The Anesthesia Record

Third Quarter, 2009

The Newsletter of The American Academy of Anesthesiologist Assistants

*President's Message*

# It Takes a Village

By Pete Kaluszyk, AA-C

**Pete Kaluszyk, AA-C, M.Ed**
*AAAA President*

The AAAA leadership has recently been evaluating our progression as a professional society. The process included a review of our internal structure as well as our organizational process. Additionally, the AAAA initiated a cross-organizational summit with organizations supporting our educational, accrediting, and certification processes to collectively examine the need for additions or improvements. This summit included anesthesia-related organizations, and discussions regarding their relation and bearing on our profession took place. I will review some of these activities and why we need to further strengthen our "professional self" as AAs through the AAAA.

There has been a movement in medicine and its specialties, over the last decade, to reassess, redefine and rearticulate to their providers the established medical professional principles and values. Additionally, there is a movement to increase emphasis about professionalism in medical school and specialty training curricula. In essence, this movement's goal was to update physicians' perception of what professionalism means in the present. This reevaluation process resulted from the dramatic changes in medicine over the last 30-40 years resulting in major changes in medical economics, health care delivery issues, societal perceptions and expectations, and on scientifically-based advances in medical practice.

Well, what is a profession? Is being an AA a professional endeavor, or is it an occupation, or both? There are many, many occupations that are not professions but all professions are occupations. Professionalism has been a concept in medicine for the last two millennia since the age of Hippocrates. He is credited with elevating medicine from a practice of philosophy and rituals, to one more categorized based on patient observation, cataloging medicines, and on anatomical studies. Hippocrates' oath made the patient paramount in medical practice and created a profession. The resulting perception of professionalism more strongly connects health care practitioners to their patients in society.

A profession may be defined as one that has a group identity; a shared educational/training requirement for admission; a special uncommon knowledge, knowledge used in the service of others and having positive social need; that involves individual judgment, a degree of autonomy in decision-making; an adherence to certain values; penalties for substandard performance. To this definition, I would like to add the ability of a profession to encourage the well-being of their practitioners in order to better serve the patient, and establish relationships with other professional societies for the betterment of patient care. The AA profession, I feel, fits these criteria.

All Anesthesiologist Assistants have a shared educational experience and training based on CAAHEP and ARC-AA standards. During the educational and training track, AAs are given uncommon knowledge that has been developed and advanced by physicians and scientists over the last two millennia. We use this special knowledge and training to provide care to those that need anesthesia-related services.

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## In This Issue



**NEW!** Question & Answer feature begins on Page 9!

**The Anesthesia Record**
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*Editor's Column*

# New Question and Answer Segment Off and Running

**By Tiffany Lewis-Roberts, AA-C**
Co-editor

**Tiffany Lewis-Roberts, AA-C**

In an effort to ensure its members are informed, AAAA has started a new segment in the newsletter that we are truly excited about.

This new question-and-answer segment is in its beginning phases, and has already gotten a great response from our members. We encourage everyone to get involved with the AAAA, and one great way to get involved is to submit questions.

The best way to be an advocate for our profession is to be well informed. Knowledge is the most powerful tool, and chances are if you have a nagging question about something, it should be addressed to a broader audience to help us all become more informed.

So go ahead and submit that question. Every time the next deadline comes around for the *Anesthesia Record*, we will send out a reminder email to the membership to turn in questions for the next publication. And don't worry, if your question doesn't appear in the newsletter, it will be coming soon in a following newsletter.

We look forward to all your questions and to beginning this new segment on page 9 of this newsletter. Thanks again to all the AAAA leaders for their efforts in answering the questions thoughtfully and articulately.

# AAAA membership selects new logo

**By Pete Kaluszyk, AA-C**
President

I would like to announce that the voting by general membership has ended and the winning design for the AAAA logo is seen here. Both the Board of Directors and Executive Committees of the AAAA decided to open the voting for the design choice to the general membership. Since the logo represents your organization we felt this was the best approach. The logo change was necessitated by technical limitations in the old design. These limitations occurred after transference of the logo to printed material and electronic documents that resulted in degradation of the image. The new design will not have these technical limitations. I would like to thank all of you who voted on the design. We hope you like YOUR new logo.

## President's Message. from page 1

AAs' training allows us to carry out the anesthetic plan prescribed by our attending physicians. Even though we are dependent practitioners within the Anesthesia Care Team model, our training permits some level of autonomy. One example of this is in the decisions AAs make when assessing the anesthetic course with its ongoing physiologic changes. Our training allows us to recognize situations where notification of the attending is appropriate, such as when a less routine situation may impact the prescribed plan. Being dependent practitioners, we are subject to sanctions for substandard practice either at the employer level or through a state's medical board process. The ultimate authority of medical boards is given through the state by the will of the people. The AAAA has worked to establish productive relationships with other organizations involved in promoting safe delivery of anesthesia. The AAAA has worked tirelessly and is continuing to define our role in the anesthesia care team model and to promote the concept of an "AA self." The professional "self" is how the AA practitioner views themselves in their dependent role within the Anesthesia Care Team model. How the professional executes their responsibilities to patients and to their profession.

In terms of values and responsibilities, the American College of Physicians several years ago adopted their "Charter of Professionalism." The values include honesty with patients, patient confidentiality, appropriate relations with patients, improving quality of care, improving access to care, just distribution of care, commitment to scientific knowledge, managing conflict of interest, and striving to maintain competence and life long learning.

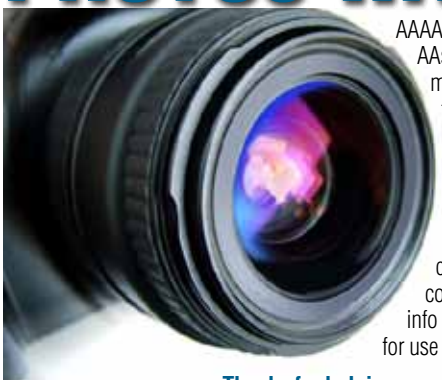
As a result of the cross organizational summit and need to further define professionalism and its values, a project was initiated that is headed by Deb Lawson AA-C to develop a set of competencies for training programs, and to lay the groundwork for the integration of the competency standards into practitioner assessment processes. The Competencies Project will cover medical knowledge, patient care, practice-based learning and improvement, systems based practice, professionalism, and interpersonal communications skills. Other allied health and medical specialties have instituted such standards. These competencies will be adapted for the way AAs practice.

Another initiative that the AAAA is undertaking is the Wellness project. Claire Chandler AA-C is heading up the project, with Ty Townsend AA-C as our liaison to the ASA and their newly initiated Wellness program. The concept of Wellness is becoming an important focus that many professional medical organizations are developing for their members. The Wellness concept has been adopted in many non-health care fields for their employees. Wellness is a broad spectrum program that will cover areas such as stress management, substance abuse, and nutrition. Last March, the AAAA met with members of the ASA and the AANA to discuss Wellness issues. The AAAA hopes to have a program or two related to Wellness at our annual meeting next year.

The AAAA initiated a work group to review our annual meeting. We examined the potential legal liabilities that a professional organization can incur in managing a meeting or being involved in extra-organizational activities. After a review it was decided that to further limit liability to the AAAA, we will increase our insurance to cover such contingencies. This modest increase in the premium will cover such organizational activities. A statement for leadership was adopted to clarify the role of leadership at official functions. We evaluated our management company's review process for conference contracts with convention facility providers. The work group made recommendations to the annual meeting committee to improve the professional aspects of our meeting. Recommendations were sent to the Association of Anesthesiologist Assistant Program Directors concerning the introduction of professionalism into the curriculum of training programs. These recommendations will probably resonate and support the Competencies Project's recommendations that will include the competencies' section related to professionalism.

Why are all these activities important? The values are important if we truly want to call ourselves professionals and have a profession and not simply an occupation. AAs are physician extenders and represent the anesthesiologist in carrying out our duties. Our AA "self", our professionalism, should reflect the core values of medicine and the way we function in the anesthesia care team model. Professionalism allows us to maintain this marvelous privilege to give care to patients who depend on us and exhorts us to do our best on their behalf.

# PHOTOS WANTED!



AAAA is in need of photos of working AAs to be used on various materials, such as postcards, flyers, etc., that promote the Academy.

**Want to help?**

Please e-mail photos of working AAs you'd like to contribute to ray@societyhq.com. Be sure to give your contact info so we can properly credit you for use of your photograph.

**Thanks for helping promote AAAA!**

# Looking for FAQs about anesthesia providers?

Please check out the ASA's link:

**http://www.asahq.org/providers/homepage.htm**

This link is now available on AAAA's website as well and is a great reference.

Inside AAAA

# AAAA Invited to FDA Meeting on Propofol

**Saral Patel, AA-C**
Chairperson, Bylaws and Ethics Committee

The AAAA was invited to participate in a stakeholders meeting sponsored by the Federal Drug Administration (FDA) on July 29th in Rockville, Maryland on the Safe Use and Handling of Propofol. This was a first ever meeting of multidisciplines to gather data and share information under the FDA's new pilot "Safe Use Initiative". Following the recent outbreaks of Hepatitis C in Nevada, the FDA has made the safe handling of Propofol a main priority. The goal was to gather different healthcare professionals to identify potential unsafe practices and provide mechanisms to enhance safety and promote safe handling of Propofol.

Representatives from major medical organizations including the American Academy of Anesthesiologist Assistants, American Society of Anesthesiologists, American Academy of Nurse Anesthetists, American College of Emergency Physicians, American Society of Health Systems Pharmacists, Society of Neurosurgical Anesthesia and Critical Care, Nevada State Medical Association, American Pharmacists Association, American Society of Gastrointestinal Endoscopy, American Gastroenterological Association, American College of Gastroenterology, and Association of PeriOperative Registered Nurses were given the opportunity to voice their concerns on the preparation, administration, and disposal of Propofol.

Discussion concerning the preparation of Propofol identified major breeches in aseptic technique by healthcare professionals. Collectively, the group prioritized the need for a universal standard of practice on the preparation of the drug. This will include a clear definition of aseptic technique along with a definition of "single use". The misunderstanding stems from a broad interpretation of a single use drug being packaged to look like a "multi use" vial (50 or 100 mLs). Also, Propofol is commonly assessed multiple times. However even under the strictest aseptic technique, each introduction of a needle could potentially cause a contamination. Therefore, the FDA will be exploring the need to revise labeling of the drug to clearly define "single draw, single use, single patient". Syringes must also be correctly labeled to include date, time and initials. It was concluded that there is a great need to educate all healthcare professionals present during the actual administration of the drug.

The cross organizational meeting provided a forum for multiple specialties who use Propofol to convene and give recommendations to improve the safe handling of Propofol. In the future, the FDA along with the Centers for Disease Control will be looking closely to promote safe practices of various drugs. Propofol has become a "hot topic" in the news, and thus has been selected as the pilot for the FDA's "Safe Use Initiative". It was a great opportunity for the AAAA to be on equal footing along with the other medical organizations. We were given an opportunity to voice our opinion and concerns on such a critical matter that directly affects our profession. The AAAA's "Statement on Use of Propofol by Non-Anesthesia Personnel" can be found on our website www.anesthetist.org.

# Second AAAA Representative Needed to Serve on Health Professions Network

**By Ellen Allinger, AA-C**
National Affairs Committee Chairman

The AAAA has need of a second representative to the Health Professions Network (HPN).

As a recognized representative, this person will join Leslie Dean Petosa, AA-C, in representing the AAAA within this association. The AAAA's Health Professions Network representatives are part of the National Affairs Committee and report directly to its chairman. These representatives attend two yearly HPN meetings (spring and fall) and are the primary conduit of information from HPN to the AAAA that may benefit the AA profession.

The Health Professions Network is a group of health care professionals who represent the diverse specialties of allied health professions, including provider organizations, educators, accreditors, credentialing agencies and administrators. The group works together in a cooperative and interactive manner on issues relevant to workforce development and the delivery of health care in the United States.

The mission of the Health Professions Network is to provide a forum for collaboration among health care professions on issues of common interest. The Health Professions Network will accomplish this mission through:

- Identifying issues of common interest
- Communicating these issues to all participants
- Seeking consensus and facilitating responses
- Advocating on behalf of health care professionals to the public, professional associations, federal and state policy makers

For more information on HPN, go online to their website at www.healthpronet.org. If interested in becoming a representative, please contact Ellen Allinger, AA-C, at allinger@comporium.net.

Professional News

# National Affairs Committee Update

**By Ellen Allinger, AA-C**
National Affairs Committee Chair
And
**Mike Nichols, AA-C**
National Affairs Committee Vice-chair

**Ellen Allinger, AA-C**
National Affairs Committee Chair

**Mike Nichols, AA-C**
National Affairs Committee
Vice-Chair

## National Activity

**H.R. 3200**

At the time that this article was written, Congress has just recessed for the summer, and the only item on the nation's radar is the continuing debate over healthcare reform. The following is an Advocacy Update from the American Medical Association on the amendments made to H.R. 3200 by the House Energy and Commerce Committee just prior to the Congressional recess.

ADVOCACY UPDATE
August 1, 2009
House Energy and Commerce Committee Concludes Health System Reform Mark Up

The House Energy and Commerce met throughout the day on Friday to mark up H.R. 3200, the "American Affordable Health Choices Act of 2009," completing its work at 9:00 p.m. last night. The bill was approved by a vote of 31 to 28, with five Democrats voting against it.

The long anticipated Blue Dog agreement was adopted late in the day as an amendment offered by Rep. Mike Ross (D-Ark.). Highlights of that agreement include:

- Public Plan Option: Requires the Secretary of Health and Human Services (HHS) to negotiate payment rates in the public plan, so that they would not be lower than Medicare or higher than the average rates paid by private plans in the Health Insurance Exchange. Requirements for physicians and other providers to opt-out of participating in the public plan are specified.
- CO-OP: Establishes a Consumer Operated and Oriented Plan (CO-OP) program, through which grants and loans will be made for the creation and initial operation of not-for-profit, member-run health insurance co-ops that provide insurance through the exchange.
- Subsidies and mandates: Those who are offered insurance by their employers would be ineligible for subsidies (affordability credits) in the exchange unless their premiums equal more than 12 percent of their income. More small businesses would be exempt from the pay-or-play mandate.
- Medicaid: Reduces federal responsibility payments (FMAP) for required Medicaid expansions from 100 percent to 90 percent beginning in 2015.
- End-of-life planning: Provides for dissemination of information on end-of-life planning by qualified health benefits plan (QHBP) entities, including option to establish advanced directives and physicians' orders for life-sustaining treatment. Specifies that the QHBP entity shall not promote suicide, assisted suicide or the active hastening of death (consistent with state law) and that the information shall not presume the withdrawal of treatment. Prohibits promotion of assisted suicide.
- Center for Medicare and Medicaid Payment Innovation: A Center for Medicare and Medicaid Payment Innovation would be established to test the effect of payment models on spending and quality of life under the Medicare and Medicaid programs. The Secretary may implement the model on a nationwide basis if it improves quality without increasing spending and/or reduces spending without reducing quality.

Descriptions of other amendments of interest that were considered yesterday follow. (The list is not exhaustive.)

- Public health plan: Rep. Cliff Stearns (R-Fla.) successfully offered an amendment that would prohibit taxpayer bailouts to subsidize the public plan. An amendment offered by Rep. George Radanovich (R-Calif.) that would have required the public plan to be subject to state taxes and other requirements was defeated. An amendment by Rep. Joe Barton (R-Tex.) was rejected that would have, in lieu of a public health insurance option, expanded state reinsurance programs and state high risk pool programs for those with pre-existing or other high risk conditions, and an amendment by Anthony Weiner (D-N.Y.) was withdrawn that would have established a single payer health care system.
- Medical liability reform: Rep. Doyle (D-Pa.) offered and the committee adopted a block of amendments (not available for review this morning) that included language drafted by Rep. Bart Gordon (D-Tenn.) that provides financial incentives to states that enact certificate of merit and/or early offers programs in medical liability cases.
- Health savings accounts: An amendment to clarify that health savings accounts are qualified health benefits plans that may be offered

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through the Health Insurance Exchange, sponsored by Rep. Michael Rogers (R-Mich.) was defeated.

- Insurance reforms: An amendment by Rep. Betty Sutton (D-Ohio) was adopted addressing limitations on preexisting condition exclusions in group and individual coverage. The committee rejected an amendment by Rep. Steve Buyer (R-Ind.) that would have allowed providers and health insurers to offer premium discounts, rebates, or modified copayments or deductibles to individuals who participate in health promotion or disease prevention programs.
- Health Benefits Advisory Committee: An amendment by Rep. Greg Walden (R-Ore.) was adopted that would require at least 25 percent of the members of the Health Benefits Advisory Committee to be health care practitioners who practice in a rural area and have done so for at least the previous five years. It also requires that the proportion of Medicare Payment Advisory Commission members who represent rural providers be proportional to the total number of Medicare beneficiaries who reside in rural areas.
- Medicaid and CHIP: Rep. Zack Space (D-Ohio) sponsored an amendment, which was adopted, that prohibits payments under Medicaid and the Children's Health Insurance Program (CHIP) for undocumented immigrants. An amendment by Rep. Lois Capps (D-Calif.) was adopted that would eliminate copayments for certain Medicaid preventive services. Rep. Eliot Engel (D-N.Y.) successfully offered an amendment to ensure Medicaid coverage of non-emergency transportation to medical necessary services. An amendment by Rep. Peter Welch (D-Vt.) was adopted that would allow a limited exception to the maintenance of effort requirement for Medicaid. An amendment by Rep. Anna Eshoo (D-Calif.) was adopted to clarify Medicaid coverage for citizens of freely associated states (Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau). Another amendment authored by Rep. Donna Christensen (D-V.I.) that would have increased Medicaid payments to the U.S. territories was withdrawn.
- Medicare benefits: Rep. Gene Greene (D-Tex.) offered a block of amendments, all of which were adopted, addressing certain Medicare benefits. One amendment addressed payment for post-mastectomy external breast prosthesis garments. A second amendment adds "presence of impairments" to the assessments for patient-centered and population-based quality measures. The Greene amendments also require the HHS Secretary to report to Congress on Medicare barriers to abdominal aortic aneurysm screening and other preventive services approved by the U.S. Preventive Services Task Force. In addition, the Secretary would be required to make the education of physicians and patients about the risk factors for abdominal aortic aneurysm a priority.
- Medicare payments: An amendment by Rep. Ed Whitfield (Ky.) was adopted to place a moratorium on Medicare payment reductions for several interventional pain management procedures covered under the ambulatory surgery center fee schedule.
- Pharmaceuticals: An amendment by Rep. Bobby Rush (D-Ill.) was adopted that would prohibit current settlement agreements between brand-name and generic pharmaceutical companies where brand companies pay a significant sum to the first generic company that files to challenge the brand company's patent. The Federal Trade Commission would be conferred with enforcement authority to regulate such agreements. Another amendment, offered by Rep. Anna Eshoo (D-Calif.), was adopted that would confer the FDA with authority to establish an abbreviated pathway to approve biosimilars for market.
- Affordability and cost containment: Amendments offered by Rep. Janice Schakowsky (D-Ill.) and Tammy Baldwin (D-Wis.) were adopted to require savings generated through various provisions in the bill to be used to make premiums more affordable for lower income people in the exchange. The amendment offered by Rep. Baldwin would also require the Secretary of HHS to adopt operating rules for specified electronic transactions and to establish a unique health plan identifier system, and would mandate the use of electronic funds transfers under Medicare by 2015. An amendment by Rep. Phil Gingrey, MD (R-Ga.) that was rejected would have required the Secretary to develop a methodology that ensures that any savings to Medicare resulting from the Medicaid and Medicare Improvements included in the bill and amendments shall be used solely for the purpose of improving the affordability of health care for Medicare beneficiaries.
- Physician hospital ownership: Rep. Joe Barton (R-Tex.) offered and withdrew an amendment that would have struck the bill's restrictions on physician-owned hospitals. After considerable discussion, Committee Chairman Henry Waxman pledged to work with Rep. Barton to develop compromise language for later incorporation into the legislation.

To view all the amendments offered during the committee debate, visit http://energycommerce.house.gov.

The Energy and Commerce Committee is the third panel in the House to mark up H.R. 3200. Over the August recess, the three committee products will be combined into a single bill for consideration on the House floor.

For the latest developments on health system reform legislative activities and AMA advocacy efforts, please go to www.ama-assn.org/go/reform.

HR 3200 continues to meet hurdles and with each one gets further and further away from the ideals that President Obama has laid out in his vision for health care in this country. The bill has been reported out of all three committees of jurisdiction in the House (Ways & Means, Energy & Commerce, Education & Labor), largely along party lines, though its report from Energy & Commerce was under the compromise with the Blue Dog Coalition (a 52 member group of fiscally conservative Democrats). In appealing to the Blue Dogs, the bill may have compromised the support from the far left Democratic base.

Legislators continue to feel the 'heat' of a concerned citizenry as we see images on CNN and Fox News about health care town hall 'meetings gone wild'. Under particular pressure are those same members of the Blue Dog Coalition, which we may see lead to further amendments and alterations to HR3200 prior to its full floor vote.

The Senate HELP (Health, Education, Labor, & Pensions) Committee

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has reported a health care reform bill as well as the HR 3200. The HELP bill includes much of the same language as the HR 3200 including a public option, but the reimbursement rates were negotiable through the DHSS not tied to Medicare constructs. This is essentially the same 'fix' that is reflected in the current House legislation as well.

The Senate Finance Committee (under the leadership of Max Baucus from MT and Chuck Grassley from IA) has been working on legislation that is set to be presented immediately after the August recess. This bill will most likely have the most favorable language for anesthesiology and the highest likelihood of bipartisan appeal.

Keep in mind that the Senate Finance Committee has to report its bill yet, which is being worked on by the so-called 'Gang of Six' (Baucus, Grassley, Snowe, Enzi, Bingaman, and Conrad). Since the HELP Committee is a subcommittee under Finance, the variations between the two bills will have to be ameliorated before being reported for a full Senate vote. Though the Senate Finance bill is likely to contain language most palatable for anesthesiology, it will have to pass muster with the full Senate, negotiate a favorable response during reconciliation with whatever the House comes up with, and then ultimately be passed by both houses of Congress again before being signed into law by President Obama. Short story…we're nowhere near the end of this ordeal.

**H.R. 2204**

The Medicare Access to Rural Anesthesiology Act of 2009 (H.R. 2204) seeks to amend title XVIII (Medicare) of the Social Security Act to provide payment under Medicare part A (Hospital Insurance) on a reasonable cost basis for anesthesia services furnished by a physician who is an anesthesiologist in certain rural hospitals in the same manner as payment is made for anesthesia services furnished by a certified registered nurse anesthetists in such hospitals. This bill, introduced April 30, 2009, was referred to the House Committee on Ways and Means, has not seen further action.

Both "Rural Pass-Through" (HR 2204) and Healthcare Truth & Transparency discussion have been usurped by the healthcare reform issue and likely won't be considered until after this issue has been resolved. The ASA and the AAAA are still firmly afoot in support of these two measures, but like many others, they have taken a back seat as the nation's future health care provisions and payment matrices are considered.

## State Activity

At this time, there is no active AA state legislation. But, this does not mean that preparations aren't being made for future AA state legislative activity. The NAC has so far participated in the following actions to assist in future AA legislation preparations:

Utah

The Utah Society of Anesthesiologists is proceeding with a process to enhance the chances of the AA licensing bill's success in the next legislative session. It was suggested during the House floor debate of HB 269 that the bill should have gone to the legislative committee designed to review the validation of new occupations and professions in Utah. The USA has now initiated that process, which requires an application for the regulation of the AA profession to what is known as the Occupational and Professional Licensure Review (OPLR) Committee. Formed around 1998 , this special legislature committee is a mixture of three senators and three representatives (with no more than two from the same political party), four past members of any of the Division of Occupational and Professional Licensing (DOPL) advisory boards, and three members at large that are not licensed by the DOPL.

The application, which consists of 52 questions, was divided between the USA and the NAC. The two sections completed by the NAC took 32 pages, plus an extensive appendix was submitted with all current state statutes and rules and regulations pertaining to AAs. It is unknown at this time if the Utah OPLR Committee will meet prior to the 2010 Utah legislative session in order to review the application.

Maryland

When SB 798, the Maryland AA licensing bill, failed to pass the Senate Education Health and Environmental Affairs Committee, its chairman, Senator Carter-Conway, officially designated the bill for interim study. The bill's primary sponsoring organization, Johns Hopkins University, is currently working with the NAC on agenda items in briefing the committee members. The briefing is scheduled to be held in December of this year.

## AA Advocacy

The Grassroots Lobbying/AA Advocacy section of the AAAA website is fully functional. Members should take advantage of and make use of the information posted there, particularly the AAAA Advocacy Manual.

AA advocacy goes beyond contacting politicians and organizing and participating in political fundraisers. Every AA and student AA has the opportunity to be an advocate for the profession. It can be as simple as always introducing yourself to patients and to those with whom you work as an AA. Or, it can take on a more active role such as speaking to college students about the AA profession, becoming a member of the state medical board committee that reviews AA applications and AA rules and regulations, or being an active member in other healthcare organizations such as the Health Professions Network. The possibilities are endless. Find what interests you. Then get involved. This is the combination that makes for the most successful advocacy.

## Professional News

# Medicare Reimbursement For AAs Threatened in NC, Then Saved

**By Megan Varellas, AA-C**

Your future income will be affected for better or worse by health care reform. Every party affected is rushing to get a seat at the table where health care reform is being decided. How do you get a seat at the table so that your voice may be heard? The short answer is lobbying. This is what AAAA and ASA do all year long on your behalf by staying on top of every issue and maintaining working relationships with both state and federal legislators.

Recently, included in a list of unprecedented cuts to North Carolina's State Health & Human Services budget, House Appropriations leaders proposed eliminating all Medicaid funding for AAs in NC. This proposal was raised by legislative staff as part of a broader overview of all new Medicaid expenditures authorized by the General Assembly over the last 2 years. When the NCSA (North Carolina Society of Anesthesiologists) learned of this, they moved quickly to explain the inequities created by completely eliminating reimbursement for one class of mid level provider. House leaders realized that this cut would not save money, but would only redistribute it to other mid level anesthesia providers. Medicaid funding for AAs was restored within 24 hours of this potentially devastating cut. Thanks to the long standing working relationships the NCSA has with legislators, we had our seat at the table, without a wait.

Why should this concern you if you don't work in NC? Your state may be next, as all states are reporting budget shortfalls and health care reform has become a top priority in our country. If you know an AA that isn't at least supporting AAAA and ASA with membership dues, then you know why your voice may not be heard when an issue surfaces that directly impacts your career and income. AAAA and ASA can only be as effective in politics as their membership numbers allow them to be.

What can you do to help?

1. Recruit your coworkers to join AAAA
2. Learn the issues anesthesiology and AAs are facing at www.asahq.org
3. Check out the grassroots lobbying section at www.anesthetist.org

# New Mexico: Gateway to the West

**By Kevin M. Hall, MHS, AA-C, PA-C**

On Saturday May 18, 2009, the Anesthesiology Assistant (AA) staff at the University of New Mexico Health Science Center had dinner and discussion about the current status of licensure for AAs in New Mexico, what is the overall feeling about AA clinical practice at UNMHSC and the Anesthesiology Assistant Student Clerkship Program (AASCP).

Chad Marchand, MSA, AA-C, started the discussion with an outlook of national, regional and state events related to the AA profession in general. He spoke about previous bills submitted in the states of Maryland and Utah, which ultimately did not pass. Chad also noted that the American Academy of Anesthesiology Assistants (AAAA) would let the membership in New Mexico know if there would be a need to help with any future legislation that would be submitted by the state of Utah.

The group added that New Mexico would be available to assist Colorado and Texas if they were attempting to submit legislation for AA licensure in the future as well. Lastly, the remainder of his discussion was about House Bill 536, tabled in the House Subcommittee and his thoughts on what would help our chances for passage of the bill in the future.

Next, Jake Menke, MMSc, AA-C, spoke about where we are and where we want to go as a group. It was agreed by the group that everyone should have membership in the American Society of Anesthesiologists (ASA), AAAA and the New Mexico Society of Anesthesiologists if we were to seek support from each of these organizations for unrestricted licensure in the state of New Mexico.

Currently, AAs are only allowed to practice at UNMHSC. Unrestricted licensure also provides the AA staff with the same bargaining power as our Certified Registered Nurse Anesthetist (CRNA) colleagues, which includes the right to work where each AA would like, consideration and creation of mid-level leadership positions and improving current benefit structure.

The group recommended a grassroots effort to allow for starting new relationships with local and statewide House and Senate members, which would improve chances for passage of a newly submitted bill. We came away noting that each member of the group has to be accountable to the group, in helping with the efforts in seeking unrestricted licensure within the state of New Mexico.

The last discussion of the night was presented by Kevin Hall, MHS, AA-C, PA-C. The topic was on the AASCP, which has been transformed to seek AA students from the five state Southwest region (Texas, Oklahoma, New Mexico, Colorado and Arizona) much the same as state universities seek undergraduate candidates from their own states.

This has succeeded in having nine of the 12 AA students have lived or have primary relatives in the Southwest region. The AASCP will have a one week continuous rotation of the General OR, Pediatrics and evening/night shift. AA students will also spend three days in the preoperative clinic learning how to evaluate patients, navigate the charts for information related to history and physical examination and improving their clinical mastery of the subject matter. Ideas about Ob/Gyn, PACU and ICU were nixed to help streamline the learning objectives for the AA student.

Overall, the discussion was a huge success and now we will have to implement these ideas for the betterment of AA practice within the state of New Mexico.

## Questions and Answers – Submit your questions to tiffy131@hotmail.com or afinamore@metrohealth.org

**Q How can the AAAA take a more active roll in encouraging the Georgia training programs to significantly increase their "out of state" matriculation?**

Short of strong-arm tactics, how can the AAAA take a more active roll in encouraging the Georgia training programs to significantly increase their "out of state" matriculation? It would be a huge benefit to the AA community to have AA students coming from states with a small AA presence rather than continuing to enroll a majority of AA students from Georgia. Most AA students from Georgia will want to stay in GA and continue to saturate this market.

(Strong-arm tactics could take the form of the AAAA encouraging AA-C's to no longer provide clinical training for a period of time, if the programs fail to recognize the impact of their enrollment policies.)

Kind Regards,
Blair Harris

**A** Your question is profound, but it deserves a salient answer. First, as I am sure you already know, the cause of the disproportionate number of AA practitioners in Georgia is multifactorial. There are two AA programs in the state, one of which has been graduating AAs since the early 1970s.

Georgia, like many other states south of the Mason-Dixon Line continues to grow in population. Atlanta is a boom town with many clinical practice opportunities, but eventually the market will become saturated and in fact, it probably already has. It is difficult to pry away AA graduates from Georgia. Even those who hail from other regions tend to stay. The jobs have been plenty and the pay has been significantly better than most regions in the country. And as we see in Ohio, there is significant flight of young professionals from the rust belt regions to the south. Those of you in Georgia have benefited from these demographic facts for a long time. Now it looks like the well is drying up.

In reference to marketing, the Georgia AA educational programs benefit from the fact that there are so many AAs in their own back yard. They certainly do not have to advertise very aggressively in their own state. I know for a fact that both Georgia programs do market nationally. But we still have to grapple with the fact that, even when new states open such as in Missouri, Florida and North Carolina, the job market floodgates do not suddenly blow apart. It is becoming more obvious that the right to practice afforded by passing a licensing bill does not necessarily allow the right to practice. The fact is that, until recently, it has been much easier to get a job as an AA in Georgia.

The educational programs are helping to debulk the glut of AAs in Georgia by continuing to craft clinical affiliation agreements with hospitals in other states. This is the best way for the programs to encourage their graduates to accept jobs in new regions. These elective rotations are essentially on-the-job interviews. Short of limiting the size of each matriculant class, a concept which has been and will continue to be hotly debated, any other intervention by the programs is unethical and inappropriate.

*Continued on page 10*

## The Students' Page

# Professionalism: The Essential Element

**By Natasha Ivey, AA-S**
Nova Southeastern University

Professionalism is far from just being a professional; it is a description that you would hope others would apply to you. If you want to look like a professional, it is important that you exhibit the characteristics to earn the title. Having a degree does not make you a professional. Demonstrating professionalism is what makes you a professional. Professionalism implies a sense of pride in work, a commitment to quality, and a dedication of interest.

Professionalism is a set of standards that are required for the way a person carries themselves. As students, it is imperative to learn professionalism early in the education process. When associated with an organization and educational program, it is appropriate to be mindful of how we represent them. Our behavior not only represents our profession and respective schools, but also our peers. As we travel, it is vital to the growth of our profession that we exhibit appropriate behavior. Over the last forty years, there have been great ambassadors that have paved the way for the different programs and the profession. It would be very unfortunate for certain behavior to taint the reputation that so many have worked so hard to establish.

So, how does someone display professionalism? We, as students and recent graduates should be mindful of our surroundings. Our profession undergoes great scrutiny, and anything that could hinder how the profession is looked upon should be re-evaluated. "Bad news travels faster than good news." When in professional venues, there are potential employers and future clinicians; so adjusting your conduct to reflect this is necessary. Let us not produce an avenue for those who are less enthusiastic about our growth. Instead, let us uphold the legacy that has been built and left for us to contribute to.

Again, let us have an enthusiastic attitude about how we represent ourselves, our peers, schools, and the profession. Show a sense of pride for the foundation and progress that has been laid out before us, by being committed to ending much of the negativity that is brought against the profession as a whole. Once this is accomplished, then I believe that the title of professional can be worn with dignity and class. So are you exhibiting professionalism? You will be able to tell by how others describe you. How are you being depicted and how are you representing the AA profession?

## Questions and Answers

So your question is, "What can the AAAA do to take a more active roll in encouraging the Georgia training programs to significantly increase their "out of state" matriculation?" I believe that there are two things our organization can do to help alleviate this growing problem. First, and this is totally based on having enough dues-paying diplomats to fund such an endeavor, we should more actively market our profession. There are several ripe organizations that we can target. One is the NAAHP or the National Association of Advisors for the Health Professions. Only one out of seven of their advisees actually matriculate to medical school. That leaves six of seven advisees looking for an option and these folks have already taken most of the prerequisites to be admitted into our programs. My experience with this group of advisors is that they rarely know what an AA is. They need to be educated. We should develop a comprehensive plan on how to do that. This will help draw applicants from new states. Of course, there needs to be job opportunities outside of Georgia for these out-of-state graduates to accept. AAAA is already actively working to help with that problem.

My second proposal, and this is much more radical, is that the AAAA should work with the Accreditation Review Committee for Anesthesiologist Assistant Educational Programs (ARC-AA) to limit the number of matriculates for each program based on market factors (job availability) and available clinical educational resources. The American Board of Anesthesiology works with the American Council on Graduate Medical Education to advise anesthesiology residency program directors how many residents each program should take based on the factors listed above. I believe that the AAAA should consider working with ARC-AA to accomplish the very same thing.

I hope that I have answered your question adequately. Please feel free to call me at 216-844-3161 if you would like to discuss this further.

Sincerely,
Joseph M. Rifici, AA-C, M.Ed.
Vice-Chair Committee on Education and Practice

**Q Who selects the NCCAA board members? What is their term of office? How does one become eligible to be a NCCAA Board member? Who makes up the exam? Who determines what is an acceptable CME and then changes the requirements without any vote etc? What is the check and balance on this elite group that pretty much dictates our credentials?**

Mark Kopel

A 1. The Board is composed of representatives of the sponsoring organizations as well as several members "at large". Under the current bylaws of the Commission, the AAAA, the ASA, Emory, and Case Western Reserve are permitted representation on the Board (it is important to note that the current bylaws governing the Commission were drafted and implemented prior to the existence of any programs other than CWRU and Emory). There can be no fewer than 3 Board members and no more than 16. The at-large members are self-nominated and those representing a participating organization are nominated by the President of said organization, at which time the candidate is vetted by the currently installed Board members and elected by simple majority vote of the Board.

The current NCCAA Board composition is as follows:

Chairman – Don Biggs, AA-C (Atlanta, GA)
Vice Chairman (and CWRU Representative) – Joseph Rifici, AA-C, MEd (Cleveland, OH)
Secretary/Treasurer – James R. Hall, MD (Atlanta, GA)
AAAA Representative – Michael Nichols, AA-C (Atlanta, GA)
AAAA Representative – Matthew Norcia, MD (Cleveland, OH)
ASA Representative – Michael Lasecki, MD (Mobile, AL)
Test Committee Chair – Sheryl Adamic, AA-C (Cleveland, OH)
Emory Representative – seat vacant
George Arndt, MD (Madison, WI)
J. Stuart Jackson, MD (Houston, TX)
Stan Mogelnicki, MD, PhD (Atlanta, GA)
John Neeld, MD (Atlanta, GA)
Deborah Rusy, MD (Madison, WI)

2. All Board members can serve a maximum of three consecutive four-year terms (a total of 12 years).

3. All Board members must meet the following basic requirements: (1) a US citizen; (2) be over the age of 21; (3) be an anesthesiologist or NCCAA-certified anesthesiologist assistant.

4. The exam is constructed by the Test Committee, currently chaired by Sheryl Adamic, AA-C. The committee is made up of practicing anesthesiologists and AAs from around the country. Though Board members may concurrently serve on the Test Committee, not all do. Additionally, psychometric, content, and language experts from the National Board of Medical Examiners also partake in the test construction. The Test Committee meets several times throughout the year to generate/review questions, discard outdated or poorly constructed questions, and to key validate the exam. Once the exams have been administered, the passing score is determined by the Board with advice from the NBME statisticians and testing experts.

5. "Acceptable" CME content is determined by the NCCAA Board, and any changes to that definition must also originate with the Board.

The NCCAA has some exciting changes coming in the near future. Currently this year, the Commission engaged in the Cross Organizational Summit with the ASA, ABA, ARC-AA, AAAA, and AAAPD to discuss strategic goals and initiatives of common interest. The AAAA has extended the offer to the NCCAA to have an informative session at the 2010 AAAA Annual Meeting including Q&A from attendees directly to the leadership of the NCCAA. The Commission is in the final stages of securing professional management services which will provide improved communication with the AA practitioners as well as an increased level of 'user-friendliness' on the website. Additionally, later this year, the NCCAA will undertake a revision/rewrite of its bylaws to reflect organizational changes.

Sincerely,
Michael S. Nichols, AA-C, MSA
Past President ; Chair, Education & Practice Committee
Vice Chair, National Affairs Committee

## Questions and Answers

**Q What is the 33% anesthesia penalty in Medicare reimbursement and why is it important to me as an AA?**

Annonymous

**A** The complete answer to this question necessitates an understanding of the mechanisms behind how anesthesia providers are reimbursed by the federal government for services and the history behind the payment disparity. While it is true that anesthesia providers are reimbursed by the Centers for Medicare & Medicaid Services (CMS) at approximately 33-34% of what private insurers pay, this is not a 'penalty' per se, but is the result of more than a decade-long payment construct that has evolved as the result of various administrative changes.

For the past thirty years, anesthesiology has been reimbursed based on monetary matrices from the Relative Value System (RVS), which assigns pre-determined 'units' and 'modifiers' based on categories of procedures types, complexity of the case, etc. To these units is added an additional reimbursement based on the amount of time spent caring for the patient, which is typically broken into fifteen-minute increments. The sum total of these basic and time units is then multiplied by a 'conversion factor' to render final reimbursement payment. So, as you can deduce, the type of case, the exact amount of time caring for the patient, and the conversion factor are all important elements of total anesthesiology reimbursements. This makes anesthesiology unique in that reimbursements are made on both base and time units, whereas other specialties are paid out a flat fee based on services, procedures, diagnoses, etc.

Until 1991, anesthesiology conversion factors were similar to those of other medical specialties. However, in 1992, the Medicare fee schedule reduced the conversion factor by 29% from its 1991 level. Another blow was dealt to anesthesiology payments in 1998 when the fee schedule was converted to a single conversion factor for all specialties except anesthesiology, thereby further reducing reimbursements by 46% of the previous fee schedule (McNeil, 2009). This payment disparity reflected nothing more than the historical relativity between the anesthesiology fee schedule and the conversion factor since 1992. Though regional variations exist, the current national average conversion factor is $21.06.

The Congressional Budget Office estimates that in 2006, Medicare physician reimbursement rates averaged 20% less than private insurance levels; for hospitals, the disparity was 30%. In Medicaid, the variation was even greater: a 40% gap in physician payment levels, when compared to private insurance rates, and 35% for hospitals (Elmendorf, 2009). To strike closer to home, in a 2007 report (GAO-07-463), the Government Accountability Office (GAO) confirmed the payment disparity between Medicare and commercial payments for anesthesia services. The GAO concluded that Medicare paid an average of 33% of what private insurers pay for anesthesia services (Government Accountability Office, July 2007).

As Congress contemplates various options for healthcare reform, the economics of this matter are essential for anesthesia providers, as they delivered close to 10 million anesthetics to Medicare patients in 2007, and broader access to health insurance for the uninsured must not see this payment disparity spread to a larger share of the patient population. Additionally, private insurers typically base their payment constructs on those of CMS, so the broadening of disproportionately low reimbursement rate could be detrimental to both the anesthesiologist assistant profession and that of our anesthesiologist colleagues.

Sincerely,
Michael S. Nichols, AA-C, MSA
Past President ; Chair, Education & Practice Committee
Vice Chair, National Affairs Committee

## Calendar of Events

*If you know of an educational event that would be of interest to AAAA members, please contact the newsletter editor for inclusion in this calendar.*

**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.

**Sept. 18 – 20 – Asheville, NC**
North Carolina Society of Anesthesiologists Fall Session XXIX. Offering a maximum of 9.0 hours of AMA PRA Category I CME. For a schedule and registration form, go online to www.ncsoa.com.

**Sept. 23 – 26 – Tampa, FL**
Health Professions Network Fall 2009 Meeting – Healthcare Reform. For agenda and online registration, go online to www.healthpronet.org.

**Sept. 24 – 27 – Atlanta, GA**
Probes and Pumps 2009: Caring for the Patient Undergoing Cardiac Surgery. Sponsored by Emory University School of Medicine and offering a maximum of 24 hours of AMA PRA Category I CMEs. Email cme@emory.edu or call 404/727-5696 (outside Atlanta call 888/727-5695) to receive a brochure.

**Oct. 1 – 3 – Laguna Beach, CA**
Anesthesia Camp. Sponsored jointly by Duke University School of Medicine and destinationCME. For complete meeting details, visit www.destinationCME.com.

**Oct. 9 – 11 – Park City, UT**
Perioperative Echocardiography Review Course. Presented by the University of Utah Department of Anesthesiology. Designated for a maximum of 26.23 hours of AMA PRA Category I Credits. For information on registering, go to http://medicine.utah.edu/anesthesiology/TEE.

**Oct. 16 – New Orleans, LA**
Ultrasound for Every Anesthesiologist (Convenient pre-ASA Symposium). Sponsored by the Duke Department of Anesthesiology. For more information, go to http://anesthesiology.duke.edu.

**Oct. 17 – New Orleans, LA**
Accreditation Review Committee for the Anesthesiologist Assistant (ARC-AA) Board meeting. For more information, go to www.caahep.org.

**Oct. 17 – 21 – New Orleans, LA**
ASA Annual Meeting. Free registration for all ASA members, including Educational Members. Go to www.asahq.org for more details.

**Oct. 26 – 30 – Poipu Beach, Kauai, HI**
California Society of Anesthesiologists Fall Hawaiian Seminar. Register online at www.csahq.org.

**Oct. 27 – 31 – Costa Rica**
Anesthesia Camp. Jointly sponsored by Duke University School of Medicine and destinationCME. For complete meeting details, visit www.destinationCME.com.

**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. Pre-conference ACLS (Oct. 31 – Nov. 1) and Peripheral Neural Blockade (Nov. 1) workshops offered. Brochure and registration available online at http://www1.wfubmc.edu/anesthesiology.

**Nov. 1 – 5 – Scottsdale, AZ**
Scottsdale Anesthesia: New Developments and Controversies. Offered by Holiday Seminars. For more information go online to www.holidayseminars.com.

**Dec. 11- 15 – New York, NY**
63rd Annual PostGraduate Assembly in Anesthesiology (PGA). Sponsored by the New York State Society of Anesthesiologists. Online registration available at www.nyssa-pga.org.

## 2010

**Jan. 27 – 30 – St. Tomas, USVI**
Anesthesia Camp. Sponsored jointly by Duke University School of Medicine and destinationCME. For complete meeting details, visit www.destinationCME.com.

**Jan. 30 – Feb. 6 – Snowmass, CO**
Aspen Anesthesia: New Developments and Controversies. Sponsored by Holiday Seminars. For more information go online to www.holidayseminars.com.

**April 10 – 14 – Savannah, GA**
AAAA 34th Annual Conference. Make plans now to attend! Watch for updates on www.anesthetist.org

## Calendar of Events

**At Home Study: Perioperative Management**

"A program designed for practitioners to limit patient risk by proper preoperative evaluation, intraoperative management, and post-operative care." Offering a maximum of 16.5 AMA PRA Category 1 Credits. Credits expire March 11, 2010. To order, go to www.cmeinfo.com/579.

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**Need CMEs fast?**

Find free CMEs online at www.cliniciansCME.com or at www.CMEZone.com.

## Opportunities

### Missouri

Western Anesthesiology Associates at St. John's Mercy Medical Center, St. Louis
Contact: Sue Chrismer schrismer@waai.net 636-386-9224 ext. 193

### Texas

Dallas Children's Hospital, Dallas
contact: Jana McAlister 940-300-3166

Texas Medical Center, Houston
Contact: Dr. Carin Hagberg 713-500-6222

### Washington, DC

**AA Positions in Anesthesiology**

The Department of Anesthesiology at Howard University Hospital is seeking experienced, well trained Anesthesiologist Assistants as well as Physician Anesthesiologists to join a growing department serving the Washington community in the District of Columbia.

Physicians appointed to the Howard University Medical School will enjoy the benefits shared by all university faculty and will have the opportunity to teach medical students, residents and practicing physicians the latest skills in anesthesiology. Physicians and AAs with experience in the subspecialties of critical care medicine, pain management, obstetric and pediatric anesthesia are especially encouraged to apply. Salary will be commensurate with experience, publication, and training.

There will also be opportunities for research in collaborating disciplines as the department continues to maintain academic excellence and practice the highest quality of care.

Interested professionals who meet these criteria should send curriculum vitae to:

John T. Herbert, M.D., M.B.A.
Chairman and Professor
Department of Anesthesiology
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2041 Georgia Avenue NW
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jherbert@huhosp.org