



the **AnesthesiaRecord**

AAAA® American Academy of Anesthesiologist Assistants

Third Quarter 2015

PRACTICE MODELS AND PAYMENT

Defining the **FUTURE** of CAA professionals



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The Anesthesia Record

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Calendar of Events

September 2015

North Carolina Society of Anesthesiologists

Annual Conference AA Lecture and Exhibit Booth
September 25 - 27 | Grove Park Inn, Asheville, NC

October 2015

ASA Annual Meeting

October 24 - 28 | San Diego Convention Center, San Diego, CA

October 24

1:00 - 3:00 pm Frontier Caucus | Hilton, Cobalt Level, Room 500
2:00 - 4:00 pm ASA Committee Meeting on Uniformed Services & VA
Hilton | Sapphire Level Room 400
2:30 - 5:30 pm Mid Atlantic Caucus | Hilton, Sapphire Ballroom CDGH
2:30 - 5:30 pm Southern Caucus | Sapphire Ballroom KLOP
3:15 - 5:15 pm Western Caucus | Hilton, Sapphire Ballroom ABEF
3:00 - 5:15 pm Midwest Caucus | Hilton, Sapphire Ballroom IJMN

October 25

1:00 - 5:00pm AAAA 4th Quarter Board of Directors Meeting
Manchester Grand Hyatt San Diego Hotel | Promenade AB Room

October 26

9:30 - 11:30 am ASA Cmte on Patient Safety and Education | Aqua Level Salon D
9:30 - 11:30 am ASA Cmte on Occupational Health | Aqua Level Salon E
10:00 - 12:00 pm ASA Cmte on Membership | Sapphire Level Room 410
10:00 - 12:00 pm ASA Cmte on Governmental Affairs | Sapphire Level Salon I
10:00 - 12:00 pm ASA Cmte on Global Humanitarian Outreach | Sapphire Level Salon L
1:00 - 3:00 pm ASA Cmte on AA Education and Practice | Aqua Level Salon C
Hilton | All Events

October 27

7:00 - 10:00 am ASA Cmte on Practice Management | Aqua Level Salon D
7:00 - 10:00 am ASA Cmte on Economics | Aqua Level Room 300
7:00 - 9:00 am ASA Cmte on Future Models of Anesthesia Delivery | Aqua Level Salon F
10:00 - 12:00 pm ASA Cmte on Anesthesia Care Team | Sapphire Level Salon I
12:00 - 1:30 pm ASA Cmte on Communications | Sapphire Level Room 400
Hilton | All Events

2:30 - 5:30 pm Frontier Caucus | Grand Hyatt, Regatta B-C
3:30 - 6:00 pm Mid Atlantic Caucus | Grand Hyatt, Coronado D-E
3:00 - 5:30 pm Southern Caucus | Grand Hyatt, America's Cup A-D
3:15 - 6:00 pm Western Caucus | Grand Hyatt, Coronado C
4:00 - 6:30 pm Midwest Caucus | Grand Hyatt, Nautical Room

November 2015

California Society of Anesthesiologists Fall Anesthesia Conference

November 2 - 6 | Grand Hyatt Resort & Spa, Kauai, HI

4th Quarter Newsletter Submission Deadline

November 6th | Email all submission requests to cwadeaaa@gmail.com

December 2015

NYSSA Post Graduate Assembly Meeting

December 11 - 15 Marriott Marquis, New York, NY

2016 AAAA membership renewal begins

December 1

April 2016

AAAA Conference

April 2 - 5, 2016 | Denver, CO

Securing the future of AA practice

Would you be alarmed if AA practice looked the same in ten years as it does today? Imagine if no additional work states or practice sites open to CAAs, or if payment and practice models evolve for other practitioners but not CAAs. This issue of *The Anesthesia Record* is focused on practice and payment, the two most important things that affect what your job looks like now and throughout your career.

“One of the intangible benefits of AAAA[®] is thought leadership.”

We are practicing in a time of unprecedented change in the healthcare and anesthesiology industries. It is widely accepted by economists that our current healthcare model is unsustainable. Annual healthcare expenditures have increased from \$147 per citizen in 1960 to \$8,402 in 2010. The United States spends over two trillion dollars per year, 2.5 times more than peer nations, and has the worst outcomes, ranking 17th out of 17 by the Institute of Medicine and 17th out of 34 by the Journal of the American Medical Association. Centers for Medicare and Medicaid Services (CMS) economists predict a 5.7% increase in healthcare spending each year from 2013 to 2023, outpacing and surpassing the national gross domestic product.

Change in the healthcare industry is necessary if we, as a nation, desire to address other societal needs such as education, transportation, food and water security, and defense. Alternative payment and alternative care models are cost containment methods that insurers and government are looking to as a solution. AAAA's[®] comprehensive strategy reflects an understanding of the changes taking place in the anesthesiology industry. It is influenced by several key trends in health care, each requiring an appropriate response:

- Payment model changes from Fee-For-Service to Fee-For-Quality models place more emphasis on preventive care and coordinated care in disease management. These changes require projections for how payment models may affect CAA employment and vigilance to ensure CAAs do not become third tier providers.

- Consumer driven healthcare markets are shifting decision-making to consumers. This requires public relations efforts on behalf of the profession.

- Accelerating reforms and new competitive structures affect industry consolidation and new care delivery models. This requires planning for new care models and how CAAs can be relevant within them.

“All CAAs should understand the issues that affect our profession and work together to ensure our future relevance.”

One of the intangible benefits of AAAA[®] is thought leadership: the comprehensive and organized effort to anticipate trends that impact your future as a CAA. Thought leadership includes creating a strategic plan to enable AAAA[®] to face challenges and opportunities with maximum efficiency and impact. The AAAA[®] Board of Directors recently met at the ASA headquarters in Schaumburg, IL to update our strategic plan, ensuring its relevance and effectiveness. A good plan keeps us consistently focused on our most important objectives and helps the organization's leaders make effective choices with very limited resources. It identifies where we are, where we want to go and how we will get there.



Megan Varellas CAA

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Since our first strategic planning session in 2012, AAAA[®] leaders restructured the organization reducing the number of committees to focus resources and streamlined the Bylaws for efficiency. Consolidating committees and clarifying tasks and objectives has made the AAAA[®] more effective in achieving its organizational goals. We also updated all of our communications material and added new dynamic public relations material.

AAAA[®] prioritized creating a mobile and connected community by providing content to members in modern and convenient ways, updating our website and newsletter dramatically, and offering more frequent electronic communications. We continue to build a social media presence for CAAs. We allocated funds for increased public relations and greater representation where it could advance our licensure efforts. Importantly, we switched management companies to obtain an executive director with lobbying and legislative experience.

Our strategic plan is made available to members because we want you to see that your dues money is wisely spent to advance and secure AA practice. The snap decision-making skill that is so useful in delivering anesthesia is the exact opposite of the strategic planning process. Just staying abreast of AAAA[®] operations, project planning, and allocating resources consumes most of the Executive Committee's time.

[Continued on page 6](#)

CAAs add value to ACT, patient care



David Biel, CAA

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Editor's note: The following article was originally published by the ASA® as an *ASA Timely Topic: July 2015: What can Certified Anesthesiologist Assistants Bring to your Practice?* It is reprinted here with permission.

Many practicing Physician Anesthesiologists are unaware that they have a choice when hiring anesthetists. If you live in one of the 17 jurisdictions, including Washington DC and even Guam, where Certified Anesthesiologist Assistants (CAAs) are authorized to practice, CAAs can make a difference in your practice. If you live outside those areas, you are part of the only medical specialty that has only one option for physician extenders. If you would like to learn more about licensing CAAs in your state, please contact the American Society of Anesthesiologists® (ASA®) or American Academy of Anesthesiologist Assistants (AAAA®).

"The ACT approach to patient care underscores CAA's education, training, and practice."

CAAs are highly skilled health professionals who work under the direction of licensed Physician Anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the anesthesia care team (ACT) environment as described by ASA®. All CAAs possess a premedical background, a baccalaureate degree, and also complete a comprehensive didactic and clinical program at the graduate school level. CAAs are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques.

All AA training programs are housed within or affiliated with a university with a medical school which either has an anesthesiology residency program in place, or the capability to have one. People often ask what a CAA brings to the table. From day one, CAAs are trained by Physician Anesthesiologists in the care team model. The ACT approach to patient care underscores CAA's education, training, and practice.

CAAs are recognized by the Centers for Medicare and Medicaid Services (CMS), Tricare, and commercial payers. Under physician anesthesiologist medical direction, CMS makes no distinction between anesthesiologist type. Medicare recognizes both certified registered nurse anesthetists (CRNAs) and CAAs as "non-physician anesthesia providers", with no differences in payment. Physician Anesthesiologists may medically direct up to 4 rooms. With the right payer mix, the ACT with CAAs is a sustainable revenue model in the ever increasing environment of downward pressures on payment.

Competition in the market place is a good thing. This includes the anesthetist pool. In major markets where CAAs have been working for years, anesthetist's salaries tend to be lower in that region. Within anesthesia groups where CAAs work, there is no difference in salary compared to that of other non-physician anesthesia providers, but introducing

more providers tends to drive salaries downward. It is simple supply and demand economics. There are several opportunities to find well qualified CAAs in the market place. The popular online Anesthesia employment resources include CAAs with their own specific listing on many. The AAAA® website (www.anesthetist.org) also offers a job listing service. With over 2000 members the AAAA® can be a great resource for finding CAAs. Another proven method of introducing as well as hiring CAAs into your practice, is to become an affiliated clinical rotation site with one or more of the existing Anesthesiologist Assistant (AA) training programs. You will have a steady stream of senior AA students throughout the year. They will spend four weeks with your group on a general anesthesia rotation or on a specialized rotation such as pediatric or cardiac anesthesia. Think of it as a 30-day interview. You will be able to pick and choose from a large potential applicant pool, and choose to offer jobs to only those that best fit your particular practice. Even if you are outside of current CAA practice areas, you are still able to help train AA students at your site. It's a great way to introduce CAAs into your practice and get a feel for the unique ACT practice model that CAAs bring with them.

"The AAAA® website (www.anesthetist.org) also offers a job listing service."

There are currently 10 AA training programs throughout the country. With the Department of Anesthesiology, Medical College of Wisconsin (MCW) commencing a formal feasibility assessment to bring an anesthesiologist assistant educational program to the Wisconsin market, an 11th may be starting soon. There are approximately 200 – 230 new

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Know billing, payment processes to boost practice

David Biel, CAA
Chair, AAAA® Practice Committee



Every dollar counts with continued downward pressure on payment in the ever-changing healthcare landscape. No one really knows how Sustainable Growth Rate (SGR) repeal, Medicare Access and CHIP Reauthorization Act (MACRA) implementation, International Classification of Diseases, 10th revision (ICD-10), “Fee-for-Value,” and other Alternative Payment Methods will affect CAAs. CAAs must position themselves to be the preferred non-physician anesthetist for physician anesthesiologists, anesthesia groups, and hospital systems.

One of the easiest and most efficient things you can do as a provider is to make sure you are paid correctly for your services. Understanding how an anesthesia bill is generated is a good start. Every payable medical procedure has a Current Procedural Terminology (CPT) code attached to it. Anesthesia has a corresponding code that is used for reporting. The ICD-10, taking effect on October 1, 2015, involves around 70,000 CPT codes alone. Fortunately, anesthesia is spared from major changes with ICD-10, except for pain management procedures. You can count on quality measures to be scrutinized more. The ability to report SCIP, HOP, PQRS and the next evolution of MACRA implementation will be paramount for future reimbursements.

Here is how it works with regard to the rules for the Centers for Medicare and Medicaid Services (CMS), which most insurers follow. There are a number of circumstances and policies that will factor into how individual insurance carriers want the bills reported and how they reimburse procedures. First, an anesthesia bill must be calculated with a base unit CPT code assigned. The higher the acuity of the case, the higher the base unit will be. The anesthesia bill is calculated by adding time in 15-minute intervals and multiplying by the conversion factor.

$$\frac{(\text{CPT Code Base Units} + \text{Time}) \times \text{Conversion Factor}}{1} = \text{Anesthesia Bill}$$

There may be payment procedures to account for, including nerve blocks for post-op pain, invasive lines for monitoring, and TEE placement and monitoring. There may also be other circumstances for adding base units such as ASA class III or higher, unusual position or field avoidance, extreme age, hypothermia, one-lung ventilation, and controlled hypotension. Each insurance company has its own policies and criteria that determine how and if these added base units are reimbursed.

Next, the bill must be reported to the corresponding insurance company. One of several billing modifiers, codes that carry specific reimbursement rates depending on the anesthetic practice model used, is attached to the reported claim. See Table 1. CMS has designated CRNAs and CAAs as *qualified nonphysician anesthetists* for payment purposes. Thus, the term *qualified nonphysician anesthetist* will be used to refer to both CRNAs and CAAs unless it is necessary to separately discuss these providers.

Table 1 Billing modifier codes signify the specific practice model implemented to provide anesthetic services and largely determine reimbursement percentage.

Modifier Code	Definitions
AA	Anesthesia services performed personally by an anesthesiologist
QK	Medical direction by a physician with two, three or four concurrent anesthesia procedures
AD	Medically supervised by a physician with more than four concurrent anesthesia procedures
QY	Medical direction of one <i>qualified nonphysician anesthetist</i> by an anesthesiologist
QX	<i>Qualified nonphysician anesthetist</i> with medical direction by a physician
QZ	CRNA without medical direction of physician
QS	Monitored anesthesiology care services (can be billed by a <i>qualified nonphysician anesthetist</i> or a physician)
GC	Service performed in part by a resident under the direction of a teaching physician

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Future Practice

Continued from page 3

Pedaling as fast as can, we still cannot fully answer members' well-placed concerns for the future of our profession. When various issues are raised in *The Anesthesia Record* or ASA® Newsletter, you may sometimes wonder, "why doesn't someone do something about that?" The truth is that nothing grinds more slowly than the advent of a good idea or a push for change within an organizational, societal, or government structure.

Our goal to achieve a future where CAAs practice in 50 states, without practice restriction or payment penalty, requires that we stay on the forefront of policy change. A strategic plan helps us get there. After all, you don't need a map if you are on a treadmill because your course is already set. All CAAs should understand the issues that affect our profession and work together to ensure our future relevance. AAAA® equips its members with the knowledge, resources, contacts, and opportunity to be that "someone" who is doing something about the issues standing between where we are and a future of unrestricted and sustainable AA practice.

CAA Value

Continued from page 4

CAA graduates each year. All the programs have multiple clinical rotation sites already set up. The process is well defined and easy to accomplish. If you have interest in setting up a clinical rotation for AA students at your facility, please contact one of the AA programs for more information.

Please contact ASA® or AAAA®, if you have questions about CAAs or would like to learn more about implementing CAAs into your practice.

Processes

Continued from page 5

Both physician anesthesiologists and CAAs often ask me which modifiers can be used for CAAs. Physician oversight of anesthesiologists is reported using either Medical Supervision or Medical Direction billing modifiers. The CAA occupation is designed to work within and promote the Anesthesia Care Team (ACT) model of physician oversight. Either Medical Direction or Medical Supervision may be used as billing modifiers for physician oversight of anesthesiologists. Medical Direction (QK/QX) is the modifier that will be attached to most, if not all, services rendered by CAAs. The physician anesthesiologist bills QK for 50%, and the CAA would bill QX for 50%, equaling 100% of allowable payment.

There are seven steps that a physician anesthesiologist must perform to fulfill Medical Direction billing requirements.

1. Perform a pre-anesthetic examination and evaluation and document it in the medical record.
2. Prescribe the anesthesia plan.
3. Personally participate in the most demanding procedures in the anesthesia plan —including induction and emergence, if applicable.
4. Ensure that any procedures in the anesthesia plan are performed by a qualified anesthetist.
5. Monitor the course of anesthesia administration at frequent intervals and document that they were present during some portion of the anesthesia monitoring.
6. Remain physically present and available for immediate diagnosis and treatment of emergencies.
7. Provide indicated post-anesthesia care and document it.

"Make sure you are paid correctly for your services. Understanding how an anesthesia bill is generated is a good start."



HAVING "SQUEEZED THE BAG" FOR OVER 20 YEARS MYSELF, I UNDERSTAND THE NEEDS AND GOALS OF ANESTHESIA PROVIDERS DURING THEIR CAREER AND IN RETIREMENT

- | | |
|-------------------------|---|
| > LIFE INSURANCE | HOW MUCH DO YOU REALLY NEED? |
| > INCOME PROTECTION | ARE YOU FULLY PROTECTED? |
| > COLLEGE SAVINGS | WHAT ARE BEST WAYS TO SAVE? |
| > OLD 401KS AND IRAS | WHAT SHOULD YOU DO WITH THESE ACCOUNTS? |
| > CURRENT 401K OR IRA | ARE YOU IN THE RIGHT INVESTMENTS? |
| > RETIREMENT PROTECTION | DO YOU NEED AN LTC PLAN? |
| > LEGAL DOCUMENTS | ARE YOU AND YOUR FAMILY PROTECTED FROM A SUDDEN LOSS OR INCAPACITATION? |

THESE ARE THE MOST COMMON ISSUES AND QUESTIONS ANESTHESIA PROVIDERS NEED TO ADDRESS SOONER THAN LATER

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Some may consider these requirements an arduous task. Ask any physician anesthesiologist who works in the ACT model, and most will tell you it is easily accomplished. CMS allows for the directing anesthesiologist to perform other duties concurrently, including:

- Addressing an emergency of short duration in the immediate area
- Administering an epidural or caudal anesthetic to a patient in labor
- Performing periodic, rather than continuous, monitoring of an obstetrical patient
- Receiving patients entering the operating suite for the next surgery
- Checking or discharging patients in the PACU
- Coordinating scheduling matters

The ASA® has published a statement on the definition of “immediately available” to ensure compliance amongst anesthesia providers.

DEFINITION

“IMMEDIATELY AVAILABLE” (WHEN MEDICALLY DIRECTING)

Committee of Origin: Economics

(Approved by the ASA House of Delegates October 17, 2012, and last amended on October 15, 2014)

An anesthesiologist who is personally performing an anesthetic is exclusively and completely dedicated to that case. A medically directing anesthesiologist is immediately available if s/he is in physical proximity that allows the anesthesiologist to re-establish direct contact with the patient to meet medical needs and any urgent or emergent clinical problems. These responsibilities may also be met through coordination among anesthesiologists of the same group or department.

Recently there has been increased interest by the anesthesia community in using the AD (supervision) modifier to bill for CAAs. Here’s where it gets tricky. First and foremost, this could be construed as CAAs straying from the ACT model. Using the AD modifier is something we would not choose to promote without the full support of the physician anesthesiologist community. Over the last several years, the AD modifier has been used in less than 1% of reported cases. There is good reason for that; it pays less than the other modifiers. Thus, from a business standpoint, it makes little sense to use routinely.

Using the AD modifier for CAAs requires careful consideration because some state statutes mandate that CAAs must be medically directed. Every CAA should read the statute that permits them to practice in the state of their employment. If you were to bill with supervision modifiers and the statute says you need to be medically directed, then you have a situation no one would want to be in when the medical board or Office of the Inspector General (OIG) starts asking questions. Those with interest in using supervision modifiers for CAAs should thoroughly investigate the feasibility and legality of doing so before they proceed.

So, where is the interest in using supervision modifiers for CAAs coming from? It begins with the QZ modifier, which indicates CRNA independent practice without physician oversight. The QZ modifier has been on the rise for the past 10 years. QZ has been reported more than QK/QX over the last several years.

“We must be doing something right!”

Why this trend? Two things are primarily driving this. 1) Money, since it pays the same as Medical Direction, with the possibility of less required work by the physician anesthesiologist. 2) Compliance, with the full weight of the Affordable Care Act (ACA) bearing down on the healthcare community, everyone is counting pennies, including CMS. The CMS fraud unit is in overdrive, which has a lot of people concerned. The QZ modifier has built-in fraud protection. If one of the 7 steps of Medical Direction is not documented or the 1:4 maximum ratio is exceeded due to short staffing one day, bills with Medical Direction modifiers that CAAs use will not be reimbursed. Whereas, in the same scenario, the QZ modifier will pay your group 100% reimbursement while being in compliance and avoiding the financial penalty of using Medical Supervision for greater than a 1:4 ratio. If you were the head of an anesthesia group, which modifier would you want to use? Unfortunately, QZ is not an option for CAAs, and Medical Supervision incurs lost revenue. Thus, CAAs have seen their market value go down resulting in fewer employment opportunities.

All AAAA® leaders have had the disheartening experience of a conversation ending abruptly when a physician anesthesiologist finds out they cannot use QZ with CAAs. However, the QZ is a double-edged sword in that CRNAs claim that all QZ cases are managed by CRNAs only, even if an anesthesiologist is involved in some way with the case or, at the very least, available for emergency rescue. When nurse anesthetists ask policymakers for independent practice or an expansion of scope of practice, it is a convincing argument to say that CRNAs provide over 30 million anesthetics a year **without** physician oversight and can cite CMS records to prove it. The QZ modifier is not going away anytime soon, so it is up to CAAs to evolve with new practice paradigms and continue to be the preferred qualified nonphysician anesthetist.

On the bright side, the support of the ASA and the physician anesthesiologists for CAAs has never been higher. It speaks volumes that physician anesthesiologists are considering incorporating CAAs under Medical Supervision billing modifiers in rare circumstances, knowing that it would pay less than QK, QX or QZ modifiers. We must be doing something right!

“The support of the ASA and the physician anesthesiologists for CAAs has never been higher.”

Policy changes impact CAA practice



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A recent article in the ASA newsletter by Dr. Stanley W. Stead provided a comprehensive preview of the new payment schedules. I recommend all interested parties to read it. The AAAA® Practice Committee is following this federal issue closely. For those with the patience and wherewithal to find out how federal payment models apply to CAA practice for the next two decades, a summary follows.

MIPS

Starting in 2019, MIPS is one of the newly instituted performance fee models that operates with a questionable reverse robin-hood system. It is based on CMS-determined quality performance measures. EPs who participate in MIPS are subject to adjustments based on merit, or quality of performance. Quantification is through assessment of the

“While incredibly complicated, these issues should be followed with an intense focus.”

In the US, every anesthesia provider, and therefore every certified anesthesiologist assistant (CAA), is affected when a federal Medicare policy is changed. The Centers for Medicare and Medicaid Services (CMS) establish rules that dictate how federal payments for anesthesia care are made. These rules are often reflected in national and statewide insurance industry standards. A bipartisan-supported bill, the **Medicare Access and CHIP reauthorization Act of 2015, or MACRA**, was signed into law on April 16th, 2015.

This legislation repealed the long maligned Sustainable Growth Rate (SGR) Medicare reimbursement rate model. By doing this, physicians avoided a 23% drop in Medicare reimbursements and a potential industry-wide “fiscal cliff”. It also created a complex new system that emphasizes a dictated progression from the current Fee-for-Service (FFS) system to Value-Based Care (“Fee-for-Value”) reimbursement models. Future payments will ultimately be based on merit/quality measurements and proof of savings metrics for every anesthesia provider, including CAAs.

From 2016 to 2019, provider fee schedule for services paid by Medicare will have a constant conversion factor increase of 0.5% annually until 2019, when baseline rates will then remain static at 0.0% until 2025 (keep in mind that average annual inflation rates are ~1.5%). During the 2019 to 2025 period, designated individual **eligible professionals (EPs)** will have the ability to supplement payments through only two methods. These payment methods are the **Merit-based Incentive Payment System (MIPS)** and the **Alternative Payment Model (APM)** program. Like physician anesthesiologists and nurse anesthetists, **CAAs are recognized as EPs**, which solidifies our continued recognition by CMS as providers.

After 2026, payment factors almost exclusively benefit providers using APM models of care. From this time forward, providers are incentivized to use the APMS models with conversion factors increasing each year by 0.75%, versus only a 0.25% increase for those providers using MIPS methods. The logical conclusion is that APM models will be the preferred future care model type if providers want the best compensation for services through the Medicare system.

following categories: a Physician Quality Reporting System (PQRS), Value Based Modifier (VBM), Meaningful Use (MU) and the newly created “Clinical Practice Improvement Activities” category. All of these recorded metric variables are used to determine whether a group gets penalized with a negative adjustment or rewarded with a positive adjustment. Regardless of whether a group becomes a “winner” or “loser”, the budget allocated to Medicare MIPS spending is designed to have a neutral or reduced impact on the overall Medicare budget. Thus, the take home message for this system is “Medicare will feed the winners and starve the losers”, with a possible net loss of budget allocation for the industry.

MIPS Payments

EP performance assessment based on composite scores from 4 categories - 0-100

Threshold score determined by Secretary

EP Composite score compared to threshold score

- EP below threshold - negative MIPS adj
- EP at threshold - zero MIPS payment adj
- EP above threshold - positive MIPS payment adj

MIPS Adjustments

Losers - Negative Adjustments

- 2019: Up to -4.0%
- 2020: Up to -5.0%
- 2021: Up to -7.0%
- 2022: Up to -9.0%

Winners - Positive Adjustments

Based on funds available from losers i.e. lots of losers means larger adjustments for winners, fewer losers means smaller adjustments for winners.

APMs

In addition to MIPS, after 2019 physicians can supplement base payments by participating in Alternative Payment Models (APMs). Several of these APM models have specifically been created by the Affordable Care Act legislation and include provider performance values (similar to MIPS), budget-based cost analysis, and bundle payment algorithms. Some APMs are already in use and may eventually be the only future model for Medicare payments.

After 2026, Medicare payments will be preferentially directed to providers that participate in APMs. If a provider requires adequate payment from CMS, this means the use of APMs will no longer be the exception, but the rule. Of note, CMS is expected to recognize the Perioperative Surgical Home (PSH) as an APM. The AAAA[®] is involved in providing a future role for CAAs in the PSH APM, as well as looking into the role CAAs can play in other APM practice paradigms.

Alternative Payment Models (APM)

EPs who participate in qualified APMs eligible for lump sum 5% bonus in 2019-2024. 0.75% bonus for 2025 and beyond.

Various models of APMs accepted - Includes those for services provided by "physicians who are not primary care practitioners."

Implications for CAAs

As the most qualified physician extender in anesthesia, CAAs will come under increased scrutiny regarding practice performance on an individual level. Metrics based on safety and cost analysis will dictate the amounts of federal payments to individuals and their respective practices. Every CAA should reflect on how new technologies used to address payment issues will affect their workplace and privacy. Electronic medical records (EMRs) and data mining resources will be used to quantify individual abilities and practice, but how this information will be passed on to government agencies for payment purposes is still unclear.

Conclusions

Present fee models are radically changing and a movement to "Fee-for-Value", rather than Fee-for-Service, is already taking place. From a practice and employment standpoint, CAAs are directly affected by federal Medicare payment policies. While incredibly complicated, these issues should be followed with an intense focus. The AAAA[®] and AAAA[®] Practice Committee continue to follow these issues, advocate for our profession, and keep our members aware of these complex policy changes.



Taking TX reins steered success



Jana McAlister, CAA

Secretary, Texas Academy of Anesthesiologist Assistants, Children's Health Dallas
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As CAAs, we are confronted with many challenges to our practice because we are relatively few in number. As a CAA practicing in Texas, a state that does not currently have licensure despite our best attempts, we face additional hurdles. Billing has been the most difficult obstacle as we seek growth in Texas.

"I was motivated to work to find a resolution."

With billing issues, we have learned that no two companies treat unlicensed providers the same. Issues vary between insurance companies, from flat out denials due to the lack of licensure (BC/BS) to being paid at a lesser rate than CRNAs due to technical glitch (TX Medicaid). At Children's Medical Center of Dallas, these issues became a major threat to our jobs, as working for free is not viable for our employer or us. Also, if your employer will make a better return on investment with another provider, you are in trouble. Thankfully, I was afforded time and support to correct these problems.

When this was first brought to my attention, I had no idea where to start. I made phone calls to previous employers and colleagues to see if they were experiencing the same issues. These questions forced me to learn more about billing and coding than I ever cared to learn. I was included in the monthly billing meetings at my facility and on teleconference calls with our billing company to learn how I may help resolve the problem. Since this problem would impact my fellow CAAs and I directly, I was motivated to work to find a resolution.

After many frustrating calls, I was able to talk to the right people at BC/BS only to be told that their policy did not allow for payment to unlicensed providers. Through contacts I had developed and maintained over the years, I was able to schedule a meeting to discuss our concerns with BC/BS representatives. Eventually, we found a resolution to allow us to be paid pending licensure. This process took at least two years with many phone calls, emails and frustrating dead ends. It was a group effort, to say the least, with support from Paul McHorse, Tim Goodridge and Gary Jones, to name a few. Together, we created spreadsheets and promptly provided any supporting documentation that was requested. Even when we thought the problem was corrected, we were met with new issues that required attention. Each issue was only resolved once we had spread the word to our colleagues and their billing offices throughout the state.

I tell you all this in the hope that if you are faced with similar hurdles that you will not be discouraged but encouraged to find a way to overcome the problem. Know that you can make a difference. It is by no means an easy road that has already been paved for you, but it is possible.

In Texas, we say that you should always take the high road and be respectful. This has served us well over the years and it will bode well for you too. Please feel free to contact me if you have any similar issues. One of the best aspects of the AAAA® is that we have the ability to connect and share our success and failures to hopefully make it easier for those following us. My goal is to grow our profession while maintaining the high standards and quality we have always shown.

"Eventually, we found a resolution."



Florida Update



Nick Davies, CAA

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Much has happened in Florida since the AAAA[®] Annual Meeting in Orlando. At that conference, we held the first ever state component meeting with well over 100 people in attendance. It was wonderful to see so much support for our state by both students and practicing CAAs. Following the announcement of a fundraising drive, we also raised a record amount of money in one weekend for our state component—well over \$10,000! The FAAA is so grateful for the support and generosity that is being shown.

"We have been emboldened to continue to fight for our place in the anesthesia care team."

Since then, we developed and presented a petition before the Florida Board of Medicine requesting clarification of the meaning of "assist" in our statute, specifically regarding neuraxial and regional procedures. Unfortunately, we gravely overestimated the board's familiarity with CAAs and AA practice. Since zero CAAs have come before the board for disciplinary matters, they have not had an AA issue under their consideration for over 10 years. Many board members had never heard of a CAA, and they are our regulatory body! Some thought that we train as CAAs right out of high school! There were simply too many misconceptions to successfully argue our petition, and the petition was withdrawn without a vote.

Naturally, the organization in the state that would love to see us disappear was thrilled, and presented a memo to their members that we were "defeated" and that the Florida Board of Medicine "voted against" CAAs performing spinal and epidurals in Florida. Of course, that was untrue. We remain in the status quo, in that each facility and practice group decides for themselves what CAAs can and cannot do. However, we have been emboldened to continue to fight for our place in the anesthesia care team. Rest assured that the FAAA, working with AAAA[®] and the FSA, will do whatever it can to protect AA practice in Florida. It may require a legislative fix or it may be fixed through regulatory channels. Either way, every CAA needs to support this effort. Our scope of practice and ultimately careers depend on it.

Please make sure you are a member of your state component society. Make sure you are a member of AAAA[®]. Make sure you are a member of your state society of anesthesiologists. It is true, there are many groups to be a part of, but your membership supports the protection of your job. We all spent tens or even hundreds of thousands of dollars on our education. Why spend that on your training and then think that ten or twenty or thirty dollars a month to be a member of your professional organization isn't worth it? In such a relatively small profession, with such strong opponents, it is absurd that not every CAA supports their national and state organizations.

If you are a Florida CAA reading this, you know what needs to be done. If you are in another state, please learn from our situation. There is so much more to advocacy than getting licensure in new states! Florida has the second most CAAs in the country and our privileges are being chipped away little by little. Gaining state licensure does not protect you from practice restrictions and challenges. Support and advocacy must be lifelong commitments not only for your own personal career, but also for everyone that came before and comes after you.

CAA Practice Census

The AA profession continues to grow since the first program was launched almost 50 years ago. Surveys show that CAAs work in all types of operative settings across all surgical specialties. CAAs can be found in urban (greater than 50,000 people) and urban cluster areas (2,500-50,000) while remaining under represented in rural areas (fewer than 2,500 people), as expected based on utilization of the care team model of anesthesia delivery. As a relatively new and growing profession, the average age of a CAA is younger than the average age of adult workers in the U.S. Women and men are represented almost equally with men being slightly more predominant. Most minority groups appear to be significantly under-represented when compared to the total U.S. population. AAAA[®] membership compares closely with the overall demographic breakdown of CAAs. As of July 2015, there are 1,885 CAAs, with a statistically insignificant number of CAAs who practice without certification, which is only permitted by the state of Georgia. Table 1 lists updated CAA practice numbers by state.

Table 2 Practicing CAAs per capita by state as of July 2015.

State	CAAs	Approx. State Population (millions)
Georgia	820*	10.1
Florida	225	19.9
Ohio	221	11.6
Texas	135*	27
Missouri	107	6.1
Wisconsin	45	5.7
D.C.	43	0.7
Colorado	41	5.4
New Mexico	36	2.1
N. Carolina	24	9.9
S. Carolina	24	4.8
Alabama	24	4.8
Vermont	18	0.6
Michigan	6*	9.9
Kentucky	2	4.4
Indiana	0**	6.6
Guam	0**	0.2

* Practice states with no CAA licensure and numbers are approximate from state academies.

**Practice state and territory that have not yet completed rules and regulations to begin issuing CAA licenses.

CAAs should be encouraged by the fact that they can practice in six of the ten most populated states and top ten in number of total inpatient surgical operations. Additionally, two of the remaining four most populated states have active CAA licensure efforts ongoing.

AA program updates

AAAPD adopts Centralized Application Process



Gina Scarboro, CAA

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Director, AAAA® Board
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The Association of Anesthesiologist Assistant Program Directors (AAAPD), the national organization of AA educators, has launched a common application for all AA educational programs. This new service is aptly named the Centralized Application Service for Anesthesiologist Assistants (CASAA) and was adopted by all 10 AA educational programs in 2015. The AAAPD initiated this endeavor in response to applicants' desire for ease of application to AA programs and the educator's goal to expand the pool of quality AA applicants. Liaison International, the company who provides the CASAA service also currently provides the application services for Physician Assistant, Dental, Optometry and other Allied Health educational programs.

In addition to the ease of use for applicants, the centralized application consolidated many of the application components that were previously different for each program. Through the use of a centralized service, references, academic histories, entrance exam scores and other components only need to be submitted once for all programs. Although the majority of the application is the same, there are also unique questions and other components for each school, which caters to the diversity and individuality of each Anesthesiologist Assistant program.

In the future, the AAAPD will be able to share composite applicant data from CASAA with all AA educational programs. These applicant statistics may be used to help guide the methods used to promote anesthesiologist assistant education and broaden our current applicant pool.

We hope that you will take an opportunity to visit the AAAPD (www.aaapd.org) and CASAA (<https://casaa.liaisoncas.com>) websites for more information.



CasePATH nonprofit model lifts, promotes profession



Jorjetta Ilieva, MSA II AA-S

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The CWRU Master of Science in Anesthesia (MSA) program in Washington, D.C. is entering its second year of fundraising through its own nonprofit organization, CasePATH. Recent program graduates, William Filbey and Lindsay Frey, spearheaded the creation of CasePATH in 2013 with the mission statement of "Promoting Advocacy Through Healthcare," and established it as a nonprofit organization (NPO) in 2014. CasePATH has teamed up with CenterPlate, a company that supplies volunteer groups for Washington D.C.'s NFL team at FedExField Stadium, to operate food and beverage stands throughout the season. First and second year MSA students volunteer to work the stands during home games from August until December. At the end of each game, CasePATH receives a percentage of the profits from beverage and food sales.

CasePATH has provided another opportunity for students to bond as a class through the teamwork and camaraderie fostered in running fundraising events. In 2014, CasePATH met its fundraising goal of \$10,000, making the first year a great success and building a strong foundation for the organization. Portions of the proceeds are distributed among the first and second year MSA students to cover expenses during the annual AAAA® conference. The remaining proceeds are given to charities and the AAAA® Legislative Fund. For instance, this past year CasePATH made a \$2,500 donation to the LifeBox Foundation, a global not-for-profit organization that provides pulse oximeters for operating rooms in developing countries. We look forward to continuing the success of CasePATH this NFL season and hope to surpass last year's fundraising goal.

If you are interested in establishing a non-profit organization for your program, here are a few ideas to get you started:

1. Discover other non-profit organizations in your community and see how they are fundraising.
2. Find a service or event that your group would be interested to participate in.
3. Establish a solid foundation and mission statement for your NPO that will inspire new members to carry forward.
4. Create and apply for the name of your NPO through your state's filing office website.
5. Reach out to your school for assistance when filing for the appropriate NPO paperwork in your state and acquiring a federal employer identification number.

The key to successful fundraising is to identify opportunities to give back to the community while also raising awareness for the AA profession. In establishing a sustainable fundraising nonprofit for future students to carry on, you will not only benefit the profession and community but also leave a legacy.



Jen Barker, CAA

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The Medical College of Wisconsin in Milwaukee will welcome students to its new Anesthesiologist Assistant program next summer. The program's leaders are in the process of accreditation and plan on matriculating ten students in August 2016. It is the eleventh AA school established in the country and the third in the Midwest. The didactic and clinical studies total 28 months, and its graduates will be awarded a Masters of Science in Anesthesia degree.

Students of the MCW program have the unique opportunity to develop their role as a CAA working within the expanding peri-operative surgical home model through teachings in pre-admission testing and post-operative care. Simulation labs, hands-on workshops and varied coursework further shape its students into well-rounded anesthesiologists.

Dr. Lois Connolly, Medical Director of the MCW AA School, has set the goal to "recruit quality students and produce excellent anesthesiologist assistants to provide care in the anesthesia care team model throughout the state." With the support of the ASA®, AAAA®, Wisconsin Society of Anesthesiologists and the Wisconsin Academy of Anesthesiologist Assistants, the Medical College of Wisconsin AA School is poised to succeed, and its graduates will continue the tradition of providing high quality patient care that CAAs have proven to deliver.

MCW to open AA program



MCW Seeks AA Program Director

Medical College of Wisconsin is recruiting a Program Director for the Master of Science in Anesthesia Program. The Program Director works in a team with the Medical Director and an Education/Program Administrator. The Program Director directs and oversees all aspects of the Anesthesiologist Assistant Program: daily operational functionality of the program including clinical and didactic curriculum content, quality assurance, program budget, marketing, political liaison with universities and state medical boards, student admissions and matriculation, student advancement, and faculty development.

As a key element of this position, the candidate must possess team-building and team membership skills. The candidate must also be able to work effectively with a wide variety of University, community, and clinical colleagues as a team player. Personal leadership development opportunities are available.

Minimum Qualifications:

- Education Requirements: Masters Degree or higher in post-secondary instructional administration, education, planning, science, or other related discipline. Completion of an accredited program in Anesthesiologist Assistant; professional certification as an Anesthesiologist Assistant.
- Job Specific Experience: Five (5) years clinical experience. Experience in graduate teaching and advising in sciences, administrative and organizational capabilities would be a plus but not essential.

Please contact Lois A. Connolly, MD at connolly@mcw.edu or 414-805-2715 if you are interested in pursuing this position.

You can locate the position at: https://mcw.taleo.net/careersection/faculty/jobdetail.ftl?job=20006981&lang=en&sns_id=mailto

Adductor Canal Block

John Ng, CAA

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Editor's note: For more information on clinical education article guidelines and submission to the Clinical Updates section, please contact John Ng, CAA, at clinicalupdates@anesthetist.org.

Your next patient is scheduled for a right knee arthroscopy for removal of loose body. The anesthetic plan includes an adductor canal block as part of the analgesic regimen. Which muscles surrounding the adductor canal would you expect to find on ultrasound?

- A. Sartorius, pectineus, iliopsoas
- B. Gracilis, sartorius, vastus medialis
- C. Rectus femoris, sartorius, vastus medialis
- D. Adductor longus, pectineus, sartorius
- E. Sartorius, vastus medialis, adductor longus

The femoral nerve, which is composed of a bundle of nerve fibers, arises from the lumbar plexus and descends deep under the inguinal ligament into the femoral triangle after giving off several branches at the level of the pelvis. It further divides into terminal branches as it travels down under the sartorius muscle in the adductor canal (AC) along the medial aspect of the thigh.

Anatomically, the AC is bounded medially by the sartorius muscle, anterolaterally by the vastus medialis muscle, and posteriorly by the adductor longus muscle. Within the AC, the femoral nerve divides into different terminal branches that supply motor and sensory innervations to different muscles and areas of the thigh and the medial aspect of the lower leg. It is accompanied by the femoral blood vessels and eventually continues to descend as the saphenous nerve. The saphenous nerve and branches provide sensory innervation to the medial aspect of the knee and lower leg, including cutaneous innervation to the medial side of the ankle and distally to the base of the great toe.

An adductor canal block (ACB) can be successfully performed under ultrasound guidance (Fig. 1). A single shot of local anesthetic is injected in the AC, which can be located and visualized in the medial aspect of the mid-thigh. At this mid-femur level, motor function of the quadriceps is theoretically spared as branches of the femoral nerve providing motor innervation to this muscle group run off in the upper thigh near the pelvis. In a recent study, quadriceps strength was found to be slightly lower with only statistical significance in ACB compared to baseline. Whereas, significant strength reduction was found in patients

after femoral nerve block (FNB) placement. Sensory innervation provided by terminal branches of the femoral nerve can be interrupted as it continues to travel down the canal. A successful ACB can provide sensory blockade in the anterior and medial aspect of the knee from the superior pole of the patella to the proximal tibia. Therefore, the ultrasound guided ACB is becoming a reliable technique used for postoperative analgesia not only following surgical procedures on the medial calf and ankle, but also following knee arthroscopy, all with less resulting quadriceps motor weakness. When compared to FNB in total knee arthroscopy, ACB was found to be superior in regards to postop quadriceps muscle strength and not inferior in regards to pain score and opioid consumption at 6 – 8 hours post-anesthesia.

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Correct Answer: E

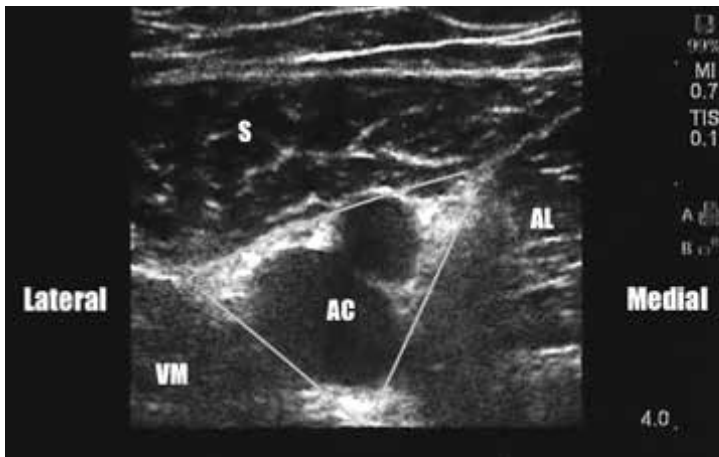


Fig. 1. Ultrasound image of the adductor canal in short-axis view using a 13-6 MHz linear ultrasound transducer. The adductor canal contains the femoral artery, vein, nerve and terminal-branches. It appears roughly in triangular shape and is surrounded by the sartorius (boat-shaped), vastus medialis, and adductor longus muscles. AC: adductor canal; AL: adductor longus ; S: sartorius; VM: vastus medialis.



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A 70 year-old, ASA class III, male patient with a newly diagnosed non-muscle invasive urothelial carcinoma of the bladder with components of sarcoma was scheduled for a Da Vinci radical cystectomy. The patient had undergone multiple resections of other bladder tumors in the past. The most recent abdominal and pelvic CT scan showed no evidence of metastatic disease. Meanwhile, the patient also had a complicated GU history of prostate cancer, which was treated with brachytherapy. The patient was an active smoker with a 100 pack-years history, a drinker with a history of alcohol withdrawal syndrome without delirium tremens, and a marijuana user who last smoked two days ago. Other medical histories included hyperlipidemia without any known significant cardiac illnesses. Current medications included Aspirin (discontinued 3 weeks ago), Lipitor, and Flomax.

Upon physical examination, the patient was afebrile with all stable vital signs. Body mass index was calculated to be 25. There was no acute distress, but mild disorientation appeared at times. The patient was hard of hearing and had a mild blunted affect. Other symptoms included fatigue, shortness of breath with exertion particularly, and gross hematuria with occasional dysuria. Preoperative airway exam revealed a MP II airway with poor dentition, a short stiff neck but with full range of motion, T-M distance of less than 3 cm, and a full beard. Auscultation to the lungs was clear bilaterally and to the heart was regular. The patient had previous general anesthesia with no known anesthetic complications. A general anesthetic with an endotracheal tube and clot evacuation was planned.

Case Report:

Unanticipated Troublesome Airway With An Unexpected Oropharyngeal Mass

The patient was brought to the operating room and standard ASA monitors were placed. Prior to IV induction, the patient was placed in the most optimal position available for ventilation and intubation. Induction began with preoxygenation for three full minutes, followed by IV boluses of Fentanyl, 50 mcg, Lidocaine, 60 mg, and Propofol, 150 mg. Although the patient's beard made one-person mask ventilation challenging, bag-mask ventilation was successful with a tight seal and assistance of joint forces of the anesthesia care team. With confirmation of effective ventilation, Rocuronium, 40 mg, was administered. Direct laryngoscopy was performed once muscle paralysis was achieved.

Despite the patient was put in the best possible sniffing position, true vocal cords could not be visualized upon laryngoscopy due to the unidentifiable airway anatomy, which was accompanied by the lack of neck extension. A Glidescope was then used for the third intubation attempt. While the lingual surface of the epiglottis was clear, a friable area on the right side of the glossotonsillar sulcus was continuously oozing of blood. The glottis was visualized and the trachea was intubated with an 8.0-cuffed endotracheal tube.

Since there was a concern for a possible primary cancer in the upper aero-digestive tract, ENT service was called to consult on the case. A rigid laryngoscopy was performed; abnormal soft tissues in the right oropharynx and tonsil were confirmed. Additionally, a right vallecular cyst was also observed. Biopsies in these areas were then taken, and surgery for radical cystectomy was postponed. The patient was extubated and admitted to the floor for a CT scan of the neck and an awake flexible laryngoscopy the following day.

DISCUSSION

Both alcohol consumption and tobacco use have a dose-response association with increased risks for various cancers, including squamous cell carcinoma of the upper aero-digestive tract. While a strong direct relationship with high frequent alcohol consumption and risk of head and neck cancer has been reported in the past, studies have also found that the risk for laryngeal cancer increases with increasing number of cigarettes smoked and duration of smoking. When combining the exposure to both alcohol and tobacco, there is a significant increase in risks for cancers of the mouth and pharynx; a heavy drinker who also smokes is at 300-times higher risk of developing oropharyngeal cancer than a non-drinker who does not smoke. Epidemiological evidence has also suggested that the areas for cancer are often found in the supraglottic region, where both carcinogens come into closest contact.

In this particular case, the patient's medical history was further complicated by the social histories, while the anesthetic turned eventful with an unanticipated troublesome airway and the discovery of an unexpected oropharyngeal mass. Considering both the duration and steep Trendelenburg position requirement of the surgical procedure, the risks for developing upper airway edema and pneumoperitoneum may have compromised safe-extubation, resulting in negative anesthetic and post-op care outcomes.

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Scarboro to lead in 2017



Carie Twichell, CAA

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The AAAA® organization has experienced change in recent years to better serve its members and to stay current within the ever-changing field of healthcare. One change is the development of a new organizational structure which includes a governance committee. A second change is the new term dates for officers and directors which now begin January 1, identical to the AAAA® fiscal calendar. Previously, terms began in April at the annual meeting. Matching the budget with term dates streamlines financial operations of the organization, improves planning and fiscal responsibility of AAAA® leaders and lends to improved transparency.

One of the duties of this committee is to oversee the nomination and election process and help orient leaders to their positions of responsibility. To better educate and transition our volunteer leaders sooner, the nomination and election period was streamlined. While staying within the guidelines of the *Policy and Procedures Handbook*, an abbreviated timeline allows for more new officer orientation and encourages participation at the fourth quarter board meeting at the ASA Annual Meeting in October. Despite a shortened election period, the number of participants in the voting process nearly tripled over last year. This is a terrific sign of an active and engaged membership.

The list of candidates offering this year is an impressive group of high-caliber professionals ready to help lead our organization. Nominees running for leadership positions varied widely in years of experience, background, interests and current practice jurisdictions including Colorado, Florida, Georgia, Missouri, Texas and Washington, D.C.

The governance committee will continue to fine tune the nomination and election process and incorporate changes that best reflect the needs of members. One addition on future ballots will be a question requesting the name of the state in which the voter currently practices. This information will assist the AAAA® in determining where the most elections involvement is. Sharing this data with state leaders may lead to more active state academies and ensure more balanced regional representation in the AAAA®.

As states open and the number of CAA practitioners continue to grow, this type of data will be useful and necessary to start discussions on incorporating a house of delegates type of governance structure. If anyone has constructive suggestions for improving the nomination and election process, do not hesitate to email me directly.

It is now my great pleasure to announce the 2015 AAAA® election results, terms beginning January 1, 2016:

Elected Leaders

President-Elect

Gina Scarboro, CAA

Secretary

Ty Townsend, CAA

Board of Directors

Nikki Block, CAA

David Dunipace, CAA

Daniel Mesaros, CAA



Scarboro



Dunipace



Block



Mesaros

Those individuals who also deserve recognition for their dedication to the profession and willingness to run for office include the following members: Samantha Evankovich, Jermaine Leclerc, Jana McAlister, Paul McHorse, Layne Paviol, Scott Plunkett, Kim Vuong, and Nathan Weirich. Many thanks to all these CAAs.



Townsend



Volunteer for 2nd AA teaching trip

Quentin A. Fisher, MD, FAAP

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Associate Professor
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A week or two spent working with Anesthesia Clinical Officer students offers a great opportunity to participate in medical systems and teaching in a very different setting. And you'll return home with the knowledge that your teaching has a far-ranging impact.

By the time you read this, we will have been well on our way with a first trip in October 2015. With the appreciation of how we can support the clinical instructors there, we are planning the second trip.

We have tentatively scheduled a second visit for February 22 through March 4th, 2016. The Kenyan senior students will be a month away from graduating, the junior students will have completed six months.

A week would be very helpful. Better yet, if you can spare two weeks, you'll find it adds immense satisfaction, seeing students adopting techniques and problem-solving that you've taught...and you'll be back in time to revel your friends at the AAAA meeting! We would expect to plan on giving a few didactic lectures, helping to manage a workshop on some TBA topic (such as OB difficulties, Peds anesthetics, Trauma, airway complications, etc.), and do a lot of basic bedside clinical skills.



Some specifics you should know:

- **Costs:** Airfare is \$900-1200
- **Travel time from US major cities is about 20 hours (18-28 hours depending on routing)**
- **Housing at the Anglican Guest house is about \$50.00 per day with two meals included**
- **Kenya visa (obtain at the airport) is \$50**
- **Yellow fever vaccination is required**
- **Malaria prophylaxis is not needed in Nairobi**
- **Travel medical evacuation insurance is strongly encouraged**

If you are an experienced AA, enjoy working with others, sharing your skills and insights, and are adaptable to austere circumstances, consider joining us to make a real difference.

Please contact Shane Angus (Shane.Angus@case.edu) or Quentin Fisher (qfisher@gmail.com) at Case DC if you'd be interested in going, and if for one or for two weeks. If you have not already done so, please send on a bit about your work, special interests, and a c.v. We'll send you some useful travel information and start a planning group.

Background

Case D.C. has been asked to assist in the training of non-physician anesthesia providers in Nairobi. This is a terrific convergence of interests and needs! We are developing a sustainable partnership of AAs to participate in performance-based teaching of Clinical Officer Anesthesia students. This consists of hands-on classroom and bedside teaching of clinical skills and problem solving. The program will be coordinated from the Case DC office.

The Registered Clinical Officer Anesthetist (RCOA)* training program at Kenyatta National Hospital takes approximately 30 students per year for an 18 month program. All the students are previously experienced in primary care, having completed a college-level training. When RCOA's have finished training, they are often posted as the only anesthesia providers in regional hospitals, so they must be equipped to handle (manage or transfer) all comers. Their work surroundings are austere and basic, but the medical conditions they must handle is not. The director of the ACO training is especially enthusiastic about AAs working with their PA-equivalent providers. Besides valuable teaching, students would be exposed to a model of well-trained and well-respected non-physician anesthetists.

*for description of the CO's, see: http://en.wikipedia.org/wiki/Clinical_officer.

Kenyatta National Hospital is an 1800 bed referral hospital for East Africa, offering a full range of anesthesia and surgical specialties. The Anesthesia department has recently introduced US-guided Regional and Pediatric subspecialties as well.



"Consider joining us to make a real difference."



Fourth Quarter Newsletter
Content Deadline November 6, 2015

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