Sentinel
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Society of Anesthesiologists
Newsletter

Winter 2012

PRESIDENT'S MESSAGE

The Post-Election Mandate: Singing the Blues or Taking Ownership

by Joshua H. Atkins, M.D., Ph.D., President

The U.S. presidential election is behind us and we now enter into a new phase of unpredictable transitions as the threats to our health care system continue unabated. This is an extraordinarily complicated and uncertain time for physicians and patients alike. It is easy to look at the multitude of policy and regulatory trends that stand in conflict with the best interests of our patients and be inclined to complain more loudly, give up all together, or still worse turn a blind eye and evolve to a state of learned helplessness.

Anesthesiologists must not be distracted by mainstream pessimism and instead remain focused with laser sharp precision on maintaining the highest standards of quality and safety in the care of our patients. If we give up now where will our patients turn?

The PSA has an unwavering commitment to legislative codification of anesthesiologist supervision and anesthesia as the practice of medicine. In this issue, our lobbyist John Milliron explains that this year we came very close to achieving this goal but politics ultimately got in the way.

In 2013, we will begin again. The lobbying team or board working alone cannot accomplish our goals. The grassroots involvement by the membership in support of HB 1570 was extraordinary. However, on a routine basis too few physicians make up a small group of advocates. Over the years, a select group of anesthesiologists have dedicated themselves to personal engagement with local and national legislators supported by broader contributions to the Z-PAC and ASA-PAC. At this critical juncture, we must continue steadfast in our efforts to recruit participation from our less involved colleagues in order to engage every single state and national legislator on the importance of physician led perioperative care.

At the same time, we should acknowledge that with the implementation of health care reform the battleground for physicians is rapidly shifting from well-defined legislative issues to more elusive regulatory challenges and payment innovations. These are equally threatening to patient access to safe, high quality anesthesia and pain care.

The good news is that anesthesiologists have an exceptionally broad purview in perioperative medicine that provides a substantial armamentarium with which to demonstrate our value. But we must be ready to take on this challenge and rejuvenate our commitment to the practice of medicine in its broadest sense. Simply providing outstanding care in the OR, procedure suite, or ICU will no longer be sufficient. In this fact lies tremendous opportunity to redefine our specialty and innovate in all aspects of care delivery.

In this issue, Lee Fleisher, member of the ASA Committee on Performance and Outcomes Measures and NQF's Consensus Standards Approval Committee, highlights the potential benefits to anesthesia for taking ownership of perioperative outcomes through

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Anesthesia 'Company Model' raises fraud and abuse concerns

by Robert Hoffman, Esq., and Sarah Carlins, Esq.

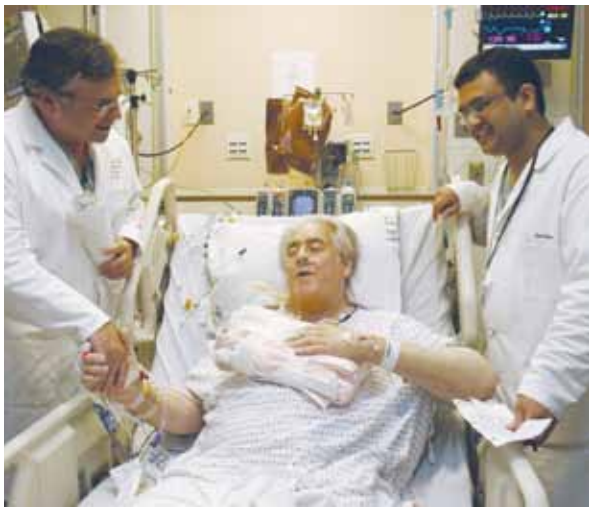
A March, 2009 article in Outpatient Surgery Magazine, headlined "Can [Ambulatory Surgery Centers] Share in Anesthesia Revenue?" described a strategy that could help ASC owners do exactly that. The article described what has come to be known as the "Company Model," under which the ASC owners form a company to supply anesthesia services; the company hires or contracts with anesthesia providers (or a practice) to provide the care; the company charges a management fee to third party payers for its services; and it keeps for itself, and ultimately its owners, the difference between payments for services and what it owes the anesthesia providers. That same month and year, the ASA asked the Office of Inspector General of the Department of Health and Human Services ("OIG" and "HHS," respectively) to review the legality of that structure. ASA, in a subsequent letter to the OIG, described the model as "fraudulent and abusive" to providers and patients and as creating "incentives and pressures" antithetical to quality anesthesia care, principally by influencing anesthesiologists' "gatekeeper" functions.

The OIG has now examined the "company model" and another variant in which the ASC receives a portion of the anesthesia reimbursement and recently given its opinion: both arrangements raise serious concerns under federal criminal anti-kickback statutes. This is a very important development for all anesthesia practices currently engaged in these arrangements or considering doing so, as well as for any physician owner of an ASC. The ASA described itself as "pleased" with the OIG's conclusion.

As background, the anti-kickback statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services that are reimbursable by a federal health care program, such as Medicare or Medicaid. The statute criminalizes the acts of both parties to an impermissible "kickback" transaction. A core concern has long been arrangements in which one purpose of the arrangement involved payments made for the referral of services or to induce further referrals. Convictions often lead to a host of other negative consequences.

The OIG opinion examined what it referred to as Arrangements "A" and "B," the latter being essentially the "Company Model." The arrangements' key attributes are:

- **Arrangement A:** The anesthesia provider would serve as the ASC's exclusive anesthesia provider and pay the ASC a per-patient "management fee" for private pay only patients. (The OIG rejected the argument that the fee was outside its purview because it was paid only as to private pay patients; the OIG believes that arrangements that seek to exclude federal health care program beneficiaries from otherwise questionable arrangements are an unsuccessful attempt to circumvent the anti-kickback statute.) The anesthesia practice would bill and retain all reimbursements received for anesthesia services, subject to paying the management fee. In return, the ASC would arrange for pre-operative nursing assessments; adequate space for the anesthesia practice, including its personal effects, materials, and documentation/records; and assistance in transferring billing documentation to the anesthesia practice's billing office. The management services fee was to be set at fair market value and would not take into account the referrals or other business conducted between the parties. Previously, the expenses for the services to be covered by the management fee were included in the "facility fee" charged to Medicare and other third party payers. In this model, the ASC would continue assessing the "facility fee" even as it collected the management fee. The result is double payment for the same service.
- **Arrangement B**: The ASC's physician-owners would establish a separate company, owned by the physician-owners' professional corporation or by the ASC itself, to pro-



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> vide anesthesia-related services. The new corporation would exclusively provide and bill in its name all of the ASC's anesthesia-related services. The newly formed corporation would, in turn, contract with an existing anesthesia practice to provide all the anesthesia services, including billing on behalf of the corporation and many other necessary administrative tasks. The corporation would pay the anesthesia practice a negotiated rate, to be paid out of the collections received for anesthesia-related services. The corporation retained whatever profits resulted.

The OIG found that both arrangements raised risks that payments would be made for referrals and that the conduct would, therefore, violate the anti-kickback statute and expose all parties to the agreement to substantial risk.

As to Arrangement A, the OIG was particularly concerned that the ASC was apparently planning to continue billing Medicare and other payers a facility fee while also charging the anesthesia practice the management fee for providing essentially the same services to private payers' patients. The underlying concern is that the ASC will prefer as its exclusive provider a company that will facilitate the double payment – from the anesthesia practice and the third party payer – of facility fees for its private payer patients. Simply put, if the ASC is going to bill the facility fee, it should not also seek payment from the anesthesia practice. The OIG's conclusion was that there was "risk that the [anesthesia practice] would be paying the Management Services fees … to induce the [ASC's] referral of all of its patients" to the practice.

It may well be likely that any OIG investigation would focus on the "double biller" rather than the anesthesia practice. That is far from a guarantee, let alone that even an OIG investigation per se might, at the barest minimum, prove an administrative nightmare. And, of course, that likelihood provides no solace to an anesthesiologist who is on both sides of the transaction.

As to Arrangement B, the OIG noted its long-standing concerns when a health care provider in one line of business, such as surgery or operating an ASC, creates a corporation to provide a new and related service, such as anesthesia, and the new corporation does so by subcontracting out substantially the entire operation to an existing anesthesia practice. When, as in Arrangement B, the corporation ends up receiving some portion of the anesthesia reimbursement, the OIG disfavors it because the new corporation appears to be doing very little, and adding very little value, for any compensation received. The OIG considered the actual business risk of the ASC's physician-owners' from the arrangement to be minimal because they could, in the OIG's view, control the amount of business they would refer. (That conclusion seems questionable for several reasons, primarily if the anesthesia practice had an exclusive contract and the owners had no alternative but to refer to that group.) The OIG concluded that the physician-owners were trying "to do indirectly what they cannot do directly; that is, to receive compensation, in the form of a portion of the [practice's] anesthesia services revenues, in return for their referrals to the [practice]."

Again, it is likely that the OIG's focus would be on the newly created anesthesia company and its owners. Significantly, under the "company model" (proposed Arrangement B), regulatory "safe harbors" might protect the payments made to the anesthesiologists for the services they provide. But the referring physicians who shared in the distribution of profits would be at risk because they are profiting from their referral stream, by pocketing the difference between the money paid by them to the anesthesiologists and the reimbursement they are receiving from the government.

The purpose of OIG advisory opinions is "to provide meaningful advice on the application of the anti-kickback statute and other OIG sanction statutes in specific factual situations." An OIG opinion has limited technical effect. Primarily, it binds HHS to its conclusions and essentially "blesses" conduct taken in reliance on it by the person requesting it; these consequences matter more when the OIG has approved a business model, which it has not done here.

Thus, an OIG opinion of the kind issued here is primarily a warning of potential pitfalls and a disincentive to engage in the conduct the OIG deems troublesome. The extent to which the opinion would apply to variants on these models is hard to assess, depending ultimately on how the variants affect the underlying concerns. Clearly, the OIG has raised its concerns about two common arrangements between anesthesia practices and ASFs.

Finally, potential consequences of a violation are severe. In additional to criminal violations, arrangements found to involve impermissible kickbacks for referrals can lead to efforts to recoup reimbursements received

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PENNSTATE HERSHEY Milton S. Hershey Medical Center

PENNSTATE HERSHEY College of Medicine

Fundamentals of Ultrasound-guided Regional Anesthesia With Hands-on Cadaver Dissection

June 8-9, 2013

Fees: $750 per person for practicing anesthesiologists: $250 per person for anesthesia residents or fellows, including instruction, handouts, lunch and other refreshments .
For more information: www.pennstatehershey.org/anesthesia or contact Linda Sanger, lsanger@hmc.psu.edu, 717-531-4264 Approved for 10.5 AMA PRA Category 1 Credits

Reminder: Membership in the Pennsylvania Society of Anesthesiologists requires membership in the American Society of Anesthesiologists.

Earn CME credits for free

PSA is excited to announce the launch of a new member benefit – access to CME journal articles from the PSA's website, **www.psanes.org**. Members must log into the website in order to access the e-learning module that contains the article, answer questions and submit for Category I CME credit.

If you have not created an account on the PSA website, contact the administrative staff at (717) 558-7750, ext. 1596, or **psa@pamedsoc.org**. The project is a collaborative effort between the PSA and Reading Hospital.

Upcoming PSA Events

March 9, 2013
PSA Board Meeting, Philadelphia Airport Marriott, 8:30 a.m.
PSA Philadelphia Regional Meeting and Dinner, TBA

September 30, 2013
PSA Board Meeting, Hilton Harrisburg, 8:30 a.m.
PSA Legislative, Reception, Hilton Harrisburg, 5 p.m.

October 12, 2013
PSA Annual Business Meeting, San Francisco, location TBA

Meningitis Outbreak Update

by Robert A. Campbell M.D., PSA Vice President

On September 18, 2012, a patient in Tennessee was diagnosed with Aspergillus fumigates meningitis 46 days after receiving an epidural steroid injection. This was the first case reported for the current epidemic of fungal infections linked ultimately to preservative free methylprednisolone acetate (MPA) injections. As of late October, there were 354 confirmed cases and 25 deaths. Joint infections account for seven of the cases while the other cases all include meningitis or stroke.

The investigation led by the CDC and FDA have implicated three lots of medications from the New England Compounding Center (NECC) in Framingham Massachusetts. These three lots are identified as #06292012@26 BUD 12/26/2012; #08102012@51 BUD 2/6/2012; and #05212012@68 BUD 11/17/2012. The first two lots have tested positive for Exserohilum rostratum growth in unopened vials, confirming the link to these rare infections. To date there has been one infection with Aspergillus fumigatus and one infection with Cladosporium. All other infections have isolated Exserohilum rostratum as the pathogen. These are common environmental fungi but exceedingly rare causes of human infections.

The three lots of medications total 17,500 vials distributed to 75 facilities in 23 states. There are two facilities known to have received implicated vials in Pennsylvania. These are Allegheny Pain Management in Altoona and South Hills Pain and Rehabilitation Associates in Jefferson Hills. To date one fatality has occurred in Pennsylvania. These three lots were recalled on September 26. On October 4 the FDA recommended all NECC medications be withheld from patient use.

Diagnosis of fungal meningitis is inherently difficult. There is limited experience with this condition in severely immunocompromised patients, such as transplant patients and patients with advanced cases of HIV. There is no clinical experience in this condition in healthy patients following epidural steroid injections. For now, any patient exposed to suspect lots should be monitored for any change in health status. Fever, nuchal rigidity, headaches, photosensitivity, redness at injection site, pain or swelling at injection site, or any neurologic findings (slurred speech, weakness, and numbness) would all warrant immediate imaging and lumbar puncture. Imaging of the brain and the spinal cord with special attention for radiologic signs of fungus growth is required.

It is important to be aware that many patients have presented with just mild systemic complaints. Nausea appears to be the most common chief complaint among all fatalities. Infectious disease consultation is advised early on. The most common CSF finding is pleocytosis. Additional CSF should be obtained for polymerase chain reaction testing and a prescribed aliquot provided to the CDC in addition to routine and fungal stains and cultures. This information for obtaining and handling CSF

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is being updated regularly and is available at **http://www.cdc.gov/hai/outbreaks/clinicians/instructions_testingandsubmission.html**.

While awaiting results of diagnostic testing, empiric treatments include voriconazole 6 mg/kg IV q 12 hours or liposomal amphotericin B 5-6 mg/kg IV daily. This information is being revised and updated regularly at **http://www.cdc.gov/hai/outbreaks/clinicians/guidance_cns.html**.

There are still many uncertainties for clinicians and patients confronting this unprecedented epidemic. It is not clear if or how additional epidural or intra-articular steroid injections may increase the risk of developing fungal meningitis or septic arthritis in patients who received epidural or intra-articular injections with a New England Compounding Center product and who are currently asymptomatic. Steroids are immunosuppressive and it is therefore possible they could increase risk in patients with sub-clinical infection. However, the duration of infection risk resulting from prior exposure to a contaminated steroid product is finite, albeit unknown.

For patients who have been exposed but are not symptomatic, there are recommendations based on when the epidural injections were received. For all patients, continue to closely monitor for development of symptoms, with a low threshold for performing lumbar puncture should the patient become symptomatic. When diagnostic lumbar punctures are performed, they should be done through a site other than the site used for the epidural injection. For asymptomatic patients exposed within the last six weeks (42 days), there is a second treatment option which is more aggressive and acceptable.

Perform lumbar puncture through a site other than the site used for epidural injection. If the cerebrospinal fluid (CSF) examination shows less than or equal to five white blood cells (WBC), the patient should continue to be followed very closely for onset of symptoms. If the patient remains asymptomatic, consider repeating weekly lumbar punctures until six weeks (42 days) have passed since the last epidural injection with contaminated steroid product, at which time the patient can be monitored closely for the development of symptoms, with a low threshold for performing lumbar puncture should the patient become symptomatic. Patients with greater than five WBCs in CSF should be treated for fungal meningitis according to current treatment guidance as outlined above.

Updated recommendations concerning this unprecedented epidemic are available at daily at the CDC and FDA websites **http://www.cdc.gov/hai/outbreaks/meningitis.html** and **http://www.fda.gov/Drugs/DrugSafety/FungalMeningitis/default.htm**.

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and disbarment from the Medicare and Medicare programs. These actions can, in turn, lead to loss of participation in various private payer programs, licensure issues with the state board of medicine and the drug enforcement agency, and privileging issues with hospitals.

If you have concerns about the arrangement your practice has, or is considering, the best advice is to consult counsel and to follow conservative, risk averse conduct. If you are involved in an arrangement that resembles the models discussed in the OIG opinion and this article, the OIG opinion provides strong leverage to revise it. In general, a contract that provides for illegal or criminal conduct is unenforceable.

Mr. Hoffman is outside counsel to the PSA; Ms. Carlins is an attorney working in the Pittsburgh Office of Eckert, Seamans, Cherin, and Mellott.

Notes

1 The OIG Opinion; a Feb. 24, 2011 Letter from Mark Warner, MD, ASA President, to Daniel R. Levinson, Inspector General, setting forth ASA's views on the issue; and the ASA's June 1, 2012 Statement about the OIG Opinion are all accessible at the ASA's website.

Trend Lines: Quality Measurement for Anesthesiologists

by Lee A. Fleisher, M.D.

Health care is undergoing a transformation and there is a clear attempt to improve the value of the care we deliver. It is now well recognized that we must bend the curve of the rise in health care dollars or the expenditures could lead to significant economic problems throughout the entire economy. Numerous strategies have been advocated to address this problem. The Centers for Medicare and Medicaid Services (CMS) has advocated the adoption of the triple aim:

1. better care for individuals;
2. better health for populations; and
3. lower costs.

As anesthesiologists, we play an important role in the delivery of surgical and procedural care, and the development of modern anesthesia practice has been advocated as one of the great advances of the past century. We have also been praised for our role in patient safety and reducing errors directly attributable to anesthesia in the Six Sigma range. That being said, do we actually add value and how can we measure the quality of the individual anesthesia care apart from the question of safety? We need to look back to 1986 and the publication by Slogoff and Keats to demonstrate that care provided by one anesthesiologist considered good care (Anesthesiologists number 7) was associated with the worst outcome compared to his colleagues with respect to perioperative myocardial infarction, an outcome not considered directly attributable to the anesthesiologist at the time. We must therefore take greater ownership of surgical outcomes, not just those directly attributable to anesthesia like PONV.

As part of the Patient Protection and Affordable Care Act as well as other bills and approaches by the insurance industry, the measurement of both processes of care and outcomes has taken on greater importance. Many perioperative processes, originally developed as part of the Surgical Care Improvement Project (SCIP), are now published at **www.hospitalcompare.hhs.gov**. CMS has transitioned from a system in which meeting performance metrics is associated with an increase in payment to a system in which not meeting metrics is associated with a reduction in payment. While there has been a great deal of debate with respect to the value of pay for performance, there is no real debate with respect to the value of measurement and public reporting. There are now numerous studies that have shown improvement in outcomes with the implementation of publicly reporting or pay-for-performance programs. The public is demanding a higher level of accountability and it is important that we respond to these demands as any industry, particularly one with a social mission such as ours, by being willing to be judged on the value we provide.

Therefore, we must be willing to develop measures upon which we can be judged and which are available publicly. As part of the SCIP project, we have developed a number of process measures for which we have nearly complete compliance in most settings. As we develop measures to which individual anesthesiologists or groups can be judged, it is important that we fulfill the public trust and develop new and meaningful measures. The National Quality Forum (NQF) is the arbiter of measures approved for use by CMS and has clearly moved in this direction in which they will only approve process measures in the absence of true outcome measures. It is critical to develop high-quality measures that do not have unintended consequences and be willing to take responsibility in areas in which we can impact outcomes, or we will be diminished in the perception of both the public and the payers.

The Committee on Performance and Outcomes Measures of the American Society of Anesthesiologists has always tried to balance these factors and is now moving toward more outcomes-based measures. This is the rationale for the development of Anesthesia Quality Institute (AQI). Our partnership with our surgical colleagues must be further enhanced by our willingness to take joint ownership with them for surgical outcomes. For example, there is increasing data to suggest that fluid and pain management can influence these outcomes, including issues such as re-admission. Measures can be advanced through the American Medical Association mechanism and to the NQF without the full input of the anesthesia community, although the desire is for us to be part of this process. Although all measures are available for public comment before they are accepted, it behooves us to be an active participant in the process.

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Race for Irrelevance

by Joseph Answine, M.D., PSA Assistant Secretary-Treasurer, PAMED Trustee

Many professional organizations have changed or are attempting to change their governance, quoting the book, "Race for Relevance," (1) as a blueprint for this change. Among these organizations are the Pennsylvania Medical Society (PAMED) and the American Society of Anesthesiologists (ASA). The current governing body at PAMED, the House of Delegates (HOD), has voted to transfer its power to the Board of Trustees with the mandate to decrease the size of the board. The ASA HOD has not enacted such sweeping changes at this time, but discussed such a plan in October.

What is the thought process behind the desire for this change in governance? It revolves around the five changes outlined in the above mentioned book by Harrison Coerver and Mary Byers, which include:

1. empowering the CEO and enhancing staff expertise;
2. rigorously defining the member market;
3. rationalizing programs and services;
4. building a robust technology framework; and
5. most importantly as per the authors, overhauling the governance model and the committee operations.

How radical is the governance change encouraged by the authors? Ideally, the governing board should be five people. Yes, only five from the 330 delegates that currently make up the PAMED HOD and five from the 352 who make up the ASA HOD. Why the need for such drastic change? It makes the decision-making process more nimble. The leadership of two of our three major organizations that represent Pennsylvania anesthesiologists (the third being the PSA) say the current way we run them is cumbersome, slow, inefficient and obsolete. Although the ASA HOD is very well attended, the PAMED HOD, of late, struggles to seat a little more than 200 delegates, so I can see the change needed there. But why shrink the size of the board? The boards of the PAMED, ASA and PSA are loaded with engaged, intelligent individuals, and all the board meetings are maximally attended.

I guess first I should explain how these governing bodies are structured. The ASA HOD is designed after the United States Electoral College with each state having a certain number of delegates based on the number of ASA active members within the state. Currently, the Pennsylvania delegation has 14 members: one of the largest in the country. The PAMED HOD is populated based on geography, specialty, and delegates with defined interests, such as the young physicians and medical students. The boards of directors of these societies, including the PSA, are quite large: each with around 40, 50, or more members. The boards are further based on geography, specialty interests and/or positions held within the organizations.

Why are our boards so large? I suppose it is partly due to the "more is better" attitude. However, house and board sizes also increase in order to maintain diverse viewpoints; to keep specialties and sub-specialties engaged; and to benefit from a diverse, "specialized" fund of knowledge. This is particularly true for the PAMED board of trustees. The board size increased dramatically over the last decade to include the specialties which, in my opinion, had a positive impact on the overall knowledge due to the diverse input from its board members.

In their book, Coerver and Byers question the benefit of adding members to fit a certain focused group of individuals. They include a story of a young contractor added to a construction association board to get the insight of what the younger generation is thinking. When asked a question about how to attract young professionals, the new member said he just didn't know. Therefore, the authors contend that adding new board members to provide the extra knowledge is useless. I contend that they just picked the wrong young contractor. In medicine, especially for an all encompassing organization such as PAMED, there is no way that one physician generalist or specialist can understand all the problems and needs of another specialty. Sure, the leadership can ask the input of an anesthesiologist if a particular question comes up involving our world, even if he or she is only temporarily involved and not in a decision-making position.

However, neither side (leadership or consultant) can understand all the nuances when making the final decision if they are not both involved in the discussions and final decision process. Plus, some of those in leadership should have "skin in the game," to steal a phrase from Warren Buffet. Does bigger mean slower? It could. However, I think that the blame for a not-so-nimble decision process falls on the chair of the board or the speaker of the house. When a question is asked, set a time frame for an answer and stick to it. If the board or house pushes for a delay, push back that it has to be done now for the sake of the society. Or it may become obvious that the governing body is correct and a hasty decision is inappropriate. This push and pull between a diverse set of members is imperative for the best possible governance of our profession as physicians.

As for the other changes proposed by Coerver and Byers, I have to agree that these are worthwhile endeavors: empowering the CEO and utilizing the expertise of a well selected staff; defining your membership; taking a hard look at the committees and programs offered; and utilizing technology.

Empowering the CEO (or chair, speaker, or president)? It makes sense to give that individual the ability and time to focus the masses for the common good of the society. He/she also needs to make the necessary commitment, which may require the provision of a reasonable stipend in order to do so. Also, you need to provide staff with the correct education and skills to aid the CEO and governing body in fulfilling the goals of the society.

Defining your membership? It makes sense to supply the resources to accomplish this goal. Utilizing cutting-edge technology? Many organizations still do not utilize effective electronic communication because some members may not have email addresses. Anymore, that excuse is as antiquated as not calling someone because they may not have a phone. Again, using current technology is a necessity. Therefore, resources should be allocated accordingly.

What about committees and programs? All of the organizations we are involved with have underutilized or never utilized committees and programs. I recently had a discussion with a colleague about a particular PSA committee. He felt such a committee sounds like a great idea and he wanted to be involved. Then, in proof of my argument, I informed him that this committee already existed and he has actually been the chair for years. Coerver and Byers write that 20 percent of an organization's committees and programs do, on average, 80 percent of the work. A hard, non-biased, systematic look at all we offer – including manpower, cost and benefits – is time well spent. The PSA is always striving to expand what we offer our members. Maybe concentrating on political advocacy, physician education (e.g. CME) and membership support is all we need to do as long as we do it well. Furthermore, committees can be formed temporarily and then disbanded after accomplishing their designated goal(s). Only a few standing committees are likely required, and their members should be engaged with frequent reporting to the leadership.

In closing, it never hurts to continuously strive to make your organization or society better. That may include taking a very serious look at governance, but I do not think that one size fits all. Five may be the right number or maybe it is 352. We in medicine know that getting physicians to work together is like herding cats, but creating a small group to represent all physicians of all specialties could be quite a step backward regardless of the members' skills as leaders. Maybe it comes down to choosing the right individuals rather than worrying about the specific number. Regardless, "Race for Relevance" is a good read with interesting view points, but let us use it as a guide, not the final word.

Notes

1 Coerver, H., Byers, M. Race for Relevance. ASAE, 2011.

Statutory Supervision Came So Very Close

by John P. Milliron, Esq., PSA Legislative Counsel

House Bill 1570 was introduced in the state house at the request of the Hospital and Healthsystem Association of Pennsylvania (HAP) in May 2011. Its stated purpose was to allow a private credentialing entity (in most cases the Joint Commission on Hospital Accreditation) to replace the Department of Health (DOH) as the primary source of inspections and licensing. HAP felt that this would streamline the process, decrease costs and actually increase the quality of care. If a hospital received the Commission's approval, then that hospital would be "deemed approved" by DOH.

The DOH had some reservations but ultimately agreed to support the legislation if several key changes were made to the bill. The hospitals agreed to an amendment that included the Department of Health regulation requiring physician supervision of nurse anesthetists. This concession by HAP was not easily obtained. They have long held the position that hospitals should determine whether CRNAs are supervised by a physician and under which circumstances.

These negotiations between HAP, the Administration, the Health Committee Chairman Matt Baker, and the Republican and Democratic leaders of the House were neither easy nor quick. The ultimate amendment – which included physician supervision – was adopted by the House Committee on Health more than a year after the bill's introduction, on June 6, 2012. By that time, the PSA had been asking all of you to call your House member (and to be prepared to call your Senator) to support HB 1570 as amended.

The final vote by the full House never occurred for several reasons. One was an objection by the nurse practitioners, midwives and pharmacists that they should be allowed to serve on hospital medical staffs. The law currently states that medical staffs shall only be comprised of physicians, dentists and podiatrists. However, the Department of Health regulations permit exceptions to this rule if requested by the hospital. This compromise was rejected by the NPs and nurse midwives.

Another problem was a side issue of nurse (RNs) staffing levels in certain departments in the hospitals. An attempt to resolve this dispute was also unsuccessful. Negotiations continued throughout the summer but the parties were unable to reach an amicable solution before the General Assembly finished voting for the 2011-2012 session. Everything must start all over again next year when the new two-year session begins.

The PSA has stated for years that physician supervision is a patient safety issue and cannot be replaced by an unknown standard from an outside credentialing agency. We will continue to fight for our patients and demand to be included in any legislation granting hospitals "deemed approved" status. We will give you a full update on our strategy for the new session early next year. Thank you for your tremendous response to make calls this year.

PA Residents Component Represented in D.C.

by Stanislav Kelner, M.D., Resident Component President

These last few months were highlighted by the American Society of Anesthesiology 2012 meeting. As most of you are aware, it was held in our nation's capital, amid the full buzz and fervor of the presidential campaign.

Resident anesthesiologists from around the country met to discuss pertinent medical and political issues at the ASA House of Resident Delegates. United States House of Representatives member Andy Harris (R-Md.), who earned his medical degree from Johns Hopkins, stopped by to speak to the assembly on issues facing young anesthesiologists. Dr. Harris made an excellent point: only through our continued interest in health care policy will we be able to ensure that care for our patients is not compromised. Following this and other speeches, votes were cast for the ASA Resident Component officers.

Resident delegates of the Pennsylvania Society of Anesthesiologists met prior to discuss the upcoming year's goals. The meeting was led by president Stanislav Kelner (PGY-4, Drexel), president-elect Trent Emerick (PGY-3, Pittsburgh), and secretary Jacob Shipley (PGY 3, WPAHS). Resident delegates included Adam Thaler (former president), Ravish Kapoor, Erika Davis, Bernard Ciongoli, Mike Roberts, April McIver, Michael Pascarella, Marlene Barnhouse, Sean Dechancie, Theodore Cios, Marc Royo, Michael Finamore, and Magdalena Bakowitz.

The projects undertaken for the year include creating greater Facebook presence for the PSA, individual initiatives by the residents to increase PAC donations, and a resident gathering with discussion of various practice models sometime in 2013.

On behalf of the Resident Component, we thank members of the society for their support in all of our efforts.

Left to right: Drs. Mike Pascarala, April McIver, Stanislav Kelner, Bernard Ciongoli, Trent Emerick, Marc Royo represented the PSA Resident Component at the ASA meeting earlier this year in Washington, D.C.

Get Involved!

Make a difference in the PSA by joining one of our committees. We encourage you to share your expertise. Contact us at psa@pamedsoc.org if you would like to serve on one of the following committees:

Bylaws Committee—Recommends amendments to the bylaws to insure consistency with the actions of the policymaking bodies of the Society.

Critical Care Committee—Studies, plans, and implements activities, policies, and practices concerning the role of anesthesiologists in the care of the critically ill patient outside the operating room.

Membership Committee—Provides input as to the value proposition for members. It also implements promotional activities and strategies to both retain current members and recruit new members.

Pain Management Committee—Studies, plans, and implements activities, policies, and practices concerning the role of anesthesiologists in the diagnosis and treatment of chronic and acute pain.

Physician Resources Committee—In recognition of our Society's public health responsibility, this committee determines the pattern of anesthesia practice in all hospitals and clinics in Pennsylvania; and recommends minimal criteria for adequate anesthesia care.

Communications Committee—Gathers information pertaining to the educational, scientific, governmental, administrative, and social activities to be published in the Society's website and newsletter.

Insurance and Legislation Committee—Investigates and considers matters pertaining to liability and health insurance programs relating to the specialty of anesthesiology and, upon request, give advice to, or act as liaison between, private insurers, governmental agencies, and members of this Society.

Professional Relations Committee—Promotes relationships of the PSA with the public, physician and non-physician health care providers, other medical organizations, hospitals, and governmental agencies.

Continuing Education Committee—Establishes the curriculum and appropriate CME accreditation for any educational activity sponsored by the PSA. A new sub-committee is responsible for collecting content for the PSA's CME journal articles that are published on our website.

Defining 'Immediately Available' and Providing for Deep Sedation by Non-Anesthesiologists

by Donald Martin, M.D., ASA District Director

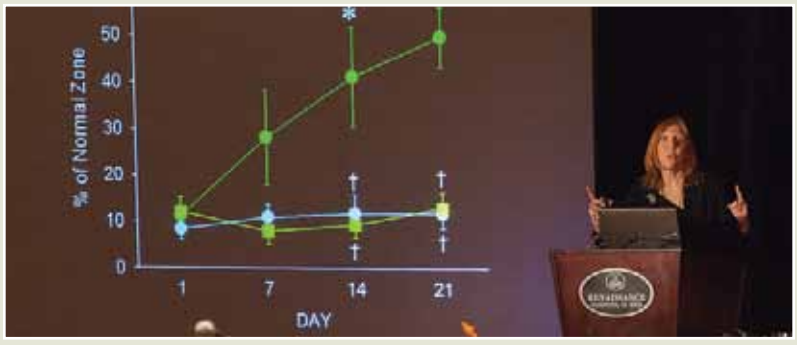
At this year's annual meeting in Washington, D.C., the ASA House of Delegates approved two statements important to the management of anesthesiology practices. The first defined the physical proximity required for an anesthesiologist to be "immediately available" when medically directing nurse anesthetists. There was some urgency to approve this statement to give the ASA an effective voice in ongoing CMS discussions on this issue. The ASA statement attempts to strike the appropriate balance between patient safety and the wide spectrum of facility configurations and clinical situations. It also recognizes the reality that most anesthesiologists now practice in groups.

The statement provides: *"A medically directing anesthesiologist is immediately available if s/he is in physical proximity that allows the anesthesiologist to return to re-establish direct contact with the patient to meet medical needs and address any urgent or emergent clinical problems. These responsibilities may also be met through coordination among anesthesiologists of the same group or department.*

Differences in the design and size of various facilities and demands of the particular surgical procedures make it impossible to define a specific time or distance for physical proximity."

The second item was the revision of the 2006 statement on "Granting Privileges to Non-Anesthesiologist Physicians for Personally Administering or Supervising Deep Sedation." It recognizes that physicians other than anesthesiologists may need to provide deep sedation. The statement does establish limits in training requirements for these physicians.

The statement, which was amended and approved by the House of Delegates on October 17, 2012, provides: *"Because of the significant risk that patients who receive deep sedation may enter a state of general anesthesia, privileges for deep sedation should be granted only to non-anesthesiologist physicians who are qualified and trained in the medical practice of deep sedation and the recognition of and rescue from general anesthesia. Non-anesthesiologist physicians may neither delegate nor supervise the administration or monitoring of deep sedation by individuals who are not themselves qualified and trained to administer deep sedation and the recognition of and rescue from general anesthesia."*



ASA courtesy of Steve Donisch and David Hills

Practice Parameters and Performance Measure Approved

by Donald Martin, M.D., ASA District Director

The ASA Committee on Standards and Practice Parameters has revised the following three practice guidelines or advisories, and the House of Delegates approved the revised documents at its October meeting:

1. Practice Guideline for Management of the Difficult Airway (last revised in 2003)
2. Practice Advisory for the Prevention of Operating Room Fires (last revised in 2006)
3. Practice Advisory for Post-Anesthesia Care (last revised in 2002)

These documents are not yet on the ASA website in their final form. Both will be available on the website and in the journal Anesthesiology in the near future.

In the meantime, you can find the approved drafts of these documents on the members only section of the ASA web site at **http://www.asahq.org/For-Members/Clinical-Information/Practice-Parameters-Request-for-Comments.aspx** or on the PSA website (**www.psanes.org**).

Additionally, the ASA Committee on Performance and Outcome Measures recommended and the House of Delegates approved

a performance measure on the "Prevention of Post Operative Vomiting (Pediatrics) – Multi-Modal Therapy." This measure will determine the frequency at which anesthesiologists and anesthesiology departments adhere to the recommendation that state:

"Patients, aged 3-18 years, who undergo general anesthesia with an inhalational anesthetic as the major anesthetic component, and have two or more risk factors for post-operative vomiting (POV), should receive at least two prophylactic pharmacologic antiemetic agents of different classes. One agent should be one of the 5-HT3 receptor antagonists, and the other from a different class: such as dexamethasone, dimenhydrinate, droperidol, preoperatively or intraoperatively for the prevention of vomiting. There are three risk factors defined for this measure:

(1) surgery longer than 30 minutes,
(2) history of PONV or history of PONV in parents or siblings, and,
(3) strabismus surgery."

ASA courtesy of Steve Donisch and David Hills

ASA courtesy of Steve Donisch and David Hills

Nomination for ASA Committees–2013-2014 Are You Interested?

by Donald Martin, M.D., ASA District Director

ASA President-Elect Jane C.K. Fitch, M.D., will begin the process of reviewing nominations to fill open positions on the committees of the American Society of Anesthesiologists for 2013-2014. Nominations are now open and will remain open until January 15, 2013. Any active ASA member is eligible for appointment to an ASA committee.

A complete listing of ASA committees along with their current members and chairs, is available on the ASA website at **https://www.asahq.org/For-Members/About-ASA/ASA-Committees.aspx**. The committees deal with almost all aspects of our medical specialty, practice management, or advocacy and organization of the Society. If you are interested in serving on any of these committees, complete the online "self-nomination form" on the "for members" section of the ASA website (**www.asahq.org**). Completing this form provides information about yourself and also informs the ASA of your interests and willingness to serve on a committee.

More information on the committee nomination and appointment process can be found at **https://www.asahq.org/For-Members/About-ASA/ASA-Committees/FAQs-About-ASA-Committee-Nomination-and-Appointment-Process.aspx** .

If you would like PSA support for your nomination, please feel free to contact either Donald Martin, M.D., ASA Director from Pennsylvania, at **dmartin1@hmc.psu.edu**, or Erin A. Sullivan, M.D., ASA Alternate Director, at **esullivan@pitt.edu**. It would be helpful to provide a CV or brief summary of the reasons for your interest, and your special qualifications for the position. In this way, the Society can provide the most specific support for your nomination.

PSA Annual Meeting

by Patrick Vlahos, D.O., PSA Secretary-Treasurer

The annual business meeting of the Pennsylvania Society of Anesthesiologists was held at the Washington Renaissance Downtown Hotel on October 13, 2012. The luncheon was well attended and attracted both active and resident members of the Society. Dr. Berend Mets, Chairperson and Professor from the Hershey Department of Anesthesia, made a presentation to promote the LifeBox project. The project is collecting funds with an attempt to place pulse oximetry in every operating room in the world.

Dr. Meg Tarpey opened the meeting with a greeting to all attending the luncheon. The minutes from last year's meeting in Chicago were seconded and approved. An update was given to report the finances of the society. Also, a schedule of future meetings for the board of directors was given as well as a reminder that the bi-annual legislative reception in Harrisburg will be held at the Harrisburg Hilton Hotel on September 30, 2013. You can find a full list of PSA meetings at **www.psanes.org**.

Dr. Joshua Atkins, chair of the bylaws committee, presented amendments that focused on the formation of a finance committee, inspection and audit and an annual financial review of the Society's finances. The revisions were voted on and approved.

Dr. Robert Early provided a report from the nominating committee. A slate of nominees was presented with one change. Due to an unexpected opening on the board of directors, nominations were accepted from the floor. The name of Dr. Kristin Ondecko Ligda was presented as a nomination and accepted. All the nominations as then presented were approved and seconded.

Dr. Richard O'Flynn, treasurer of Z-PAC, gave an update as to the monies collected annually as well as the changes that have occurred throughout the year for the Society's political action committee.

John Milliron, the PSA's lobbyist, made some timely remarks focusing on the political changes that are being attempted in the state to reduce physician supervision of anesthesia care. He commented on the success of the Society in holding fast to the belief for physician supervision during every anesthetic provided within Pennsylvania.

Dr. Tarpey acknowledged and thanked all the members of the board of directors for their support throughout the year. Dr. Tarpey passed the symbolic gavel to the incoming president, Dr. Atkins. Dr. Tarpey was then recognized for her leadership.

Dr. Atkins presented a lively agenda for the upcoming year. He has set an aggressive slate of ideas that he plans to accomplish. Dr. Atkins energetically and with great enthusiasm focused on the need for every member of the board of directors and the members of the Society to participate in his vision.

The meeting was then adjourned with hopes of another great meeting in San Francisco in October 2013.

2012-2013 Executive Committee

President: Joshua Atkins, M.D., PhD

Immediate Past President: Margaret Tarpey, M.D.

President-Elect: Richard O'Flynn, M.D.

Vice President: Robert Campbell, M.D.

Secretary-Treasurer: Patrick Vlahos, D.O.

Assistant Secretary-Treasurer: Joseph Answine, M.D.

District Director: Donald Martin, M.D.

Assistant District Director: Erin Sullivan, M.D.

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Active

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Andrew J. Costandi, M.D.
Stanley Defay, M.D.
Elizabeth M. Elliott, M.D.
Electra L. Foster, M.D.
Megan M. Freestone-Bernd, M.D.
Jorge A. Galvez, M.D.
Cynthia Groff, D.O.
Sitha Katragadda, M.D.
Mohamed A. Kourtu, M.D.
John Paul Malayil, M.D.
Anthony S. Marshall, M.D.
Colleen M. Moran, M.D.
Ryan J. Ness, M.D.
Tejas D. Parikh, M.D.
Srikantha Rao, M.D.
Misako Sakamaki, M.D.
Ker-Shi Wang, M.D., PhD
Glenn E. Weaver, D.O.
Samuel E. Wilson, M.D.

Affiliate

Thomas Cwalinam, DMD

Resident

Sean P. Antosh, M.D.
Flower Austin, D.O.
Benjamin B. Bruins, M.D.
Mark M. Caruso, M.D.
Stacy Dunbar De La Motte, M.D.
Yukli Elliott, M.D.
Tanna J. Ferrara, D.O.
Rachel A. Hadler, M.D.
Michael B. Hatch, M.D.
Nathaniel N. Hsu, M.D.
Maisie L. Jackson, M.D.
Lauren G. Keeney, D.O.
Catherine L. Kim, M.D.
Arthur A. Kitt, M.D.
Zev N. Kornfield, M.D.
Eugene Kremer, M.D.
Yue M. Li, M.D.
Bridget Perrin, M.D.
Nicole L. Renaldi, D.O.
Marc B. Royo, M.D.
Joshua M. Schiffman, M.D.
Meron A. Selassie, M.D.
Ronak M. Shah, M.D.
Pranav Shah, M.D.
John T. Wenzel, M.D.
Paul T. Yarincik, M.D.
Yuliya Yermolina, M.D.
Elizabeth Y. Zhou, M.D.

TREND LINES
continued from page 9

As we transition to new payment models and greater accountability, it is critical that we are active participants and collaborate closely with our surgical colleagues. If not, it would belie the public trust and not achieve our promise to provide the best care for our patients.

Dr. Fleisher is the Robert D. Dripps Professor and Chair of Anesthesiology and Critical Care, as well as a Professor of Medicine at the Perelman School of Medicine. He is also a Senior Fellow at the Leonard Davis Institute of Health Economics, University of Pennsylvania. He is a member of the ASA's Committee on Performance and Outcomes Measures.

PRESIDENT'S MESSAGE
continued from page 1

development of self-measurement tools and national quality and outcomes measures. Participation in the data collection and analysis offered by the Anesthesia Quality Institute (AQI) is a starting point for engagement at the hospital level. Leadership in this process is one avenue toward strengthening our seat at the table in negotiating future arrangements with health systems, private payers, and perhaps even CMS.

We know that anesthesiology services are indispensable to the effective functioning of any health system. Our extensive clinical training in pharmacology and physiology and professional expertise in process management and standardization is unique. When fully engaged we can bring tremendous benefit to patient care across disciplines. Anesthesiologists should be the undisputed leaders in developing programs and setting standards for pain management, sedation services, and safety improvement.

We can't rest on our laurels and assume that our value is self-evident. Without initiative and collaboration less informed decision makers might assume that we can be usurped of this role and replaced with nurses, technicians, or policy wonks. Seeking every opportunity for participation in key hospital committees, private payer policy groups, advisory boards, and medical staff leadership councils is an important element of our professional activities.

The bottom line is that NOW is the time to refocus as individuals and as a profession on the core skills that we bring to patient care. The PSA leadership stands poised and ready to promote and defend our specialty and our patients at every turn. Please consider direct involvement with the Society to help this cause. We are nearing a fork in the road. Do we begin to ask ourselves whatever happened to the physician practice of anesthesiology, critical care and pain medicine? Or shall we stand front and center in hastening the arrival of a new era of professionally rewarding, integrated, high-quality, and even cost-effective perioperative medicine?

Do ENGAGE with your peers, the Society, and legislators at this critical time.

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Remain Involved

by Paul J. Schaner, M.D., Sentinel Editor

The Presidential election of 2012 is history. Your vote was important. It did impact the selection of the winner. Hopefully, your candidate was elected not only by your vote but by your financial and other support.

Even if your candidate was not elected, your continued involvement is crucial for impacting the future direction of our local, state and federal governments. You are a constituent of those who campaigned for your vote. The elected candidates can't tell how you voted, but they can tell if you voted. You continue to be an important part of their political lives.

If you do not know the elected candidate(s), arrange to meet at the earliest convenient time. Have yourself and a colleague(s) take him or her to lunch. At least send a congratulatory note on their successful campaign.

The health care of our country is a changing. Offering your input in your area of expertise is one of the best ways to begin a dialogue with your elected officials. Announce your willingness to provide input into any area of medical concern. This is beneficial for you providing easier future access, and it is also a valuable asset for the official who may well lack background knowledge for medical legislation. It is a much better approach than making contact once an issue surfaces. Ongoing input is the key to success.

Hopefully you have contributed to the PSA's political action committee (Z-PAC) as well as the American Society of Anesthesiologists' ASAPAC. These PACs are critical elements for the success of crucial legislation that is unfolding for medicine. Z-PAC only supports state candidates and ASAPAC federal candidates. While you may not be able to support every candidate, this is a way to support many.

Your PACs are working year round in concert with the anesthesia societies to promote the best and safest medical care for your patients and family. I strongly encourage you to contribute on a monthly basis, because it is an easy way to accomplish a significant contribution on a budgeted basis. You can do this via credit card or monthly payroll deduction that can be readily setup. John Milliron's office will happily help with the setup of the payroll deduction which is not difficult. Call (800) 822-6789 for more details. Annual contributions are always welcomed. You can find a contribution form on the PSA website, **www.psanes.org**.

Your personal commitment is essential for your patients' and families' future health care. If you do not take the interest, who will? Those who step in to take up the battle in your absence may not have your best interests in mind. Your future involvement is encouraged and anticipated. Without your advice, support and aid, we cannot succeed in providing the best quality and safest anesthesia for patients. Please join me in shaping the best healthcare for patients and family.