), the first anesthesiologist to serve in Congress.

It is often a humbling experience to attend a conference like this in which so many anesthesiologists and CAAs give of their time to advocate for the specialty and the profession. The Legislative Conference offers an opportunity for these state leaders to share stories, gain new insight, and provide experiential knowledge – the real work begins when everyone returns to their respective states.

"the real work begins when everyone returns to their respective states."

Sacramento, CA (April 14, 2015) – Representatives of the AAAA and the California Society of Anesthesiologists joined health care colleagues at the California Medical Society's lobby day at the State Capitol. AAs educated physicians and lawmakers on the qualifications and training of AAs and promoted licensure in the state.

The California Assembly Committee on Business and Professions has passed Assembly Bill 890 which would create licensure for AAs in that state. The bill now goes to the California Assembly Committee on Appropriations and, if passed, on to the Assembly Floor for a vote.

A group of advocates from the California Society of Anesthesiologists and the AAAA attended the annual California Medical Association lobby day on April 14, 2015 emphasizing how Certified Anesthesiologist Assistants should be partners with physician anesthesiologists in advancing patient safety and access to care to California's 38 million citizens.

The CSA, AAAA and individual Certified Anesthesiologist Assistants who wish to move their practices to the Golden State are working collaboratively on multiple fronts to advocate for AB 890. Strategies include meeting with legislators who have decision making power over how health care bills can and will be considered in the Assembly and, later, in the state Senate.

AAAA leaders also exhibited at the recent CSA conference where dozens of physicians learned more about adding AAs to their practice models.

New York CAA Lobby Day

Gregg Mastropolo, CAA
Member, Board of Directors
Clinical Assistant Professor of Anesthesia Sciences
Quinnipiac University
North Haven, CT
greggmastropolo@me.com

If you're like me, you look forward to the day when AAs can practice in all 50 states. On Monday April 27, 2015, we took another step closer to achieving that goal. On this day a group assembled near the Legislators Office Building (LOB) in Albany, New York, to lobby for the CAA profession. Senators occasionally came "off the floor" of the Senate to meet with us in a meeting area just outside the senate chambers, such as my own New York senator, David Carlucci. This was an opportunity to network, educate and ultimately convince legislators to pass a bill providing CAA licensure.

Albany, NY (April 27, 2015) – AAAA Director Gregg Mastropolo (center) and AAAA New York lobbyist Bob Reid discuss AA licensure legislation at the New York Capitol with state Senator John A. DeFrancisco, R-Syracuse.

We were very fortunate to have two prominent NY anesthesiologists supporting our lobby day efforts, Dr. Michael Duffy (current NYSSA President) and Dr. Michael Simon (former NYSSA President) along with Stuart Hayman, MS (NYSSA Executive Director). The anesthesiologist assistant representatives were Dr. William Paulsen PhD, CAA, Gregg Mastropolo, CAA (NY Resident), and Erman Hoosick, AA-S Case Cleveland (NY Resident). AAAA New York Lobbyists Shauneen McNally and Bob Reid also donated their time and talents to the project.

Our lobby strategy this year included a letter-writing campaign in which approximately forty NYSSA anesthesiologist members wrote to their legislators requesting support of our bill on the higher education committee. Secondly, we chose to target legislators in upstate New York and Syracuse near Dr. Michael Duffy's practice. His relationship with Dr. Hugh Bonner, Dean of The College of Health Professions at SUNY Upstate Medical University, has opened many doors. Dr. Bonner, who has worked with the Accreditation Review Committee for the Anesthesiologist Assistant (ARC-AA) and the Commission on Accreditation of Allied Health Education Programs (CAAHEP), sent letters to several members of the higher education committees in the NY Assembly and Senate. Dr. Bonner requested their support of this bill he emphasized would allow graduates to stay and work in New York following the establishment of a NY CAA education program.

Our group of eight managed to attend thirteen separate meetings with either legislators or key staff. These efforts received overwhelming response from legislators to support CAA legislation. A dynamic realization seemed to evolve as the meetings progressed, in that the training and employment of CAAs in upstate New York was an economic incentive to the region. Legislators saw the profession as a conduit to providing higher quality, profitable jobs to their constituents while simultaneously supporting the medical educators. Although much ground has been gained in this "education phase" of lobby efforts, there is still much to be done. I urge you to get involved in some way to help AA practice become nationwide. If we don't demonstrate that we care enough to grow the profession, how can we expect others to champion the profession on our behalf. However unmerited, our opposition is mounting against us, and we have to become proactive. The CAA must be recognized as a highly educated anesthesia provider who works under an anesthesiologist in the anesthesia care team model to deliver quality, safe anesthetics to our patients. Please feel free to join the effort and reach out to me or any other legislatively-involved members working on opening up a state for AA practice.

MAAA -- A Model for State AA Advocacy

J. Kent Knight, CAA
President, Michigan Academy of Anesthesiologist Assistants
Grady Memorial Hospital
Atlanta, Georgia
jkentknight@gmail.com

Greetings! I wanted to take a moment to share my experiences, good and bad, so that all CAAs can see how they can be an advocate in any state.

"I can do this."

I started my journey by simply observing. I visited a new AA program and was amazed at the accomplishments and professionalism. A curiosity was sparked that lit a fire of commitment. I read about the accomplishments that had recently occurred in the Wisconsin legislature and thought to myself, I can do this. I researched the neighboring midwest state, Michigan, and was amazed at the similarities. I happened to have a few good friends from Michigan and shared my thoughts and questions with them. In a serendipitous moment, I discovered that many anesthesiologists wanted CAA licensure, but that no one had "picked up the ball" and run with it. Well... I picked up the ball and here are the events that have continued in this metamorphosis.

> "no one had 'picked up the ball' and run with it."

1) I contacted an anesthesiologist who is a former state senator to lay out my ideas. It was important to know CAA advocacy history, which I had researched on my own. The information is out there for all CAAs. The bullet points are brief and concise. I don't pretend to know it all, and thus I'm always looking for more contacts and resources.

2) These resources led me to more and more contacts until one led me to the President of the Michigan Society of Anesthesiologists. He invited me to make a presentation at the board of directors meeting, which I accepted. The idea of Michigan CAA licensure was not born that day, it was resuscitated.

3) Bill language was discussed. MSA, AAAA, helped draft the important language in the bill utilizing other state CAA bill language.

4) Lines of communication between me, the MSA, AAAA and CAAs in Michigan were open and routinely used. Open dialogue has encouraged a brainstorm of ideas from all parties involved.

5) The Michigan Academy of Anesthesiologist Assistants (MAAA) was created. We modeled many of our bylaws with the Wisconsin Academy and other state CAA societies.

6) In today's world, immediate visual identity is critical in the advocacy and education of anything. Therefore, the MAAA hired a creative design company to professionally design our logo. Instructions were to make it bold, readily identifiable, yet non-medical, making it easy to grab a lawmaker's attentive eye.

7) With logo created, a website was developed with the help of an AA student from Michigan. Again, we wanted to keep the design clean and with a corporate feel. Thus, the website michiganaaa.org was born.

8) In the meantime, a CAA licensing bill was created with the blessing of the MSA and assistance of its lobbying firm.

9) To support this bill, we needed to support the sponsor. Therefore, the MAAA helped organize a fundraiser for our senate sponsor. Donations from friends, family and contacts helped cement our relationship with the MSA and the senator. This demonstrated commitment to the long process to not only the senator but also the MSA.

10) The MAAA has been involved at the yearly MSA conference. We had our logo emblazoned on a tablecloth so that it caught the attention of as many anesthesiologists as possible. Countless strategies and opportunities to educate and advocate were entertained.

11) The MAAA has understood the value of presence to fellow CAAs and to student AAs. Therefore we first held an information meeting in Detroit, in order to be as convenient to the practicing Michigan CAAs as possible. Secondly, we held an open social for all CAAs at the AAAA conference in Orlando to increase our visibility as well as to say thank you!

12) The MAAA has continued to identify obstacles for CAA practice in Michigan. It was discovered that CAAs could not be reimbursed for workers compensation cases. With the help of a little research, and contacts made through lobbyist, a proposal was made to the Workers Compensation Administration of Michigan to alleviate this snafu. I'm happy to say this process has been moving forward and will hopefully be resolved at years end.

13) Partnerships are vital, and the MAAA has understood this. Representation and involvement with our national organization, AAAA, is very important. Therefore, a representative is always at the national conference as well as the state meeting. In addition, we have formed a communication partnership with the CAA staffing agency, Soda Lime Associates. This group is based in Michigan and will provide a streamlined approach to not only AA staffing but also student rotations. This partnership has recently included the MSA, forming a powerful communication network.

14) The MAAA continues to educate anesthesiologists in Michigan about what a CAA is and how we are committed to the ACT model. The president of the MAAA published an article in the MSA newsletter, "The Ventilator".

15) Reinforcing the article as well as our presence at the annual MSA conference, the MAAA bought an advertisement in the upcoming MSA newsletter. The repeated reminders will aid in the effort to advocate.

16) Most recently the president of the MAAA arranged a meeting with the MSA president, MSA lobbyist, and chairman of the state senate health policy committee. The meeting was very successful. It established a strategy that will help develop a strong foundation for a new and more formidable bill. It helped outline multiple tasks from each organization and how we can achieve these goals.

This advocacy in Michigan may seem tedious and complex, but anyone can do it in other states with the commitment we all possess as professionals. We did not become CAAs or student AAs without a personal level of commitment and a determination to succeed. Advocacy for CAAs in all states helps all of us personally, financially, and professionally in the long run. I've come a long way as an individual CAA. I'm hoping to shorten the process for others by using my examples, good and bad. I would like to thank everyone; nothing was achieved alone.

> "Open dialogue has encouraged a brainstorm of ideas."

CAAs active in Colorado!

Laura Knoblauch, AA-S
University of Colorado
Masters of Medical Health Sciences in Anesthesiology
Laura.knoblauch@ucdenver.edu

Deborah Agustin, CAA
President, Colorado Academy of Anesthesiologist Assistants
Recent Graduate Commissioner, CAAHEP
Instructor, Children's Hospital Colorado
Department of Anesthesiology, University of Colorado
Aurora, Colorado

Nikki Block, CAA
Director, Master of Medical Science in Anesthesiology Program
Instructor, Children's Hospital Colorado
Department of Anesthesiology, University of Colorado
Aurora, Colorado

An hour south of Denver in Colorado Springs, CAAs, student AAs and anesthesiologists from across the nation convened for the annual meeting of the Colorado Society of Anesthesiologists. Lectures were heard, vendors were met and connections were made all while enjoying the gorgeous Colorado weather at the Broadmoor Hotel.

"Lectures were heard, vendors were met and connections were made."

All the students from the University of Colorado program and two students from the Emory program attended the conference to hear stimulating lecture series focused on regional and cardiac anesthesia from experts in the specialties. CAAs from Children's Hospital and University Hospital in Aurora refreshed on the topics and obtain CMEs. The students also advertised and registered players for the annual charity golf scramble where all proceeds from the event go to Ronald McDonald House Charities of Denver and Lifebox Foundation, Inc. (USA). The event will be on August 16, 2015 at Arrowhead Golf Course in Littleton, CO, and players of all experience levels are welcome to play. If you are interested in participating please email laura.knoblauch@ucdenver.edu for more information.

Nikki Block, University of Colorado AA Program Director, and Deborah Agustin, President of the Colorado Academy of Anesthesiologist Assistants (CAAA), met with anesthesiologists from across the state to discuss the integration of CAAs into their practice and how to set up a care team model. They also provided information of our education, training, and clinical skills. Director Block worked on opening student rotations across the state. The University of Colorado AA Program and the CAAA hosted a wine and cheese "meet and greet" session where anesthesiologists were able to socialize with the students, CAAs and anesthesiologists who have worked with CAAs in the care team model. Conversations of billing and supervision occurred between the physicians, and questions about the CAA profession were answered. Anesthesiologists left the "meet and greet" feeling very well informed about our profession and took information back to their groups about how to integrate CAAs as they advance forward with the care team model.

Overall, it was a very successful meeting! We will continue to educate anesthesiologists aboutour profession and work with them to integrate CAAs into their practice.

Laura Knoblauch, AA-S, (left) describes AA roles in the Anesthesia Care Team model to anesthesiologist Dr. Sharon Wetherall of Good Samaritan's Hospital.

Broadmoor Hotel, Colorado Springs, CO – CAAs joined physicians at the Colorado Society of Anesthesiologists annual meeting. (left to right) Nikki Block, CAA at Children's Hospital of Colorado and Program Director at University of Colorado Hospital, Deborah Augustin, CAA at CHC and CAAA president, Kevin Blick, CAA, and CAAA officer, Dr. Erik Nelson (Anesthesiologist at UCH), Nick Frank, CAA at CHC, and Dr. Chuck Carter (Anesthesiologist at CHC).

Kelly Maas, AA-S, and Laura Knoblauch, AA-S, encourage charitable participation at the Colorado Society of Anesthesiologists annual meeting.

"We will continue to educate anesthesiologists about our profession."

Are Anesthesiologist Assistants really equivalent to Nurse Anesthetists?

William Paulsen, MMSc, PhD, CCE, CAA
Member, Board of Directors
Professor of Medical Sciences
Frank Netter MD School of Medicine
Director, Anesthesiologist Assistant Program
Quinnipiac University

I hear AAs make this claim everywhere I go, from the ASA to meetings with legislators. The reason is clear, more people are familiar with nurse anesthetists than with AA practice, but does that really do our profession justice?

I was invited to Thomas Jefferson University a few years ago to discuss starting an AA program. In addition to meeting with the chairs and directors of a number of departments, I was asked to meet with the dean of the school of health professions, who was just admitting their first class of nurse anesthetists. I described my meetings during the day as positive with outstanding support from the School of Medicine and the departments of physiology, pharmacology and anesthesiology. He asked, "How are AAs different from CRNAs?"

I proceeded to explain that the educational programs are different, AAs are taught by faculty of medical schools, not nursing schools, and how the emphasis was placed on acute care physiology and pharmacology, patient monitoring and anesthesia technology, and how, analogous to nurse practitioners and physician assistants, anesthesiologists should have the choice of hiring a nurse or an anesthesiologist assistant.

He then said "I heard that AAs were equivalent to CRNAs when employed in hospitals, but that CRNAs could deliver anesthesia for dentists and surgeons in the hospital or the office without supervision from anesthesiologists, something that AAs could not do. In the event of a shortage of anesthesia providers, why would I start an expensive new program to educate AAs when all I have to do is increase the size of my SRNA class?"

Game over.

Why would anyone hire an AA if they were only equivalent to a nurse anesthetist in the operating room during the day? Nurses offer billing advantages, call advantages and the ability to provide services to a broader range of patients if you include plastic surgery offices and dental offices to name a few. Why would physician anesthesiologists raise the money to enter a legislative battle to have AAs licensed or registered in their state?

The answer could be that they are looking for competent anesthetists who will maintain the profession of anesthesiology rather than letting the profession fall to nurse anesthesia (nurse anesthesiology as they call it).

However, for our own professional satisfaction, we need something to distinguish ourselves from nurse anesthetists. Nursing schools have chosen to require that all entry level (after completing their BS in nursing and working for one year in the intensive care unit) student applicants participate in a 36- month program (all programs will be 36 months) that awards a Doctor of Nurse Practice (DNP or DNAP) with less coursework and clinical training than many of our current AA programs. We will not be pursuing a clinical doctorate degree for AAs, so how do we become the favored non-physician anesthesia provider outside of being the recipient of the spoils of the nursing battle for independent practice?

While Drs. Steinhaus, Gravenstein and Volpito came together to seek grant funding for new anesthesia personnel, each had their own idea of what an anesthesiologist assistant was to become. John Steinhaus, MD, PhD, Chairman of the Department of Anesthesiology at Emory University, implemented his concept of assistants to the anesthesiologist in the late 1960s. After a period of focusing on the more technical provision of anesthesia care, Dr. Steinhaus modified the AA training program to provide a deeper educational experience in anesthesia sciences with the goal of creating a highly competent anesthetist who could manage anesthesia care of the patient under supervision of an anesthesiologist, who was responsible for multiple operating rooms.

Today, training program curriculum is focused on producing competent anesthetists. These programs are responding to the need for competent anesthesia providers who want to work with anesthesiologists and offer an alternative to independent nurse anesthesia practice. Is this where we want to be?

If we are to be different than nurse anesthetists we need to bring something different to the table. Perhaps we should all review our curriculum and focus on providing academic centers with AA graduates who can appropriately manage very sick patients and evolving surgical procedures. This may fit well into the surgical home as the residents are required to expand their presence in perioperative care. In general, AAs may fit better than a nurse in the academic operating room with complex procedures and very sick patients.

AAs have a good reason to be proud of their profession, but if we are seen as equivalent to nurses we really have nothing to offer and we will be perceived as a less attractive provider of anesthesia care. We need to demonstrate the ability to perform above the level of nurse anesthetists. That shouldn't be difficult as their doctoral education is at best equal to our curriculum at the master's level. In addition, they have a short program for people to do online that enables conversion of the master's degree to the DNP or DNAP.

There are other issues that could bring us to a higher level when working with anesthesiologists. We might consider remuneration similar to anesthesiologists and different from nurse anesthetists. In order to position ourselves as the "value proposition" we might consider our salaries and accept a salary with periodic bonuses instead of overtime so we are perceived as professional and not nurse union employees on the clock.

There are some challenging times ahead and I think that we need to decide if we are going to be equivalent to nurse anesthetists or are we going to provide a deeper level of expertise and a higher level of professionalism. We need be able to respond to all who ask "What is an AA?" by replying that an AA is a higher level nurse anesthetist with more extensive education and who delivers a higher level of patient care.

Advocacy assures improved patient care

Tim Goodridge, CAA
President-Elect, AAAA
Baylor Scott & White Healthcare
Round Rock, Texas
Tgoodridgecaa@outlook.com

The recent 39th annual AAAA conference at the Gaylord Palms Convention Center created an intersection of AA education, clinical and practice updates, advocacy, and much more. One of the many resourceful lectures was the professional update from the American Society of Anesthesiologists® (ASA®). The ASA update is a valuable presentation of national agenda items and issues that specifically impact the AA profession, the greater anesthesiology community and patient care.

> "the AAAA and the ASA will have to be involved in all policymaking and processes affecting our profession."

Dr. Daniel J. Cole, MD, ASA President-Elect and a past President of the California Society of Anesthesiologists, presented the 2015 AAAA Gravenstein Memorial Lecture and ASA Update. Dr. Cole began the lecture with a reminder that he attended his first AAAA conference more than a decade ago as a lecturer; he was happy to attend once more. As a constant and consistent supporter of the AA profession, it is with immense gratitude we thank him for his unwavering support and informative and pertinent lecture.

Dr. Cole commenced with an emphasis on the changing landscape of medicine and the need for our involvement as stakeholders in the evolving dynamic of health care. To this point, Dr. Cole addressed the proposed changes to the VHA Nursing Handbook. These changes will significantly affect patient care within the United States Dept. of Veterans Affairs (VA). For those unaware of the changes, this policy mandates all Advanced Practice Registered Nurses (APRNs), including nurse anesthetists, to be recognized and practice as "licensed independent practitioners in every state and every facility. While the present VA system has many issues related to adequate patient care, this untimely rule change directly affects the quality of care for all VA patients.

Veteran Service organizations, the greater Medical Community, and even the U.S. Congress (through a formal request of stakeholder input to the VA) have joined the ASA to oppose such a deleterious rule change. The next step in the rule-making process is issuance of the proposal in the Federal Register, the government notification publication, and the ensuing public comment period. Physician anesthesiologists are indispensable in delivering safe and qualified patient care in the perioperative setting, especially in the high acuity cases commonly seen in the VA operating rooms. The AAAA is laser focused on supporting the ASA in opposing to the proposed VHA Nursing Handbook changes by urging its members to post a comment on the Federal Register.

> "Adequate representation begins with strong membership."

The second issue in the ASA update was the changes to the Medicare Physician Reimbursement Fee (MPFS) schedule. In the U.S., every anesthesia provider (and therefore every AA) is affected when federal payment rates are changed. The information provided here was a backdrop for the coming changes associated with the Affordable Healthcare Act, or ACA (also known as Obamacare). To say these new rules for federal reimbursement are complex and controversial is an understatement. Legislation implementing the new payment rules and procedures was actually passed the week immediately after the AAAA conference. Look for an in depth review and analysis of this section of Dr. Cole's presentation in the next issue of the *Anesthesia Record*.

Daniel J. Cole, MD

The support from national organizations in the legislative front is highly important. CAAs and AA students continue to support the ASA with significant legislative ASAPAC donations. Dr. Cole recognized and emphasized the appreciable contribution by the AA community and the role the ASA political action committee has in the legislative arena.

One of the continuing themes presented by the ASA is the Perioperative Surgical Home (PSH) model of care. Dr. Cole described this multimodal approach to patient care. The PSH is a quality and safety driven model that looks to improve operation efficiency and cost, while strategically aligning the anesthesia specialty with newly proposed Alternative Payment Models (see the next AR for a review of these types of reimbursement).

The PSH is a care model that starts from the moment a patient initially plans for surgery to 30-days postoperatively. As perioperative specialists in most (if not all) stages of surgical care, the physician anesthesiologist has the knowledge, techniques, and leadership to apply themselves as leaders in the PSH model. The ASA is committed to this model of patient care and has provided a well-presented in-depth introduction to the PSH on the ASA website: https://www.asahq.org/PSH.

The PSH is used by some of the institutions where CAAs are employed and while the applicability of this model of patient care is still being debated, it is very important the AAAA membership be made aware of this potential change to the future patient care delivery model.

One of the best moments of the presentation, in my opinion, was Dr. Cole's emphasis on the role of the stakeholder in patient health care. A stakeholder needs to be involved, attentive, and represented. Every year, the number of practicing CAAs is increasing nationally and significant changes are occurring in healthcare. As the professional organization dedicated to the advocacy of the AA profession, the AAAA needs to not just be "at the table" but must have "a bigger chair at the table."

> "Membership in the AAAA and ASA is pivotal for future efforts of advocacy."

To play an important role in the decision making, the AAAA and the ASA will have to be involved in all policymaking and processes affecting our profession as well as having a significant voice in the decision making. Adequate representation begins with strong membership. All CAAs are encouraged to join the AAAA, the only organization primarily dedicated to the advocacy of the AA profession.

Dr. Cole presenting

Orlando, FL -- ASA President-Elect Dr. Dan Cole first presented at an AAAA Annual Conference more than a decade ago. He remains a committed and engaged supporter of the AA profession and the role of AAs in the Perioperative Surgical Home team model of patient care.

Advancing Quality and Safety within the anesthesia community was the next topic discussed. The Anesthesia Quality Institute (AQI) continues to provide a comprehensive picture of the future of anesthesia safety. A recent AQI study was presented at the ANESTHESIOLOGY® 2014 annual meeting. A review of 3.2 million anesthesia cases showed a decrease in adverse events from 2010-2013. ASA and AQI were featured in a story in The Wall Street Journal on October 27, 2014 and AQI Executive Director Richard Dutton, MD was quoted regarding the study.

The ASA continues to support professional education. Notably, the ANESTHESIOLOGY® 2015 Annual Meeting is in Dr. Cole's home state of California in San Diego October 24-28. AAAA representatives will participate; and there are CAAs on more than 12 ASA committees. Join ASA and take the opportunity to attend this great conference.

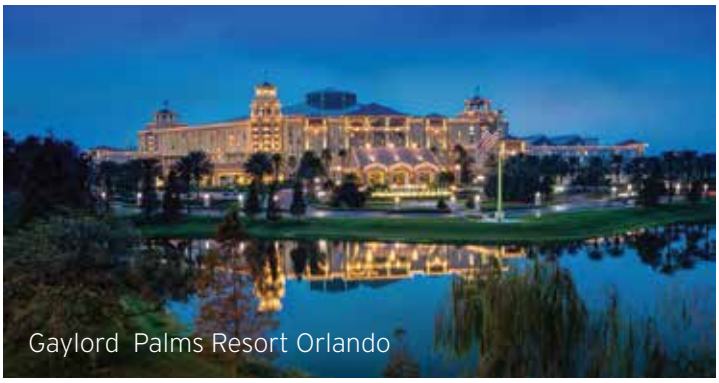
In closing to his presentation, Dr. Cole presented the valued role of CAAs in the ASA and the opportunities available with ASA and AAAA membership. Membership in the AAAA and ASA is pivotal for future efforts of advocacy. As the globalization of the world is moving at a fervent pace, the respective national organizations will work together to recognize, address, and optimize the issues of safe, qualified anesthesia patient care.

The AAAA annual conference welcomes physician leaders of our profession. The ASA has been a vocal and constant supporter of the AA profession and the AAAA. In the quickly changing landscape of modern healthcare, the AAAA is fully aware of the synergy that is the partnership with the ASA. As other provider organizations continue to drive legislation contrary to the combined goals of the AAAA and ASA, it is imperative we continue to fully support the efforts of the AAAA and the ASA.

Membership in both organizations allows for a greater political presence and representation at the national level towards the goal of "advancing the practice & securing the future".

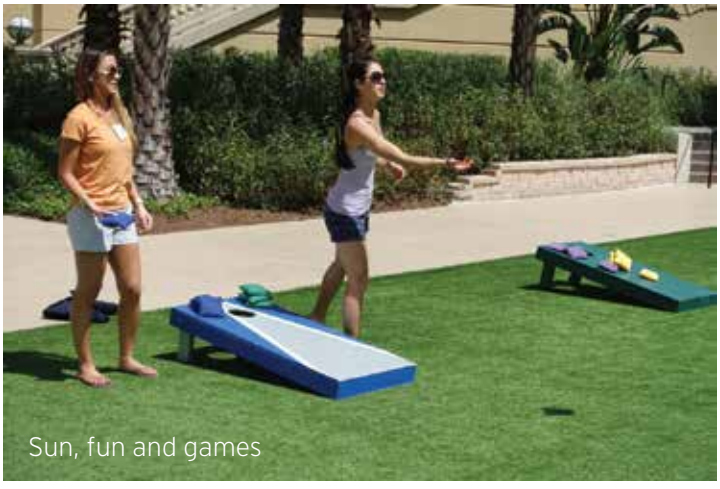
2015 Annual Meeting

Daniel Mesaros, CAA
Chair, Annual Meeting


Gaylord Palms Resort Orlando

Congratulations Chairman Daniel Mesaros on an outstanding Annual Meeting!

Attendance	206 Fellows 13 Physicians 371 Students


Sun, fun and games


ACLS Workshop


Sherry Adamic, CAA | Chair, NCCAA

Paul Yost, MD

Thank you exhibitors and sponsors for making it possible!

Gold Exhibitor
NOVA Southeastern University

Bronze Exhibitor
Greater Houston Anesthesiology

Exhibitors
American Anesthesiology
Anesthesia Patient Safety Foundation
Anesthesiology Associates of Tallahassee, Inc.
ASA-PAC
Ashford Advisors
DCSA & DCAAA
Eagle Pharmaceuticals
Florida Academy of Anesthesiologist Assistants
Medical Bookstore of Florida
Missouri Society of Anesthesiologists
National Commission for Certification of Anesthesiologist Assistants
Northside Anesthesiologist Assistants
PAJUNK Medical Systems
Parker Medical
ProjectConcert
Sensational Anesthesia Staffing
Soda Lime Associates
The Gideons International
University of Wisconsin Madison Hospital Department of Anesthesiology

Steady hand, right words helped advance AA practice

Deb Lawson, CAA, and former student Angela Hovis, CAA, at Case alumni event 2014.

Editor's note: Former AAAA President and Board Chair Deb Lawson, CAA, enters retirement this year. AAAA recognizes her career-long dedication to advancing the education, licensure and practice of CAAs throughout the nation. The impact of her work and sacrifice on behalf of the organization and the profession is manifest every day and every time an AA treats a patient. Hers is one of the faces of advocacy: durable commitment to advancing the profession wherever the opportunity exists.

The following stories tell of that durable commitment.

From Pete Kaluszyk, CAA, friend and co-laborer:

Deb started to contribute to the profession by physically pioneering the expansion of our profession going back over thirty years. She was one of the first AAs to practice in Illinois in the late 70s, then moving on to Wisconsin, in the eighties, where she and her husband Greg Kychun worked for many years. Their contributions helped to solidify AA practice in Wisconsin, after which they practiced in Ohio, Georgia, and Texas.

Deb rose very quickly within the AAAA leadership and attained the offices of the President and Chair of the Board of Directors. She made a particularly important contribution in the organizational development of the governance of the AAAA in the early 2000s.

She testified before many State committee hearings around the country when asked. She once testified in Louisiana during a very, very bitterly contested legislative battle to license AAs. She showed poise, polish, and courage (at a hearing in Baton Rouge) while eloquently testifying, in chamber, while the public gallery was filled with nurses. The State nursing lobby showed up in force dressed in scrubs with collar draped stethoscopes in an effort to intimidate both the legislators and Deb. Although she never flinched, the legislators politically buckled under the intimidation.

From Ellen Allinger, CAA:

I didn't understand the power of words until I met Deb Lawson. I had just entered the world of AA leadership which also meant entering AA politics. An opportunity arose to testify on behalf of the AA profession at a committee hearing at the Louisiana state capitol. My colleague, mentor and educator on that trip was Deb. She counselled and educated me prior to stepping into that committee room, but nothing could have prepared me for what happened next. I witnessed the sausage-making process that is called politics at its worst. Afterwards, I was still trying to figure out what had just happened when I noticed that Deb was not idle. She was making a plan of action with the LSA president and lobbyist and then was off to talk one-on-one to the very legislators that had essentially just spit in our faces.

Through the years, I have watched Deb and listened to what she says. Her uncanny ability to use the correct words at the appropriate moment has always amazed me. She has educated future AAs and advocated for the AA profession using a myriad of skills, but I consider her ability to say exactly the right thing at the right moment her specialty.

From Aislynn Walker, CAA, graduate of the first class at Case-Houston, current instructor:

When I'm in the OR with students I say, "Do the Deb technique. Start on the left and sweep to the right. Does everything look as it should?" I hope to honor her awesome teaching skills by keeping her methods in practice!!

From Angela Hovis, CAA, former student and mentee:

From I first met Deb in the spring of 2010, my third semester as a first year AA student at Case-Cleveland. I was on a weeklong rotation at an outpatient hospital. I don't remember the case or the patient, all I remember is feeling absolutely exhausted. But she pushed me, elevated my expectations thus making me a better student.

Deb and I had many conversations (during my time as an educator) about becoming more involved in the AA community outside of a program. She gave me a list of organizations she thought I might take an interest to and suggested that she introduce me to young leaders. I will never forget how she walked around the Case Alumni event at the AAAA in search of specific people to introduce me to. I felt so honored to have Deb Lawson vouch for me and work so hard to see my career advance. What a special privilege to have Deb Lawson as a reference.

Kayla Bober, CAA, former Case-Houston student and current Clinical Coordinator, with Deb at 2012 White Coat Ceremony.

Deb and husband Greg Kychun, CAA, celebrate at a former students' wedding reception.

All photos credit Shawn Sharifi

Considerations for inhalational induction of pediatric Down's syndrome dental patient

John Ng, CAA
WellStar Medical Group
Division of Pediatric Anesthesia
choatl66@yahoo.com

You are about to perform an inhalational induction on your next patient, who is a 6 year-old girl with Down's syndrome for dental restoration. Which oral RAE tube size would be the most appropriate choice for endotracheal intubation?

A. 4.0
B. 4.5
C. 5.0
D. 5.5

Down syndrome (DS), or trisomy 21, is a chromosomal defect that involves an excess of a complete or partial copy of chromosome 21. According to the National Down Syndrome Society, the prevalence of DS is one in 691 live births in the United States. It remains as one of the most common birth defects and the most frequent genetic cause of mild to moderate mental retardation.

Characteristic facial features associated with DS include Brushfield spots, mandibular hypoplasia, narrow nasopharynx, small oropharynx, large protruding tongue, and short neck. Preoperatively, the airway should be carefully examined as upper airway obstruction is often anticipated. The troublesome airway may also be accompanied by an increased incidence of obesity, as 50% of patients with DS aged between one-month to 18-years have a body mass index above the 85 percentile (1). With an increased incidence of adenotonsillar hypertrophy, it is not surprising that DS patients are at risk for obstructive sleep apnea. Since a slow transition from spontaneous ventilation to assisted spontaneous mask ventilation under general anesthesia can be achieved with incremental titration of sevoflurane, an inhalational induction is often a favorable choice in patients who present with potential difficulties in bag-mask ventilation.

Multiple studies have well documented that the prevalence of bradycardia during and following inhalational induction with sevoflurane is higher in DS children compared to ones without DS (2, 3). Therefore, it is crucial to be vigilant with the amount of volatile agent being delivered. Furthermore, second and third degree heart block could also appear during inhalational induction, especially in those who are status post atrioventricular canal repair. In addition to immediately lowering the inhaled sevoflurane concentration, pharmacological intervention or even CPR is necessary in these circumstances. Epinephrine is listed as the drug of choice in the PALS algorithm for heart block and is preferred over anticholinergic agents, as studies have failed to show an increased heart response to normal doses of atropine in patients with DS (4).

There is a higher incidence of both congenital and acquired subglottic stenosis in patients with DS. It is important to listen preoperatively for existing stridor and wheezing, as they may indicate airway abnormalities. When endotracheal intubation is warranted, appropriately sizing the endotracheal tube (ETT) is of utmost importance in patients with DS. Downsizing the ETT to at least half centimeter smaller is always recommended (age/4 + 4 and height in centimeters/20 are formulas used for normal ETT sizing). Post-intubation stridor may occur due to subglottic edema. Administration of IV dexamethasone and use of racemic epinephrine by nebulization can decrease the frequency and severity of post-intubation stridor (4).

Cervical spine stability must be carefully interrogated prior to induction. It is wise to look out for any neurological signs and symptoms such as neck stiffness, weakness in the extremities, torticollis, and hypotonia. Atlantoaxial instability (AAI) with associated myelopathy such as subsequent spinal cord injury is common neurological findings in patients with DS. Involuntary movements of the head and neck after induction and during direct laryngoscopy may post further risks for neck injury. In 2011, the Committee on Genetics of the American Academy of Pediatrics published updated supervision guidelines for children with DS. According to these new guidelines, routine radiologic evaluation of the cervical spine is not necessary for asymptomatic DS children. That is because plain radiographs do not predict an increased risk of AAI, and radiographs with normal findings do not provide assurance that spine problems will not develop in the future. On the other hand, a cervical spine radiograph (neutral vs. flexion/extension) is recommended for patients with neurologic symptoms.

For more information on clinical education article guidelines and submission to the Clinical Column, please contact John Ng, CAA, at clinicalcolumn@anesthetist.org.

References
1. Ivan DL, Cromwell P. Clinical practice guidelines for management of children with Down syndrome: part II. Journalof Pediatric HealthCare 2014; 28: 280-284.
2. Bai W, Voepel-Lewis T, Malviya S. Hemodynamic changes in children with Down syndrome during and following inhalational induction of anesthesia with sevoflurane. Journalof Clinical Anesthesia 2010; 22: 592-597.
3. Roodman S, Bothwell M, Tobias JD. Bradycardia with sevoflurane induction in patients with trisomy 21.Paediatric Anesthesia 2003; 13: 538-540.
4. Borland LM, Colligan J, Brandom BW. Frequency of anesthesia-related complications in children with Down syndrome under general anesthesia for noncardiac procedures. Paediatric Anesthesia 2004; 14: 733-738.

Answer = C

Hospital Credentialing
An Essential Component to Clinical Practice

Michael Stout, CAA
Assistant Professor and Program Director
Department of Anesthesia, Nova Southeastern University
ms664@nova.edu

Finally, after years of training and thousands of hours of patient care experience, you're ready to begin your career as a practicing anesthetist. Or, perhaps you are a competent provider with several years of experience relocating to a new facility. In either case, there is no getting around it: you must undergo hospital credentialing.

When asked which words describe the credentialing process, two recently credentialed CAAs replied "slow", "tedious" and "frustrating". So, do we fully understand the importance of hospital credentialing in maintaining the AA scope of practice? This article will provide valuable insights, which every CAA should know, as well as provide tips from Trudy Kraemer, CPCS, CPMSM, President-Elect of the Florida Association of Medical Staff Services, on how to expedite your credentialing application and get you into the operating room sooner.

As allied-health practitioners, Certified Anesthesiologist Assistants are required to undergo hospital credentialing along with Physician Assistants and Advanced Practice Nurses. The process stems from the Joint Commission Standards requiring hospitals to ensure providers are "competent to perform the privileges requested." Providers must be credentialed initially, then every two years with monitoring of practice patterns along the way. According to Trudy Kraemer, "The primary goal of the Medical Staff Office is ensuring patient safety. This is achieved through two main objectives: 1) verifying the accuracy of information provided to hospital credentialing committee and 2) ensuring the appropriateness of requested privileges." The latter is key to maintaining the AA scope of practice. A Delineation of Privileges (DOP) will be included consisting of the provider's requested core privileges (the common competencies in the provider's field) along with additional privileges (those which are added through additional training and experience).

> "Credentialing, if properly applied, can document your patient care competency throughout your career."

Medical Staff Professionals (MSPs) develop the DOP by reviewing a provider's training, previous healthcare experience, and requests of the hiring department. Once approved, they constitute the provider's patient care role within the facility. The Credentialing Committee reviews for recommendation of the application, along with the DOP, to the Medical Executive Committee (or Med Exec). The Medical Executive Committee commonly includes physician leadership, top administrators in the hospital including the Chief Medical Officer, the Chief Nursing Officer (or VP of Nursing), and a governing board member. If recommended by the Medical Executive Committee, the request will go to the board for final approval. CAAs must be proactive to ensure their DOPs are consistent with their competencies. These efforts ensure your practice opportunities present the greatest opportunity and value to your department.

Historically, credentialing was a time-intensive process of correspondence. However, with the advent of online verifications of licensures and certifications, the process is much quicker. Typically, references from peers remain the rate-limiting step. As providers, we are often unaware of the multiple unanswered requests for references from the MSPs.

According to Trudy Kraemer, "Applicants should follow-up with their colleagues and ensure that they are prepared to provide their reference for you. And, if they don't seem to be responsive, you should move on to another provider. When everyone is working together, we have completed applications in as little as 5 days at our facility." Cooperation between the providers and the MSPs can ensure the application moves swiftly through the committees for timely board approval.

Will we ever enjoy completing credentialing applications? Probably not... yet, we can help facilitate its success. Credentialing, if properly applied, can document your patient care competency throughout your career. As CAAs, we must remain knowledgeable of key practice management issues that support our role as highly skilled anesthesia providers.

AAAA Executive Offices
1231-J Collier Rd. NW
Atlanta, GA 30318

Third Quarter Newsletter
Content Deadline August 10, 2015