The Anesthesia RECORD

The Newsletter of the American Academy of Anesthesiologist Assistants

3Q 12

Third Quarter • 2012

PRESIDENT'S MESSAGE

The "Dignity of Risk"

By Claire Chandler, AA-C
AAAA President

As I write this article, the USA still trails China by one medal in the overall tally for the 2012 Summer Olympics. By the time you read this article, the Olympics will be over and we will have all gone back to watching the commentary on the political race for President of the United States or perhaps, our favorite premium channel series.

Which country wins the most medals is ultimately immaterial. What the Olympic Games demonstrate are the best characteristics of humanity. It is an ancient tradition which provides an opportunity for every nation, every individual, to stand side by side in appreciation of human excellence, raw determination, unparalleled courage, unwavering confidence, and amazing stamina. It makes us rethink what we can do and how we can push ourselves. In a word, it inspires.

There were many firsts during the London Summer games. Michael Phelps became the most medalled Olympian in history and Gabby Douglass was the first black woman to win the Olympic all-around event in gymnastics. One of the most inspiring stories however, was that of the "Blade Runner", Oscar Pistorius of South Africa, who advanced to the semifinals in the Men's 400m and was the first double amputee runner to compete in the games on his carbon fiber prosthetics. Yes, Pistorius was born without fibulas and had both legs amputated below the knee before his first birthday.

While what Pistorius accomplished physically is astounding, the example he has set for the world is even more inspiring. He has blurred the distinction between what is considered abled and disabled. He has brought to the forefront the "dignity of risk". He has reminded us that the world does not have to be what it currently is and the future is not written.

As an organization and as individual professionals we can all learn something from these Olympic athletes. We have more opportunity now than ever before to grow our profession but we have to maintain our stamina, take risks, and get involved. We must remain true to our values and maintain faith in something larger than ourselves just as the Olympic athletes do. It does not matter if we win every battle as long as we keep trying and keep our overall goal in mind. Phelps didn't win every race but he came out ahead of every other Olympian in history in the end.

I can't state it any better than Pistorius' mother, who taught him "A loser isn't the person that gets involved and comes in last, but it's the person that doesn't get involved in the first place."

INSIDE THIS EDITION

VOTE!

See the Special Bulletin of *The Anesthesia* **RECORD** at

www.anesthetist.org

for photos and biographical information on candidates for open AAAA board of directors positions. The slate of candidates will remain online until September 30, 2012. The election ballot will be open from October 3 - 14, 2012.

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The Anesthesia Record
Published four times a year by the American Academy of Anesthesiologist Assistants. Please direct all general inquiries to the AAAA's management at the mailing address below, fax number or e-mail address. Opinions expressed in this newsletter are those of the individual authors and do not necessarily represent AAAA policy.

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Resurfacing of Old Issues

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

National Update - Congress

As Congress recesses for five weeks from August 4 until September 10, and with elections coming up on November 6, not much is expected to be accomplished by Congress for the remainder of 2012. Congressional bills supported by the ASA and AAAA organizations on Healthcare Truth & Transparency, Rural "Pass-Through" legislation, and Preserving Access to Life-Saving Medications, as well as sweeping changes to the Sustainable Growth Rate formulas, are not expected to be addressed by the end of this session.

Ellen Allinger, AA-C

State Update - Ohio

On March 15, 2012, the State Medical Board of Medicine issued its Statement on Anesthesiologist Assistants: Performing Epidural and Spinal Anesthetic Procedures. In this statement, which can be viewed in its entirety on the AAAA website at http://www.anesthetist.org/other/OSMB_Anesthesiologist_Assistant_Statement.pdf, the following statement is made:

Ohio anesthesiologist assistants may perform epidural and spinal anesthetic procedures as requested by and performed under the direction of a supervising anesthesiologist who is physically present in the room.

This statement clarifies the discrepancy between the ruling of the Ohio State Supreme Court in 2007 in Hoffman v. State Medical Board of Ohio, 113 Ohio St.3d 376, 2007-Ohio-2201, and the language of Rule 4731-24-04(A), Ohio Administrative Code (OAC), which states that an anesthesiologist assistant may not perform epidural and spinal anesthetic procedures. The State Medical Board of Ohio plans to delete the "offending language" in Paragraph A. However, when checked on August 8, 2012, the planned new rule had not been announced on the board's website. This is being followed consistently by the Ohio Academy of Anesthesiologist Assistants.

The Ongoing Issues of Payment for AA Services

Past articles have reported issues with payment for AA services by various state and federal medical insurance providers. Elsewhere in this issue an article appears on the promised resolution from TRICARE North of AAs that graduated from AA programs other than CWRU or Emory being denied payment for anesthesia services to military personnel and their families. This was an issue unique to TRICARE North as both TRICARE South and TRICARE West paid for all graduate AA services. It took the action of Representative Todd Akin from Missouri to correct this issue through the House Armed Services Committee. This speaks to the level this issue was taken by the AAAA in order to get the problem resolved.

Sadly, this was just one victory in a war that both the National Affairs Committee and the Practice Committee, along with several AAAA leaders, are trying to address. On the national level, the Blue Cross Blue Shield Federal Employee Program, known as Federal Blue, does not pay for AA services and requests to Federal Blue to address and correct this item have gone unanswered over the past two years. On the state level, state and regional Blue Cross Blue Shield providers consistently deny payment for AA services or pay at a lower rate than nurse anesthetist services when both are being used in the Anesthesia Care Team model of patient care.

In addition, state Medicaid programs have denied claims for AA services, primarily in states where the AA profession is newly introduced, but this is not always the case. Only earlier this year did Texas Medicaid start paying for AA services because of a combined effort of the TAAA, the AAAA, the TSA and the CWRU-Houston AA program. All this time, anesthesia practices and hospitals that employed AAs were not being paid for AA services by the Texas Medicaid program despite the fact that AAs have been legally working in Texas for some 30 years.

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Federal Affairs Sub-Committee Update

By Melanie Guthrie, AA-C
Federal Affairs Subcommittee Chair

The Federal Affairs Sub-Committee of the National Affairs Committee met at the AAAA Annual Meeting this April to discuss necessary action for the upcoming year. The committee outlined two areas of primary focus: AA reimbursement from federally-funded insurance companies and veterans' affairs.

The sub-committee is excited to announce that with extensive assistance from our anesthesiologist colleagues in Missouri and their relationship with Representative Todd Akin, we have resolved issues regarding reimbursement for AA services with the insurance group Tricare North.

Many may not realize, but Tricare North would previously only reimburse for AA anesthesia services if the practitioner had trained at Emory or CWRU, while the other two Tricare groups paid for all AA services. Representative Akin went through the House Armed Services Committee requesting that the Department of Defense investigate the matter. This resulted in the revision of the Tricare policy manual to include proposed language that reflects the regulatory provision for all accredited AA education programs.

This is a huge step for us, as the AAAA has spent more than two years trying to get this issue resolved. We owe the anesthesiologists in Missouri and Representative Akin our gratitude for helping us to find resolution with this problem.

The sub-committee is currently working on AA reimbursement issues for services with Federal Blue and will hopefully have an update later this year. Resolving inequality in reimbursement is crucial not only to the growth of, but also the maintenance of our profession.

If anesthesia groups cannot be paid for AA services, they may not hire them. If your group has any reimbursement issues involving AA services with insurance companies, please contact the AAAA.

Thus far with Veterans' Affairs, the subcommittee is actively fostering and building relationships within the veterans' anesthesia services and anesthesia departments across the country. These relationships will help us when moving forward to challenge the salary differences between AAs and CRNAs within the VA system. Salaries are determined by GS rankings and are inhibiting AAs from taking employment within their ranks. Potential change regarding an issue of this magnitude is a huge undertaking that will take a lot work, time, and patience.

National Affairs from page 2

Inconceivable? And yet, because payments for anesthesia services for all providers continue to decline, payment of services has come to the forefront of determining which profession to hire – AAs or nurse anesthetists. As of right now, decreased or nonpayment of anesthesia services provided by AAs is the single largest reason for private practices to NOT hire AAs. This supersedes the fact that only AAs work exclusively within the Anesthesia Care Team model with anesthesiologists and the fact that AAs do not try to pass themselves off as being as qualified as anesthesiologists or try to encroach on the scope of practice of anesthesiologists through legislation and revision of federal rules and regulations. It's only a matter of time before hospitals and other centers look at these discrepancies and also decide that it is more profitable for them to hire nurse anesthetists rather than AAs.

Because this is such a vast issue, everyone - students and practicing AAs, as well as anesthesiologists - need to be on constant alert to any indications or discussions where payment for AA services is a factor in decisions on hiring. It's only by directly dealing with the medical insurance provider that these issues will be resolved. The AAAA is the only organization that is dedicated to dealing with these issues for the AA profession. Be aware and bring to the attention of the AAAA leadership ANY issue involving payment for AA services.

Looking to 2013

Suffice it to say that, at this time, there is serious interest in supporting AA legislation, both in the revision of existing statutes and in new AA licensing laws, in at least four states. Support by the entire AAAA organization, both directly and monetarily, will be more important than ever. So get ready!

Direction Versus Supervision: What you should know, why you should care

By Megan Varellas, AA-C

All AAs should understand not only how they are granted privileges to practice and the terms of their license and certification, but also how an employer is paid by insurers for the work they perform.

If you think direction versus supervision doesn't matter to you, then put yourself in the following scenario: You know your anesthesia group's contract has come up for periodic renewal. One day you go to work and find out hospital administration has put out an RFP (request for proposal) for anesthesia services. Time goes by as you hear about different groups vying for the contract. Your employer is confident the hospital is just shopping around and because there are no problems within the department or with services provided by the department, tells you not to worry.

Despite a long-term presence in the hospital and good relationships between your anesthesiologists and administration, your group loses its bid. So does the largest practice in the state, which is already established in the area and holds many contracts at surrounding facilities. A large national anesthesia company also loses a bid for the contract.

Unexpectedly, a local anesthesiologist that has a small firm of CRNAs and MDs wins the bid. As you seek the contact information to ascertain if you will be offered your existing position, you start hearing about the specifics of this new anesthesia group from various interested parties. All the anesthetists and anesthesiologists work as 1099 employees, as opposed to W-2 employees, meaning they are self-contracting and receive no benefits. They also get paid on an hourly basis.

As you come to terms with the pros and cons of such an arrangement over several weeks, you ultimately find out that you aren't even eligible for hire because this new group bills medical supervision, not medical direction. If you had been savvy to anesthesia billing practices, then you would have recognized immediately that this group would be unwilling to hire you as an AA.

Direction and supervision are common terms with similar meanings in everyday language but have significant differences in anesthesia. The definitions of medical direction and supervision largely depend on who is asking the question, and why.

Medical direction and medical supervision are terms used by insurers, including CMS, to determine how much they will pay for anesthesia services, and to whom. You will hear different definitions based on the profession, personal agenda, or personal experience of the individual you ask. For an accurate definition, you need to know which insurance company is being billed, what that particular state's law says specifically about supervision, and whether the state law goes on to define the term supervision.

All of this is important, since it directly affects if, and how much, an anesthesia provider will get paid for their services, whether or not a state licensing board will discipline a provider, the validity and outcome of a medical malpractice lawsuit, and the cost of health care for us all.

Medical "direction" by anesthesiologists is a billing term describing the specific anesthesiologist work required and restrictions involved in billing payers for the management and oversight of non-physician anesthesia providers. This pertains to situations where anesthesiologists are involved in not more than four concurrent anesthetics. See individual payer manuals for specifics. Medical direction pays 100%, split 50-50 between the MD and CRNA or AA. The anesthesiologist must meet certain requirements listed below:

- Performs a pre-anesthetic examination and evaluation;
- Prescribes the anesthesia plan;
- Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
- Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
- Monitors the course of anesthesia administration at frequent intervals;
- Remains physically present and available for immediate diagnosis and treatment of emergencies;
- Provides indicated-post-anesthesia care.

Medical "supervision" is a payment policy that contains a special payment formula for "medical supervision". It applies "when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedures."

[Note: The word "supervision" may also be used outside of the Anesthesia Care Team to describe the perioperative medical oversight of non-physician anesthesia providers by the operating practitioner/surgeon. Surgeon provided supervision pertains to general medical perioperative patient management and the components of anesthesia care that are medical and not nursing functions (e.g., determining medical readiness of patients for anesthesia and surgery, and providing critical medical management of unexpected emergencies).]

Payment for supervision is based on three units (plus one additional if the anesthesiologist participated in induction) for the MD, and the usual 50% for the CRNA.

CRNAs sometimes explain supervision and direction not in billing terms, but to indicate that under supervision the anesthesiologist is a second pair of hands in an emergency or simply collaborates as an equally trained provider.

Debra Malina, AANA president, states, "Both CRNAs and our physician colleagues receive essentially the same extensive didactic education and clinical training in anesthesia." CRNAs further argue that under medical direction, the anesthesiologist dictates the anesthetic plan and the CRNA is prevented from practicing to the full ability and scope of their practice.

Since AAs work only under medical direction, CRNAs have claimed an AA can't actually respond to a medical need of a patient during an anesthetic until an anesthesiologist enters the operating room and directs the AA to give a medication or change the anesthetic, thereby putting patients at risk.

Needless to say, such statements get legislators' attention when the AANA opposes AA licensure in a state. It's worth noting that hospital administrators, surgeons, patients, and hospital staff usually assume that when

Continued on page 5

Missouri Anesthesiologist Assistant Update

By Mary Roberts, AA-C
MAAA President

Missouri Anesthesiologist Assistants are having a tremendous 2012. Missouri AA growth is booming due to the hard work of the UMKC AA school, AAs within the state and the anesthesiologists who tirelessly support us. We are proud to share some of the year's highlights.

In January, the UMKC Master of Science in Anesthesia Program welcomed the class of 2014 as the school's largest ever with 15 students. Then in May we graduated our third class of six exceptional AAs, all of whom accepted jobs within Missouri.

In very recent news, Dan Hladky, a long time and well respected AA, accepted a full time UMKC teaching position beginning August 2012. In addition, the UMKC program has had wonderful political exposure.

A new class of students at UMKC

In February, AA students joined members of the Missouri Society of Anesthesiologists in Jefferson City for Anesthesiologists Day at the State Capitol. Also, the program was honored to have Missouri Governor Jay Nixon visit in June.

Across the state, three St. Louis area practices hired their first AA; Barnes Jewish St. Peters Hospital, St. Louis University Hospital, and Christian Hospital. There are now six hospitals in St. Louis where AAs are practicing. Recently, hospitals in Springfield, MO opened to AAs and have been steadily hiring. By fall 2012, we hope to have 50 AAs in the state.

The MAAA component society also gained steam in 2012. We created a mission statement, Facebook group and are working to incorporate CME credit in our next annual meeting. Membership is on the rise as more AAs gain employment and see how important it is to support further AA growth.

I look forward to writing this update next year as we strive to attain the highest level of education and professional growth. Thank you to everyone who was involved in getting us where we are today.

Direction vs. Supervision from page 4

an anesthesiologist is anywhere in the perioperative locale, all cases are being medically directed. Neither the patient nor hospital (unless they are responsible for anesthesia billing) typically cares about billing terms and will not be aware if the anesthesiologist is supervising two or 10 cases.

Interestingly, supervision does not create surgeon liability for anesthesia complications or errors when a surgeon supervises a CRNA. Supervision is not the same as control over the CRNA and the anesthetic, which is a necessary element under most tort law in order for liability to be determined.

Forty states do not have any physician supervision requirement for CRNAs in their laws or regulations. The laws of every state permit CRNAs to work without an anesthesiologist and directly with a physician or healthcare providers such as dentists and podiatrists. In states that do require physician supervision, the supervising physician is not required to have any training in anesthesia, except in New Jersey and Washington D.C., and only when a general anesthetic is administered in Washington D.C. Medical supervision is a convenient billing practice that puts the AA at a disadvantage.

AAs can only work under medical direction. AAs are not eligible to practice independently under "opt out" arrangements or under medical supervision.

Confused yet? Any time you talk about money, you will find loopholes and rules that allow exceptions and optimization of profit for certain parties. Our federal tax system is one such example. The government is desperate to reduce healthcare spending because the current system is poised to go bankrupt in the next 10 years; some economists predict healthcare spending could bankrupt the entire country.

Medicare is a huge business. According to the United States Department of Health and Human Services, the costs for Medicare and health expenditures will be 19.3%, or nearly one-fifth of the GDP by year 2019. 'Opt out' and 'medical supervision' are early modifications to help government, both state and federal, reduce expenses and increase access to anesthesia care.

Both government and private insurers are making it clear that the current reimbursement system is changing towards any system that is less costly. Unfortunately for AAs, anesthesiologists, and patients, most are coming to the conclusion that less supervision by anesthesiologists, and greater use of CRNAs, is the most efficient way to make that happen (see "KY becomes 17th state to opt-out" pg. 6 Anesthesia Record 2nd Q 2012).

It's important for all AA-Cs to be able to readily explain not only that supervision and direction are billing or payment terms, but also exactly how the anesthesia care team functions. If you plan to work as an AA for five or more years, then you should get serious about understanding the reimbursement system and recruiting your colleagues for AAAA and ASA membership, the only organizations fighting for the Anesthesia Care Team model of practice, and the only way that AA-Cs get reimbursed for their services.

1. Anesthesia Care Team Statement, ASA, October 21, 2009
2. "Anesthesiologist-CRNA Teamwork Common, but Groups at Odds", *Medscape Anesthesiology*, John C. Hayes, April 12, 2012

Georgia Academy of Anesthesiologist Assistants Update

By Bill Buntin, AA-C

What a great time to be a member of the Georgia Academy of Anesthesiologist Assistants (GAAA)! We now have over 50 members, including both fellow AAs and students. We are growing fast and looking forward to a very productive year. Currently, we are in an election process for Officers and Directors and we anticipate many great ideas from the new leadership.

Thirteen fellows and three students recently attended the Georgia Society of Anesthesiologists (GSA) meeting at the Ritz Carlton Lodge at Lake Oconee. The GSA graciously provided the GAAA with a vendor table to promote the AA profession and with meeting space for the GAAA meeting.

AAs were able to network and speak with GSA leadership including Dr. Howard Odom, AA Education and Practice committee chair and ASA director, Dr. Steven Walsh, President of the GSA, and Dr. Jerry Cohen, President of the ASA. We discussed important mutual topics such as reimbursement, employment and anesthesia safety.

Claire Chandler, AAAA President, graciously flew in from another distant meeting to attend the GSA, and lent her knowledge and influences to support the GAAA.

Claire Chandler, AA-C; Bill Buntin, AA-C; Steven Walsh, MD; and Jerry A. Cohen, MD at the GSA Conference.

We hope to have many more AAs attend next year's GSA/GAAA meeting to keep the relationship strong between AAs and anesthesiologists. Please take time to join your state societies of anesthesiologists and anesthesiologist assistants. Your job depends on them.

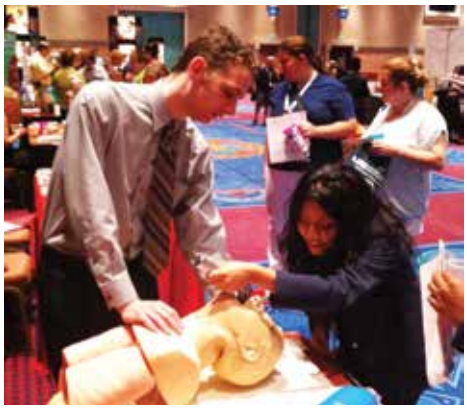
If you are interested in joining the GAAA, please visit our website: Georgiaaaa.org Facebook: Georgia Academy of Anesthesiologist Assistants.

AA Profession Showcased at National HOSA Conference

By Nick Davies, AA-C
Treasurer, Florida Academy of Anesthesiologist Assistants

The AAAA was represented at the Health Occupations Students of America's (HOSA) National Leadership Conference in Orlando, Florida in June. High school students, teachers, and guidance counselors from across the country attended the conference. During the four-day exhibition, the AAAA booth was very popular. Hundreds of students came by to learn more about the AA profession and practice intubating on an airway mannequin. Many guidance counselors interested in knowing more about the profession, received promotional material to take home to their students.

On the second day of the conference, Lauren Hojdila, AA-C and I conducted an hour-long workshop that gave more details about our education pathway and additional insight into the profession. The room was filled to capacity such that people had to be turned away. The students and teachers were all very impressed to learn about what we do, what our role is, and how to become an anesthesiologist assistant.



Nick Davies with attendee

The exhibit was a great success thanks to Nova Southeastern University - Tampa for providing airway demonstration equipment, Case Western Reserve University for providing informational packets from their school, and to the AAAA for providing other supporting equipment and information. Thank you also to Alison Matis, AA-C and Sabrina Palilonis, AA-C for donating their time to help staff the AAAA exhibit booth. With this team effort, we were able to reach many young people who are interested in a health career and who now may be prospective AAs. The conference organizers heartily thanked us for our participation and welcome us back again next year.

Following the Lead of Pediatric Anesthetists

By Kevin M. Hall
Chair, Anesthesiologist Assistant Employment Task Force
John Ng
Chair, Committee on Pediatric Anesthesia

Since 2006, growth of the AA profession is unlike any time in history. When taking a closer observation, pediatric anesthesiology has led the way in providing nurturing opportunities for AA students and new AA graduates to develop their clinical skill set. Often, the faculty of pediatric anesthesiologists has been committed to the success of AAs in their practice.

Fast forward to 2012 and we see that those pediatric anesthetists are now integral members of the Anesthesia Care Team model. Children's National Medical Center, Children's Hospital Colorado (formerly Denver Children's Hospital), Children's Medical Center of Dallas, Children's Mercy Hospital, Cardinal Glennon's Hospital, Texas Children's Hospital, American Family Children's Hospital, and Children's Hospital of Wisconsin either have pediatric anesthetists or are involved in the pediatric anesthesia training of AAs.

In the future, the Anesthesiologist Assistant Employment Task Force (AAETF) will partner with the Committee on Pediatric Anesthesia (CPA), led by John Ng, to strategically look for additional opportunities for both pediatric anesthesia training and/or employment of AAs into the anesthesia care team model at academic pediatric hospitals and medical centers.

At Children's Hospital Colorado, pediatric anesthesia is a recognized subspecialty where pediatric AAs choose to practice because of their love and passion involving the perioperative care of the entire spectrum of children. The faculty and staff are committed to the overall success, growth and development of AA student pediatric training, which in turn allows for personal recognition and interest into the field of pediatric anesthesia.

In general, as more AA programs continue to develop, it is critical that the AAAA, through the CPA and AAETF, allow for strategic targeting to develop newfound partnerships with pediatric hospitals and medical centers in states where AAs practice but may have little or no presence. We are committed to this end.

AA Student Involvement in the AAETF

By Chaveli Ezpeleta, AA-S
Sarah Fisher, AA-S

Hello! My name is Chaveli Ezpeleta and I am currently a second year AA student at Case Western's Houston program. I am extremely excited to serve as co-lead student liaison of the AAETF along with Sarah Fisher.

Although I am originally from the Philippines, I grew up mostly in Illinois and went to college at the University of Illinois in Champaign-Urbana, where I earned a B.S. in General Engineering. Before starting at the Case-Houston program, I worked at a physician's office and as a safety engineer for a consulting company.

I am thoroughly enjoying my time as an AA student and look forward to providing patients with high-quality anesthesia care as an AA!

My name is Sarah Fisher. Currently I am enrolled at Emory University in Atlanta. I am about to start my final year in the AA Program. Before going back to school, I was an emergency room nurse for over six years. Also, I am married with two beautiful children.

Going back to school has been a challenge for many reasons, but I have loved where this new career is going to take me. As an "old nurse" and being in an AA program rather than a CRNA program has had its own challenges and it has made my decision for joining the AAETF more personal. I am hoping with the AAETF we can educate the public, politicians, hospitals, and nurses that we are well educated, competent, safe and effective practitioners.

I hope that we can prove that we can all work together with the same goal in mind, taking care of patients. I am excited to be a part of the AAETF and hopefully help open more doors and career opportunities for AAs in the future.

As co-lead student liaisons of the AAETF, we would like to provide AA students with resources for seeking employment, such as directing them to the employment related section the AAETF is planning to create in the AAAA Forum of the AAAA website.

Additionally, we plan on relaying the employment concerns of current AA students to the rest of the AAETF, so that Task Force members are aware of the most pressing of students' concerns regarding employment. Also, we would like to provide students with contact information for employment related inquiries at specific hospitals or with specific anesthesia groups.

Our members range from current students and recent graduates to those who have been practicing AAs for years. It will be a way for students and currently practicing AAs to have instant camaraderie and connections to the job market.

Also, we will be posting current advancement concerns related to the AA community, using the AAAA website as our home base for information and updates. We hope that the Facebook page will also inspire more students and practitioners to join the AAAA to increase our efforts of advancement.

We are very excited to be involved with the AAETF and we look forward to watching the progress that we can make when we all work together.

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CALENDAR OF EVENTS

Sept 21 – 23 – San Francisco, CA

The Changing Practice of Anesthesia. UCSF designates this live activity for a maximum of 18 *AMA PRA Category 1 Credits*™. Pre-Conference Workshops held Sept. 20th. For all the information, go to www.cme.ucsf.edu.

Sept. 28 – 30 – Myrtle Beach, SC

NCSA/SCSA 32nd Annual Meeting. The Wake Area Health Education Center designates this live activity for a maximum of 11 *AMA PRA Category 1 Credits*™. Check online at http://www.ncsoa.com.

Oct. 11 – 12 – Washington, D.C.

The Society of Anesthesia and Sleep Medicine presents Anesthesia and Sleep Medicine: What Every Health Professional Needs to Know. Register online at: http://anesthesiaandsleep.org.

Oct. 12 – Washington, D.C.

Society of Ambulatory Anesthesia (SAMBA). This one-day live meeting is designated for a maximum of 6.25 *AMA PRA Category 1 Credit(s)*™. For more information and registration, go online to https://s4.goeshow.com/samba/2012MYM/ereg544600.cfm?clear.

Oct. 13 – 17 – Washington, DC

Anesthesiology 2012. American Society of Anesthesiologists' Annual Meeting. More information online now at http://www.asahq.org/Annual-Meeting.aspx.

Oct. 28 – 31 – White Sulphur Springs, WV

18th Annual Advances in Physiology and Pharmacology in Anesthesia and Critical Care. This live activity is designated for 17.25 *AMA PRA Category 1 Credits*™. Additional workshops available on Oct. 27 & 28. To register, call 336-716-2712 or go online to www.nwahec.org/?36707.

Oct. 29 – Nov. 2 – Naples, FL

Survey of Current Issues in Surgical Anesthesia. Free space-limited workshops included in registration fee. Web address: www.ccfcme.org/SurgAnes12.

Nov. 28 – Dec. 2 – Houston, TX

Global Conference on Perioperative Medicine: Care of the Elderly and the Cancer Patient. A maximum of 38.5 *AMA PRA Category 1 Credits*™ has been designated for this live activity. For registration questions call 713-792-6911 or email anesworkshop@mdanderson.org.

Dec. 12 – 18 – New York, NY

66th Annual PostGraduate Assembly in Anesthesiology. This live activity is designated up to 46.5 *AMA PRA Category 1 Credits*™. Online registration available at www.nyssapga.org. Come visit the AAAA booth in the exhibit hall!

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*™.