

President's Message

AAAA - On the Horizon

My remarks are about the AAAA and its role in guiding our profession into the future. The future is always a difficult prospect to fully envision and predict, because we are limited by the knowledge we have in the here and now. For the coming year, I have been given the privilege, by you, to lead this growing and maturing organization. One of the responsibilities of the AAAA leadership is to plan for the future so that the members can anticipate any potential benefits.

I am reminded of ships in the golden age of exploration when nations wanted to expand their existing borders like we are trying to expand ours. The ship's command, at sea, could only see the future as demarcated by the horizon. The captain wondered what challenges lay beyond that ever-changing line and how best to prepare for the journey. The ship's officers would accumulate the best maps and information, hire the best crews with experience and potential, and at times ally themselves with other ships by convoy to better deal with the trials that would lie ahead.

I am fortunate that our previous helmsperson, using 21st century political correctness here, Deb Lawson, has given me a solid organizational vessel to help navigate towards this future. More on Deb later.

In order to meet the challenges, the AAAA will continue to seek more knowledge of the professional health care world around us, how it works, how to develop new leaders, and how to continue to develop alliances that benefit our profession and the patients we serve.

We cannot stand pat on what we have accomplished but need to look forward; anticipating what that horizon may bring beyond its approaching edge.

The health care sea is not always calm. Strong winds and storms of change bring on challenges that can suddenly appear. We will need to know how to change course to smooth out the journey or to weather these storms. To plot our courses in navigating our profession, we will seek the advice of others from time to time. One example of this external support is our strengthening relationship with the ASA. The AAAA is continually in the process of strengthening this relationship. The AAAA leadership will continue to meet semi-annually with key members of the ASA leadership to discuss common issues that affect the anesthesia care team. AAs currently sit on three committees in the ASA, including one that is a standing committee strictly dealing with AA affairs. We have petitioned the leadership of the ASA to expand our participation



Pete Kaluszyk, AA-C, MEd
AAAA President

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The Editor's Column

Don't Judge a Horse by the Odds

Alyson Finamore, AA-C, co-editor

This is the lesson I learned a few weeks ago at the Kentucky Derby as I saw the horse with 50-1 odds come out of nowhere to win the big race. Most people were just dumbfounded as this horse threw off any potential winning combination they had gambled on, including me. Mind that Bird (the horse's name) really proved that nothing is for certain, and sometimes, no matter how scientific and how intelligent those bookies are, they just don't know squat.

I hate to delve into the topic of the economy because it's all we hear about these days, but let's face it—no one understands what is going to happen over the next few years in terms of healthcare. Odds are not looking good for healthcare professionals. The president's message on the first page clearly demonstrates how vital it is that we cover all our bases, don't become complacent, and don't leave things up to chance. The odds are bound to get you. Let's not forget about our recent Ohio lawsuit that came out of nowhere. Our leaders are still working to rejoin forces with the OSA.

The AAAA has been sending this message since probably way before I was a student in 2004. Thanks to AAAA leaders for always keeping a watchful eye and never becoming too complacent with our slowly growing profession. We have some very experienced leaders who have had a part in expanding our profession since the 1980s, and I know that it hasn't been easy, but we've all learned a lot from their efforts. With their guidance and expertise, I'm sure we can weather this healthcare storm better than anybody, but I plan on doing my part to promote the AA profession too.

I'm not sure anyone is feeling particularly complacent today, but I know that some have in the past, and I hope these tough times prove to be a lesson to all of us, especially our new graduates. I hope now, more than ever, they see the need for an organization who has its sole interest in Anesthesiologist Assistants. A quick message to new graduates since most of you will be starting out this summer or fall: This is probably the toughest job market our profession has seen in the last decade, but I know there are still an abundance of jobs out there, and you all have a great rewarding future ahead of you. Choose carefully and don't always refer to the bottom line. Your future career is worth so much more than a little sign-on bonus. Be grateful for all the options you may have. Show your appreciation by making a financial commitment to your future with the AAAA and ASA. Hopefully, I will see you next year in Savannah, and I will be talking about my new strategy for the upcoming Derby.



Alyson Finamore, AA-C

AAAA New Toll-Free Number

Because of issues with its long-standing number, the AAAA was forced to seek a new toll-free number this year. Established in March, the new toll-free number is:

1-888-443-6353

Toll-free access to the AAAA office in Richmond, VA, is a benefit of membership and encourages those seeking answers about the AA profession to call and speak to a courteous professional.

President's Message — continued from page 1

to additional committees. These ASA committees deal with a wide range of issues, from anesthesia practitioners' wellness to medical economics. We will announce these appointments once they are approved. Some of these committee appointments will be on a trial basis to explore whether our involvement is of mutual benefit. This expansion of AA involvement in ASA committees will be a tremendous achievement, in that, in 2006 we were involved in two committees; in 2008 it was three; and in 2009 it may be as many as eight. We are also petitioning for an AA to be seated on the ASA's Political Action Committee's (ASAPAC) Board of Directors.

Additionally, we will continue to send representatives to the ASA's annual Legislative Conference held each year in Washington. This will be our third year of participation in promoting issues that are important to anesthesiologists, AAs and the public. At the Legislative Conference, the AAAA also has the opportunity to meet leaders from many ASA state component societies, and the legislative meeting offers a strategic venue to promote the expansion of our profession.

The AAAA will continue to have a presence with the Anesthesia Patient Safety Foundation and are looking into joining the American College of Surgeons' (ACS) Council on Surgical and Peri-Operative Safety. The AAAA sent Rob Wagner, President-Elect, to Chicago to initiate the process for AA participation. Hopefully, we can establish some direct association with the surgeons.

We will continue to work with the NCCAA, AAPD and other educational organizations to ensure that the AAAA has an ongoing interest in the vital area of education. Quality of education and the subsequent demonstrations of quality are vital to the profession's future and fundamental to our profession's future existence and ability to compete in the marketplace.

Internally, the AAAA will make a goal this year to further develop the Delegate Assembly by giving it a greater role in issues that AAAA's Board of Directors and Executive Committee will have to deal with. I will work to have the Delegate Assembly mature further, in the modern parlance, into a renewable and sustainable source of organizational energy and new leadership for the AAAA for years to come.

Another new project we hope to promote is the development of Quality Improvement and Patient Safety, under the direction of the Education and Practice Committee. This AAAA committee, among other goals, will be involved in promoting a culture of safety within the profession and interaction with outside national agencies involved in prevention of medical errors. This committee's work would dovetail nicely with the ACS' Council on Safety, if we are successful in gaining a seat there.

This year, a unique and history-making opportunity was serendipitously thrust upon the AAAA from an initiative started by Dr. Roger Moore, President of the ASA and a great friend to our profession, regarding the topic of wellness. Wellness is a very rapidly growing trend in all fields of medicine, allied health, and nursing. Wellness is concerned with the general physical and mental well being of the various professions' practitioners. In late March of this year, the leadership of the AAAA was asked to participate in a round-table discussion about wellness with the ASA and the AANA. The meeting was held in Chicago the day after the AAAA met with ASA's leadership. The AANA also meets twice a year with the ASA. The meeting was historic because it was the first occurrence of a direct face-to-face organizational meeting with AAAA and the AANA leadership.

The AAAA will begin to develop its own wellness program and hopefully by the next annual meeting, the AAAA will be able to offer some well-

ness programs to our members. These programs will hopefully become a regular part of our annual meeting and will be offered year round. The information we gathered at the Chicago meeting will serve as the seed knowledge to help us develop our own program. We have nominated a representative to the ASA's committee dealing with the wellness initiative.

The AAAA will continue to ceaselessly lobby the remaining State Component Societies to introduce legislation for the licensing of AAs. We have had a busy year so far. These efforts not only require time and effort, but money as well. We need members to give to the AAAA Legislative Fund AND to the ASA's PAC. Both of these funds help us expand our profession and increase your job mobility. Legislative campaigns aren't cheap, and by contributing to the ASAPAC, it shows that we are a partner worthy of their support.

The organization must always be on guard to make sure the twin obstacles of organizational complacency and unconfirmed assumptions do not strangle our ability to progress. We have witnessed these malicious twins bring down whole sectors of our economy in the last 10 months that have, and will have, a ripple effect on our workplaces sooner or later. AIG...the money was rolling in; Bear Stearns...invincible; GM and Chrysler...we make cars that function, everything is okay, and the sub-prime mortgage banking industry...more money than we know what to do with. All these institutions were brought to their knees, or to their demise, by complacency and false assumptions that everything was okay. We have to fight the organizational temptation of being satisfied with provincial complacency and respond with a cosmopolitan organizational dynamism.

The ability for us to succeed on our professional journey requires not only a vigilant leadership, but the participation and vigilance of its members. The most fundamental way you can participate is simply to be a member of the AAAA. To reword a catch phrase from the environmental movement, "act locally, think globally," would be for our practitioners to "join organizationally so the AAAA can respond nationally" for you. Additionally, I encourage all of you to also become educational members of the ASA. Your membership in both organizations is smart money because it is an investment in the future. YOUR FUTURE! Membership allows you to become a member of a group of like-minded individuals who will look out for each our interests. Membership allows you to give something back to a profession that has given you a great working opportunity that not many have in our society. Together we will be better able to steer through storms and squalls from challenges that can suddenly arise from governmental and regulatory agencies, the marketplace, and other competitive forces. When these storms come, the question you have to ask yourself is whether you want pay your way to be on a large stable ship or in a dinghy by yourself when the unpredictable swells of the healthcare future arise suddenly.

Finally, I want to say something about Deb Lawson. I have used a sailing analogy throughout this talk, and in a way, it was my way of a tip of the hat to Deb. Many of you may not know this, but Deb is quite the sailor. She has steered this organization in the past 14 months through some very rough seas, and we are the better for her having been at the helm. She has overseen a challenging major business transition during our switch to a new management company and has worked tirelessly to solidify the structure of the organization and increase the organizational dynamism with all of the organizations that have a direct effect on our profession. I would like to thank Deb for her leadership during the past year.

National Affairs Update

Ellen Allinger, AA-C

National Affairs Chairman

At this time of year, many state legislative sessions are drawing to a close or have already ended while the national legislative scene is just gearing up for various healthcare issues. The AAAA's National Affairs Committee involves itself in all of these issues. Following is a rundown of what has transpired so far this year.

STATE ACTIVITY

One of the most active years for state AA legislation has culminated in some of the greatest frustration for the AAAA organization, its members and supporters of the AA profession. At the time that this article is being written (May 16, 2009), the following is the status of those AA state initiatives:



Ellen Allinger, AA-C

New Mexico

House Bill 536, sponsored by Representative Nora Espinoza (R), failed to pass the House Business & Industry Committee. The AAAA National Affairs Committee representative speaking on behalf of this bill in the committee hearing was Chad Marchand, AA-C, with Kevin Hall, AA-C, both of Albuquerque, New Mexico, in attendance. AAs may already practice in New Mexico but are limited to the University of New Mexico Hospital. This bill only sought to remove that restriction. Because the New Mexico legislature has an every-other-year budget only session, this issue can not be revisited again legislatively until 2011.

Utah

House Bill 269, sponsored by Julie Fisher (R), even after undergoing two substitutions, failed to pass on the floor of the House by just five votes. This bill would have created new licensing in Utah for AAs. Interim legislative committee schedules may allow for further study of this bill. The AAAA National Affairs Committee continues to work with the Utah Society of Anesthesiologists in promoting the AA profession within Utah.

Maryland

Maryland's AA legislative effort is a prime example that, especially when politics is involved, even the best laid plans can go awry. Supported by Johns Hopkins University (JHU) and their esteemed Department of Anesthesiology, a well-prepared panel supporting Senate Bill 798 appeared before the Senate Education, Health, and Environment Affairs (EHE) Committee to support this AA licensing bill. The panel included JHU chairman of the department of anesthesiology, Dr. John Ulatowski, D.C. anesthesiologist Dr. Eileen Begin, and numerous AAs, which included AAAA director, Saral Patel, AA-C.

Despite JHU's work with the Maryland Society of Anesthesiologists and the state's Board of Physicians on this bill, the opposing panel included a representative of the Board of Physicians, along with nurse anesthetists representing the Maryland Society of Nurse Anesthetists (MANA), and a Maryland nurse anesthesia program. In addition, the opposing panel sub-

mitted letters and a petition in opposition to the AA licensing bill signed by anesthesiologists and other physicians. After a nearly two-hour debate, the committee made no immediate decision on the bill.

Later, the chairman of the EHE committee and sponsor of SB 798 officially designated the issue of anesthesiologist assistants for legislative interim study. This keeps the issue of AA licensing viable and allows supporters of SB 798 to provide in-depth information on the AA profession without having to stay within the boundaries of arguing for or against the bill.

A concurrent AA licensing bill, House Bill 1161, died when the lobbyist for MANA talked the bill's sponsor, Delegate John Donoghue (D), into withdrawing his sponsorship of the bill.

Texas

The last of the four AA bills to be introduced so far this year was in Texas, HB 3376 and its concurrent bill, SB 1794. With the Texas legislative session coming to a close and the heavy debate in the bill's hearing on April 28 in the House Public Health Committee, the chair of the committee desired that the bill be referred for interim study. Therefore, the bill was left pending in committee. The bill was supported by both the Texas Academy of Anesthesiologist Assistants and the Texas Society of Anesthesiologists, both of which sent representatives to speak in support of the bill.

The concurrent AA licensing bill, SB 1794, was referred to the Senate Health & Human Services committee but never heard.

Although AAs currently work in Texas under physician delegatory authority, the bills would have allowed for licensing of AAs by the state's medical board and codified the ability of AAs to work in Texas. As it stands now, there is no change in the ability of AAs to work in Texas.

The inability for AA legislative activity in four states to pass in one session is a reminder to this organization and to the AA profession as a whole that we cannot become complacent based upon last year's unusual success of Oklahoma's AA licensing legislation passing unscathed in just one legislative session. We have already forgotten the hard-fought battles for four years in Florida and three years in North Carolina, both of which were well-planned and well-funded AA legislative campaigns. True defeat occurs when we do not return to these AA legislative initiatives, such as what occurred in Kentucky, based upon one unsuccessful attempt.

NATIONAL ACTIVITY

H.R. 2204

To date, only one national healthcare issue directly affecting the AA profession have been introduced: H.R. 2204 "Medicare Access to Rural Anesthesiology Act of 2009." This bill will allow rural hospitals the opportunity to offer incentives to anesthesiologists who practice in underserved areas. Interestingly, both nurse anesthetists and anesthesiologist assistants are already allowed more generous Medicare Part A payments for working in rural areas. However, without anesthesiologist services, AAs cannot work in rural hospital settings. Passage of H.R. 2204 would give rural hospitals the ability to draw anesthesiologists, and therefore AAs, to their facilities.

The inability of AAs to work in rural hospitals because there is not an anesthesiologist on staff is one of the top arguments currently used against our profession by nurse anesthetists in state AA licensing

Continued on next page

2009 AAAA Annual Meeting

Christopher Caldwell, AA-C
AAAA Annual Meeting Chair

When I returned home and went back to work in Cincinnati after attending the 34th AAAA Annual Meeting in Clearwater Beach, Florida, I kept getting asked the same question, "So how was the meeting?" When I finally got a minute to step back and look, I could honestly say that it was an excellent meeting. It only had a couple of subtle changes from meetings in the past, but everything it had was of the highest quality. Everything from the speakers at the podium to the cup of morning coffee exceeded my expectations.

The AAAA strongly believes that the key to any successful educational meeting should be the quality of the speakers and the topics that they present. I would like to take this opportunity to publicly thank all of our speakers for volunteering their time to speak to us, because they truly were the backbone of our 34th Annual Meeting. Shane Angus, AA-C and Joe Mader, AA-C gave us a great lecture on clinical education and followed it up with a clinical instructor workshop the next day. One of Dr. Gerald Maccioli's (ASA Director for North Carolina and Chair of the ASA Section on Education and Research) lectures gave us an eye-opening look at what it is like to be a part of a malpractice lawsuit. Dr. Alexander Han-

enberg (President Elect of the ASA) gave an excellent talk on the state of the ASA, and he also explained how Washington DC can affect all of us. One of Dr. Robert Morell's (Editor of the APSF Newsletter) lectures reminded us how important it is to properly position our patients in order to avoid injuries. Dr. Ann Bailey (Univ. of North Carolina) gave us quite possibly the two best pediatric lectures we have had at our Annual Meeting in years. Dr. Tricia Meyer's (Texas A&M Univ.) lectures reviewed PONV and discussed medication safety. For the third year in a row, Dr. Roy Soto (Director of Anes. Edu. at Beaumont Hospital in Detroit, Michigan) gave two excellent talks—one on trauma and the other on alpha-2 agonists. Mike Nichols, AA-C (Former AAAA President) discussed the use of medical simulators in the training of AAs and its possible place in AA certification. The AAAA's moderator of Jeopardy, Dr. Joel Zivot (Medical Director of the Cardiac ICU at St. Boniface General Hospital and the Winnipeg Regional Health Authority in Winnipeg, Canada) returned to give us an excellent lecture on pulmonary artery catheters and new cardiac output monitoring technologies. We were very fortunate to have Dr. Tong Gan (Vice Chair of Anes. at the Duke Univ. Medical Center and President of the Society of Ambulatory Anes.) lecture on some of the drugs we might see

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Inside AAAA

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efforts. This is an excellent opportunity for our profession to help ourselves on both the national and state fronts. Every AA is encouraged to contact your congressional representatives in order to request that they co-sponsor and/or support H.R. 2204.

Grassroots Lobbying

The term "grassroots lobbying" has been thrown around a lot in recent years and was promoted extensively in the last U.S. presidential campaign. But how do AAs involve themselves in grassroots lobbying? Now, there are two avenues available to AAs.

The first is information that has been put together by Mike Nichols, National Affairs Committee vice-chairman, into an AAAA Advocacy Manual for 2009. This extensive manual explains how to communicate effectively with your Senators and Representative, the legislative process, lists all members of congress and lists various congressional committees and their members, and explains various healthcare reform issues important to AAs such as Medicare's Sustainable Growth Rate as well as existing healthcare bills such as the Rural "Pass-through" and Pain Care bills in addition to expected healthcare bills such as Truth and Transparency. The manual also contains a Congressional Appointment Evaluation Sheet that every AA is asked to complete and return to the AAAA office after contacting a member of congress so that we may track AAAA member contact with Senators and Representatives, and follow up on grassroots lobbying efforts.

This manual is accessible through the members-only section of the AAAA website at www.anesthetist.org.

The second avenue available to AAs for grassroots lobbying is through the American Society of Anesthesiologists. The ASA has recently launched a Grassroots Network that can be accessed through the organization's website at [\[roots.htm\]\(http://www.asahq.org/Washington/grassroots.htm\). You do not need to be a member of the ASA or an ASAPAC donor to sign-up and participate in this Grassroots Network, although both are encouraged! Encourage not only your fellow AAs to sign up for this Grassroots Network, but also your friends and family as well.](http://www.asahq.org/Washington/grass-</p>
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Both of these avenues make participation in grassroots lobbying easy, but it is effective only if you participate. Do so now.

INTERNATIONAL

Canada's Anesthesia Assistant profession continues to gain support and momentum. Three training programs currently exist: Thompson Rivers University in British Columbia, Michener Institute for Applied Health Sciences in Toronto, Ontario, and Fanshawe College School of Health Sciences and Nursing in London, Ontario. Although not standardized, all three programs require applicants to be either an experienced registered respiratory therapist or experienced registered nurse, and the programs are between 30 to 38 weeks in length. The Canadian Anesthesiologists' Society published an official position paper in 2006 on the anesthesia assistant's profession in Canada, which outlines guiding principles, training and education, and scope of practice. More information on this Canadian profession can be viewed online at http://www.cas.ca/members/sign_in/guidelines/practice_of_anesthesia/default.asp?load=appendix_v.

Professions similar to AAs in other countries are the United Kingdom's ODPs (Operating Department Practitioners), or Anaesthetic nurses that provide support to the physician anesthetist. In New Zealand, anaesthetic technicians complete a course of study recognized by the New Zealand Association of Anaesthetic Technicians and Nurses. However, none of these professions are as extensively trained or practice in the same manner as AAs in the United States. Currently, there is no reciprocity to allow U.S. AAs to cross-over into these international anesthesia professions.

New AAAA Officers and Directors Take Office

Ellen Allinger, AA-C
Secretary, AAAA

During the general membership business meeting held on Sunday, April 19, the following AAAA officers and directors were seated on the Board in new or re-elected positions:

President

Pete Kaluszyk, AA-C, MEd

President-elect

Robert Wagner, AA-C, RRT

Immediate Past President

Deborah Lawson, AA-C

Treasurer

Barry Hunt, AA-C

Director #6

Michael Nichols, AA-C

Director #7

Carie Twichell, AA-C

Strong leadership is a sign of a good organization. This year should prove to be another excellent year for the AAAA organization.

In addition, the AAAA would like to thank those who fulfilled their terms on the Board this past year in the following positions:

President

Deb Lawson, AA-C

President-elect

Pete Kaluszyk, AA-C, MEd

Immediate Past President

Michael Nichols, AA-C

Director #6

Robert Wagner, AA-C, RRT

Your service and dedication to the AAAA organization is deeply appreciated.

MEMBER NOTICE

Bylaws Changes Approved at AAAA General Business Meeting April 19, 2009

Under Section 5 of the AAAA Bylaws, the following amendments were passed at the General Business Meeting held on Sunday, April 19, 2009, in Clearwater, Florida:

1. The President shall appoint all liaisons to external organizations.
2. The President shall review all existing committee chairpersons and liaisons to external organizations when taking office.
3. The President or Treasurer may approve the allocation of funds from the general budget or from the Legislative Fund in the amount of no more than five hundred dollars (\$500). The sum total of such allocations may not exceed one thousand dollars (\$1,000) between Board meetings without the approval from the Board of Directors. All fund allocations must be reported at both the next regularly scheduled Executive Committee meeting and the Board of Directors' meeting.

Please note that the Bylaws are now available to view online under the "About AAAA" Section of the website.

POLICIES & PROCEDURES MANUAL

The Policy and Procedures Handbook is now available to view under the "Members Only" Section of the website.

2009 AAAA Annual Meeting – continued from page 5

one day in anesthesia and on fluid management. One of Dr. Matt Zeleznik's (St. Joseph's Hospital, Atlanta, GA) talks focused on the new area of using intralipid in the treatment of local anesthetic toxicity. Claire Chandler, AA-C gave us a very nice update on two very important organizations involved with AAs, the Commission on Accreditation of Allied Health Education (CAAHEP) and the Accreditation Review Committee on Education for the Anesthesiologist Assistant (ARC-AA). To wrap-up the 2009 AAAA Annual Meeting, we were very lucky to have Dr. John Ellis (Univ. of Pennsylvania and Vice President of the Society of Cardiovascular Anesthesiologists Foundation) talk to us about preoperative cardiac evaluation and myocardial ischemia.

In addition to all the great speakers and lectures, we had an excellent group of sponsors and exhibitors for the weekend and a

very nice turnout at the job fair. The 2nd Annual Blood Drive was extremely successful, as was the 2nd Annual Golf Scramble, with a nice sized donation going to The Children's Cancer Center in Tampa, Florida. Jeopardy was even more enjoyable this year with the help of NOVA Southeastern University supplying the buzzers and Emory University pulling out the win. The Student Forum, lead by G. Henry (South Univ.), was very informative and a huge success as well.

If you didn't attend this year's meeting you can see all you missed, and hopefully that will give you some incentive to make it to the 34th Annual Meeting, April 10 – 14, 2010, at the Hyatt Regency in Savannah, Georgia. The AAAA and the Annual Meeting Committee are already planning to make the 2010 meeting the most successful yet.

**Be Sure to Visit AAAA's Annual Meeting
Online Photo Gallery**

Community Initiatives: Golf Outing and Blood Drive at the 33rd Annual AAAA Meeting

Golf Outing

At the 33rd Annual AAAA Conference, members, students and guests participated in the 2nd charity golf event. Held at the Belleview-Biltmore Golf Course on Tuesday, April 21, the weather was perfect for nearly 60 golfers to have fun while raising money for the Children's Cancer Center (CCC). Approximately \$3,000 was donated to the CCC in the name of the AAAA.

The final winners of the outing went to the fab foursome comprised of: Nichols, Oakley, Zeleznik and Johnson. The following were winners of other golf contests: Closest to Pin – Adam Fernandez; Closest to Pin – Bill Kennedy; Putting Contest – Sami Ghani; Longest Drive; Dave Howard; Longest Drive – Dave Biel.

Thanks to everyone who helped plan the event and sponsor students and competitions. In addition, Nova Southeastern University sponsored the post-outing refreshments. An extra special thanks goes to the five Case students who graciously donated their time to help collect money and run the special competitions. They are: Kim Vuong, Katie McClain, Michelle McCourt, Colleen O'Malia and Ashley Shupienis. Recognition of the golf outing and student sponsors are as listed below.

Platinum Golf Sponsors

Nova Southeastern University

Gold Golf Sponsors

Case Western Reserve University

Silver Golf Sponsors

Barry Hunt and Mike Nichols

The AAs of St. Joseph's Atlanta; Ruggles Service Corporation

Student Golf Sponsors

Richard Davis (NSU); Brad Oakley; Apollo MD; Rob Wagner, Don Biggs; Rich Bassi; Claire Chandler; Gina Scarboro; Rhea Sumpter; Carie Twichell; Pete Kaluszyk; MetroHealth Medical Center - Cleveland (x3); Ellen Allinger; Lauren Hojlida; Mike Nichols; Kevin Busdiecker; Dave Biel; Patrick Bolger



Dane Johnson, Brad Oakley, Mike Nichols and Matt Zeleznik won the Second Annual AAAA Gold Scramble at Belleview Biltmore Golf Club.

Blood Drive

From Saturday, April 18, through Sunday, April 19, the AAAA had 112 people donate blood through the Florida Blood Service (FBS). The FBS set up at the Hilton Clearwater Beach Resort during the 33rd Annual AAAA conference, and the response was amazing. The majority of the donors proudly came from the student body in attendance. A competition between the AA schools was based on the percentage of student donors in relation to the number of students at the meeting from each respective school. The blood drive contest was won by UMKC, with 100% of their students donating. The Case students placed second with nearly 80% of their students participating. A \$100 gift certificate to the resort was awarded to the UMKC students at the student forum.

We all know and appreciate the importance of this type of community service. A special thanks goes out to everyone who took the time (and blood!) to donate at this event.

Historic Events for the AA Profession

Deb Lawson, AA-C

Immediate Past President

A series of ground-breaking developments for the AAAA in the last few months deserve attention:

March

The AAAA joined the leadership of the American Society of Anesthesiologists (ASA) and American Association of Nurse Anesthetists (AANA) in a first-ever joint meeting in Chicago on March 30. Discussion was on the subject of wellness and the problem of substance abuse among anesthesia practitioners. The ASA and AANA have well-es-



Deborah Lawson, AA-C
Immediate Past President

tablished programs to support recovery and promote resistance to this troubling affliction, and the AAAA will develop a program to educate its members on the problem, consequences, the need for prevention, and options for recovery. Watch for details in the coming year.

April

The AAAA proudly hosted the first meeting of all stakeholder organizations of the AA profession. The Cross-Organizational Summit was held April 17, the Friday before the AAAA Annual Meeting, and was attended by representatives from the National Commission for the Certification of Anesthesiologist Assistants (NCCAA), the Commission for the Accreditation of Allied Health Education Programs (CAAHEP), the Accreditation Review Committee – Anesthesiologist Assistants (ARC-AA), Association

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AAAA Leaders go to Washington

Ellen Allinger, AA-C

From May 3 to May 6, eight AAAA representatives attended the 2009 ASA Legislative Conference held in Washington, D.C. Initially attended only by the AAAA president and president-elect, the National Affairs Committee (NAC) has made this ASA event a priority and has sent representatives for the past few years. It is an informative event; it builds a better bond between ASA and AAAA leaders; it allows an opportunity for AAs to meet with state senators and representatives to discuss national issues that affect the AA profession; and it is an ideal opportunity for NAC members to meet with various ASA state component society leaders to discuss the AA profession.

One of the standard items on the program is the State Issues Forum where state legislative and regulatory issues are discussed. This is the second year that state AA legislation was discussed, and the first time ever that an AA was allowed to address the audience as part of the panel. Deb Lawson, AAAA immediate past president, outlined the key components and repetitive problems with AA legislative initiatives to an audience of about 200 ASA state leaders. The topic, as well as Deb's presentation, was very well received.



Soren Campbell, AA-C, NAC member from Kentucky, in front of the U.S. Capitol Building, Washington, DC.

Along with presentations on federal healthcare issues and ASA advocacy, conference attendees also hear from various Senators and Representatives involved in congressional health care committees. These speakers included such well-known congressmen and congresswomen as The Honorable John "Jay" Rockefeller (D-WV), Chairman, U.S. Senate Subcommittee on Health Care and member Committee on Finance, and The Honorable Orrin Hatch (R-UT), Senior Republican and also a member of the U.S. Senate Subcommittee on Health and Committee on Finance.



Megan Varellas, AA-C, NAC member from NC, meets with U.S. Senator Kay Hagan (D-NC). Senator Hagan voted in favor of AA medical licensing when she was a member of the North Carolina state legislature.

Although working with the ASA on important healthcare issues is paramount, the AAAA representatives made their own visits to Senators and Representatives in support of issues that directly affect the AA profession. As mentioned in the National Affairs Update and articles on national healthcare issues, the current Medicare's SGR and H.R. 2204, Medicare Access to Rural Anesthesiology Act, as well as the upcoming Truth and Transparency Act, all affect the AA profession. Visits were made to Florida, Georgia, Ohio, Kentucky, North Carolina and South Carolina congressional leaders to present these topics using AAAA printed material. This material, along with the 2009 AAAA Advocacy Manual, is available on the AAAA website at www.anesthetist.org.

AA Data Collection Update

Joseph M. Rifici, AA-C, MEd

Immediate Past President Lawson charged Megan Varellas, Soren Campbell and me in 2008 with the formation of a task force to collect as much data about AA practice and demographics as possible.

Megan, Soren and I have compiled a spreadsheet of over 1,400 names of graduates from four of the five AA educational programs. The Case Western Reserve University MSA Program has hired a graduate student researcher to help track down every AA, practicing or non-practicing, in the country. Her name is Susan Raber, and we welcome her to the cause.



Joseph M. Rifici, AA-C, MEd

So far, we have had a great response to our initial e-mails, and we want to thank all of you who have provided us with your contact information. Out of 1,437 possible practicing AAs, we have heard from a total of 134 people, which is a 9.3% response rate. Therefore, we are still waiting to hear from many of you! So please take a moment to e-mail us your information.

The higher the participation, the more accurate our information will be, which will be good for our profession. So please help us reach our goal of 100% participation by August of 2009!

Please contact Susan Raber at susan.raber@UHhospitals.org or 216-983-5842 with the following information:

Name • E-mail • Phone • Address
School Name • Graduation Year • Degree(s)

The Growing AA Population: Is this Good or Bad for Working AAs?

Ellen Allinger, AA-C

A new discussion has been taking place in the past year or two concerning AA workforce numbers. With the addition of AA programs in Savannah, Ft. Lauderdale, and Kansas City, along with Emory creating an additional AA education track specifically designed to attract Master’s level trained PAs, the number of AA students entering the workforce yearly has risen from what once was a constant of approximately 50 per year to an expectation of approximately 150 new AAs entering the workforce this year. Add to this the fact that a new AA program is set to open this year in Tampa, and other schools and universities have interest in opening new AA programs. Some wonder—are too many AAs being trained?

For the first three decades of the AA profession, only two AA programs existed in the entire nation: at Case Western Reserve University in Cleveland, Ohio, and Emory University in Atlanta, Georgia. Since the start of the AA profession, the need for anesthesia providers has risen. The rapid expansion of ambulatory surgery centers, as well as office-based surgery, out-of-OR needs for anesthesia services in such areas as endoscopy, CT & MRI suites, and interventional radiology areas, as well as the ever-aging U.S. population and advances in surgical techniques, anesthesia pharmaceuticals and monitoring, means that more patients than ever are candidates for anesthesia services. All of these factors have placed additional burdens on anesthesia services. Until five years ago, there certainly were not more AAs being put into the market on a yearly basis to fill this growing need.

To address this issue in its entirety, figures from the other anesthesia providers need to be reviewed. Although AAs do not compete for anesthesiologist jobs, their numbers certainly have an impact on the AA profession since AAs always work under the supervision of an anesthesiologist. The December 2007 edition of the ASA’s NEWSLETTER (Volume 71, Number 12) contains an article, “2007 Anesthesiology Resident Class Sizes and Graduation Rates,” which includes the chart to the right, Table 1/“Anesthesiology Residents in Training in the United States, 1988–2007.”

Since a twenty-year low in 1999 for the number of graduating anesthesiology residents, the numbers have steadily risen, but still lag by nearly 330 CA3s from the all-time high in 1994. The real comparison, however, needs to be made against those anesthesia providers in the same mid-level classification as AAs, which are the nurse anesthetists (NAs). What that profession has accomplished as far as increasing graduating and certifying numbers is what truly affects the AA profession. The following table on page 10 is taken from the ASA’s November 2004 NEWSLETTER (Volume 68, Number 11) from Dr. Alan Grogono’s article, “Resident Numbers and Graduation Rates From Residencies and Nurse Anesthetist Schools in 2004.”

Accurate data on nurse anesthetist numbers are available only through 2003, as the American Association of Nurse Anesthetists no longer will release the number of yearly certified nurse anesthetists. However, according to information presented at the 2009 ASA Legislative Conference, the number of graduate nurse anesthetists jumped from just under 1,000 in 2000 to 1,500 in 2003, reached 2,000 in 2006, and continues to rise. Within six years, the nurse anesthesia programs were

Year	PGY-1	CA-1	CA-2	CA-3	Total
1988	322	1,511	1,449	1,281	4,563
1989	293	1,592	1,541	1,450	4,876
1990	479	1,656	1,593	1,518	5,246
1991	387	1,801	1,753	1,565	5,506
1992	360	1,904	1,781	1,720	5,765
1993	380	1,853	1,864	1,675	5,772
1994	281	1,873	1,843	1,871	5,868
1995	207	1,436	1,607	1,701	4,951
1996	580	1,073	1,259	1,454	4,366
1997	507	1,132	972	1,107	3,718
1998	507	1,225	1,001	939	3,672
1999	463	1,387	1,194	919	3,963
2000	446	1,453	1,339	1,105	4,343
2001	543	1,466	1,374	1,253	4,636
2002	638	1,471	1,420	1,357	4,886
2003	510	1,496	1,473	1,399	4,878
2004	431	1,439	1,608	1,511	4,989
2005	514	1,572	1,557	1,513	5,156
2006	644	1,576	1,615	1,502	5,337
2007	729	1,566	1,631	1,546	5,472

able to double the number of nurse anesthetist graduates, a number that still outstrips AA graduates by 1,333%! So, from where is the real competition for mid-level anesthesia jobs coming? Is it 100 more AAs per year or 1,000 more nurse anesthetists a year?

Now knowing that there are presently at least 13 new nurse anesthetist graduates for every new AA graduate, where does that put the AA profession nationally in relationship to the nurse anesthesia profession? The total number of working AAs and nurse anesthetists are not entirely known, but a best guess here is based upon AAAA survey results and membership numbers, AANA membership numbers, and the U.S. government’s 2004 Registered Nurses Survey results. The AAAA estimates the number of working AAs around 1,200. The number of li-

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The Growing AA Population, from page 9

censed nurse anesthetists was estimated at 32,523 in March 2004 by the Department of Health and Human Services. The AANA currently states that it has a membership of more than 39,000, and that it “is the professional organization for more than 90 percent of the nation’s CRNAs.” This means that there are at least 27 NAs for every AA, and it may be as large as 36 NAs for every AA.

In addition, you have to look at the distribution of AAs and nurse anesthetists. NAs practice in all 50 states and are also employed in every branch of the military. AAs work in 17 states plus the District of Columbia. Both professions are not distributed evenly within their geographical locations, but probably the AA workforce has the largest discrepancy in distribution. Without question, the densest population of AAs is in the state of Georgia. Because AAs work in Georgia under a physician assistant license, it is an arduous task to separate out from the state medical board database how many AAs hold a Georgia license. This attempt is being made currently by the AAAA, but it is evident that several hundred AAs are licensed in Georgia and are heavily concentrated in the greater Atlanta area. The next concentrated area for AAs is in Ohio, where somewhere between 100 to 200 are employed. Beyond these two states, AA populations are considered sparse, and they are usually grouped into a few cities and/or anesthesia departments. But there are areas where AAs are being sought, but the positions are not being filled. Greenville, North Carolina, Tulsa, Oklahoma, and St. Louis, Missouri, are all looking to hire AAs, just to name a few. Greater Houston Anesthesiology of Houston, Texas, ran an employment ad in every edition of the AAAA newsletter in 2008, as well as the 2009 first quarter newsletter. So, there are plenty of jobs for AAs—maybe just not where an individual AA specifically wants to work. Is this a problem?

There is definitely a paradigm shift in anesthesia employment among all anesthesia providers. Because of the increased number of anesthesiologists, NAs, and AAs, the days when providers could change jobs at will within the same region, sometimes even within the same city, are disappearing. And, interestingly, this is not new to the anesthesia field. Thirty or so years ago, anesthesia providers had to go where the jobs were and watch for opportunities to apply for jobs where they really would prefer to work. The ability of all anesthesia providers to change jobs easily in order to obtain better benefits, increased salaries, and find better working environments occurred when there was a rapid expansion in the need for anesthesia providers without a concurrent increase in the number of those providers. Now, the expansion bubble has slowed, and the number of new anesthesia providers is increasing. So in order to maintain high salaries and extra work opportunities, should the AA profession self-govern itself to stop the increase in AA providers?

The short answer is—NO! And this is why: It is not an extra 100 new AA providers this year that is causing the change in anesthesia work opportunities. It’s nearly laughable to argue this point when there are over 2,000 new nurse anesthetists each year. The NAs aren’t cutting the number of graduates that they are producing. For the AA profession to do so would kill our profession faster than our opponents could succeed in such an attempt. The number of NAs and their political clout would outstrip AAs even more than they do today. In addition, other factors that neither NAs nor AAs can control are driving this train. It is a directive by our U.S. president to reduce healthcare costs, and hospitals and employers will be looking at the cost of mid-level anesthesia providers and how to curtail and even reduce that expense as NAs and AAs are two of the highest paid non-physician healthcare professions.

The AA profession cannot be on an even playing field with the nurse anesthetists as long as we are outnumbered at a ratio between 27 and 36 to one. The individual AA needs to look beyond the immediate personal inconvenience of not being able to switch jobs every few years without moving, or not being able to line up convenient weekend locums jobs at high fees, and look at the long-term ability of being able to make the AA profession viable for the future. Newly graduated AAs, along with other anesthesia providers, will need to be flexible and willing to move away from their program and clinical rotation sites in order to secure jobs. Already practicing AAs will have to weigh the pluses and minuses of lifestyle vs. salary. This is the impending reality of healthcare. But the AA profession has to be sure that it doesn’t kill the goose in order to get the golden egg.

Year	Grad	Cert
1989	592	574
1990	642	660
1991	730	943
1992	791	793
1993	914	891
1994	990	1,003
1995	1,054	1,082
1996	1,079	703
1997	934	982
1998	942	975
1999	948	881
2000	1,075	997
2001	1,159	1,129
2002	1,333	1,235
2003	1,474	1,454
2004	1,679	
2005	1,870	

Nurse anesthetists graduating (Grad) and being certified (Cert) during the years 1989-03 with conservative projections for 2003-06 based on numbers in training.

AAAA Needs Your Creative Mind!

AAAA’s logo needs a facelift! The AAAA would like to develop a more stylized, current and versatile logo that will reflect the mission and purpose of our organization. We’re looking for submissions from the creative minds of our membership. The following is a list of guidelines to keep in mind for this contest. Submissions should be made via AAAA’s web site at www.anesthetist.org.

Deadline for submission is July 1, 2009. Design submissions must be:

- Professional and relevant to AAs
- Submitted for review as a .jpeg file
- Designer must be prepared to submit, if chosen, the logo as a vector .eps file as well as including the original application file (*Adobe Illustrator preferred*).
- Logo must be designed with all type (fonts) converted to paths, and should not include transparent or opaque elements.

If my logo design is chosen, I agree that the AAAA will become the sole proprietor of my design.

Please visit the Members Only section at
www.anesthetist.org
 to submit your design.

The Sustainability of the Sustainable Growth Rate (SGR)

Michael S. Nichols, AA-C

Soren Campbell, AA-C

Contributions from Alexander Hannenberg, MD

The American Academy of Anesthesiologist Assistants supports an overhaul of the current Medicare payment formula to ensure that this nation's patients have continued access to efficient, quality anesthesia care. The current reimbursement mechanism has significant flaws, causing compounding reductions in provider payments and prompting an increasing number of specialty physicians to reconsider their participation in the Medicare program, limit services to Medicare beneficiaries, or restrict the number of Medicare patients they will treat. However, as hospital-based specialists, anesthesia providers are obligated to treat any patient with whom they are presented, regardless of ability to pay for service, and the only mechanism by which to "select" patient payment type would be to preferentially choose employment locations that have a favorable payer mix. Looking into the future at the expanding pool of Medicare beneficiaries as our population ages, it is easy to predict an untenable situation that will continue to put the healthcare of our nation's seniors at risk.

Background

Medicare payments for services of physicians and certain non-physician practitioners are made on the basis of a fee schedule. The fee schedule assigns relative values to services that reflect physician work (i.e., time, skill, and intensity it takes to provide the service), practice expenses, and professional liability costs. The relative values are adjusted for geographic variation in costs, and these adjusted relative values are then converted into dollar payment amounts by a conversion factor. The law specifies a formula termed the Sustainable Growth Rate, or SGR, for calculating the annual update to the conversion factors and, therefore, the resultant fees.

This poorly constructed formula determines reimbursement for each service paid under the Medicare Physician Fee Schedule. Each year, the Centers for Medicare and Medicaid Services (CMS) updates this conversion factor, thereby setting an "expenditure target" for all services reimbursed under the system. If actual expenditures are less than the target, reimbursements receive a positive update and the conversion factor rises. The converse is also true, if expenditures exceed the target, federal law mandates that CMS impose a reduction in reimbursement by commensurate lowering of the conversion factor. More problematic is that the SGR system fails to take into account the increasing professional costs healthcare, including improved technology, insurance and administrative costs. Additionally the formula incorporates the gross domestic product (GDP) that limits the ability of the formula to accommodate growth in services or cost of services. This troublesome formula has led to an untenable payment system that can cause sudden and unpredictable negative corrections in reimbursement, making it difficult to adequately meet the rising costs of medical care. Moreover, as dependent practitioners, the ability of employing entities to pay for the comfortable salaries of anesthesiologist assistants is directly tied to the reimbursement rates for provided services; this is especially poignant in light of a burgeoning Medicare-age population in the United States and current SGR-based reimbursement rates that fall below the adjusted market-based compensation of an AA.

Congressional Action

While the tribulations with the SGR were, in some respects, anticipated when the law passed Congress in 1997, the first detrimental effects were not experienced until 2002, when services paid under Medicare Part B (including anesthesiologist assistants) received a 5.4% reduction in reimbursements. Since that time, the dire consequences of the flawed SGR formula have forced Congress to pass three temporary measures to keep the system from completely imploding.

Within the 2003 Omnibus appropriations bill, Congress authorized CMS to fix accounting mistakes that were made during 1998 and 1999, thereby infusing an additional \$54 billion into the Medicare physician payment system and prevented a second consecutive year of reductions in reimbursement. Although in order to accomplish this piecemeal correction Congress had to institute a 0.65% across-the-board cut to all federal departments, the legislation did nothing to fix the underlying problems that are inherent to the SGR formula.

With a looming 4.4% reimbursement reduction in 2004, Congress again acted by authorizing a conversion factor increase of at least 1.5% in both 2004 and 2005 fiscal years (Medicare Prescription Drug, Improvement and Modernization Act of 2003). However, yet again, this legislation did little remedy the intrinsic challenges of the SGR formula. Moreover, since the provisions prevented further reimbursement reductions in 2004 and 2005, it failed to authorize additional funds to pay for this temporary patch (i.e. budget neutrality), and therefore the money used to fund the increase in these updates must be paid back to the Medicare program, with interest, over the next ten years. This effectively saddles the system with principle and interest payments on top of continual negative updates to the CMS reimbursement schedule.

Another "fix" was fashioned with the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA"), which increased the update to the conversion factor for Medicare physician payment by 0.5% through the end of 2008 and set the update to the conversion factor to 1.1% for 2009. The conversion factor for 2010 and subsequent years will be computed as if this modification had never applied, so unless further legislation is passed, the update formula will require a 21% reduction in physician fees beginning January 1, 2010 and by additional reductions of roughly 5-6% annually for at least several years thereafter. In other words, Medicare practitioners will receive less reimbursement in 2013 than they did in 2002 for the exact same procedure, regardless of inflation and increases in practice costs. While the nation's practitioners face a likely reimbursement cut by over 30% under the current SGR formula, it is estimated that costs for providing those services will increase by close to 20%. While this situation may lead some physicians to simply elect not to treat Medicare beneficiaries, the grim reality is that anesthesia providers do not have the luxury of choosing which insurance carrier any patient has when they show up for a surgical or diagnostic procedure.

Correcting The Problem

Last minute 'band-aid' fixes to the reimbursement constructs of the Medicare system have been tantamount to Congressional procrastination. While legislators have staved off the imminent meltdown of the program, it is imperative that a permanent fix to the formula be cre-

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The Sustainability of the Sustainable Growth Rate, *from page 11*

ated so as to put an end to the stop-gap measures. The question is not “should the SGR-based reimbursement program be remedied?,” but more, “how should the system be fixed?”

The hard pill to swallow is that any reasonable ‘fix’ will require hundreds of billions in taxpayer dollars. As a benchmark point of reference, implementing a simple ten-year freeze on Medicare reimbursement rates at the current level would cost approximately \$285 billion!

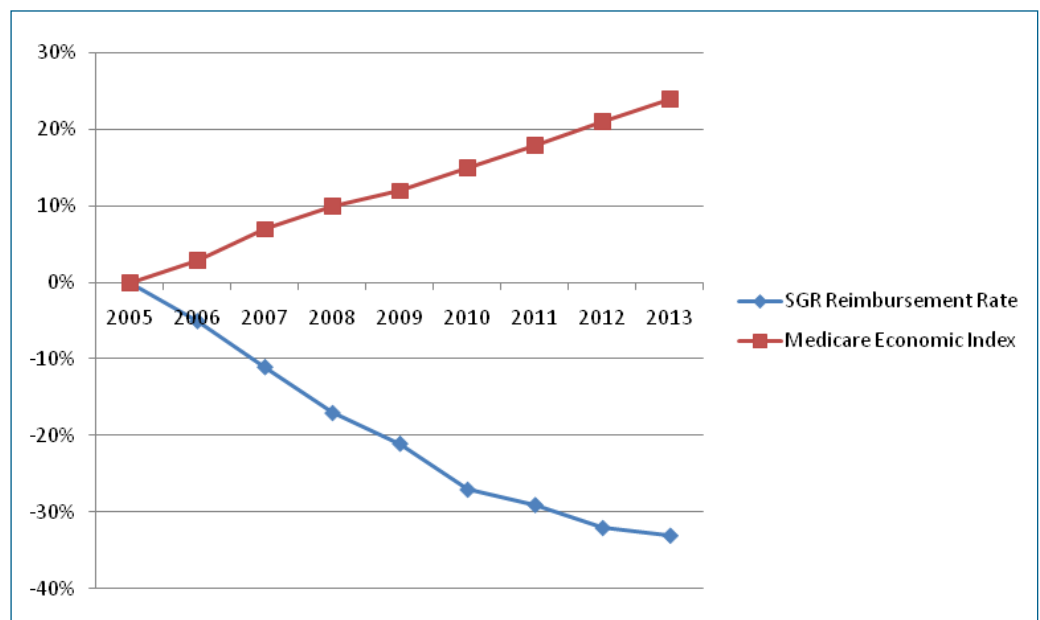
As a component of President Obama’s push for meaningful healthcare reform in the United States, several options are currently under consideration to restructure the Medicare payment program: (1) the first option would update the fee schedule by 1% in 2010 and 2011 and by 0% in 2012. The calculations under the SGR system to determine updates would then revert to the current law for 2013; and (2) the second option would have the same schedule of updates for 2010-2012 as under Option 1, however, once the update calculation reverted to current law SGR for 2012, a floor of -3% would be in effect. Beginning in 2014, the fee-schedule updates for localities with 2-year average fee-for-service growth rates at or greater than 110% of the national average would have a -6% floor. From the vantage point of the healthcare practitioner, neither of these scenarios is particularly appealing. Also consider that as a separate piece of the sweeping healthcare reform package, Congress is contemplating a widely-popular notion of a ‘public plan option’ wherein every citizen of the United States shall be afforded some measure of health insurance even if that is provided by the federal government. If the reimbursements for this public option are based on extension of Medicare rates, and Medicare severely underestimates the cost of medical care (through the SGR formula), then adding at least 46 million more Americans into a system that under-funds providers will have cataclysmic results.

Simply stated, any new formula utilized to set the reimbursement update should reflect the ‘real-world’ cost of providing care to Medicare beneficiaries rather than the gross domestic product (GDP) that is currently used as a measure of inflation. One potential method would be a reimbursement system based on the Medicare Economic Index (MEI), a measure of inflation faced by physicians with respect to their practice costs and general wage levels. The MEI includes a bundle of inputs used in furnishing physicians’ services such as physician’s own time, non-physician employees’ compensation, rents, medical equipment, etc. The MEI measures year-to-year changes in prices for these various inputs based on appropriate price proxies. As such, this index is a fairly accurate measure of healthcare costs. However, the MEI’s current role in establishing reimbursement levels is overridden because the SGR uses the GDP as an additional factor for measuring inflation.

As Congress contemplates mechanisms by which to reform the Medicare payment system, several problematic components of the current system must be addressed:

1. The SGR system adjustments are cumulative over the life of the system instead of from year to year, which makes it nearly impossible to recover from even one year of negative correction if that year’s actual expenditures exceed the target. Under this mechanism, if in one year the expenditure target was set too low, or if actual spending was too high, it will have an ongoing effect on reimbursement rates. On the other hand, if the actual costs exceed the target, future targets are not adjusted but instead reimbursements are cut in an effort to bring spending back under the level set by the target.
2. Changes in law and administrative regulations, including national coverage decisions that increase demand for healthcare services are not appropriately reflected by changes in the expenditure target. Each year, new benefits are added to the Medicare program and the increased costs to provide these added services should be reflected in the expenditure target.
3. If healthcare providers are to be held accountable to an expenditure target, then there must be a fair, accurate, and transparent way of determining the expenditure target in advance.
4. The population of the United States is getting older and sicker, and yet the Medicare fee-for-service fails to take this into account. When setting the expenditure target, CMS only considers the number of enrollees in the Medicare system, not the types of diseases from which they suffer and other factors that influence healthcare consumption.

The American Society of Anesthesiologists (ASA) continues to advocate for Congress to repeal the SGR formula and to find a system that reflects increases in healthcare practitioner costs. Specifically, the ASA urges a complete replacement of the SGR by 2015 and concomitant positive updates in reimbursement rates from 2010-2015 set by statute and linked to the aforementioned MEI for each year until a replacement takes effect. As employed mid-level anesthesia practitioners, AAs must take an active role with both our ASA colleagues and our elected Congressional representatives to ensure a stable and predictable Medicare reimbursement policy.



Historic Events for the AA Profession, *from page 7*

of Anesthesiologist Assistant Program Directors (AAAPD), American Society of Anesthesiologists (ASA), and the American Board of Anesthesiology (ABA). The goal of bringing these groups together is to build a framework for engagement that respects the integrity of the independent missions of each organization, but provides a forum for collaboration and support to meet the common goal of maintaining core values and standards in practice and education. Through this collective, the AA profession can more effectively develop the means to assure that its high standards are maintained and the expectations of the public are properly met.

May

Though a growing delegation from the AAAAA has been attending the annual ASA Legislative Conference in Washington DC, 2009 marks the first year that an ASA Educational Member has been featured on the State Issues Panel to discuss AA legislative initiatives. This support is just one example of the interest within the ASA to gain insight on the

experience the AAAAA leadership has collected from every attempt at AA licensure, and the growing recognition that the AAAAA can play a valuable role in this area.

The AAAAA gained recognition by the American College of Surgeons by acceptance to the Committee on Perioperative Care's list of recognized health care organizations, and for the first time, sent a representative to participate in a meeting in Chicago.

The AAAAA plans to follow through on the promise of each of these historical developments, and to continue to break ground wherever possible. With your support, the stature of the AA profession will continue to rise. None of this would be achievable without a strong AAAAA, and such progress is unsustainable without your willingness to join those who are already engaged. Support your profession with dollars and volunteerism through the AAAAA. Your future depends on it.

Professional News

NCCAA Update

Donald Biggs

Chairman, National Commission for Certification of Anesthesiologist Assistants

This is the first of what is planned to be ongoing periodic updates to the AA community on the activities of and changes within the NCCAA.

In January of this year the leaders from the NCCAA met with leaders of the AAAAA to discuss overlapping issues of the two organizations regarding the future of AA practice. At that meeting the AAAAA graciously agreed to use its resources to survey their membership, on behalf of the NCCAA, regarding the interaction of the NCCAA and AAs. The AAAAA provided the NCCAA with an excellent breakdown of the survey. On behalf of the NCCAA I thank the AAAAA and all participants in the survey.

The results of the survey have been incorporated into the model of the new business plan the NCCAA will undertake this year. I believe this new business model will resolve many if not all of the concerns

expressed in the survey. A major goal of the plan is to provide a broader range of communication avenues and more timely communications between the NCCAA and AAs.

After the new business model is in place, the NCCAA will look toward revising its Bylaws in an effort to respond to the ever increasing number of AA practitioners and the expansion of AA practice into a greater number of states and a greater interest in AA practice within the anesthesiology community.

In April of this year the NCCAA participated in a Cross Organizational Summit that also included the AAAAA, ASA, ABA, ARC-AA, CAA-HEP and the AAAPD (Association of AA Program Directors). The broad reaching agenda included topics relative to the education, certification, employment and practice of AAs. The NCCAA looks forward to participating in such meetings in the future.

As the last item in this update, the NCCAA has accepted the offer from the AAAAA to have representatives available at future AAAAA annual meetings for updates and Q and A sessions.

I wish to personally thank all stakeholders in AA practice for their continued support of the education, certification and employment of AAs.

Students' Column

Clinical Instructors' Educational Workshop

Jeffrey R. Hall, AA-S

Vice President, Class of 2009 NSU SEC

Like many other AA students, I attended the 33rd Annual AAAAA Conference in Clearwater with a desire to improve my knowledge of anesthesia. Unlike other students though, I had the pleasure of attending the clinical instructors' educational workshop on Sunday, April 19, led by Shane Angus, AA-C and Joe Mader, AA-C. After hearing about this workshop, I expressed a desire to attend because I knew that if all goes well these last few months, I could potentially be instructing AA

students in the clinical setting very soon. Many AAs do not have formal training in education, yet they are called upon to train and instruct students along their path to graduation, and it is for this reason that this workshop was developed.

Within the workshop, methods of clinical instruction were discussed with the main goal being the success of the student. A lesson pertaining to Bloom's Taxonomy, specifically the cognitive domain, was discussed with the purpose of challenging the participants' perioperative "pimping" abilities. Like many students, hearing the word "pimp" in this context

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Students' Column

Getting Involved

Natasha Ivey, AA-S
Student Representative, Chair
Nova Southeastern University

The Annual AAAA Conference took place in Clearwater, Florida this year. This five-day conference served as a relaxing atmosphere to join other friends and peers, but most importantly a place to gain a vast amount of information and knowledge about the profession and the organization. Beginning on Saturday with seminars discussing anything from trauma to clinical instructors' training, and then ending with a fun tournament of golf to raise money for charity, there was a great opportunity for education and fun.

One thing that was of particular interest to me was the involvement of students. As students, many assume that there is little involvement needed or wanted of us. This assumption was disproved quickly during the conference. Students are the lifeline of the AAAA organization, as stated

by the president, Deborah Lawson, and president-elect, Pete Kaluszyk. The AAAA is advocating that students not only become involved, but also to stay involved once their matriculation has ended. It is essential to the organization and the profession that students become involved in the political process and all affairs dealing with the profession.

So I am writing on behalf of the AAAA and the profession urging you to become involved. Whether it is on a political, educational, or professional level, we serve as an indispensable source of life to our organization and profession. The AAAA is looking for students to volunteer their time and provide any contribution that would be beneficial for years to come. All ideas for the improvement of the conference and the profession are welcomed. As incoming Chair of the Student Representatives to the AAAA, I am making myself readily available to you for concerns and ideas. If interested, please notify your AAAA student representative for information as well.

My Journey

My AA Journey

Keisha C. Ashley, AA-C

Late spring is my favorite time of year in Madison, Wisconsin. The sun is out, the tulips are blooming, and I can finally pack away my winter coat. The best part about it is that everything seems so fresh, and all of a sudden it is hard to even imagine that there was such a long, cold winter. I feel like I am in the spring season of my AA journey because everything is fresh and there are so many opportunities ahead.



My AA journey began only a few years ago. I had graduated from the University of Wisconsin-Madison with a double major in Life Science Communications and Nutritional Science and was working for the Population Health Improvement Department at the UW Medical Foundation. After a few months of working on several grant projects with clinicians in various fields throughout the UW Health system, I decided that I wanted to pursue a career in clinical medicine. While researching various options like medical school, PA school, and other allied health professions, my husband read about the AA profession. Soon, I was shadowing one of the AAs at UW Hospital and Clinics and filling out my applications. The sunny south Florida beaches and the prospect of being in

the first class of the Nova Southeastern University AA program made my husband and me make the move across the country.

During our time in Florida, I made some great friends, spent some wonderful lazy afternoons at the beach, but mostly ate, slept, and breathed anesthesia. And, just like a warm spring day makes winter feel so long ago, it's hard to believe that just one short year ago I was reading and reviewing as much material as I could to get ready for the certification exam. Now, my husband and I are back in Madison, and I am working at UW Hospital and Clinics. Despite having a rough time getting re-acquainted to the harsh winter, we are happy. Spring means new life and new opportunities. Working at a large academic hospital has given me the opportunity to continue my learning and grow as an anesthetist by working in the inpatient and outpatient ORs, as well as the new pediatric hospital. I now have a job that I enjoy that allows me to enjoy life...especially on a warm spring afternoon.

TELL US ABOUT YOUR JOURNEY.

E-mail your story and a photo to Newsletter Co-Editors
Tiffany Lewis-Roberts (tiffy131@hotmail.com)
or Alyson Finamore (alyson715@hotmail.com)

Clinical Instructors' Educational Workshop – continued from page 13

instantly made me break into a sweat, but only for a moment, because I knew these questions would not be directed at me. Without going too far in depth, the cognitive domain contains a hierarchy of six levels from which questions could be developed, with knowledge being the simplest form of a question: knowledge, comprehension, application, analysis, synthesis, and evaluation. A primary goal of the workshop was for clinical instructors to push their level of questioning into more complex realms, with an interest in ultimately improving students' clinical competency.

Overall, I found this workshop to be very informative, and I am interested to see where it goes from here. There are many questions that clinical instructors have, that other clinical instructors may be able to answer. Sitting in a small room with AAs representing every program, it was great to see the amount of concern and desire to be better clinical instructors, all for the benefit and growth of the AA profession. For the 34th Annual AAAA Conference in Savannah, Georgia, as long as space permits, I would encourage more practicing AAs, as well as students, to attend this workshop.

Program Update

Case Western Reserve University

Joseph M. Rifici, AA-C, M.Ed.

The anesthesiologist assistant program at Case turns 40 in 2010. In 1969, Joachim S. Gravenstein, M.D., brought with him to Case the concept for the program, and it was formally approved by the university in 1970. We are saddened by the fact that Dr. Gravenstein passed away several months ago. His legacy lives on within every AA from Cleveland and around the country.

We are preparing this year for our ruby anniversary by celebrating our program's past, and recognizing its achievements and challenges over the past four decades. As we look back on our accomplishments during our program's history, we invite our alumni to share with us their memories and join us in our celebration.

We will celebrate the Class of 2009 at our Honors Dinner on May 16, the evening before commencement. Some of the states where our graduates have received jobs are Texas, Georgia, Washington D.C., and Ohio.

This year our student body has honored four clinical instructors and faculty with awards, which will be presented at our Honors Dinner. Shawn Duvall, AA-C, and Dave Zagorski, AA-C, will be receiving Outstanding Clinical Instructor awards. Michael Altose, MD, has been named Outstanding Attending, and Jafer Ali, MD, Outstanding Resident.

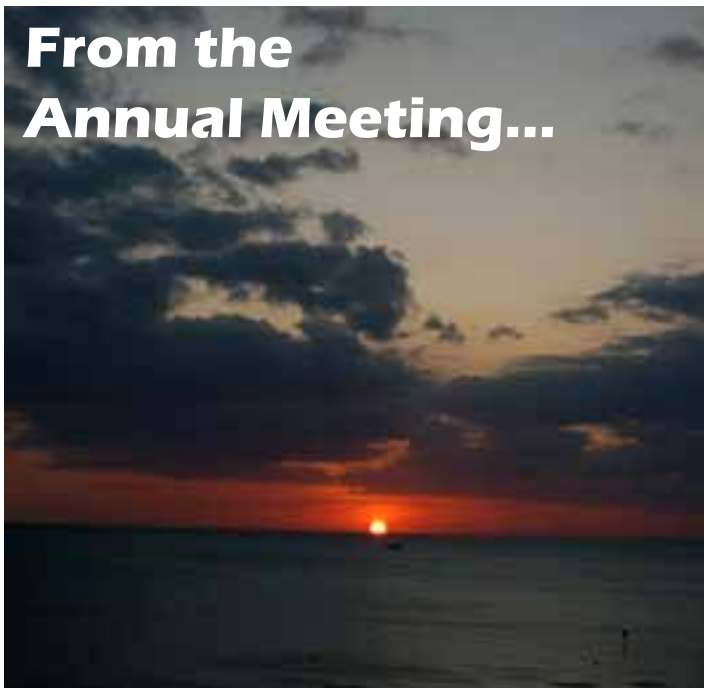
Twenty-four of our 27 students attended the AAAA Annual Conference in Clearwater this April, and feedback from our students has been overwhelmingly positive. We would like to thank Christen Donohoe and Jenna Saraniti, our second year AAAA student representatives, for representing our program this year and heightening awareness of our profession among our student body.



Case Western Reserve University Jeopardy teammates Erin Bodnar, Colleen O'Malia, Kim Vuong contemplate an answer during the competition at the AAAA Annual Meeting.

We welcome an incoming class of 15 students on June 1. Our new class is very strong academically and brings with them an average combined MCAT score of 25.9, an average overall GPA of 3.47, and an average science GPA of 3.65. As we welcome our new class, we send our congratulations to our graduating students, all of whom have completed and passed their certification examination. We expect nothing less than great things of them in their future careers.

From the Annual Meeting...



Left: The famous Clearwater Beach Sunset. Above: ASA President-Elect Alexander Hannenberg, MD addresses Quad A attendees.

For more photos, check out the Annual Meeting Photo Gallery!

Calendar of Events

June 18 - 21 – Asheville, NC

Carolina Refresher Lectures 2009: Care of the Surgical Patient. Sponsored by the University of North Carolina at Chapel Hill School of Medicine.

June 26 - 28 – Palm Beach, FL

Florida Society of Anesthesiologists (FSA) 2009 Annual Meeting. For event details, go to www.fsahq.org.

June 27 – Nationwide Testing Centers

NCCAA Certification and Continuing Demonstration of Qualification (CDQ) Examinations. For more information, particularly on timelines, go to www.aa-nccaa.org/Examinations.htm.

July 31 - Aug. 2 – St. Simons Island, GA

Georgia Society of Anesthesiologists' 2009 Summer Meeting. Information available at www.gsahq.org.

Aug. 21 - 23 – Dallas, TX

Oklahoma Society of Anesthesiologists Annual Meeting. Event details available at www.osahq.org.

Sept. 6 - 11 – Vail, CO

New Horizons in Anesthesiology. Designated for a maximum of 25 hours of AMA PRA Category I Credits by the Emory University School of Medicine. Online brochure and registration available at www.med.emory.edu/CME

Sept. 10 - 13 – San Antonio, TX

Texas Society of Anesthesiologists 2009 Annual Meeting. Offering a wide array of anesthesia topics. For more information, go to www.tsa.org.

Sept. 11 - 13 – Sheboygan, WI

Wisconsin Society of Anesthesiologists Annual Meeting. For details, go to www.thewsa.org.

Sept. 12 - Seattle, WA

Washington State Society of Anesthesiologists Fall Scientific Meeting. Details available at www.wa-anesthesiology.org

Oct. 17 - New Orleans, LA

Accreditation Review Committee for the Anesthesiologist Assistant (ARC-AA) Board meeting. For more information, go to www.caaahp.org

Oct. 17 - 21 – New Orleans, LA

ASA Annual Meeting. Go to www.asahq.org for more details.

Nov. 1 - 4 – Amelia Island, FL

15th Annual Advances in Physiology and Pharmacology in Anesthesia and Critical Care. Sponsored by the Department of Anesthesiology, Wake Forest University School of Medicine. ACLS and Peripheral Neural Blockade Workshops offered. Brochure and registration available online at <http://www1.wfubmc.edu/anesthesiology>.

2010

April 10-14 – Savannah, GA

AAAA 34th Annual Conference. Make plans now to attend!

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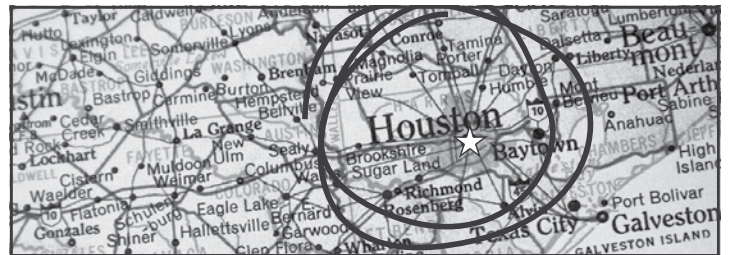
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contact: Sue Chrismer schrismer@waai.net or 636-386-9224 ext. 193

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