The Anesthesia
RECORD

The Newsletter of the American Academy of Anesthesiologist Assistants

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First Quarter • 2012

Mission Accomplished!

By Michael S. Nichols, AA-C

Every great organization or business starts with a powerful mission statement. A well-written mission statement clearly states the goals and values of an organization and conveys the future vision that propels the organization in all efforts. It is more than just fancy words – it must overtly state the purpose of the organization and its primary objectives. With this in mind, the Board of Directors set out to craft a statement that encapsulates what the AAAA does, how we do it, and to what goal we strive.

It is with honor and great pleasure that I introduce to you the new and improved mission statement of the American Academy of Anesthesiologist Assistants.

The statement intends to clearly and concisely express the direction of the Academy. It is worth noting that several components anchor this statement of purpose.

The statement begins with our Academy name prominently conveyed as the organization for AAs; the one and only entirely committed to the profession.

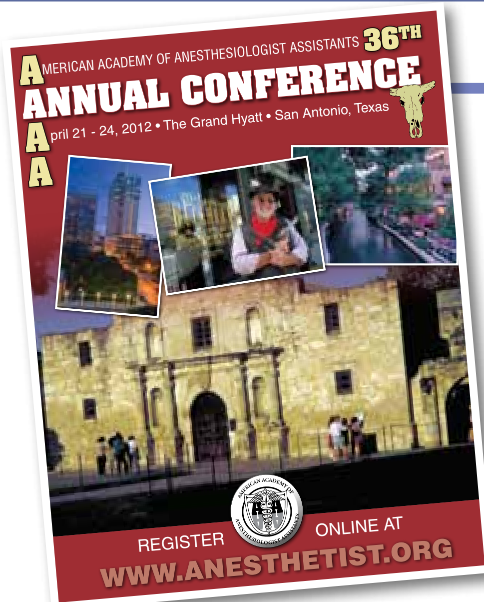
The statement defines our trade as a profession and ensures a dedication of the Academy to advancement of that profession. Furthermore, it commits the Academy to conduct itself in an ethical manner.

The statement defines our secondary, but equally important, purpose to strive for excellence during the care of every patient we serve.

The statement constructs the three tenets of the Academy's plan to achieve promotion and excellence: (1) education; (2) advocacy; and (3) promotion of the Anesthesia Care Team (ACT).

The mission statement essentially defines how we will measure our success as an organization. By crafting a clear statement, we can powerfully communicate our intentions to realize an attractive and inspiring common vision of the future. The AAAA will not cease promoting the AA profession and will remain dedicated to excellence in clinical care. We will educate the public, our patients, and all who will listen about the benefits of the profession and the ACT. We will advocate tirelessly on your behalf to ensure the continued success of AAs nationwide!

> The American Academy of Anesthesiologist Assistants is the national organization dedicated to the ethical advancement of the Anesthesiologist Assistant profession and to excellence in patient care through education, advocacy, and promotion of the Anesthesia Care Team.



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AAAA Welcomes New and Renewing Members!

By Saral Patel, AA-C
Secretary

Thank you to all of our members for renewing their memberships. By renewing your membership, you are actively promoting the AA profession as well as contributing to the advancement of our profession. It is your membership dues that allow the AAAA to offer informative educational conferences, direct proactive legislative initiatives, cultivate professional relationships with other organizations, expand awareness of the AA profession and endorse professional development.

A special reminder to all our members to utilize the AAAA website, www.anesthetist.org. There are many valuable tools at your disposal, including a searchable member database, interactive AA Practice Map, and AA Web Forum to discuss hot button topics with other AAs.

I'd also like to highlight the committee online sign up as well as online Annual Meeting registration. New this year is the AAAA capability of accepting online contributions to the Legislative Fund as well as monthly withdrawal options. I strongly encourage each member to donate generously to the AAAA Legislative Fund. It is the second most important thing you can do to promote the AA profession - second only to joining the AAAA.

In the past three years, the AAAA has dispersed over $45,000 to legislative efforts in Texas, Wisconsin, and New Mexico. In the next year, the AAAA will be focusing on two states that will be reviewing AA licensure in addition to building relationships with numerous anesthesiologists' state societies. I urge you to donate to the AAAA Legislative Fund online, by mail, or stop by the Legislative Fund Booth at the Annual Meeting.

To all the new members who are receiving this printed newsletter for the first time, your involvement and participation is greatly valued. On behalf of the AAAA, I'd like to extend a personal thank you for taking an active role in the proliferation of the AA profession.

New members are encouraged to become engaged in our organization by joining a committee. Let your voice be heard and influence the direction in which our profession is heading. Becoming actively involved in our professional organization on a committee level is paramount to the growth and sustainability of our profession.

You may be a recent graduate or been out of school for a number of years and have decided to rededicate yourself to your profession; either way, the leaders of the AAAA greatly appreciate your membership and hope to see you all at the Annual Meeting next month in San Antonio.

New AAAA Members (9/2011- 2/2012)

Victoria Aranda
Sara Davis
Courtney Degner
Kristen Dell
Jessirae Frerichs
Michael A. Guerzon
William B Holland
Lindsey M. Hopkins
Monica L. Huynh
Nancy Landry
Phat Le
Matthew Levin
Brooke Loo
Travis Lundell
Lisa N. Manuzak
Angela M. Marquis
Michael Mohr
Heather C. Morgan
Shelley S. Morgan
Grant Mury
Antron J. Palmer
Marc Ranfone
Margaret Riffel
Purvesh Ronvelwala
Louis Saez
Samantha S. Salman
Sean M Schafer
Alison Stoeri
Gilbert O. Wasonga
Regina Yarbrough
Katherine Zimmermann
Benjamin C. Zirlin

2012 Membership Incentives

Receive $50 off your 2013 AAAA dues

All practicing AAs should support the work AAAA does to keep our services reimbursable and expand our job opportunities. Refer two non-student members to AAAA and receive a $50 discount on your 2013 member dues. Referred members cannot have been members during 2012. To receive your discount, the new member must include the referring member's name on their application.

Free annual meeting registration

Convince your coworkers to join this cause and their professional organization by July 1, 2012 to be entered into a drawing to receive AAAA's newest member benefit: one free annual meeting registration. You can be eligible for the drawing if you are on the January billing cycle by renewing your dues before December 31, 2012! AAAA wants to reward its supporters and its loyal members with these two incentives, and hopes that you will recruit your coworkers to join the only organization that focuses solely on issues affecting the AA profession.

AAAA Responds

The 2011 Membership Satisfaction Survey Results are In!

Members are overwhelmingly satisfied with AAAA, would recommend AAAA to a colleague, and feel AAAA enhances the future of the profession. Only eight respondents felt the cost of dues was unreasonable compared with other organizational dues. The results of this survey suggest our membership will be a positive force in recruiting colleagues to support the only organization working solely on issues that affect the AA profession.

Thanks to all members that completed our survey! Your input is appreciated. In an effort to communicate with membership, look for this section "AAAA Responds" in future Anesthesia Record issues as well.

Help more with expanding into other states. Keep us more informed about legislation for our profession.

94% of respondents felt e-blasts were helpful in receiving legislative information and 66% of respondents respond with letters to legislators when asked to do so. All AAAA leaders recognize expanding AA practice as a #1 priority and work year round to do so. The National Affairs Committee wants members informed but also recognizes that legislative information changes rapidly and is often sensitive. Any good coach will agree that publicizing your playbook might be detrimental to winning the game, and narrating each play in a newsletter or website will be grossly out of sync with what's actually happening in the game. The best way to get in the game is to support AAAA and show up for practice.

I don't feel the AAAA is standing up to the NCCAA in our best interest and just letting that committee, which was spawned by the AAAA officers, do what they want. It is a committee that has no checks and balances and no elections.

The NCCAA is a certifying organization that was created when AAAA leaders realized that national certification was essential to the progress and recognition of the profession. AAAA firmly believes a national certification process is essential to maintaining reimbursement and legitimacy of our profession. AAAA must be separate from the NCCAA or the process becomes biased and suspect. The bylaws of the NCCAA do outline commissioner terms. Concerns about the adherence to these bylaws should be addressed to the NCCAA.

Critique the accreditation exam and whether or not it is truly a good measurement of continued proficiency.

The committee responsible for writing the CDQ exam is not trying to keep AA-Cs up to minimum standards, but has embarked on an agenda to make the test harder by asking bad and obscure questions. The mission of this committee is to help AA-Cs, not impede their ability to work.

Complaints about the recertification process is not a topic AAAA leaders spend time discussing because the purpose of AAAA is not to govern the NCCAA. Many members have concerns about the NCCAA and those concerns should be expressed to the NCCAA first and foremost. AAAA allows editorials and articles to be published by our members that wish to communicate with the membership in our newsletter but does not simply act as a broadcaster for complaints against other organizations. AAAA posed a series of questions to the NCCAA at the request of our members and their responses can be viewed on the member forum of the website, under "What's the deal with the CDQ?"

The National Commission's purpose is not to assist the practitioner in obtaining certification. The NCCAA does have a charter that includes assuring the public that certified anesthesiologist assistants (AA-C) meet basic standards related to fundamental knowledge and application of that knowledge to the duties of practicing as an anesthesiologist assistant. Certification offers some level of assurance to employers and the public that the AA profession places patient safety before all else and certified AAs have to maintain a certain level of continued education. The content and process is overseen by the National Board of Medical Examiners. Accordingly, the test writing committee within the NCCAA does not receive input from AAAA about content or design of the exam.

The term "accreditation" is a matter related to educational programs, not certification.

Focus on job placement, focus on increasing relationships with employers in new states. More aggressively pursue listing of additional job openings in the members section.

In 2011, AAAA developed an Employment Task Force to focus solely on this topic because this is a priority of the organization and of AAAA leaders. Posting jobs on the website job board is free but voluntary. Viewing posted positions is available in the members only section of the website. AAAA relies on employers and our membership to make this a useful tool for AAs. AAAA welcomes any AA volunteer on the Employment Task Force.

A general guideline on how to go about being the first into a new hospital would be great. I became the first AA into a hospital where the state has long had AAs. However, the hospital credentialing committee has asked for specific documentation to back up my scope of practice

The AAAA website now has documents available online under members only that includes a general outline of beginning practice in a facility or work group new to AAs. The documents are relevant to all practicing AAs because they explain how each of us is granted the privilege to work in a facility. Scope of practice varies with each state medical board and the credentialing facility. All AAs should understand and be able to list the responsibilities they request of a credentialing committee. Certification, a valid license, and ACLS typically serve as documentation that an AA can perform the specific duties they include in their scope of practice. It's a testament to AA practice growth that these documents were formally created in 2009 and then requested often enough to be placed on our website. Every practice or facility that uses AAs does so because at one time an AA made the effort to open that practice. AAs should never give up on gaining the right to work in a state, facility, or practice. Politics and knowledge of our profession are always changing and willingness to hire AAs is, too.

Start recommending to programs to stop flooding job markets with graduates that struggle to find jobs. Lower the graduate rates in Georgia since markets are saturated and people are losing their jobs.

Continued on page 4

Expanding the AA profession

By Claire Chandler, AA-C
President Elect

Recent membership feedback indicates that employment is a growing concern among practitioners and new graduates. The AAAA has taken proactive steps to address this on many levels.

A recent measure was to host an exhibit booth at the ASA sponsored Practice Management meeting in January, with the purpose of informing potential employers about how AAs fit in today's complex anesthesia practice environment.

Of the over 745 attendees present, two-thirds were anesthesiologists (including many department and practice chairs) and one-third were practice managers. This focused audience was fundamentally educated about AAs and the Anesthesia Care Team model.

Practice Management 2012 Attendees: Dave Biel, Practice Management Chair; Saral Patel, Secretary; Soren Campbell, Practice Management Vice-Chair; Claire Chandler, President-Elect

Expressed interest included requests for more information about hiring AAs in states with current legislation or delegatory authority, where and how to recruit AAs, the AA credentialing process, and further speaking engagements with various state societies.

We expect the subsequent benefits of this endeavor to be significant and tangible. It is your membership dollars that make such targeted outreach projects possible. Thank you for your continued support.

AAAA Responds, from page 3

It is not within the purview of the AAAA to recommend how AA programs manage admissions. Nor has an AA program or affiliated university ever requested AAAA input regarding admissions. Educational standards are established by the Commission on Accreditation of Allied Health Programs in consultation with the Accreditation Review Committee for Anesthesiologist Assistants. That being said, the number of program matriculates is a matter of institutional autonomy and is not regulated by the accrediting body.

All AA program directors are currently members of the education committee of AAAA, which does discuss class size among all other aspects of AA education. The job market is a reflection of supply and demand. AA jobs will not be protected by limiting the number of AA graduates. In fact, limiting AA practitioner numbers is a very real threat to the longevity of the profession.

Consider how the job market might look for AAs if our numbers reduce us to an endangered species. As recent as 1995, AAs could only find employment in four or five cities in Georgia and two or three in Ohio. Expansion of AA practice happens because our numbers grow.

CRNAs are quite effective at restricting AA practice opportunities. CRNAs have 112 programs at present and growing. Most CRNA programs enjoy federal funding for expansion, investment in technology, and tuition reimbursement. CRNAs have been successful in opposing AAs in the past because our numbers were small enough to ignore and keep our voices unheard.

AAAA is unaware of any certified and qualified AA that has lost their job due to competition in the field. High salaries at a masters degree level are likely to keep mid-level anesthesia provider careers, both CRNA and AA, in the forefront of consumer awareness, which translates into more programs and more applicants. AAs continue to have relative security in finding jobs compared to other competitive fields such as law and business.

Get more people involved. I feel like the committees are a small select group.

Approximately 75 members currently volunteer for AAAA in some capacity. New volunteers are always welcome. The committee sign up form can be found on the website under members only. Almost every committee in AAAA is currently seeking more volunteers. Most members get involved in leadership because they identify something they would like to change, improve, or create in our organization.

Offer a review course for the CDQ! That's not too much to ask!

In the past, AAAA had a review course for the CDQ exam at our annual meeting. As the priority of creating a budget neutral annual meeting became important, the course was discontinued, due to cost and lack of interest. This is certainly a suggestion that could be revisited if a number of members both requested it and were willing to pay for it. AAAA would welcome any AA volunteer wishing to create such a program and run it. All AAAA business is accomplished by AA volunteers that have full time jobs, just like our members.

I would like a print version of the newsletter.

The survey results show members get their information almost equally from the website and the newsletter and are satisfied with content of both. Slightly more respondents prefer an electronic newsletter, but the members that want a print newsletter have very strong opinions about it.

As we return to a print newsletter, members will have the option of changing their account preference to receive only the electronic version.

ACO: The medical acronym of the decade

By Megan Varellas, AA-C, MMMSc

Call it what you like, Obamacare, Romneycare, HMOs on steroids, but these are just labels for a program designed to keep Medicare solvent. The American Research Institute estimates that Medicare will go bankrupt in 2019, 11 years sooner than previously predicted. The problems in our current system have been brewing for 50 years under the leadership of both political parties and have many complex causes. Accountable Care Organizations (ACOs), are mandated by the Patient Protection and Affordable Care Act (PPACA), which was passed by Congress in 2010. The objective is to change the payment system to reward for quality and outcomes rather than pay for volume. Health and Human Services (HHS) estimates that ACOs could save Medicare up to $960 million in the first three years, which is less than one percent of Medicare spending during that same period. If the program is successful, the Secretary of HHS is permitted to expand it.

What is an ACO?

An ACO is a network of doctors, hospitals, and other healthcare providers (that's us!) that accepts a shared responsibility to deliver a broad set of medical services to a defined set of patients across the age spectrum that is held accountable for the quality and cost of care through alignment of incentives. The goals of an ACO are to improve the quality and efficiency of healthcare services and to demonstrate increased value from healthcare expenditures. In the new law, an ACO would agree to manage all the health care needs of a minimum of 5,000 Medicare beneficiaries for at least three years.

Why should you care about ACOs?

Most of us plan to use Medicare at some point in our lives and most AAs depend on Medicare reimbursement for their services to keep their jobs stable. With one in six Americans on disability and baby boomers entering retirement, the market share of patients using your anesthesia services that also rely on government healthcare is increasing every year. ACOs are the fastest growing trend in healthcare and will also be in place for private insurers as well as Medicare beneficiaries. It's possible that in the future ALL patients and all providers will be part of one or more ACOs.

Who am I going to be working for and who is going to be in charge?

Hospitals, insurers and doctors are all vying to run ACOs. The question of who is in charge is left purposefully vague in the PPACA because many types of provider organizations can manage an ACO but no one knows yet which will yield the best care for the lowest cost. Some areas already have large groups of physicians

Continued on page 6

AAs Join The Lifebox Global Oximetry Campaign

By Alexander A. Hannenberg, MD and Michael S. Nichols, AA-C

Beginning in 2004, world leaders in anesthesiology targeted avoidable anesthesia mortality in the developing world with a campaign to improve surgical and anesthesia care. A collaboration of the World Federation of Societies of Anaesthesiologists (WFSA), Association of Anaesthetists of Great Britain & Ireland (AAGBI) and General Electric launched a pilot project to make pulse oximetry available in four regions of India, Uganda, Vietnam and Philippines. Many of these settings appear to have avoidable surgical mortality rates as high as 1:133. And while many lack a great number of resources we take for granted – such as reliable electricity and water supplies – the achievability of making oximetry available produced a commitment to target this particular, high impact intervention.

Nearly simultaneously, the World Health Organization (WHO), under the leadership of Dr. Atul Gawande, developed the Safe Surgery Saves Lives program that gave rise to the landmark study on the impact of the surgical checklist.

1,337 Oximeters Deployed
October 2010-October 2011

Azerbaijan	Cambodia	Cameroon
China	Congo	Cote d'Ivoire
Djibouti	Eritrea	Ethiopia
Georgia	Ghana	India
Indonesia	Kazakhstan	Kenya
Lao PDR	Malawi	Mali
Nepal	Nigeria	Pakistan
Philippines	Russia	Rwanda
Senegal	Sri Lanka	Tajikistan
Tanzania	Timor-Leste	Uganda
Ukraine	Uzbekistan	Viet Nam
Yemen		

WHO, WFSA, AAGBI and the Harvard School of Public Health brought these goals together in the Lifebox campaign, a global program to produce, acquire and distribute low cost pulse oximeters, provide training in their use and to introduce the surgical checklist in remote, low income settings. Through the WHO, a maker of an affordable, custom-designed portable pulse oximeter was identified. This device is highly durable and intended for use in challenging environments – the "Jeep" of oximeters. It is available for $250, including training materials. Lifebox has deployed more than 1,300 devices around the world in its first year and has trained the users in interpretation of the readings and management of hypoxemia. The campaign's goal is to reach all of the 77,000 operating rooms in need, in which more than 35 million patients annually undergo surgery without oximetry.

Global partners of the Lifebox campaign include SmileTrain, the American Society of Anesthesiologists (ASA) and many national societies of anesthesiology. ASA's 2011 Annual Meeting featured Dr. Gawande as its keynote speaker, and the ASA campaign for Lifebox, launched at that meeting, has raised more than $125,000 to date.

In the coming weeks, the AAAA will be joining the ASA as a partner organization of Lifebox to further drive awareness of this important initiative. By doing so, AAs are joining anesthesia professionals worldwide in the campaign to make safe surgery and anesthesia available, saving lives and avoiding tragedy. Go to www.asahq.org/gho/lifebox to learn more and to donate.

ACO, from page 5

that can simply become an ACO by networking with hospitals. Other areas have large hospital systems that are buying up physician practices to become an ACO by directly employing their providers. Meanwhile, some insurers like CIGNA, Humana, and United Healthcare have been experimenting with similar initiatives since 2007. If you are not already part of a forming ACO, look around and you will likely find one nearby.

What about the money?

In the traditional Medicare 'fee for service' payment system, doctors and hospitals are paid more when patients get more tests and procedures. ACOS don't get rid of 'fee for service', but create savings incentives by offering bonuses when providers keep costs down and meet quality benchmarks. You can find detailed information about how the shared savings and measurement of quality improvement is designed at www.healthcare.gov. If an ACO doesn't save money, it still gets standard Medicare fees but loses on the cost of investment to improve care, such as additional employees or new technology and software.

One goal of an ACO is to decrease the costly burden of unnecessary admissions and errors. More than half of Medicare beneficiaries have five or more chronic conditions. These patients receive care from multiple physicians. A failure to coordinate care can lead to patients not getting the care they need or duplicate care and an increased risk of errors. On average, every year, one in seven Medicare patients admitted to the hospital has been subject to a harmful medical mistake. One in five discharged is readmitted within 30 days, which can be avoided when care outside the hospital is aggressive and better coordinated. Anesthesia providers already understand the financial advantage to outpatient procedures and decreased admissions. *The New York Times* reported on the Geisinger Health System, a successful ACO in Pennsylvania, that was able to drive down costs from eliminating unnecessary admissions enough to lower their own insurance premiums such that a statewide teachers strike was not only prevented, but every teacher received a $7,000 raise. Whether or not you like ACOs, you can see why they make sense to lawmakers.

How do ACOS work for patients?

Primary care is the foundation of an ACO. Primary care doctors in ACOs will be required to tell patients if they are in an ACO. Patients are free to see doctors outside the ACO network without paying more, unlike in an HMO. A successful ACO not only saves money by decreasing unnecessary admissions but also by getting patients involved in their own care with electronic reminders of labs or appointments due with the ability to schedule them online at a number of different facilities. Any patient who has multiple doctors can tell you about fragmented care, unavailable medical records, duplicated tests, or repeating their medical information repeatedly to different doctors. ACOs are designed to lift this burden from patients, while improving the partnership between patients and doctors in making decisions and giving doctors better information about their patients. It's easy to imagine how much easier and more accurate patient history is when all the patient's doctors are entering information in the same format and location. Patients choosing care from providers participating in ACOs will have access to information about how well their doctors, hospitals, or other caregivers are meeting quality standards.

What is the downside of ACOs?

Hospitals are positioning to be more integrated systems, which includes mergers and purchasing physician practices. Provider consolidation creates greater market share, which can end up costing more in negotiations with insurers. Consolidation was already a trend prior to the PPACA law, but as it becomes more common, cost increase is a greater possibility.

As more ACOs form, the nature of anesthetist employment is likely to change as more practices integrate to become owned by the health system or hospital with which their anesthesia group currently contracts. Another risk to AAs is that market forces are going to drive regulations toward reducing educational requirements for caregiving staff. The U.S. Air Force already allows CRNAs to practice without supervision by an anesthesiologist. ACOs may create an opportunity for the Anesthesia Care Team to become less desirable or even obsolete. While you will see increased quality measurements being incorporated into pay-for-performance compensation, the toughest part for the practitioner will be weak information systems that fail to give the care giver adequate point of care information.

Spiraling health care costs is a complex issue without an easy solution. Many aspects of the discussion are beyond the scope of this article such as tort reform, cost shifting, and antitrust concerns. The important thing for AAs to remember is that complaining about change rarely solves a problem but we can be part of the solution by continuing to show the health care community and patients that we provide quality care in any system that employs us.

You Decide How to Receive Your Newsletter

In response to member requests, we're mailing a printed version of the Anesthesia Record to members who would rather read the newsletter in printed form. If you would rather not receive it in print, it will always be avalable in PDF form in the members' section on anesthetist.com.

You can opt out of the print version at any time. Go to www.anesthetist.org and click on Members Only, then AAAA Member Services, Update My Address.

National Affairs Update

By Ellen Allinger, AA-C
National Affairs Committee Chairman

2012 State AA Legislation

One of the major priorities of the NAC is to assist state efforts with quality AA legislation. At the time of this article's submission in late February, Wisconsin and Kentucky have introduced AA legislation for 2012. Watch www.anesthetist.org for updates.

Wisconsin

AAs have worked in Wisconsin under physician delegatory authority for over 30 years. AB 487 and SB 383 are concurrent AA licensing bills that seek to create licensure requirements and practice standards for AAs. Passage of these bills will assure patients of certain standards for AA practice in Wisconsin while also assuring AAs that those who do not meet these standards cannot practice in the state as an anesthesiologist assistant.

Both bills were heard in their respective committees in early to mid-February where each was passed. At each hearing there was strong opposition by the nurse anesthetists. Before each bill was voted upon by the respective legislative house, three amendments were added to the bills in order to obtain public support from the Wisconsin Association of Nurse Anesthetists. SB 383 passed the Senate and AB 487 passed the Assembly on February 21st. The bills cannot become law until signed by the Governor, which is expected to occur in March.

Kentucky

On Tuesday, February 21st, HB 435 was introduced into the Kentucky State Legislature. This bill seeks to amend existing state statute that has effectively prohibited new AAs from entering the state to practice since 1986. Current Kentucky Revised Statute states that a practicing AA must also be a certified Physician Assistant (PA). Since the 1980s, only two AAs have, and continue, to practice in Kentucky, their ability to practice grandfathered per existing statute without having to become certified PAs. HB 435 will instead add AAs as a type of PA that has graduated from a specifically accredited AA program and is certified by the NCCAA and will remove the requirement for PA training and certification.

Resolving AA Reimbursement Issues

Texas

For some time the AAAA, the Texas Academy of Anesthesiologist Assistants (TAAA), the Case Western Reserve University–Houston AA program and the Texas Society of Anesthesiologists (TSA) have been working together to resolve medical insurance reimbursement issues for AAs in Texas. Although AAs have been working for several decades in Texas, the profession largely did not practice outside of Houston and a great deal of effort was expended by the group to align AAs with cases that reimbursed for their services. The largest offenders for non-reimbursement for AA services were Texas Medicaid, Blue Cross Blue Shield of Texas, and Aetna.

In the MEDICAL AND NURSING SPECIALISTS, PHYSICIANS, AND PHYSICIAN ASSISTANTS HANDBOOK section of the 2011 Texas Medicaid Provider Procedures Manual, it clearly states that reimbursement for "non-CRNA qualified professionals" (i.e., AAs), is 100%. Details about proper reimbursement coding for Texas Medicaid will be posted on the AAAA website.

Blue Cross Blue Shield of Texas and Aetna will both reimburse anesthesiologist supervision anesthesia services, regardless of provider type (CRNA or AA) up to a maximum of four concurrent anesthetics. The AA Modifier (a common modifier that has nothing to do with the AA profession) must be used.

Many thanks to all involved, particularly those in Texas, that stuck with this issue to see the final resolution that breaks down the barriers of AA employment that had occurred due to these issues with reimbursement for AA services.

Ohio

The Ohio Bureau of Workers' Compensation requires the completion of a Council for Affordable Healthcare (CAQH) form in order to receive reimbursement for anesthesia services. Although AAs were being reimbursed by the OBW for their services, it was discovered that AAs were not listed on the CAQH form.

If AAs were being reimbursed, why was this omission of the AA profession an issue? Investigation into the purpose of the CAQH finds the following on its website: "The Universal Provider DataSource was developed by America's leading health plans collaborating through the Council for Affordable Quality Healthcare, or CAQH. The Universal Provider DataSource is the leading industry-wide service to address one of providers' most redundant administrative tasks: the credentialing application process. Under the CAQH program, providers use a standard application and a common database to submit one application, in order to meet the needs of all of the health plans and hospitals participating in the CAQH effort." In other words, placement on the CAQH's Universal Provider DataSource would streamline the insurance credentialing process for all AAs throughout the nation that use this CAQH's system.

An email from CAQH in response to the request to add AAs to their provider list stated that AAs were on the list to be added to the system. This should clear up any confusion by new employers of AAs as to whether or not they will be reimbursed for AA services.

New York

Last fall, to help meet the goal of reducing New York Medicaid costs, the NAC undertook the task of submitting documentation to the New York Medicaid Redesign Team's (MRT) Workforce Flexibility and Change of Scope of Practice Work Group to request the inclusion of the Anesthesiologist Assistant profession as reimbursed anesthesia providers for NY Medicaid recipients.

AAAA members were informed of this opportunity in early November and asked to write emails of support. Unfortunately, the Work Group did not include AAs on their Top 12 List of Proposals to the MRT for Phase 2 reform action. Review of the New York MRT information provided on their website does not seem to allow for another opportunity to introduce the idea of adding AAs as a reimbursable NY Medicaid anesthesia provider. Continued monitoring will occur as long as the New York

Military Medicine is Rapidly Becoming Military Nursing

By Megan Varellas, AA-C

For the first time in history, the Surgeon General in the Army is a nurse.

A new Air Force (USAF) policy, announced on January 20, 2012, authorizes directors of USAF treatment facilities to name either a CRNA or anesthesiologist as chief of anesthesia. Although most AAs and anesthesiologists find the idea of equating nurses to physicians disturbing, there is little interest in the military or congress to change this approach to healthcare.

How did this come to be? The military is based on a rank system. Because the pay differential between Military and Civilian Anesthesiologists is so extreme, few Military Anesthesiologists rise through the ranks and make the military a career. Most Military Anesthesiologists are junior officers paying back their military obligations for medical school tuition, whereas nurses are making the military a career.

The pay differential between Military and Civilian Nurse Anesthetists is negligible, which leads nurses to remain in service longer. Nurses make rank and pursue professional advancement while rising to positions of leadership and authority, where they can influence policy.

The new policy is not actually that new. In fact, the Navy adopted this policy ten years ago and CRNAs view the USAF policy in keeping with military standards.

While AAs don't practice in the military as yet, AAs should care about this policy because it further threatens the Anesthesia Care Team (ACT) concept and serves as a model of anesthesia as a specialty being led by nurses and care being delivered primarily by nurses.

Military policy is essentially a government policy that often affects the private sector. The ACT model is the only method of anesthesia delivery in which AAs can bill for their services.

A recent press release headline from the AANA reads, "New Air Force Policy Recognizes Full Scope of Nurse Anesthetist Practice. AANA Commends USAF for Ensuring Access to Safe, Cost-Effective Anesthesia Care for Men and Women Serving Our Country and Their Dependents". Full scope is meant to imply practice "in collaboration with", not directed by anesthesiologists, or completely independent of anesthesiologists.

AAs can help ASA and AAAA fight for the ACT by joining and educating non-members about the importance of supporting our professional organization.

STUDENT NEWS

Ohio AAA Update

By Patrick Bolger, AA-C
OAAA President

Since the year 2000, the Ohio Academy of Anesthesiologist Assistants (OAAA) has fought for AA practice in the state of Ohio. The OAAA has been instrumental in the passage of SB 278 which granted licensing for AAs in Ohio. With this bill in place, the OAAA further added key input on interpretation of the rules of SB 278. When the Ohio State Medical Board ruled that AAs could not place epidural or spinal anesthetics, a case was heard before the Ohio Supreme Court which in turn ruled in favor of AAs performing these types of procedures. The OAAA spent considerable time and energy in these legislative and legal struggles over the past decade. In 2011, the OAAA began to look past such battles.

Pictured (from left to right): Joseph Mader, AA-C; Patrick Bolger, AA-C; John Zerwas, MD; Carie Twichell, AA-C; David Biel, AA-C; and Michael Patrick, AA-C

The Ohio Academy of Anesthesiologist Assistants held its annual meeting in May 2011 in Cleveland, where a number of new endeavors were discussed. The OAAA is in the process of establishing a website for its members which should improve the communication of AAs across Ohio.

The OAAA leadership also attended the Ohio Society of Anesthesiologists annual meeting in Cincinnati in September 2011. At this meeting the OSA approved a plan for AAs to join the OSA as affiliate members, which was a very exciting development. The OAAA representatives also met with Dr. John Zerwas, the ASA president-elect. Dr. Zerwas, an anesthesiologist and current legislator in the Texas House of Representatives, will be a featured speaker at the AAAA annual meeting in San Antonio.

This past October the OAAA was also granted a charter membership as a state component society of the AAAA. The OAAA looks forward to working with the AAAA to improve and enhance the AA profession in the state of Ohio.

Wisconsin AAA Update

By Sara Strom, AA-C
WAAA President

The WAAA has been busy this winter introducing legislation for the licensure of AAs in Wisconsin.

Two bills, AB 487 and SB 383 were introduced in late January. These are the identical bills that the WAAA compromised with WIANA on in the last legislative session (spring 2010).

After the amendments were made to appease WIANA in 2010, the president of WIANA sent a letter to the entire Wisconsin legislature urging them to pass the AA licensure bill. Surprisingly, WIANA opposed the current legislation in Wisconsin despite the letter of neutrality and despite the bill being identical to last session.

The WAAA recently testified in support of the bills to the Assembly Public Health committee and to the Senate Health committee. A link to the testimony is available on the Wisconsin Eye website at http://www.wiseye.org/videoplayer/vp.html?sid=7634, where you can see the arguments made for and against licensure of AAs.

On February 21, 2012, the Wisconsin legislature (the senate floor and assembly floor—all in one day) voted in favor of SB 383, putting AA licensure successfully through the legislature. We are now awaiting the governor's signature for the bill to become law. Governor Walker has not yet indicated if he will sign the bill or if he will veto the bill.

Wisconsin has an abbreviated legislative session this spring, due to the recalls ongoing in the state, so the fact that in one month this went from introduction to passage through both houses is impressive work on our lobbyist's and the WSA lobbyist's behalf.

Thank you to everyone that called or emailed legislators to show support for SB 383/AB 487. A huge thank you also goes out to the WAAA board members as well as the WSA for all their support and encouragement over the past several years.

The fight for licensure in Wisconsin is not over yet—we are hoping to know more about whether or not the governor will sign the bill by the end of March.

Stay tuned!

Nova Southeastern Student Wins Sheridan National Allied Health Scholarship

Congratulations to Wenjun Scott, Nova Southeastern University Anesthesiologist Assistant Program, Class of 2012, winner of the first Sheridan National Allied Health Scholarship for Anesthesiologist Assistants.

The Sheridan National Allied Health Scholarship for Anesthesiologist Assistants recognizes student AAs for exemplary clinical and leadership skills. Each year, one $5,000 scholarship is awarded to an AA student in a nationally accredited program. The award is made possible by the Education Outreach Program (EOP) at Sheridan Healthcare, Inc. EOP is a resource designed to assist allied health students, residents and fellows with their transition from training to practice.

The deadline for next year's scholarship is January 15, 2013. For information about scholarship eligibility and to download an application, please visit the Career Center at www.sheridanhealthcare.com.

AA Student help to bring "Smiles for Christmas"

By Jonathan Beavers, AA-S

On December 9, 2011, five students from the Nova Southeastern University (NSU) Tampa AA Program provided anesthesia to 42 pediatric patients requiring extensive dental rehabilitation. A total of $100,000 in free dental care and $40,000 in free anesthesia care was given throughout the day. All of the children came from low-income families who would not have been able to afford the medical care otherwise. A majority of the patients had special needs including autism, cerebral palsy, and down syndrome.

The event took place at "Safari of Smiles", the pediatric dental office of Dr. Frank Pettinato in New Port Richey, FL. Anesthesia was provided by Dr. Hector Vila of Pediatric Dental Anesthesia Associates (PDAA). The NSU students who participated in the day were Carolina Aibar, Jacqueline Darna, Steve Smith, Jonathan Beavers, and Steve Coffman. Dr. Vila said, "This event would not have been possible without contributions made by the Nova students. They all helped to make a brighter Christmas for these children."

CELEBRATE AA DAY

JUNE 1, 2012

ANESTHESIOLOGIST ASSISTANTS

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April 15 – 20 – Cozumel, Mexico
New Horizons in Anesthesiology. The Emory University School of Medicine designates this live activity for a maximum of 25 *AMA PRA Category 1 Credits™*. Register online at http://emorynewhorizons.com.

April 21 – 24 – San Antonio, TX
36th Annual AAAA Conference. This live activity is requesting 24hours of AAPA Category 1 Credits by the Physician Assistant Review Panel, which meet NCCAA CME recertification requirements. All conference information, including registration for the conference, hotel, 5K Fun Run and 5th Annual Student Charity Golf Scramble for players and sponsors may all be found online at http://www.anesthetist.org/other/conferences.iphtml.

April 29 – 30 – San Diego, CA
2012 CAAHEP Annual Meeting. For more information go to http://www.caahep.org/Content.aspx?ID=26.

April 30 – May 2 – Washington, D.C.
ASA Legislative Conference. For more information on attending, go to http://www.asahq.org/For-Members/Advocacy/Legislative-Conference.aspx.

May 2 – 6 – Monterey, CA
Society for Obstetric Anesthesia and Perinatology (SOAP) 44th Annual Conference. Meeting brochure and registration found online at http://soap.org/43-AM.php

May 3 – 5 – Miami, FL
SAMBA 27th Annual Meeting. Program, hotel, and registration info at www.SAMBAhq.org.

May 5 – 6 – Colorado Springs, CO
19th Annual Anesthesia Symposium and Colorado Society of Anesthesiologists Spring Meeting. More information coming soon at http://www.penrosestfrancis.org/annual-anesthesia-symposium-may-4-5-2012.

May 14 – 18 – Boston, MA
Harvard Anesthesia Update – Innovation and Transformation in Anesthesiology. The Harvard Medical School designates this live activity for a maximum of 57 *AMA PRA Category 1 Credits™*. Register at www.cme.hms.harvard.edu/courses/harvardanesthesia.

May 18 – 21 – Boston, MA
IARS 2012 Annual Meeting. Visit www.iars.org/congress/ to download the preliminary program and to register.

June 8 – 10 – Palm Beach, FL
2012 Florida Society of Anesthesiologist Meeting. For more information go to www.fsahq.org.

June 11 – 15 – Lake Buena Vista, FL
5th Annual Emerging Technologies in the OR and Great Fluid Debate. Sponsored by the Duke University School of Medicine. This activity is designated for a maximum of 25 *AMA PRA Category 1 Credits™*. Registration available at: http://anesthesiology.duke.edu/.

June 13 – 17 – Kiawah Island, SC
25th Annual Carolina Refresher Course: Perioperative & Anesthetic Care of the Surgical Patient. The Carolinas HealthCare System/Charlotte AHEC designates this Live Activity for a maximum of 25 *AMA PRA Category 1 Credit(s)™*. More information, including brochure, resort accommodations and registration can be found online at http://www.med.unc.edu/anesthesiology.

July 20 – 22 – Greensboro, GA
Georgia Society of Anesthesiologists 2012 Summer Meeting. Save the date. More information to come at http://www.gsahq.org/upcoming-meetings.

Online CME

Perioperative Management of OSA Patients. A maximum of 1.5 hours of *AMA PRA Category 1 Credits™* may be claimed for this activity. Access online at http://cme.ucsd.edu/OSAonline.

Earn continuing medical education credits online at www.csahq.org.

Are you an ASA member? Find continuing education products and events at reduced rates at www.asahq.org/continuinged.htm. Products include the ASA Refresher Courses in Anesthesiology with current and previous volumes available for ordering at http://journals.lww.com/asa-refresher/pages/default.aspx. Print + online with CME available for $95.00 with $15.00 savings for online only. Earn up to 22 *AMA PRA Category 1 Credits™*.

Video & Audio Programs

Perioperative Management. Designed for practitioners, including anesthesia providers, to limit patient risk by proper preoperative evaluation, intraoperative management, and postoperative care. Presented by Johns Hopkins University School of Medicine. Practitioners may earn a maximum of 16.25 *AMA PRA Category I Credits™*. Program costs start at $695. For fastest service, order through the website at www.cmeinfo.com/775 or call 1-800-284-8433. Date of credit termination: July 31, 2014.

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Dollars and Cents of the AAAA Annual Meeting

By Carie Twichell, AA-C
Annual Meeting Chairman

When you attend the AAAA Annual Meeting, you're getting more than your money's worth. Currently, the average CME credit hour is $25-30. The AAAA annual meeting offers 24 CME credits and is a steal at just $16.66 each, for fellow members.

At the upcoming 2012 annual meeting, there is a new series of problem based learning discussions (PBLD) offered for FREE! No doubt you're aware of, if not frustrated about, the increased cost of destination CME meetings. The rising costs of staging a meeting aren't unique to the AAAA.

In 2011, the ASA eliminated free meeting registration for members to their annual meeting. Meeting costs are on the rise but so are the number of licensed AAs and student AAs attending the annual meeting. So why is the cost of registration so high?

Despite the comparatively low registration fee, many AAs still think the meeting is too expensive. If the AAAA covers a large portion of the expenses and exhibitors add to this revenue, what do your registration fees cover?

While a complete budget of the 2011 annual meeting can be viewed on the AAAA website, here is a brief list of the larger budget items:

- Food and beverage accounted for just under $60,000. This includes the weekend continental breakfast, the Saturday welcome reception and the Sunday business luncheon, open to all fellow and student members. Other organization's annual meetings don't even provide free coffee, let alone complementary breakfasts, a luncheon and receptions with refreshments and beverages.
- Audio-Visual. This expense was over $14,000 and continuing to rise for all organizations.
- Travel expenses account for all speakers, as well as management staff.
- Meeting material and supplies, including shipping to and from the meeting location.

The AAAA annual meeting is host to many great speakers, several considered the experts in their field. We are able to do this by word of mouth and personal relationships developed by active AAAA leaders. Speakers receive reimbursement for coach airfare or mileage (at .55 per mile), one night in the hotel and a per diem of up to $225 in actual expenses for two days; there are no honorariums given. AAs that speak at the meeting are NOT reimbursed for their travel or stay.

The AAAA annual meeting isn't just a chance to catch up with old classmates anymore. It's the financially responsible meeting all practicing AAs and student AAs need to attend to stay up-to-date on pertinent legislative changes, medical issues and educational modalities specific and vital to continued AA practice.