Pete's Booth Tips

For

ASA Annual Meeting

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Anesthesiologist Assistants, Program Staff and Students,

Thank you for taking the time represent the AA programs and profession at the 2013 ASA Exhibit Hall. Below is guide that will assist you while staffing the booth.

STAFFING EXPECTATIONS

Timing

Faculty and students should plan on arriving 10 minutes early to their scheduled shift. Upon arrival please sign in with the Program Coordinators. The Program Coordinators will let you know where you will stand and will keep the booth running smoothly for us.

Appearance:

All persons staffing the booth should be in business professional attire with their name badges clearly visible. There should be no eating, doing homework, reading or cell phone use at the booth. Remember we are representing our profession to the people that will be hiring us!!

Students Role:

This should be a learning experience for you on how to present your future profession to anesthesiologists. You will be partnered with a faculty member from either your school or another AA program. Faculty members should supervise student conversations with the anesthesiologists and help guide them. This is also a time for students to get to know program faculty from other programs. All students participating in the booth will be required to attend the pre-conference update on the booth. The update will be held by teleconference generally the week before the conference

INITIAL INTRODUCTIONS

Drawing people in

Whenever someone approaches, try to make eye contact and smile. If they are strolling past the booth and hesitate for a moment trying to decide if they should stop, then take the initiative and say, "I would be happy to answer any questions you may have about anesthesiologist assistants," or "Have you heard of anesthesiologist assistants?" If they don't want to talk to you, offer them a brochure and mention if they have any questions later they can call the phone numbers in the AAAA brochure. Thank them for stopping by the booth.

Conversations:

These should be a one-on-one conversation; the entire booth staff should not gang up on one visitor. Let the visitor complete his question and don't interrupt. Visitors may make comments, such as, "Are you folks the ones that take care of the equipment and clean up in between cases?" Do not show any offense and simply say that we are not and that they are referring to anesthesia technicians and technologists. There may be other comments that seem "outrageous" to you, but may be based on ignorance or misinformation. We are there to educate people about our profession. Always answer "yes sir", "yes ma'am", or "yes doctor."

If a person approaches the booth and they do not have an identifying title after their name (such as MD, DO, RN, etc.) then you have to assume that they are a doctor. If a RN or CRNA approaches the booth, then be pleasant and answer any questions politely. Remember that there has been a great deal of misinformation disseminated about AAs to the general nursing population by their leadership, and it is beneficial to our profession that nurses get the truth.

Students or other booth staff, if you do not know the answer to a question, either ask one of the other senior booth staff or say "I don't know the answer to that question, but I will get in touch with someone who will get that information to you." Giving incorrect information can do much more harm and is very difficult to correct later. Make sure you obtain contact information by scanning their meeting ID badges or by writing their information down. Once your conversation is over say "Thank you for stopping at our booth. If you or any of your colleagues have any further questions, please call the number in our brochure."

OPENING PRESENTATION

The below items following are items that can be studied prior to working the booth. The opening presentation is great way talk about our profession once you have lured them into the booth. The frequently asked questions will help you answer any questions people may have.

Opening Presentation

"Anesthesiologist Assistants are highly trained allied health personnel who are specifically trained in anesthesia and can ***ONLY**** work under the medical direction of an anesthesiologist. AAs receive a Masters degree and 24-27 months of training from a program that is affiliated with a medical school. Training programs have a recognized national accreditation and the graduates sit for a certifying examination that is covalidated by the NBME (National Board of Medical Examiners). AAs must maintain 40 CME credits every two years to maintain certification, and must ***SIT*** for a written examination every 6 years. Clinical duties are the same as CRNAs in the OR except that we work ***STRICTLY*** under the direction of an anesthesiologist. Medicare and the Veteran's Administration (VA) recognize AAs as anesthesia care providers and are reimbursed the same as CRNAs. AAs are defined as members of the anesthesia care team by the ASA and we offer another alternative for your practice. Can I answer any other questions?"

* Underlined, larger font, bolded words should be verbally emphasized in the opening presentation.

►T*his whole presentation can be done in less than 2-3 minutes and hits all the key points that anesthesiologists are interested in at a basic level. Anesthesiologists want to hear that they have control over the medical decisions involved in the case and we believe that an anesthesiologist is charge of the anesthesia care team. By doing this we are simply restating the obvious in that we recognize their advanced knowledge and training. Next, they will appreciate the fact that our training takes place with a medical school affiliation. To them this means that our training is congruent with the training they receive and the medical principles are the same. Anesthesiologist involvement in our training sets us apart from CRNAs where didactic content is determined by nursing. Mentioning that we are involved from time to time with residents in clinical training and didactic sessions infers a comfortable relationship between the anesthesiologists and us.*

The accreditation statement eases apprehensions about the validity of our training because they know that the training programs are reviewed periodically. We need to point out that the National Board of Medical Examiners (NBME) is covalidating our national exam. Physicians respect the work of the NBME because their testing process is the "gold standard" for graduate medical education. The mention of the NBME with its prestigious standing usually erases any concerns about our certification process. Be careful not to use the term "Board certified or AAs sit for Boards" as we are only certified not board-certified and that is touchy item for some doctors.

The mentioning of the similar job descriptions between AAs and CRNAs answers a lot of questions about how we are used clinically. At this point it is important to mention again that we can ***only*** *work under the direction of an anesthesiologist. The key difference here is that* ***any*** *licensed physician can medically direct CRNAs. The anesthesiologists will view AAs as non-competitors which is especially important after the recent American Association of Nurse Anesthetists' current movement to have States' governors "opt out" from supervision of CRNAs by all*

physicians. In those states that "opt-out" of physician supervision, Medicare patients can receive the delivery of anesthesia care by CRNAs without physician oversight.

Mentioning that AAs are recognized by Medicare as anesthesia care providers is very important because it means the practice that hires AAs can get reimbursement for patients that have an AA involved in their anesthetic.

*Lastly, we need to mention that AAs present an alternative. You might want to emphasize that AAs offer anesthesiologists a choice. Of all 29 recognized medical specialties, anesthesiology is the **only** specialty whose practitioners have only **one** choice when it comes supporting allied health personnel. All other specialties "enjoy" the ability to choose from at least four different allied health groups. This statement is usually an eye opener for most anesthesiologists.*

FREQUENTLY ASKED QUESTIONS

Most importantly if you don't know the correct answer to something do not give out misinformation. It is best to try to guide them in the correct direction, ask someone else at the booth or get their contact information and follow-up with them later.

How long have AAs been in existence?

AAs have been in existence for over 40 years.

How many training programs are there and where are they?

There are ten.

1. Emory University in Atlanta, Georgia
2. South University in Savannah Georgia
3. Nova Southeastern University in Ft. Lauderdale
4. Nova Southeastern University in Tampa, Florida
5. University of Missouri-Kansas City in Kansas City, Missouri
6. Quinnipiac University in North Haven, Connecticut
7. University of Colorado in Denver, Colorado
8. Case Western Reserve University, Cleveland, Ohio
9. Case Western Reserve University, Houston, Texas
10. Case Western Reserve University, Washington DC

What are the minimal requirements for admission to the programs?

Generally speaking, the candidate must have a minimum of a baccalaureate degree or greater from a recognized college or university with a pre-med core curriculum. Applicants usually have science or medical backgrounds, including chemists, paramedics, and even nurses. Depending on the program, all applicants must take either the MCAT or GRE examination.

►*The emphasis should be made on pre-med curriculum. This lets them know that our candidates have a strong university-based science education. This insinuates a higher level of scientific background that is similar to the background of anyone applying to med school. The MCAT and GRE exam validates the university based science training and they had to take a similar exam to get into med school.*

What degree do AAs earn when they graduate from a program?

Masters. There are some early graduates that have BS degrees but all future programs will be at a Master Degree level.

In how many States do AAs currently practice?

AAs currently practice in 17 States and the **District of Columbia**. **Alabama**, **Colorado**, **Florida, Georgia**, Kentucky, Michigan, **Missouri**, New Hampshire, **New Mexico**, **North Carolina, Ohio**, **Oklahoma**, **South Carolina,** Texas, **Vermont**, West Virginia, and **Wisconsin**.

►*States in bold type have statutes that allow for licensure or registry of AAs. All others are under delegatory authority and practice under the anesthesiologist's license. The difference between a license and registry is that a license usually involves a separate board regulating that license whereas, registry usually implies the registered individual answers to a board that is not regulated by their own profession. For example, doctors have their own board and registered respiratory therapists answer to the medical board. Licensure and registry carry the same legal weight.*

Which State agency typically regulates AA practice?

In all States in which AAs practice, they come under the regulatory authority of the State Medical Board. The AAAA seeks to have AAs under State Boards of Medicine.

►*Again an important issue to anesthesiologists because we are not seeking an independent licensing Board where they will have no input. CRNAs fall under a separate nursing board in all States.*

Why aren't AAs licensed as physician assistants?

Physician assistants are trained under a different accreditation and certification process and all State laws pertaining to PA licensing require passing the PA national certification examination. Therefore, since AAs cannot sit for the PA examination we cannot apply for a PA license.

►*Georgia is the only state that recognizes AAs as PAs. The reason is that the initial legislation was passed in the late 70s at a time when PAs weren't clearly defined. The AA concept was based on the PA model with the difference being that AAs (being trained specifically as specialists) could only work under anesthesiologist supervision, whereas, PAs (being trained as generalists) could work under any physician supervision. Since that time PAs have worked very hard at standardizing their definition and including surgical assistants the umbrella of the current State definitions. In Alabama, we are licensed under the "assistants to physicians" code which includes PAs. AAs were able to be included here because the term "assistants to physicians" has a different meaning than "physician assistants" in the contemporary meaning.*

What is the basic difference between AAs and CRNAs?

CRNAs can only practice under the supervision of a licensed ***physician*.**

Exception is for Medicare patients in states that have an "opt-out clause for physician oversight of CRNAs.

AAs can only practice under the supervision of a licensed ***anesthesiologist*.**

►*If any anesthesiologists initially seem not to understand this, then repeat and emphasize the physician difference. This is a key concept in that it reinforces the fact that we can only work under an anesthesiologist and the CRNAs can work under any licensed physician. The fact that we can only work under anesthesiologist direction reinforces the concept that we cannot compete with them.*

How are AAs utilized in the clinical situation?

A good answer to this question is: "AAs have been utilized clinically the same way that CRNAs function in the OR. In all settings where a department hires AAs/CRNAs, the job descriptions for clinical duties are the same. We feel it's up to the individual department to define our roles based on your practice's needs. AAs practice in the Anesthesia Care Team model."

►*The key points here are that we, at a minimum, are equivalent providers to CRNAs and are* ***interchangeable*** *in the Anesthesia Care Team model. This is important in that it confirms that the anesthesiologist won't have to sacrifice any clinical function if he/she hires an AA. Secondly, the statement again emphasizes that the anesthesiologists control the medical direction of the anesthesia care team. If the issue of spinals/epidurals comes up then simply state that we are trained for this, however, the anesthesiologists' practice protocols will determine if we perform this task or not. "We have found that most anesthesiologists prefer that we perform these tasks under their medical direction.*

How are AAs supervised?

Generally speaking, the anesthesiologist should be immediately available within the perioperative suite and within the building.

Can I bill for AAs when they are used on Medicare cases?

Yes. AAs are recognized as a Medicare provider of anesthesia services. We are defined under Medicare Rules for participation. AAs fill out the same form that CRNAs do in order to obtain a national provider number.

►*If anyone needs additional information, we can provide it.*

In what ratios are AAs utilized when it comes to Medicare patients?

The ratios are the same as those for CRNAs; that is, 1:4, as defined by CMS for reimbursement. However, we have found that most practices use the 1:2 or 1:3 typically. The reimbursement rate for services rendered is the same.

► *CMS stands for the Federal agency Centers for Medicare and Medicaid Services. Medicare is the program under which people who have a Social Security account can receive medical benefits. CMS doesn't limit the ratios of MD to anesthetist they just will not pay for more than 1:4 supervisory ratio.*

Are AAs reimbursed for Medicaid patients?

"Usually. Each State has different policies governing Medicaid reimbursement. You'll have to check with the State agency governing your Medicaid program."

► *Medicaid is the Federal program that oversees medical insurance coverage for the people enrolled in State Welfare programs.*

Can AAs be reimbursed by third party medical insurance carriers?

Yes. Again, AAs are reimbursed the same as CRNAs, if the plan covers non-physician anesthesia services.

Can AAs be covered for medical malpractice?

Yes. AAs have been covered by their employers or can be covered under the anesthesiologist's medical malpractice coverage.

Are salaries for AAs less than for CRNAs?

Not usually. To our knowledge, in all hospitals that hire AAs, the pay is the same for AAs/CRNAs. If the practice can negotiate a lower salary with an AA then that is that individual's choice. Typically, the idea is: same work, same pay. It's a function of the marketplace in your region.

►*This question comes up often so don't react negatively if you are asked this question. The emphasis is that salaries are market driven and they'll have to negotiate with the individual.*

How can I get AAs in my state?

Refer them to the National Affairs Committee Chair at present the chair is Mike Nichols.

► *A general AAAA card with Mike's information will be available at the booth*

We have AAs and are having billing issues or we have heard there are billing issues for AAs.

Refer them to Dave Biel AA-C he is Chair of our Practice Committee

►*Dave's Board of Directors card will be available at the booth*

►*In general we are trying to refer people to actual person rather than the AAAA in general. If they have general questions feel free to give them generalized card. We will also have the AAAA President and President-Elect cards at the booth*

If we allow AAs to practice in __(State)___ then you might wind up competing against us in the future.

AAs cannot compete with anesthesiologists since we can only work under the direction of an anesthesiologist.

- Anesthesiologist Assistant (AA) concept was developed by anesthesiologists
- Anesthesiologist Assistant sponsorship to AMA was initiated by AAs and anesthesiologists
- AAs can only legally practice under the direction of an anesthesiologist
- AA training programs must be affiliated with a medical school and must be directed by an anesthesiologist
- AA training program review involves AAs and anesthesiologists
- AA students are taught and trained by anesthesiologists
- AA students are trained along side residents in anesthesiology
- AA certification process involves AAs and anesthesiologists
- AA recertification process involves AAs and anesthesiologists