The Anesthesia Record

October - December 2013

Under New Management
Cornerstone Communications Group

Affordable Care Act
New Healthcare Challenges

Georgia Strong
GAAA's Surge in Membership

The Newsletter of the American Academy of Anesthesiologist Assistants

CONGENITAL HEART DISEASE

ANESTHETIC MANAGEMENT FOR PATIENTS WITH TETRALOGY OF FALLOT

The Anesthesia Record
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White Coat Ceremony
Professor Mike Provost, AA-C (left) with Hanh Duong, AA-S, Karen Sorchini, Lena Assaf, AA-S, and Program Director Llalando Austin, AA-C at NSU Tampa' Campus' White Coat Ceremony for the Class of 2015

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Looking *Back* on 2013 and *Forward* to the Future

By Saral Patel, AA-C

HAPPY NEW YEAR! As we transition into 2014, we must look forward to the future and plan our goals for the upcoming year. However, we must reflect on the past 365 days. Reflection offers us a time to examine our actions, events that shaped our lives and reminisce over fond memories made over the past year. We reflect on 2013 and hope the organization has conducted itself in a manner that exemplifies our core values, in addition to being productive in advancing the organization towards its strategic goals. Teamwork, leadership, communication, professionalism, and mentorship are the pillars lending support to sustain the profession. Adherence to these values will cause the AAAA to mature in 2014. Growth will be in areas of practice opportunities, legislative initiatives, as well as maturing as an organization. Essentially the AAAA is still in its infancy stage. Each month, the organization is reaching milestones and experiencing growth spurts. Membership numbers have increased to over 1250, a record high for the organization as the number of practitioners graduating each year has increased to 182 graduates sitting for the NCCAA exam. 2014 will be the AAAA's 39th anniversary of incorporation and we hope it will be another record breaking membership year.

Teamwork is the combined action of a group of people towards a common goal. The AAAA could not survive without the collaborative efforts of many. The Board functions to guide the organization toward the achievement of the strategic goals; however it is the efforts of the committee chairs and volunteers that drive this organization. To be effective, committees must function as a team with a common goal and purpose. Teamwork is also applicable to the profession as a whole. Anesthesiologist Assistants are integral members of the Anesthesia Care Team. Our input and skill benefit each patient for which we care.

Leadership is the vehicle by which the organization achieves its goals. This year we have seen the organization flourish under the leadership of new, fresh leaders. Carie Twichell will be coming in to lead the organization in April with a wealth of experience as a Board member and Committee Chair. Carie has been a strong preceptor and mentor to many AA students and the AAAA will continue to thrive under her leadership.

Brian Tracy said, "Communication is a skill that you can learn." In 2013, the AAAA spent much effort on improving the organization's communications skills. The most obvious change was the newsletter. *The Anesthesia Record* is a testimony of professionalism and success. It exemplifies the transition of the organization from a small, hobby-like organization to a key stakeholder of the perioperative community. As our communication grows, the AAAA will see gains internally and externally.

Merriam Webster defines Professionalism as the skill, good judgment, and polite behavior that is expected from a person who is trained to do a job well. As the practice issues and legislative initiatives demand attention by the organization, it is more imperative than ever for the organization to foster professionalism. In 2013, we saw the organization taxed more than ever with multiple challenges to our practice. The AAAA addressed each challenge with swift, accurate responses. The AAAA was represented by professional leaders providing testimony and information to multiple agencies like Centers for Medicare and Medicaid Services (CMS), the Veterans Affairs Department and Blue Cross Blue Shield, to name a few.

Equally important as leadership, mentorship will sustain this organization. In order for the organization to flourish, AAAA leaders must teach and mentor the next generation. As we undergo committee restructuring, mentoring will play an even greater role. The immediate past president will be chairing the Governance Committee, being a natural mentor to the AAAA Board by leading Leadership Development and Board Orientation.

As I reflect on 2013, I am proud of all the organization has accomplished, while remaining true to the core values of the organization. I am also confident that 2014 will bring the AAAA closer to its strategic goals and even more victory for the profession as a whole.

Welcome, Cornerstone Communications Group

AAAA Begins 2014 with a New Management Company

Cornerstone Communications Group offers a buffet of services in the disciplines of government relations, public and media relations and association management. Cornerstone has served clients in Georgia and the southeast since 1991.

Founding CCG principal James E. "Jet" Toney has earned 38 years experience working for and with elected and appointed government officials. He has managed multiple client organizations as an executive and strategist since 1995. Jet is a cum laude graduate in Newspapers from the University of Georgia and has consulted on more than 200 electoral campaigns at the local, state and Congressional level. Jet will serve as the Executive Director of the AAAA.

Devon Bacon will serve as Associate Director and is responsible for communication and meeting management. Devon served in the Press Office of Georgia Governor Nathan Deal where she created and posted his weekly on-line newsletter. Ollie Lawson is the AAAA Member Services Manager. She is responsible for membership renewal and applications and member fulfillment.

CCG's business and financial services team is led by LeAnn Johnston, a graduate of DeVry University in accounting. LeAnn will keep AAAA's books and assure compliance with state and federal record-keeping and tax filing. LeAnn has successfully integrated on-line member dues payment and registration activities with organizational accounting for several entities. Her attention to detail assures annual meetings and other revenue events run smoothly and on budget.

LeAnn Johnston (left) and Jet Toney (right)

Run for the Warriors® Team Places Fifth in Overall Fundraising

AAAA's Run for the Warriors® team (pictured above in San Francisco on October 13, 2013) was comprised of 35 generous donators and runners who raised a total of $2,810, landing them 5th in the overall team fundraising.

Welcome New Members

Colorado
Kelly A. Maas, AA-S
Dylan A. Hartley, AA-S
Laura K. Knoblauch, AA-S
William M. Thompson, AA-S
Talia R. Cozzetta, AA-S

Florida
Glenn Walter, AA-S

Georgia
Rachael Koigi, AA-S
Robert C. Johnson, AA-S
Megan Tunstill, AA-S
Christopher Helwig AA-S
Timothy C. Trower, AA-S
Brian D. West, AA-S

Missouri
James Piontek, MD

Virginia
Priscilla Patel, AA-S

The AAAA Student Component Announces The AAAA Cup

By
Kristen Dell, AA-S

THE AAAA STUDENT COMPONENT WOULD LIKE TO ANNOUNCE THE NEW AAAA CUP. The AAAA Cup has been created to increase student excitement at the AAAA Conference and encourage student participation within the student component throughout the year. Each individual program will participate as a team at the AAAA Conference. Schools with various campuses will each compete separately, making a total of 10 teams. Each team will be given a score of 1-10 on each of the five categories. The school with the closest average to 1, over all the components, will take home the AAAA cup. The five categories are:

1. Money donated to the Legislative Fund
2. Percentage of program attendance at the AAAA Conference
3. Jeopardy competition placement
4. Percentage of Program Attendance at the AAAA Conference student social
5. LifeBox sales/donations

Attendance at the Conference and student social will be scored 1-10, based on percentage of total students in each program.

Legislative fund donation points will be based on the amount of students from each program and every class that donates at the level of Student Leaders of Advocacy ($100 Donation) from January 1, 2014 to April 1, 2014. Points will be given as follows:

Bronze (10 points): 25% or less donated to reach Leader of Advocacy level.

Silver (6 points): 50% donated to reach Leader of Advocacy.

Gold (4 points): 75% donated to reach Leader of Advocacy.

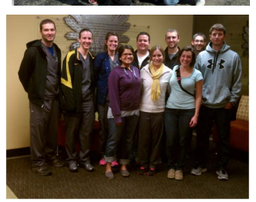
Platinum (1 point): 100% of students donated to reach Leader of Advocacy.

We hope you all will support the students with these various adventures throughout the year and at the AAAA conference, whether it is through a donation to their Lifebox fundraising or supporting your program at Jeopardy. The winner will receive the coveted AAAA Cup and bragging rights for the year. Let the competition begin!

UMKC's AA Students Give Back

STUDENTS RAISE MONEY FOR LIFEBOX AND DONATE TIME TO COMMUNITY CHARITIES

UMKC AA STUDENTS HAVE BEEN WORKING HARD TO RAISE MONEY FOR LIFEBOX. A recent fundraising event the AA students have participated in was at Worlds of Fun Halloween Haunt as zombies at Asylum Island! There they spent their evening scaring guests as well as helping with admissions and directing guests in the park. UMKC AA students are not only working hard to raise money for Lifebox, but they are also passionate about giving back to the local community. Recently they donated their time working a church's fall festival which included activities such as basketball with the kids as well as helping prepare and serve a meal. UMKC AA students spent several hours at Harvesters, a community food network. They spent the evening packaging soda and water for distribution to local food banks. Despite these students' days beginning early in the OR followed by an exam in their Anesthesia & Co-Existing Diseases class, they rallied that evening to selflessly give their time to help those in need.



BREWING A PROMISING FUTURE WITH DISTINGUISHED FACULTY

NSU TAMPA'S CAMPUS WELCOMES PROFESSOR MIKE PROVOST, AA-C

by Amanda Diaz, AA-S

MICHAEL PROVOST, AA-C, IS THE NEWEST FACULTY ADDITION to the College of Health Care Sciences, Anesthesiologist Assistant (AA) program located at the Tampa Regional Campus of Nova Southeastern University (NSU). With an educational background in science and anesthesiology, Professor Provost earned his bachelor's degree in Microbiology and Cell Science from the University of Florida in 2006 and his Master of Health Science degree with a specialization as an Anesthesiologist Assistant from NSU in 2009. He was the recipient of the NSU Chancellor's Award of his graduating class, which is awarded to the student who has demonstrated the characteristics of scholarship, leadership, integrity, humanity and loyalty to the AA profession.

Professor Provost was appointed Assistant Professor of the Tampa AA Program in May 2013, as course facilitator of Electrocardiography for the AA. His clear understanding of this subject and vast amount of knowledge in complementary information truly shined through as the course progressed.

Like all other faculty members of the Tampa AA Program, Professor Provost is a strong advocate of supporting our AA profession through enrollment in both the national and state component society organizations for the AA profession. He is an active member in the American Society of Anesthesiologists, Florida Society of Anesthesiologists, and American Academy of Anesthesiologist Assistants. He encourages students to continue their involvement in the AA community following their graduation from NSU.

There are many things Professor Provost enjoys about being an Assistant Professor, particularly witnessing his students grasp a difficult concept or skill. He stated that "the look in [his students'] eyes as everything that they have learned and worked hard for up to date finally clicks together" is the most rewarding part of his job. Professor Provost also humbly remarked that getting used to speaking and lecturing in front of a large group of students was quite difficult and endearing at first. In watching him give a lecture today, it is evident that he certainly overcame this difficulty and strives to become an excelling instructor with each day of teaching.

Further, Professor Provost combines his clinical obligations as an Anesthesiologist Assistant and his professional duties as Assistant Professor with that of his family life, which he describes as being of great importance to him. During his interview, he candidly discussed being happily married to wife Stephanie and together having a beautiful 18 month old son, Ryan. In his spare time he enjoys fishing, SCUBA diving, and homebrewing beer.

"My main goal as a professor is to instill the knowledge and skills in our students to allow them to be successful AAs," said Provost. Professor Provost has a genuine interest in the program, the students, and the potential impact he will have on both. Indeed, through the addition of distinguished, goal-oriented faculty members such as Professor Michael Provost the College of Health Care Sciences and the Tampa AA Program are destined for continued greatness and a long, successful path for many years to come.

STATE of AFFAIRS

UPDATES FROM STATE COMPONENT ACADEMIES OF ANESTHESIOLOGIST ASSISTANTS

GEORGIA

GAAA JOINS WITH GSA, UPCOMING WINTER FORUM WILL FACILITATE LEGISLATIVE DISCUSSION

By Joy Rusmisell, AA-C
President, GAAA

GREETINGS FROM GEORGIA! We are shaking off the summer heat, and prepping for the holidays to come. This fall the GAAA has been busy advocating for our profession and establishing relationships that are sure to grow our organization. In July, at the GAAA Annual Meeting held in Hilton Head, SC, the GAAA realized our goal of a joint membership program with the Georgia Society of Anesthesiologists (GSA). This partnership allows all GAAA members to hold an educational membership with the GSA by submission of a single dues fee, and seamless online registration process. This combination membership provides the GAAA with increased advocacy and support of the AA profession via recognition by the anesthesiologist members of the GSA. In addition, AAs are able to gain access to quality CME opportunities, have representation within certain committees of the GSA, and actively participate in advancing the AA profession in Georgia by developing key relationships with anesthesiologists. The GAAA retains the autonomy of its governance; however, issues affecting the Anesthesia Care Team can be addressed through a combined assessment involving the leaderships of both the GAAA and GSA. This result is due to the hard work of our GAAA members, GSA physicians, and GSA management company, and we are excited to see the products of our combined mission flourish.

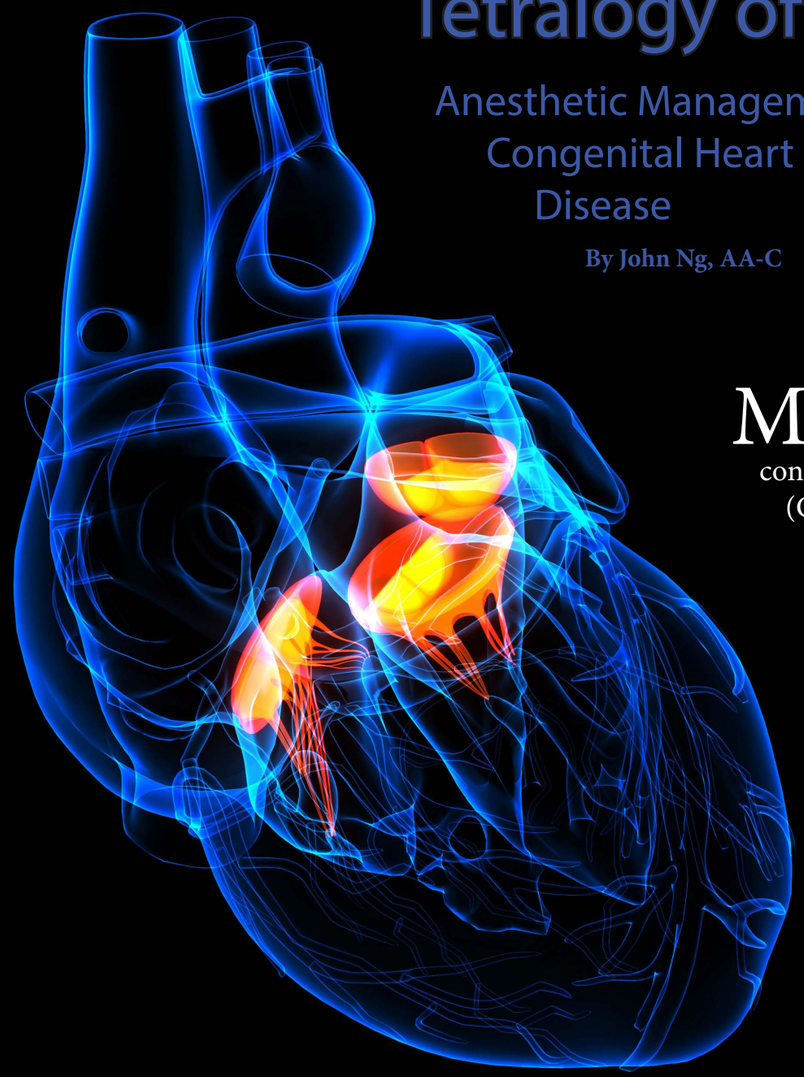
In upcoming news, the GAAA will host a Legislative workshop on Sunday January 12th during the GSA Winter Forum at the Marriott Perimeter Center in Atlanta, GA. We are honored to have State Senator and AA, Chuck Hufstetler, leading a panel discussion addressing the importance of AA relationships with state legislators, basics of interacting with legislators, developing a consistent message for legislators, and the most effective way of delivering that message. All conference attendees are invited to participate in the workshop, and several GSA leaders will also be present to offer a GSA perspective. The GAAA understands that in the face of a changing healthcare environment it is more important now than ever to establish connections with our legislators, and gain the attention of our policy makers in order for the growth and sustainability of our profession. The goal of the workshop is to provide attendees with a clear understanding of the GAAA legislative talking points so that every AA can deliver our mission and message with a unified voice. If you are a Georgia AA or in the Atlanta area, please make plans to attend the GSA Winter Forum and GAAA Legislative Workshop January 11-12, 2014. Online registration is available at http://www.gsahq.org/upcoming-meetings

We continue to grow our membership through grassroots efforts, and advocate for our profession on the state and national level. The GAAA has shown a 25% increase in fellow members and 100% increase in student members during the 3rd Quarter. We are thrilled by the advances made in AA Advocacy in Georgia, and look forward to the continued interest and involvement of student and fellow members. Please support your state component societies. The function and necessity of professional organizations have a great impact on the growth, success, and sustainability of our profession. Join the GAAA to help continue the support and advancement of AAs in Georgia. Online registration is available at www.georgiaaaa.org.

Tetralogy of Fallot

Anesthetic Management of Congenital Heart Disease

By John Ng, AA-C



Managing anesthesia care for patients with congenital heart disease (CHD) in both cardiac and non-cardiac operations can be challenging. With an estimated 85 percent of children born with CHD reaching adulthood, the population of adults with CHD will continue to grow. The initial diagnoses, surgical history, and anatomic and physiologic changes after corrective or palliative heart surgeries must be carefully reviewed prior to induction of anesthesia. In this article, we will evaluate the anatomic and physiologic significances of Tetralogy of Fallot (TOF), surgical interventions for this type of heart defect, and long-term cardiovascular complications related to these procedures.

TOF is the most common cyanotic cardiac lesion that occurs in 5-10 percent of all CHD. It is the fifth most common type of CHD with an incidence of one in 10,000 births. It is a midline-type defect that develops from an incomplete conotruncal rotation during septation with an anterior malalignment of the outlet ventricular septum. This leads to the underdeveloped subpulmonary conus, a hypoplastic RV infundibulum, and an anteriorly malaligned outlet ventricular septal defect (VSD). By definition, the "tetralogy" of this disease includes an overriding aorta, a malaligned VSD, pulmonary stenosis, and right ventricular hypertrophy.

The pathophysiologic consequences of TOF are dependent upon the severity of the right ventricular outflow tract (RVOT) obstruction and the resistance to pulmonary blood flow (PBF). Tet-spells, or hypercyanotic spells, occur when decreased PBF causes excessive right-to-left ventricular shunting. This increase in intraventricular shunting leads to severe arterial desaturation and systemic hypoxemia. Hence, greater PBF becomes essential for improving oxygenation. Anesthetic management for patients with existing TOF should be focused on balancing pulmonary and systemic circulations and on preventing acute alteration in PBF, resulting in profound systemic hypoxemia. Preload is a major factor in determining PBF. Increased volumetric pressure plays an important role in recruiting volume into the pulmonary circulation, as RVOT obstruction can be exacerbated by hypovolemia, tachycardia, and myocardial hypercontractility. Therefore, appropriate fluid replacement and maintenance and a normal heart rate are keys to maintaining cardiovascular stability. Administration of a beta antagonist helps prevent infundibular muscle spasm by controlling tachycardia, which is especially beneficial when the RVOT obstruction often appears dynamic. Likewise, deepening the anesthesia with inhalational agents and using opioids such as fentanyl and morphine blunt the release of catecholamines and slow down heart rate, which in turn decreases myocardial hypercontractility. For these reasons, commonly used drugs that can cause tachycardia such as atropine and pancuronium should be avoided. The balance between pulmonary and systemic circulations can also be affected by deviations in vascular resistance in both circulations. For example, a sudden drop in systemic vascular resistance (SVR) during induction of anesthesia lessens the resistance to flow to the systemic circulation, which promotes greater right-to-left shunting and exacerbates systemic hypoxemia. Using a pure alpha agonist and putting the cyanotic child in a knee-to-chest position help raise SVR and thus decrease right-to-left shunting through the VSD. Meanwhile, adequate alveolar ventilation and oxygenation can alter arterial partial pressure of O2 and CO2 and help lower pulmonary vascular resistance (PVR). Although this drop in PVR has minimal impact on lowering resistance to flow through the RVOT obstruction, the decrease in PVR does help promote blood flow in the distal pulmonary circulation.

Anesthetic management for patients with existing TOF should be focused on balancing pulmonary and systemic circulations and on preventing acute alteration in PBF, resulting in profound systemic hypoxemia

Recurrent symptomatic hypercyanotic spells and SpO2 averages less than 75-80 percent are known indicators for surgical correction of TOF. When anatomy of the RVOT and the pulmonary arteries are favorable, a complete repair of the defect is often performed on patients three months or older (Fig. 3). The reparative surgery is designed to prevent excessive ventricular shunting and to alleviate obstruction of the RVOT; the former involves a patch-closure of the VSD, while the latter is usually done by patching over the stenotic RVOT. Depending on the degree and type of RVOT obstruction, the repair may also include a pulmonary valvectomy or resection of RVOT infundibular muscles. Additionally, the stenosis on which the RVOT patch is applied may be subannular or transannular. If a transannular patch is placed due to a restrictive pulmonary valve annulus, resulting free pulmonary insufficiency (PI) is guaranteed after the repair. Mild-to-moderate PI is usually well tolerated. Nonetheless, in severe cases, chronic volume overloading can cause RV dilation, biventricular dysfunctions, arrhythmias, and heart failure.

In extreme cases, infants born with TOF may present with severe RVOT hypoplasia. Prostaglandin infusion is warranted to maintain patency of the ductus arteriosus and thus PBF. As a temporary treatment, palliative shunts are placed in order to augment PBF until a complete repair is applicable. Blalock-Taussig (BT) shunts are often inserted in these patients and can be either the classic or modified type (Fig. 4). It is important to be aware of inaccurate blood pressure measurements from the left arm if the patient has had a classic BT shunt with the left subclavian artery sacrificed for the procedure; therefore, the pre-ductal right upper extremity should be used for placement of the noninvasive blood pressure cuff or arterial line.

Since the survival rate for children born with CHD continues to rise, these children are more likely to require both cardiac and non-cardiac surgeries into adulthood. Even though patients with TOF can undergo complete repair of the defect, long-term complications such as residual RVOT obstruction, right ventricular dilatation and dysfunction, pulmonary valve incompetence, and ventricular or supraventricular arrhythmia are associated with the reparative procedure. All information regarding these patients' past surgical and medical histories must be properly evaluated before administration of anesthesia in order to provide safe and quality care.

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State and Federal Governments Struggle Over Health Care

By
Mike Nichols, AA-C

The Patient Protection and Affordable Care Act (PPACA), also referred to as "Obamacare," the legislative and regulatory overhaul of the nation's health care system, will most likely cost more, insure fewer people and probably take longer to implement than originally planned – as one might expect with such a massive and sweeping piece of statutory language affecting roughly 20% of the federal budget.

State and the federal governments are struggling to meet the deadlines for creating on-line marketplaces, known as 'Healthcare Exchanges,' in which individuals and families will be able to purchase affordable health insurance policies. The exchanges began enrolling customers by October 1, 2013 with a time horizon goal of full operationalization by January 2014. According to the Kaiser Family Foundation, states are facing "…serious challenges…" and some may be lagging in their efforts to meet these deadlines.

The deadlines are even more challenging for the federal government. When the original PPACA was passed in 2010, and its constitutionality subsequently upheld by the Supreme Court two years later, the administration clearly anticipated that most states would choose to run their own exchanges. This has not been the case, particularly in those states controlled by Republican governors.

The District of Columbia and 17 states, most of them controlled by Democrats, have decided to operate their own exchanges. Seven other states are planning to partner with the U.S. Department of Health and Human Services (DHHS). Twenty-six states, predominantly under GOP control, have left operation of the exchanges entirely to the federal government. There is a certain irony to this outcome, as one of the principal Republican objections to Obamacare is that it puts too much control in the hands of Washington. By deciding to create state exchanges, Republicans have voluntarily acquiesced to the federal government even more control of health care in their states.

Democrats can take scant comfort from the Republican inconsistency. The Obama administration from the beginning underestimated both the costs and complexity of the new health care law, which among other things did not provide funds for DHHS to set up the federally run exchanges. In the current budget, the President seeks $1.5 billion for this purpose. Congressional reaction to the request has been cool, to say the least. The budget also diverts money to the exchanges from a fund meant to support preventive health care, a tactic described as "…totally illogical and self-defeating…" by U.S. Sen. Tom Harkin (D-Iowa).

The price tag on the total costs of the exchanges, federal and state, is elusive, but ever skyrocketing. Budget documents the administration submitted to Congress in April said DHHS expected to spend $4.4 billion this year on grants to help set up the state exchanges. Last year DHHS estimated the cost at just over $2 billion.

Cost overruns aren't the only concern with the implementation of health care reform. The exchanges were supposed to stimulate competition among insurance companies, which may happen in states such as California, Colorado, Minnesota, New York, and Oregon, which already have such competition. However, states such as Alabama, Hawaii, Michigan, Delaware, Alaska, North Dakota, South Carolina, Rhode Island, Wyoming and Nebraska have been and will continue to be dominated by a single insurance company, in which competition isn't feasible or likely.

The PPACA is inundated with other problems as well. When the law was passed, it was presumptuously envisioned that states would expand Medicaid, the federal-state program that provides health care for the poor and disabled, to cover everyone up to 138% above the poverty line. The exchanges would then make insurance available for persons or families with incomes up to 400% above the poverty line. If Medicaid is not expanded, there will be a hole in the coverage for the working poor who may not be able to afford even heavily subsidized policies on the exchanges.

But the Supreme Court decision upholding the law gave states the option of rejecting the Medicaid expansion without penalty and many GOP-controlled states have taken this escape 'clause'. According to data from the Kaiser Family Foundation, 28 states and the District of Columbia have decided to expand Medicaid, with Kentucky the latest. Kansas and South Dakota are still weighing their options, while 20 have opted to reject expansion, though the precise data is tough to nail down. Regardless, when it comes to Medicaid expansion, GOP-run legislatures have been the primary obstacle.

Another provision of the PPACA requiring large employers to offer health insurance to part-time employees working 30 hours a week or more may be back-firing. Many employers are reducing hours to avoid having to purchase insurance for part-timers. The city of Long Beach, California, for example has 1,600 part-time employees and recently decided

to limit them to 27 hours a week on average. City officials defended their action by saying that providing health care benefits to these employees would cost $2 million annually and require layoffs and reductions in other various city services.

All told, the myriad of glitches in implementing the PPACA have reduced the number of uninsured projected to be covered from 32 million to 27 million, according to a February report by the Congressional Budget Office. In addition, up to 8 million people will lose health care plans now offered through their employers, three times the original CBO projection, leaving them to acquire health insurance through the exchanges or other means.

To be sure, delays and shortcomings were probably inevitable for a single legislative measure that seeks to overhaul the most expensive health system in the world. What worries many health economists and the DHHS more than any other issue is the formidable task of enrolling millions of uninsured persons on line in light of polls showing that most of them don't even know what an exchange is. As the law requires, however, DHHS and the state exchanges are training "navigators" to help people with the web sites. The task is daunting. Some of the prospective applicants have never had health insurance; others may never have used a computer.

An April poll, commissioned by the Kaiser Family Foundation, discovered that 4 in 10 Americans (42%) were unaware that the PPACA was the law of the land. Six in ten (58%) of the uninsured said they did not have enough information to make a decision about a health care policy.

Even so, among PPACA's supporters, a sense of cautious optimism remains that the exchanges, both state and federal, will eventually function even if the original deadlines are missed. Medicare had its share of start-up problems after its creation in 1965 but within a few years became woven into the fabric of American life. The health exchanges, or most of them, may take longer than anyone would like to achieve full functionality, but the Affordable Care Act is not going away.

AAAA Executive Offices
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Calendar of Events

December

6 – 8 – Chicago, IL
27th Annual Challenges for Clinicians. Sponsored by the University of Chicago, online registration coming soon at http://event.uchicago.edu/maincampus/detail.php?guid=CAL-402882f8-3bd7b87a-013b-de48f2d0-00000093eventscalendar@uchicago.edu

13 – 17 – New York, NY
67th Annual PostGraduate Assembly in Anesthesiology. The NYSSA designates this live activity for a maximum of 46.5 AMA PRA Category 1 Credits™. For more information go online to www.nyssa-pga.org.

January

11 – Atlanta, GA
GSA 2014 Winter Forum. Information available online at http://www.gsahq.org/upcoming-meetings

15 – 18 – San Diego, CA
UCSD Anesthesiology Update 2014. Presented by The University of California, San Diego School of Medicine, this live activity is designated for a maximum of 20.0 AMA PRA Category I Credits™. Further information available at: http://anes-som.ucsd.edu/2014_Update.

February

15 – 19 – Las Vegas
The 16th Annual Pain Management Symposium. The Cleveland Clinic Foundation Center for Continuing Education designates this live activity for a maximum of 39.25 AMA PRA Category 1 Credits™. Register online at ccfcme.org/NoPain or call 216-448-0777.

March

9 – 12 – Marco Island, FL
Perioperative Management – In Its 30th Year. The Johns Hopkins University School of Medicine designates this live activity for a maximum of 23.75 AMA PRA Category I Credits™. Register online at www.HopkinsCME.edu.

Online CME

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Video & Audio Programs

Harvard Anesthesia Update. Intended to provide anesthesia practitioners with a comprehensive review of the most important advances in clinical anesthesiology and each of its major subspecialties. Sponsored by the Harvard Medical School Department of Anesthesia and Continuing Education. A maximum of 27.5 AMA PRA Category 1 Credits™ may be claimed for this enduring material activity. Video, audio, or a combination of both are available starting at $695. Order via website for fastest service at www.cmeinfo.com/HarvardAnesthesia or call 1-800-633-4743. Date of credit termination: April1, 2015.

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.