Georgia Society of Anesthesiologists, Inc.

scope Newsletter

Winter 2012

Timothy N. Beeson, MD | President 2011

President's Letter

Practical, RELEVANT VALUE 2011 GOAL

What a year it has been! Our encompassing goal has been to increase the value of membership in the organization in ways that are relevant and practical to one's practice and personal enrichment. This newsletter chronicles several accomplishments of the organization realized this year and others which were commenced.

First, allow me to state that serving the GSA is an honor and an education. I really appreciate how this organization works and all the support I have received over the past year as your president. Many individuals are involved from idea to implementation. The GSA is truly a team effort.

You MAKE a DIFFERENCE and make the GSA better.

Public Policy

Three years ago an effort to establish office-based surgery and anesthesia guidelines was proposed. When initially vetted at the state level, this idea met with much resistance and faced the backburner. But two years ago another stronger effort was engineered out of the GSA executive committee. Persistence and input from many individuals encouraged the Georgia Composite Medical Board to adopt the state's first Office-Based Surgery Guidelines in early December. This GSA initiative will make office-based procedures safer for patients. This outcome is the result of many hours of work by GSA members. Thank you, Drs. Steve Sween, Howard Odom and Rick Hawkins.

At the federal level, GSA demonstrated its members care about federal policy when more than two dozen members participated in the ASA Washington Legislative Conference and visited all 15 U.S. House and Senate members from Georgia. Only two states sent more physicians to our nation's capitol. These advocacy activities are exemplary of the effective pathways to survival in the upcoming uncertain future.

Physician Payment

Earlier this year, the GSA Board approved funding to join the Medical Association of Georgia's Third-Party Payor Advocacy program. This relationship allows GSA members to access MAG's aggressive representation of practice groups against resistant third-party payor organizations. The program has the ability of empowering GSA members to receive thousands of dollars in earned compensation from resistant payors.

Regarding government payor issues, I salute Drs. David Gale and Raph Gershon for their tireless and intellectual representation of anesthesiology before state and regional administrators of Medicare and Medicaid. Without their diligence, physician payment for government-backed treatment would be even less appropriate. See Dr. Gale's CAC Update on page nine.

On the subject of the encroachment of the controversial "company model/fee splitting" for providing anesthesia in endoscopy centers, GSA has broadcasted legal warnings to members at the Winter Forum and in published reports on the website and this newsletter. The information provided is intended to equip members when discussing such federally prohibited financial arrangements with physicians who own facilities.

GSA continues to seek legal and regulatory tools at the state and federal level to equip members in fighting encroaching anesthesia providers who operate in a gray area not consistent with experience-tested quality patient care.

Continuing Education

This summer the GSA started a new way of providing CME hours in a pilot program with the ASA. This unique relationship has equipped GSA to enhance its CME offerings and assure high quality, cutting edge instruction on scientific and practice management topics. The result has been increased attendance at attractive family-oriented conference destinations.

Political Involvement

GSA-PAC's successes are well-documented. Simply cross-match winners of state-level campaigns with the list of candidates supported by your political action committee to create a scorecard of bold political action. GSA's Committee for Responsible Health Care is well-known among Georgia's legislative and statewide leaders who support physician-led medicine.

continued on page 12

GSA needs the intellectual equity of its members.

Winter 2012

Editor's Corner

Kathryn Stack, MD, Chair, Communications Committee, Editor, GSA *scope*

Good year for GSA

I hope you are well as we head into another new year that promises to bring plenty of debate over the economy, politics, and healthcare on the state and national level. Make your plans now to attend the 2012 GSA Winter Forum, "Protecting Patients, Practice in a New Healthcare Era", to be held on January 21, 2012 at the Westin Atlanta Perimeter North. Drs. Ginger Zarse and Heather Dozier have assembled a great program.

The two residency training programs in Georgia, Medical College of Georgia at Georgia Health Sciences University and Emory University School of Medicine, continue to thrive in difficult times. Emory welcomed a new Chair this summer. Dr. Laureen Hill came to Atlanta from Washington University School of Medicine in St. Louis, where she was Vice Chair of the Anesthesiology Department and Professor of Anesthesiology and Cardiothoracic Surgery. Dr. Hill's expertise is in critical care medicine, preoperative assessment and intraoperative anesthetic care for patients undergoing cardiac or thoracic surgery and adult patients with congenital heart disease requiring noncardiac surgery. At Medical College of Georgia, 2012 will mark the 75th anniversary of the Department of Anesthesiology. Established in 1937 by Dr. Perry Volpitto, the Department of Anesthesiology and Perioperative Medicine has been under the leadership of Chair C. Alvin Head since 2002. Please look for reports from Drs. Head and Hill as well as updates from residents of both programs in this issue.

In other very important business, GSA's Government Affairs Committee has earned a reputation for solid, successful advocacy in the public policy arena. While much of the success has been engineered under the Golden Dome of our State Capitol, a steady undercurrent of activity is required at the state regulatory level. In this issue, Government Affairs Chair Dr. Mark Huffman and Executive Secretary Jet Toney chronicle the recent and ongoing activities on three important issues which directly impact our members – new

continued on page 12

The GSA Newsletter is published quarterly by the Georgia Society of Anesthesiologists, Inc. Opinions expressed in this publication do not necessarily reflect the official position of the Society. Direct correspondence to:

GSA Newsletter
1231-J Collier Rd. NW
Atlanta, GA 30318
Phone 404-249-9178
Fax 404-249-8831
www.gsahq.org

Editor
Kathryn Stack, MD
kstack@emory.edu

Senior Editor
Carolyn Bannister, MD
cbannis@emory.edu

Executive Secretary
James E. "Jet" Toney
jet.toney@politics.org

Member Services Manager
Heather Groover
heather.atha@politics.org

Letters to the Editor may be sent to kstack@emory.edu.

Officers

President
Timothy N. Beeson, MD 1/12
Tnbeeson@comcast.net

President-Elect
Steven Walsh, MD 1/12
stevenwalsh@bellsouth.net

Vice-President
Jay Johansen, MD 1/12
jjohans@emory.edu

Immediate Past President
Rickard S. Hawkins, MD 1/12
rshawk007@comcast.net

Secretary-Treasurer
Katie Meredith, MD 1/13
katiemeredith@yahoo.com

ASA Director
Peggy Duke, MD 1/13
pduke@emory.edu

ASA Alternate Director
Howard Odom, MD 1/13
npac@mindspring.com

ASA Delegates
Timothy N. Beeson, MD 1/13
tnbeeson@comcast.net

Bruce Hines, MD 1/13
21bhines@bellsouth.net

Rickard S. Hawkins, MD 1/13
rshawk007@comcast.net

Howard Odom, MD 1/14
npac@mindspring.com

Jay Johansen, MD 1/14
jjohans@emory.edu

William R. "Bob" Lane, MD 1/14
blane@nexusmedical.net

ASA Alternate Delegates
Edwin D. Johnston, Jr, MD 2/11
edwinj6036@gmail.com

Mary Arthur, MD 1/12
marthur@mail.mcg.edu

Katie Meredith, MD 1/12
katiemeredith@yahoo.com

Steve Tosone, MD 1/12
stosone@emory.edu

MAG Delegates
Barry Barton, MD 1/12
barryjbarton@gmail.com

Jonathan Newton, MD 1/12
JNewton@gaanes.com

MAG Alternate Delegates
Gerald E. Moody, MD 1/12
mithrander56@yahoo.com

Matthew A. Klopman, MD 1/12
mklopma@emory.edu

Resident Section Officers

President
Vikas Kumar, MD
drvicks@yahoo.com

Vice-President
Justin Drummond, MD
jdrumm2@emory.edu

Secretary
Andrea Dillard, MD
adillar@emory.edu

Treasurer
Danika Little, MD
Dlittl2@emory.edu

Resident Liaison to the Government Affairs Committee
Haley Gillis, MD
hgillis@emory.edu

Immediate Past President
Matt Patterson, MD
Mpatte2@emory.edu

We defend.

THERE'S A GUIDING PHILOSOPHY TO MAG MUTUAL'S EFFORTS to defend your reputation: *Whatever it takes.* Claims committees staffed 100% by physicians. An exhaustive review and medical opinion for every claim filed. Outside help, when needed, to prepare a physician for deposition. Deep exploration of the best available expert witnesses. A detailed game plan weeks before trial. Testing the defense with focus groups. Mock trials. Continuous involvement of MAG Mutual's claims specialists.

Much of the above represents an "expense" to other carriers – an expense they often don't want to pay. So, they're often inclined to settle. ***But settling just to avoid cost isn't in the best interest of the physician, whose reputation, life and livelihood are at stake.***

MAG Mutual... a clear advantage.

1-888-834-5950 • www.magmutual.com

MAG MUTUAL®
MAG MUTUAL INSURANCE COMPANY

INSURANCE • FINANCIAL SERVICES
OFFICE SOLUTIONS • PRACTICE MANAGEMENT

RESIDENT EDUCATION at Emory

Laureen L. Hill, MD, MBA

Professor & Chair, Dept. of Anesthesiology | Emory University School of Medicene

These are no ordinary times. As we prepare for the uncertainties of health care reform including proposed cuts to graduate medical education, it is an appropriate time to reflect on the state of our academic programs. And there is much going on!

It is that time of year again when we are busy with residency recruiting and we are delighted to have so many young and promising candidates. To date we have received over 720 applications for our 16 positions and we are offering interviews to approximately 150 candidates. This year all of our positions will be required to participate in the National Residency Match Program (NRMP) and we will no longer be able to recruit candidates that have completed one or more years in another specialty training program outside the match. This has been identified as an area of concern by academic anesthesiology leaders and discussions are underway regarding possible exceptions or modifications. I suspect we will be hearing more about this in the months to come.

Our residents continue to be active in scholarly pursuits with three residents this year doing six-month research blocks with their faculty mentors in the areas of physician wellness and fatigue, effects of clarithromycin on long-term potentiation and neuropathic pain therapies. This year one of our residents presented a scientific poster at the ASA on her work examining a potential role for thrombin inhibitors after brain injury using neuronal cell cultures. Another resident presented two medically challenging cases involving cesarean section of a parturient with severe hypertrophic cardiomyopathy under epidural anesthesia and anesthetic management of a six-year-old with a large anterior mediastinal mass.

In accordance with the ACGME required competencies, every year our residents complete a group project related to one of three core competencies including professionalism, patient care and safety or system-based practice. A few selected projects are presented at the annual School of Medicine "Science of GME Day" celebration and all of them are presented as posters at the summer GSA meeting. This past summer we had several resident project presentations describing their work on communication between providers, massive infusion protocols, fatigue, failed spinal anesthetic blocks, prevention of epidural catheter infections and airway fires. We are proud of their efforts and look forward to another productive year.

Simulation plays an increasing role in education and life-long learning for all of us and anesthesiology residents are now required to have at least one training exercise in the simulation lab each year. We have developed a robust introductory simulation course for our CA1 residents at the beginning of their

continued on page 11

RESIDENT PERSPECTIVES at Emory

J. Kirk Edwards, MD

Chief Residents | Emory Anesthesiology

Gaurav Patel, MD

It is an exciting time for the Emory Anesthesiology residency program. As we continue our strong tradition of solid clinical and scholastic training, we are also welcoming new changes and directions. First and foremost, on August 1st, our department welcomed Dr. Laureen Hill, from Washington University in St. Louis, as our new chair. Dr. Hill arrived with an impressive clinical background in cardiothoracic anesthesiology and critical care, and her goals include prioritizing resident education while providing outstanding patient care. Among her many ideas is diversifying resident rotations to include training that will keep up with the changes in our field; these include off-site anesthesia rotations, transplant and transfusion medicine rotations, training in critical care-specific procedures, and the business of anesthesiology, to name a few.

Our new CA-1s are off to a good start; they are all beginning to form their foundations in anesthesia. CA-2s are increasing their knowledge in the subspecialties. The seniors are in the process of applying for jobs and getting ready for a multitude of fellowships. This year's CA-3s have been accepted to fellowships in regional, cardiothoracic, and pediatric anesthesia.

Progress is being made in other fronts as well. In anticipation of ENT surgery's move to Emory University Hospital Midtown (EUHM), plans are under way for CA-1s to rotate at EUHM, not only for continued ENT anesthesia training, but also for exposure to cases at EUHM, previously staffed solely by anesthetists.

At Grady this winter, a new and expanded OB anesthesiology lounge is on the verge of completion. The space will improve residents' education and comfort during their time on the labor & delivery suite. Likewise, budgeting approval has been obtained for renovations to Emory Hospital's anesthesiology resident office. Within the next few weeks, we will be unveiling a new, user-friendly website. These latter changes have been executed, in large part, secondary to the efforts of motivated, proactive residents.

We are also underway with the new interview cycle and hope to recruit another solid residency class.

Of course, in the midst of all this change, we are continuing to provide time-proven training at all of our hospitals, including EUH, EUHM, Grady, Egleston, the VA, and Executive Park. We look forward to melding what has worked so well for Emory residents in the past with these new additions, making us an even stronger residency program.

Perspective

RESIDENT EDUCATION at GHSU

C. Alvin Head, MD

Chairman, Anesthesiology & Perioperative Medicine | GA Health Sciences University

As we turn our thoughts to the holidays, many of us have something else dancing in our heads: the whirlwind of activities associated with resident-candidate interviews. Prospective residents touring our facilities have seen the digital makeover of our resident classroom. The renovation included multiple video and audio feeds and the Echo360 lecture capture system. The plan is to capture all classes and conferences for the residents so that they can view lectures and other educational content ubiquitously, including the university, hospital, and clinics, whenever they have a free moment. Residency Director Jim Mayfield and I are planning to investigate the effectiveness of this exciting new technology.

Resident testing is also going digital. Assistant Residency Director Mary Arthur is creating multiple-choice tests using Blackboard which enables our residents to take their tests anywhere and anytime, rather than in the classroom using a paper and pencil.

At the national level, we were once again well represented at the American Society of Anesthesiologists meeting in Chicago, with two abstracts and 11 medically challenging cases. Clerkship Director Ranita Donald presented a three-day educational exhibit on ambulatory thyroid surgery.

Closer to home, excellence in clinical and research training by residents was lauded at our recent awards banquet, where Dr. Thomas Gallen received the Robert D. Dripps Memorial Award; Dr. Ellen Abellana, the Robert S. Crumrine Award; and Dr. Miram Afridi, the Journal Club Award. Dr. Stephen Anderson, who was honored with the Resident Educator of the Year Award, will serve as chief resident in the coming school year. Among our faculty, Dr. Mary Arthur was presented with the Margaret B. DeVore Residents' Choice Award for the second year in a row and Dr. Nina de Vilmorin received the Jack B. Williams Award of Excellence in Anesthesia Education.

Fellowship opportunities are also available at GHSU. In addition to our Pain Medicine Fellowship under the direction of Dr. Ines Berger, we are proud to announce that we have been accredited for an Anesthesiology Critical Care Fellowship. We are accepting applications for this new program, which will begin in July under the direction of Dr. Manuel Castresana.

As the oldest academic department of anesthesiology in the South, we are proud of the accomplishments of our department and of our alumni practicing at academic institutions and in private practice across the country.

RESIDENT PERSPECTIVES at GHSU

Stephen Wells, MD

Chief Resident | GA Health Sciences University Anesthesiology

I have been asked to discuss the state of our residency program from a chief resident's view. This topic is very timely as we are fully involved in the interview season for our resident applicants. Every week we discuss this topic in order to present our program and find the right group of incoming residents. I ask the usual perfunctory questions: "How was your trip?", "Did you enjoy the applicant dinner last night?" and "If you could be any kind of tree, with a glass half full, and you fell in a forest where no one could hear you, given your own personal strengths and weaknesses...would you choose a Miller or Mac blade and why?"

My next question is, "What are you looking for in a residency program?" I have yet to meet an applicant who wants the "country club" experience which requires the absolute minimal effort on his or her part. Rather, the applicants I see crave challenging cases, difficult patients, new technologies and techniques. They want to pass their boards and get a great job or fellowship. They want to be part of a team.

I believe our program delivers on this wish list. The changes that have occurred during my residency have made us even better than when I started. Notable developments include the pediatric, cardiothoracic, regional, pre-op, critical care, and didactic areas.

The Children's Medical Center routinely draws the sickest pediatric patients in the region. The Pediatric Surgery departments are aggressively recruiting additional pediatric surgeons in several subspecialties. The Children's Medical Center OR will be putting another room on line to accommodate the additional caseload. These changes will make an already strong pediatric anesthesia rotation even better. Likewise, the procedures performed in our Electrophysiology department continue to increase. In addition, the highly anticipated Bariatric Surgery program is just beginning and should be in full swing in a year.

Fellowship-trained attendings have added expertise in regional anesthesia procedures on both the adult and pediatric sides. As residents, we are performing more and more nerve blocks. Patients are requesting them and so are surgeons (for their patients, that is).

Last year, of nine graduates, four went on to fellowships. A similar number are pursuing them in my class. Our department now offers three Pain Medicine and two Anesthesiology Critical Care fellowship positions. So for the fellowship-minded applicant, we have them and our residency places them.

continued on page 12

Protecting Patients, Practice in a New Healthcare Era

GSA 2012 Winter Forum

January 21, 2012

The Westin Atlanta Perimeter North | 7 Concourse Parkway | Atlanta, GA 30328

Located near Perimeter Mall and 300 (+) retail stores

Target Audience:

Physicians
Retired Physicians
Residents
Anesthesiologist Assistants
CRNAs
Medical Students
Business Managers

Reduced fee for GSA members!

Register at www.gsahq.org

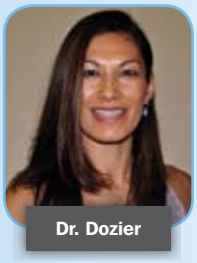
Jointly sponsored by...

American Society of Anesthesiologists

Georgia Society of Anesthesiologists, Inc.

Activity Co-Directors:


Dr. Zarse


Dr. Dozier

Ginger Zarse, MD
Northside Anesthesiology Consultants, LLC
Heather Dozier, MD
Northside Anesthesiology Consultants, LLC

As the relationship with ASA continues, GSA enjoys the special honor of jointly sponsoring the Winter Forum. The pilot program proved to be a success at the 2011 Summer Meeting and allows for increased focus on the educational needs and objectives of GSA members and expands marketing to a larger audience.

Content for the Winter Forum is based on your feedback in educational surveys and post-meeting evaluations over the last few years. The educational focus will update attendee knowledge on some of the basics of anesthesia as well as snapshot the future of anesthesia in the clinical setting.

This CME activity is supported by educational grants. A complete list of supporters will be published in the course syllabus.

Activity Agenda/Schedule

Friday, January 20, 2012

3:00 – 6:00p	**Registration**
4:30 – 6:30p	**Board of Directors Meeting**
5:00 – 9:00 p	**Exhibitor Set Up**
6:30 – 7:30p	**Welcome Hospitality with Exhibitors**
7:30p	***Dinner on your own with family and friends***
7:45 p	***Board of Directors Dinner***

Saturday, January 21, 2012

6:00 a — **Exhibitor Set Up**

6:30 – 7:20a — **Registration/Breakfast with Exhibitors**

7:25 a — ***Welcome***
Tim Beeson, MD | GSA President

Introductions
Ginger Zarse, MD & Heather Dozier, MD
Winter Meeting Activity Co-Directors
Northside Anesthesiology Consultants, LLC

7:30-8:30 a — ***Anesthesiology and Healthcare Reform: An Update***
Norman Cohen, MD
American Society of Anesthesiologists
Vice President for Professional Affairs
Oregon Health & Science University
Associate Professor
Portland, OR

8:30-9:30 a — ***Navigating Medicaid's Changing Tide***
David A. Cook, Esq., Commissioner
Department of Community Health
Atlanta, GA

9:30-10:00 a — **Break with Exhibitors**
Resident Section Meeting

10:00-11:00 a — ***Making Your Practice Indispensible***
John F. DiCapua, MD
North Shore University Hospital;
Long Island Jewish Medical Center
Glen Oaks, NY

11:00a-12:00 p — ***How Emerging Medico-Legal Issues Will Impact Patient Care, Your Practice***
Jennifer Malinovksy, JD
Nelson Mullins Riley & Scarborough, LLP
Partner
Atlanta, GA

12:00-1:00 p — **Lunch and GSA General Business Meeting**

1:00-2:00 p — ***Accountable Care Organizations: Viable Solution or Flash in the Pan***
Norman Cohen, MD
American Society of Anesthesiologists
Vice President for Professional Affairs
Oregon Health & Science University
Associate Professor
Portland, OR

2:00-3:00 p — ***Future of Academic Anesthesia***
Laureen Hill, MD
Emory University Hospital
Chair, Anesthesiology Department
Atlanta, GA

3:00-3:30 p — **Break with Exhibitors**

3:30-4:30 p — ***What's Behind SCIP and Why Should I Care?***
Peggy Duke, MD
ASA Director; ASA Committee on Performance and Outcome Measures, Chair
Emory University Hospital
Atlanta, GA

4:30-5:30 p — ***Advances in Chronic Pain***
Susheel Dua, MD
Northside Anesthesiology Consultants, LLC
Atlanta, GA

5:30 p — ***Meeting Adjourns***

5:30-6:30 p — ***Evening Reception with Exhibitors***

6:30 p — ***Dinner on your own with family and friends***

6:45 p — ***Faculty Dinner***

2012 Winter Forum ***Protecting Patients, Practice in a New Healthcare Era*** ***register at www.gsahq.org***

Faculty Disclosure/Resolution of conflicts of interest:
The American Society of Anesthesiologists and The Georgia Society of Anesthesiologists adhere to ACCME Essential Areas, Standards, and Policies regarding industry support of continuing medical education. Disclosure of the planning committee and faculty's commercial relationships will be made known at the activity. Speakers are required to openly disclose any limitations of data and/or any discussion of any off-label, experimental, or investigational uses of drugs or devices in their presentations.

In accordance with the ACCME Standards for Commercial Support of CME, the American Society of Anesthesiologists will implement mechanisms, prior to the planning and implementation of this CME activity, to identify and resolve conflicts of interest for all individuals in a position to control content of this CME activity.

Special Needs Statement:
The Georgia Society of Anesthesiologists is committed to making its activities accessible to all individuals. If you are in need of an accommodation, please do not hesitate to call and/or submit a description of your needs in writing in order to receive service.

Commercial Support Statement:
Cancellations and/or changes in registration or participation in all or any portion of the meeting must be received at GSA headquarters by Monday, January 16, 2012, to qualify for refund. Absolutely no refunds will be issued for changes received at GSA headquarters after Monday, January 16. The cancellation policy will be strictly enforced.

Accreditation Statement:
This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of American Society of Anesthesiologists and The Georgia Society of Anesthesiologists. The American Society of Anesthesiologists is accredited by the ACCME to provide continuing medical education for physicians.

Credit Designation:
The American Society of Anesthesiologists designates this live activity for a maximum of 8 AMA PRA Category 1 Credit(s)™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Norman Cohen, MD
Vice President, ASA Professional Affairs
Associate Professor, Oregon Health & Science University | Portland, OR

Anesthesiology and Healthcare Reform: An Update
At the conclusion of the presentation, the learner will be able to:
- Identify macroeconomic drivers of healthcare reform
- Discuss PPACA provisions and cost
- Review PPACA implementation timeline
- Analyze financial impact on anesthesiology
- Recognize areas for advocacy focus

David A. Cook
Commissioner , Department of Community Health | Atlanta, GA

Navigating Medicaid's Changing Tide
At the conclusion of the presentation, the learner will be able to:
- Identify and apply elements of the Georgia Medicaid redesign effort for 2012 to patient care in the future
- Relate the 5010 and ICD 10 Coding initiatives to anesthesia practice
- Apply the Medicaid incentive program to patient care/anesthesia practice
- Equate anticipated public policy issues and 2012 legislative issues with medical practice/patient care

John F. DiCapua, MD
North Shore University Hospital; Long Island Jewish Medical Center | Glen Oaks, NY

Making Your Practice Indispensible
At the conclusion of the presentation, the learner will be able to:
- Review and recognize economic factors affecting the relationship of Anesthesia Departments with Hospitals
- Analyze and classify Anesthesia Delivery Models
- Identify factors that can strengthen the relationship of Anesthesia Departments and Hospitals

Jennifer D. Malinovsky, JD
Partner, Nelson Mullins Riley & Scarborough LLP | Atlanta, GA

How Emerging Medico-Legal Issues Will Impact Patient Care, Your Practice
At the conclusion of the presentation, the learner will be able to:
- More effectively assess the role(s) he/she may play in ACOs to assure patient safety and the delivery of high quality peri-anesthesia care
- Apply factors and considerations to help determine which employment/contract arrangement best suits one's practice.
- Avoid illegal or questionable contract arrangements which could negatively impact patient care and physician payment.
- Discern how evolving definitions and interpretations of UCR impact payment, performance and patient care.

Norman Cohen, MD
Vice President, ASA Professional Affairs
Associate Professor, Oregon Health & Science University | Portland, OR

Accountable Care Organizations: Viable Solution or Flash in the Pan
At the conclusion of the presentation, the learner will be able to:
- Explore evolution of healthcare payment methodologies in US
- Describe value-based purchasing initiatives
- Define Accountable Care Organizations (ACO) and review refinement of ACOs
- Discuss Medicare's proposal for ACOs
- Describe private ACO initiatives
- Prognosticate on future directions for ACOs or alternative models

Laureen Hill, MD
Chair, Emory University Hospital Anesthesiology Department | Atlanta, GA

Future of Academic Anesthesia
At the conclusion of the presentation, the learner will be able to:
- Generalize the complexities related to fulfilling clinical, teaching and scholarship missions
- Describe the direct and indirect effects of ACGME requirements on resident education and teaching programs
- Express the impact of shrinking federal funding and conflict of interest policies on anesthesiology research
- Project the anticipated changes due to health care reform on anesthesiology training and practice

Peggy Duke, MD
Director, ASA; Chair, ASA Committee on Performance and Outcome Measures
Emory University Hospital | Atlanta, GA

What's Behind SCIP and Why Should I Care?
At the conclusion of the presentation, the learner will be able to:
- Review SCIP standards and recognize why they are necessary
- Differentiate the difference between SCIP and PQRS
- Contrast who is promulgating these standards and differentiate between these group
- Differentiate implications of participation and non-participation in SCIP standards
- Recognize the role of compliance in future payment reform and hospital negotiation
- Recognize that Anesthesiologists need to continue to define and report measures for our specialty
- Compute and apply what the AQI is and its implications to our practice

Susheel Dua, MD
Northside Anesthesiology Consultants, LLC | Atlanta, GA

Advances in Chronic Pain
At the conclusion of the presentation, the learner will be able to:
- Associate data on occurrence and severity of Chronic Pain with current patient data
- Analyze anatomy and pathology of common Pain conditions to compare patient conditions
- Correlate and apply newer therapeutic options available for treatment of Chronic Pain to patients

Cancellation Policy:
Cancellations and/or changes in registration or participation in all or any portion of the meeting must be received at GSA headquarters by January 16, 2012 to qualify for refund. Absolutely no refunds will be issued for changes received at GSA headquarters after January 16.

Contact information for registration: Heather Groover, GSA Member Services Manager, 404-249-9178 x 6, heather.atha@politics.org

Register at www.gsahq.org

CAC Update

New LCDs govern payment

David W. Gale, MD | GSA Representative to CAC

Editor's note: Dr. Gale and Dr. Raphael Gershon serve as GSA representatives to Medicare and Medicaid administrators at the state and regional levels. The organization is indebted to these volunteer co-reps.

The CMS Carrier Advisory Committee has been very busy the second half of the year dealing with Medicare policy changes for Epidural Steroid Injections (ESIs), Lumbar Facet Injections, and Continuous Peripheral Nerve Blocks. Each of these now has a new LCD (Local Carrier Determination), which are 'policies' on how each of these specific areas will be compensated. These LCDs now have specific documentation requirements that must be in the record in order for the procedure to be correctly reimbursed.

the information will affect your ability to perform

Remember, the dollar amount of reimbursement is maintained at the federal level, not the local policy level that we deal with. Each LCD has specific utilization requirements and documentation requirements for the CPT codes involved. **If you perform any of these types of procedures, you really need to go to the GSA website and download the particular PDF file.** While the reading is not particularly exciting (each one is only a few pages) do it because the information will affect your ability to perform and get properly reimbursed for these procedures.

The LCD on Continuous Peripheral Nerve Blocks (CPNB) is primarily for use within the realm of OR anesthesia. Essentially, if the continuous peripheral nerve block is to be used primarily for post-op pain control, and NOT the primary anesthetic, then it is separately reimbursed. However, if the continuous peripheral nerve block is the primary mode of anesthesia, it will not be separately reimbursed. Dr. (Raph) Gershon and I were able to insert language into the final LCD (along with agreement from the CAHABA medical directors documented in the CAC minutes) which views this procedure as you would for an epidural catheter to be used for post-op pain control. As with epidurals, you can place a catheter, test dose it, and then perform a general anesthetic and have the catheter separately compensated. Documentation requirements needed in the medical record for CPNB are similar as well.

The LCDs for ESIs and Lumbar Facets are a bit more complicated, and I suggest that you download the actual LCD PDF and read it over several times (and make sure your billing staff does the same).

In the last edition of ***scope***, Dr. Gershon did a great job outlining the regional Medicare system. As a quick refresher, each regional Medicare carrier has the ability to make policy for certain codes that they feel are not being used appropriately in their region. Usually, there is a 'spike' in utilization rates that spur the decision to implement an LCD (Local Carrier Determination, essentially a regional policy). Our local carrier for Medicare Part B claims is CAHABA which has the contract for the tri-state GA/AL/TN region.

Epidural injections and facet injections have been subject to LCDs beginning 10 years ago as interventional pain management (IPM) began to grow. We feel this growth is due to our ability as physicians to provide non-surgical treatment alternatives to our patients -- which is a good thing. IPM should be viewed similar to cardiologists placing coronary stents in lieu of CABG procedures. However, CMS and CAHABA simply looks at the increased usage (spike) and takes action to control their costs by placing acceptable guidelines for use.

I have sat at the CAC table for the past 10 years representing GSA primarily for pain related topics. To be quite honest, this is about money. CAHABA continues to see increased utilization (overutilization from their viewpoint) of epidural and facet procedures.

most recent draft LCD would have placed true Draconian restrictions on interventional PAIN procedures

Over the past 10 years, we have gone through two rounds of LCDs (policy changes) to restrict usage. The most recent draft LCD would have placed true Draconian restrictions on interventional pain procedures. The draft epidural injection LCD allowed only 4 ESIs to be allowed anywhere in the body per year. Similarly, facet injections were allowed to be performed 4 per year regardless of levels, etc. Furthermore, radiofrequency lesioning would only be allowed if the patient had an 80% decrease in their pain scores (e.g. going from a VAS of 8/10 to a 2/10 is only a 75% decrease and would not be allowed).

Many of you (hopefully all of you) sent comments during the 6-week comment period in Aug/Sep. We were even able to get congressional letter for one of our representatives, Dr. Tom Price, to support working with the local societies in making policy changes. CAHABA's final LCD was somewhat better for IPM, but still contained the 80% language, which I strongly felt was unacceptable. One week before the LCD was set to become final in November, I was granted a teleconference with the two CAHABA medical directors to discuss these LCD's. I anticipated about 10 minutes of them listening, but only to say their decision is final. However, I was ultimately able to have a dialog that lasted two hours. Five days later, they published the final ESI and Lumbar Facet LCDs, and I am proud to say that our ability as anesthesiologists to continue to perform medically necessary injection procedures will remain.

continued on page 13

Go to www.gsahq.org for new LCDs

2011 GSA-PAC Donors

(November 1, 2010 – October 31, 2011)

Super Donors

Rickard S. Hawkins, MD	**$750**	**Christopher G. Gunn, MD**	**$500**
Steve M. Walsh, MD	**$750**	**Robert C. Ham, MD**	**$500**
Timothy N. Beeson, MD	**$500**	**Jian J. Hua, MD**	**$500**
Alrick G. Brooks, MD	**$500**	**David M. Kalish, III, MD**	**$500**
Amanda K. Brown, MD	**$500**	**William "Bob" R. Lane, Jr., MD**	**$500**
Brian A. Bledsoe, MD	**$500**	**James K. McDonald, MD**	**$500**
Peggy G. Duke, MD	**$500**	**Donnie L. McMickle, MD**	**$500**
Mauro Faibicher, MD	**$500**	**Justin P. Meschler, MD, PhD**	**$500**
Timothy M. Grant, MD	**$500**	**Alvin D. Sewell, MD**	**$500**
Arthur R. Gray, MD	**$500**	**Sanjiwan Tarabadkar, MD**	**$500**

Active Members

Chad M. Achilles, MD	*$200*
Naureen Adam, MD	*$200*
Audrey S. Alleyne, MD	*$200*
Robert Arasi, MD	*$200*
Michael E. Ashmore, MD	*$200*
Michelle Au, MD	*$200*
David B. Austin, MD	*$25*
Jaiwant M. Avula, MD	*$50*
M. Daud Azizi, MD	*$200*
David R. Bailey, MD	*$250*
James M. Bailey, MD, PhD	*$200*
Richard S. Ballard, MD	*$200*
Carolyn F. Bannister, MD	*$200*
Laurie B. Barone, MD	*$200*
Anne T. Hartney-Baucom, MD	*$200*
Deborah H. Bauman, MD	*$25*
Robert C. Baumann, MD	*$200*
James F. Beatty, MD	*$200*
Daniel J. Beeson, MD	*$200*
Arnold J. Berry, MD	*$200*
John R. Blair, MD	*$200*
Timothy W. Boozer, MD	*$200*
Cordell L. Bragg, MD	*$300*
Karen L. Bramblett, MD	*$200*
Kurt S. Briesacher, MD	*$200*
James Braziel, III, MD	*$200*
Jerome L. Bronikowski, MD	*$300*
John J. Byrne, MD	*$200*
James L. Carlson, MD	*$200*
Alan K. Carnes, MD	*$200*
Donn A. Chambers, MD	*$200*
Bessie B. Chen, MD	*$100*
Larry L. Corbitt, MD	*$200*
Keith D. Craig, MD	*$200*
Edward D. Culverhouse, Jr., MD	*$200*
Mark F. Davidson, MD	*$250*
Gwen K. Davis, MD	*$200*
Lee S. Davis, MD	*$200*
C. Phillip deJarnette, MD	*$100*
Preston C. Delaperriere, MD	*$200*
Alice L. Dijamco, MD	*$200*
Sheryl S. Dickman, MD	*$200*
Gary Lee Dove, MD	*$200*
Heather J. Dozier, MD	*$200*
Lisa R. Drake, MD	*$200*
Susheel Dua, MD	*$200*
Eddy N. Duncan, MD	*$200*
Christopher J. Dunkerley, MD	*$75*
Joel S. Dunn, MD	*$250*
Michelle English, DO	*$200*
Darryl F. Feldman, MD	*$200*
Roderick C. Finlayson, MD	*$250*
Anthony J. Fister, MD	*$200*
James E. Fletcher, MD, MBBS	*$100*
Joseph B. Floyd, MD	*$200*
Jennifer R. Foley, MD	*$100*
Rex B. Foster, MD	*$200*
Scott C. Foster, MD	*$200*
Henry Frysh, MD	*$250*
David W. Gale, MD	*$200*
Robert M. Gantt, MD	*$200*
Garcia G. Gaston, MD	*$100*
Gregory L. Gay, MD	*$200*
Karen A Giarrusso, MD	*$200*
Maurice B. Gilbert, MD	*$100*
Marcel Gilli, MD	*$200*
Cary B. Gilman, MD	*$200*
Jeffrey N. Gladstein, MD	*$200*
Patrice A. Goggins, MD	*$200*
Stephen C. Golden, MD	*$200*
Lawrence H. Goldstein, MD	*$200*
Patrick G. Goodman, MD	*$200*
Michael J. Greenberg, MD	*$200*
Kathryn A. Grice, MD	*$200*
Stephen C. Grice, MD	*$200*
Timothy D. Griner, MD	*$200*
Beata K. Grochowska, MD	*$200*
Matthew L. Guidry, MD	*$200*
Kevin Haim, MD	*$200*
William C. Hallowes, MD	*$200*
Kimberley D Haluski, MD	*$200*
Mark E. Hamilton, MD	*$200*
Sue Han, MD	*$100*
Preston P. Hawkins, MD	*$50*
Amber M. Henderson, MD	*$200*
Bruce A. Hines, MD	*$200*
Howard Y. Hong, MD	*$200*
Charles S. Hoover, MD	*$200*
Keith A. Housman, MD	*$200*
Steven M. Huffman, MD	*$250*
Robert Introna, MD	*$200*
Paola D. Iqbal, MD	*$200*
L. Lester Jackson, MD	*$100*
Robert H. Jarman, MD	*$200*
Jay W. Johansen, MD, PhD	*$250*
R. Allen Johns, MD	*$200*
Edwin D. Johnston, MD	*$200*
Joseph F. Johnston, MD	*$25*
Aida I. Joiner, MD	*$200*
Daniel M. Joseph, MD	*$200*
David A. Josephson, MD	*$200*
Alan R. Kaplan, MD	*$200*
Peter M. Kaye, MD	*$200*
Brian T. Kinder, MD	*$100*
Jeffrey M. King, MD	*$200*
Matthew A Klopman, MD	*$200*
Nevin S. Kreisler, MD	*$200*
Michael T. Lama, MD	*$200*
Kristyna M. Landt, MD	*$200*
Forrest J. Lane, DO	*$200*
Igor A. Lazar, MD	*$100*
Jason Lemons, MD	*$200*
Jonathan P. Levelle, MD	*$200*
Richard R. Little, MD	*$200*
Hugh S. MacGuire, MD	*$200*
Michael E. Maffett, M.D	*$200*
Girish N. Makwana, MD	*$125*
Samuel D. Mandel, MD	*$200*
Ian Marks, MD	*$100*
Daniel G. Marshburn, MD	*$100*
Josiah S. Matthews, MD	*$200*
Richard Clay McCormick, DO	*$250*
Courtney A McKay, MD	*$250*
Keith M. McLendon, MD	*$200*
Donald S. McLeod, MD	*$200*
Charles D. McMillon, MD	*$200*
John C. McNeil, MD	*$200*
John B. Meisinger, MD	*$100*
Catherine K. Meredith, MD	*$200*
Stephen L. Miller, MD	*$200*
Stanley R. Mogelnicki, MD	*$200*
Rodney L. Moody, MD	*$200*
Gerald E. Moody, MD	*$250*
Robert O. Morris, MD	*$100*
Wyndham G. Mortimer, MD	*$100*
John J. Moss, MD	*$200*
Richard J. Muench, MD	*$200*
Pradeepkumar R. Nalla, MD	*$125*
John B. Neeld, MD	*$200*
Jonathan C. Newton, MD	*$200*
Mark C. Norris, MD	*$200*
David J. Nusz, MD	*$210*
S. Howard Odom, MD	*$200*
Shaun P. O'Rear, MD	*$200*
Yetunde O. Orimogunje, MD	*$100*
Rogerio M. Parreira, MD	*$200*
Rafael P. Pascual, MD	*$250*
Bradley Phoenix, MD	*$200*
Standford R. Plavin, MD	*$200*
J. Austin Quina, MD	*$200*
Derrick W. Randall, MD	*$200*
Tonya R. Raschbaum, MD	*$200*
William M. Redwood, MD	*$100*
David A. Reeder, MD	*$200*
Linda B. Ritter, MD	*$100*
Howard K. Robinson, MD	*$200*
Kent H. Rogers, MD	*$50*
Stephen E. Rogers, MD	*$200*
Ana Maria D. Roxo, MD	*$100*
James M. Sams, MD	*$200*
Albert H. Santora, MD	*$100*
Mary C. Santora, MD	*$250*
Anthony Schinelli, MD	*$200*
Fred J. Schwartz, MD	*$200*
Stephen J. Schwartz, MD	*$200*
Kathy L. Schwock, MD	*$50*
Justin C. Scott, MD	*$200*
Karl J. Sennowitz, MD	*$200*
Gurudatt K. Setty, MD	*$200*
Eric D. Shapiro, M.D	*$250*
David G. Shores, DO	*$300*
Najeeb I. Siddique, MD	*$200*
Gary E. Siegel, MD	*$200*
Antonio R. Silva, MD	*$100*
Donald B. Silverman, MD	*$200*
Alan M. Smith, MD	*$200*
Samuel Smith, MD	*$150*
Kenneth D. Smith, MD	*$200*
Lisa B. Snyder, MD	*$200*
John S. Solitario, MD	*$200*
Gautam M. Sreeram, MD	*$200*
Myra C. Stamps, MD	*$200*
John H. Stephenson, MD	*$200*
Kenneth S. Stewart, DO	*$100*
Mark J. Stewart, MD	*$300*
Stacy H. Story, MD	*$100*
Charisse N. Stovall, MD	*$200*
David Evan Strick, MD	*$200*
Frank J. Sullivan, MD	*$200*
Steven L. Sween, MD	*$200*
Trent S. Tadsen, MD	*$200*
Donald B. Talley, MD	*$200*
Marvin Tark, MD, PhD	*$300*
J. Mark Tatman, MD	*$100*
William M. Taylor, MD	*$200*
Damon A. Templeton, MD	*$200*
Brian L. Thomas, MD	*$200*
Elise M. Tomaras, MD	*$200*
Kathy C. Trawick, MD	*$200*
Richard W. Trent, MD	*$250*
Raul G. Velarde, MD	*$200*
Alan S. Walters, MD	*$125*
Deryl H. Warner, MD	*$200*
Jesse R. Warren, DO	*$200*
Reuben P. Wechsler, MD	*$150*
Thomas B. West, MD	*$200*
Jeffrey Todd Wheeler, MD	*$200*
Brian P. White, MD	*$200*
Christopher D. Whitson, MD	*$250*
Gennifer N. Wiley, MD	*$200*
Deborah A. Wilkowski, MD	*$100*
Roger S. Williams, MD	*$200*
Gordon S. Williford, MD	*$100*
Dawn C. Wilson, MD	*$200*
Jung S. Kim-Wirsing, MD	*$200*
Joseph C. Woods, MD	*$200*
Jason E. York, MD	*$200*
Ginger E. Zarse, MD	*$200*
Matthew W. Zeleznik, MD	*$200*
Kerry T. Zottnick, MD	*$250*

Resident Members

Brian Bobzien, MD	*$20 (R)*
Mark Caridi-Scheible, MD	*$20 (R)*
Nikki Carignan, MD	*$20 (R)*
Mofya Diallo, MD	*$20 (R)*
Andrea Dillard, MD	*$20 (R)*
Justin Drummond, MD	*$20 (R)*
Kirk Edwards, MD	*$20 (R)*
Lyndsay Fry, MD	*$20 (R)*
Ryan Guffey, MD	*$20 (R)*
Melissa Hirsu, MD	*$20 (R)*
Vadim Ioselevich, MD	*$20 (R)*
Kevin Knight, MD	*$20 (R)*
David Knowles, MD	*$20 (R)*
Vikas Kumar, MD	*$20 (R)*
Danika Little, MD	*$20 (R)*
Jill Maslowski, MD	*$20 (R)*
Marissa Omurtag, MD	*$20 (R)*
Gaurav Patel, MD	*$20 (R)*
Matthew Patterson, MD	*$20 (R)*
Jeffrey Prinsell, MD	*$20 (R)*
Melissa Rader, MD	*$20 (R)*
Natalie Reisman, MD	*$20 (R)*
Joanna Schindler, MD	*$20 (R)*
Katherine Sramek, MD	*$20 (R)*
Margaret Van De Water, MD	*$20 (R)*
Chris Voscopoulos, MD	*$20 (R)*
Matt Whalin, MD	*$20 (R)*
Shaun Williams, MD	*$20 (R)*
Anna Woodbury, MD	*$20 (R)*

Educational Affiliates (AA)

Michael S. Nichols, AA-C	*$200*
Rhea M. Sumpter, AA-C	*$200*
B. Donald Biggs, AA-C	*$100*
William H. Buntin, III, AA-C	*$100*
Claire L Chandler, AA-C	*$200*
Barry Hunt, AA-C	*$50*

State Issues

Regs impact anesthesiologists, protect patients

Mark Huffman, MD
Chair, Government Affairs

James E. "Jet" Toney
Lead Lobbyist

Georgia's state licensing and regulatory boards of medicine and pharmacy produced new regulations in 2011 which could impact many anesthesiologists and will increase protections for consumers of medical services. The GSA has been at the forefront of one of the patient protection initiatives and is helping shape another. The Society has worked efficiently to notify members of proposed changes, especially those immediately impacting members who regularly prescribe Schedule II drugs.

The following summaries recount GSA's involvement in key state regulatory initiatives:

Office-based surgery guidelines

In early December, the Georgia Composite Medical Board approved minimum standards for providing office-based surgery and anesthesia. The action culminates more than three years of advocacy by the Society for creation of Georgia standards. Drs. Howard Odom, Rick Hawkins and Steve Sween worked with members of the Medical Board for more than a year to create the details. The adoption aligns Georgia with more than 25 other states where law, rule or guidelines govern standards for physician office procedures. A special note of appreciation to Medical Board members and 2011 Chair Dr. Alex Gross is in order here.

Schedule II Prescribing

GSA staff monitored Georgia Board of Pharmacy drafts which require all Schedule II prescriptions to be written on security paper. Through the Medical Board, GSA staff advocated for extended grace periods for compliance and "safe harbor" actions by members who provide treatment of chronic pain till such time vendors can fulfill orders for printing of security paper. A note of appreciation to the Medical Association of Georgia for its advocacy on behalf of physicians is appropriate here.

Pain Management Regs

In October, the Medical Board released a first draft of proposed rules for pain management and unprofessional conduct. Via email blast to Society members and posting on gsahq.org, headquarters staff solicited comment from all GSA members. More than two dozen responses were accumulated and tabulated. Dr. Tim Beeson coordinated the member comments and submitted a written GSA response to the Medical Board for its early December meeting. Other individuals and organizations also submitted comments. GSA member Dr. Gary Siegel personally attended the December Medical Board hearing and testified. The Board's second draft was released in mid-December and addresses the GSA's several concerns. Final action is expected early in 2012. The rules for pain management precede anticipated action by the General Assembly to crack down on illegal prescribing of pain medications. The 2011 legislature adopted a state prescription tracking system to combat illegal "pill mills". Tennessee lawmakers have introduced a pain management bill for 2012 and similar legislation is expected in Georgia. It is hoped that the Medical Board's action will preclude state lawmakers attempting to devise rules for medical treatment of chronic pain. A note of appreciation to anesthesiologist Dr. Marion Lee, the Medical Board member who has spearheaded this public health/safety initiative, is appropriate here.

Dr. Marion Lee

Dr. Gary Siegel

Regulations available at www.gsahq.org

Emory ...continued from page 4

training and this year we are introducing a critical event management simulation exercise for our CA2 and CA3 residents. Our School of Allied Health is also using simulation as an ongoing tool in the education and training of our talented Anesthesiologist Assistants. We are investing in simulation education and competency assessment in the department and intend for our growing expertise in this area to support training, maintenance of certification and ongoing provider performance evaluation requirements.

The department is currently leading the development of a robust and comprehensive preoperative assessment program, and we are excited about this expanding role for the department in the health system and the progressive educational experience residents will have in this domain. We are also establishing a Division of Safety, Quality and Cost Effectiveness Research (DiSCovER) with the purpose to support quality improvement initiatives and health services investigation. This is a new area of focus and we look forward to the opportunities to advance safe and efficient patient care and develop future leaders in health care delivery.

Public Policy

Scope, Workers' Comp bills on tap

GSA reps to MAG HOD: Dr. Gerry Moody (l) and Dr. Barry Barton

The 2012 Session of the Georgia General Assembly will see modest rises in state tax revenue and immodest – if not bold – attempts by non-physicians to widen scope of practice. Despite some positive economic indications, state revenues are but 70 percent of where they would be had the state and national economy not stumbled three years ago.

A lagging economy encourages both business owners and health care professionals at all levels to seek innovative expansions of their revenue centers. Often these individuals and their statewide organizations petition legislators to sponsor their innovative ventures by introducing legislation to expand scope or otherwise empower one sector to reduce overhead costs at the expense of another. As an example, GSA members may anticipate that during the 2012 legislature, the following legislation will be introduced and debated by Georgia's 236 state legislators:

Workers' Comp MTGs

Business owners will ask the legislature to pass legislation requiring the establishment of medical treatment guidelines for medical care of injured employees. MTGs would create structured treatment environments that capitate costs and expenses for employers.

Psychologists RX Counseling

The state Board of Psychology is considering a rules change which would authorize psychologists to counsel patients on the potential use of prescription drugs, though the definition does not authorize the prescribing. Expect the Georgia Psychological Association to seek a state law expanding such counseling options.

Clinical Nurse Specialists

CNSs have asked the state Board of Nursing to adopt language which would describe CNSs as primary health care providers, authorize CNSs to supervise other providers and to provide counseling and liaison services – all vague phrases which feather the edges of current sharp-edged scope of practice descriptions. Expect legislation to accomplish this by law if new regulations/definitions are not adopted.

MAG HOD adopts GSA Rez

At its October meeting, the Medical Association of Georgia's House of Delegates adopted a resolution jointly sponsored by GSA and the Medical Association of Atlanta which places as a public policy priority opposition to any proposed Georgia legislation which would tie physician licensure to acceptance of patients under government payor programs. The final resolution was expanded to include opposition by MAG on any legislation which ties physician licensure to participation in any health benefit plan.

Practical ...continued from page 1

Member Services

For the convenience of existing and prospective members, headquarters has streamlined the membership renewal and application process. What was a tedious six-month approval process is now a 24-hour turnaround. GSA applicants benefit from quick resolution of their applications and swift access to critical information available on-line and via email blast.

These issues, briefly described, are only a few examples of the reasons I feel very fortunate to serve as president of the GSA. I wish to encourage your participation in the organization because GSA needs the intellectual equity of its members. You make a difference and make the GSA better.

Good Year ...continued from page 2

rules for Unprofessional Conduct/Pain Management, new guidelines for Office-Based Surgery/Anesthesia, and new prescription-writing rules for Schedule II drugs.

Make no mistake, my fellow colleagues – without the GSA advocating for our members in the public policy and regulatory arena, we would soon find ourselves severely restricted, or exposed, in ways which would directly adversely impact our ability to provide the highest quality patient care. I urge you to respond when the GSA Communication Committee sends requests for feedback to you by email and on the website. Your response to critical emerging issues and policy proposals equips our Government Affairs Committee and executive officers to make the best decisions on how to represent our medical specialty.

GSHU ...continued from page 5

Our department has made significant improvements to the pre-op clinic over the last year in order to streamline the surgery process and reduce cancellations. We are moving toward the "surgical home" concept, and future residents will be more involved in its implementation. Additionally, the leadership in our department has made several changes to benefit resident learning including hiring faculty with a strong desire to teach, improving the quality and quantity of didactic lectures, and implementing scheduled practice exams to benchmark our progress.

In summary, the program to which I was excited to receive a position has made and continues to make significant improvements. I believe we have a lot to offer incoming applicants. Future residents will be well prepared for fellowships and the marketplace.

Letters to the Editor

Pain variables challenge us


Dr. West

"No Patient Shall Be Harmed by Opiod-induced Respitory Depression"

- APSF headline for fall issue 2011

"The right of patients to appropriate assessment and management of pain…"

- Joint Commission on Accreditation of Healthcare Organizations

Dear Editor,

Who can disagree but, "WOW!" On one spectral end is a patient's expectation that appropriate management will result in a pain score of 2 and at the other spectral end is APSF envisioning "no patient shall be harmed…" Add to this each hospital's desire to have published patient satisfaction scores above the community norm.

Yes, I know -- pain management is more than opiates. Reposition the patient, cold packs, hot packs, encouragement, NSAIDs, and even intravenous acetaminophen. But, in many cases these options are just not enough. Peripheral nerve blocks are increasingly an option for some but are not exempt from implementation risks and failures. The need for "improved education" and "better assessment" is self evident and pragmatically never fully achieved. Will increased electronic monitoring perfect vigilant post-operative care or become a crutch?

I write not to disparage the goal we all share. Rather I am concerned for those of us who must deal with the reality of patient variability, OSA, emotional temperament, imperfect analgesics and lofty goals. Notwithstanding the online disclaimer, any hint that "no patient harm is ever fully achievable but for…" is idealistic. The APSF article does acknowledge that "limited resources" are an impediment to continual monitoring of "all inpatients receiving postoperative opiods." Try navigating that statement when ANY patient receiving ANY opiod has ANY adverse event reviewed by an expert who asserts that respiratory depression might have been a causative event.

Respectfully,
Tom West, MD

LIFEBOX CHALLENGE: saving lives

The Lifebox Challenge: To save the lives of thousands of people undergoing surgery in under-resourced countries through the use of a pulse oximeter.

There are about 234 million operations performed globally. Imagine having to administer anesthesia to your patient without the use of a pulse oximeter. In more than 70,000 operating rooms across the developing world, your anesthesia colleagues have no other choice. Pulse oximeters are missing. They are just too expensive. Access is the most significant barrier to widespread oximetry use and millions of lives are placed at unnecessary risk.

Lifebox is a not-for-profit organization that grew out of a global initiative, the WHO Safe Surgery Saves Lives Initiative, to make surgery safer worldwide. Use of a simple surgical checklist has been shown worldwide to improve the safety and quality of surgical care by significantly reducing surgical complications and death by more than one third. Item #4 on the WHO Surgical Safety Checklist is, "a pulse oximeter is on the patient and functioning."

lifebox

Saving lives through safer surgery


Faye M. Evans, MD

Pediatric Anesthesiologist | Emory University School of Medicene

Lifebox has developed the world's foremost low-cost, high quality pulse oximeter that is compliant with international standards. A $250 tax-deductible donation in support of this project will put a pulse oximeter into the hands of colleagues who need it most. A key part of this project is that each oximeter is supplied with educational materials including videos, tutorials, and a manual. Lifebox is working to make sure that no person dies during surgery simply because a pulse oximeter was not available and basic safety checks were not done.

Lifebox is a joint project by the Association of Anaesthetists of Great Britain & Ireland and the World Federation of Societies of Anaesthesiologists under the leadership of Professor Atul Gawande at Harvard School of Public Health and Brigham and Women's Hospital. It is also supported by the American Society of Anesthesiology, the Canadian Anesthesiologists' Society, the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists.

New LCDs ...continued from page 9

With this goes the responsibility to read and understand the new policies as there are specific restrictions on total number of injections and frequency of injections. We must document in the medical record that the patient has tried and failed conservative treatments and that the injections are increasing patient function at every step along the process. As we all know, Medicare resources are finite. We compete with every other specialty for Medicare dollars. If we do not use them wisely, there will be yet another LCD that will be much less favorable (the Pacific NW carrier Noridian has nearly gutted interventional pain management in that part of the country).

So please, go to GSAHQ.org and download the three LCDs in PDF format & enjoy the read!!

New Officers tapped for 2012

Nominating Committee Chair Dr. Steve Walsh submits the following recommended slate of new officers for 2012:

Steve Walsh, MD, President
Jay Johansen, MD, President-Elect
Kathryn Stack, MD, Vice-President
John Stephenson, MD, ASA Delegate

For a complete list of current and continuing officers, go to page two. Elections will be held on Saturday, January 21, 2012 at the winter general business meeting in conjunction with the Winter Forum.

SAVE THE DATE

July 20-22, 2012

GSA 2012 Summer Meeting

The Ritz-Carlton Lodge Reynolds Plantation on Lake Oconee Greensboro, GA

AQI Activates Incident Reporting System (AIRS)

Richard P. Dutton, MD, MBA
Executive Director, Anesthesia Quality Institute

On October 1, 2011, the Anesthesia Quality Institute activated the first nationwide system for collecting individual adverse events from anesthesia, pain management and perioperative care. We're calling it AIRS: the Anesthesia Incident Reporting System. Here's how it happened, and how it works:

Background and Rationale

Anesthesiology is characterized by a very low rate of serious complications. This scarcity makes it difficult to recognize recurrent problems and to achieve the statistical power necessary to understand risk factors and test potential solutions. Paradoxically, the very safety of anesthesia has reduced our ability to improve. Consider the example of postoperative visual loss (POVL). By the late 1990s most experienced providers had seen or heard of at least one case, but very few providers knew of more than one. It was not until enough cases had accumulated in the ASA Closed Claims Project Registry that we realized this was a recurrent safety issue, more common in certain kinds of cases, and potentially influenced by our anesthetic practice.

The problem with relying on closed claims for our safety "signal" is that not all serious events result in lawsuits, not all malpractice insurers make their records available, and only those events that result in a patient injury are ever captured. It can take many years for a malpractice case to run its course and for the records to be abstracted. Hence the need for a more timely system.

Anesthesia registries, such as the National Anesthesia Clinical Outcomes Registry (NACOR) function at the opposite end of the spectrum. By capturing every case, every day, they will inevitably include some with serious adverse outcomes. Over time, a picture will emerge of the relative rate of serious occurrences, and the kinds of cases they occur in. But registries are lacking in different way: granularity of reporting. Standardized data entering the registry does little to identify the nuances of patient disease, evolving clinical circumstances, and anesthesiologist judgment that contribute to an unusual occurrence – and these are the things that we would most like to know. Nor do registries capture near misses, when no adverse event occurs.

This is why critical incident reporting, based on either actual adverse events or "near misses," is a common concept in anesthesia department quality management (QM) at the local level. Most hospitals and most anesthesia departments mandate the reporting of critical or "sentinel" events, and most academic departments have regular "Morbidity and Mortality" conferences to discuss unusual cases. Such systems work best when there exists a 'safety culture' among practitioners, with free and open discussion about negative events. The desire for improvement must outweigh fear of the consequences of reporting. Yet even when such systems flourish at the local level there is still an unfilled national need. Many serious anesthesia events occur at such a low frequency that a given group of providers might never see more than one occurrence. And the closed mouth nature of the legal system makes it difficult for one group to learn from the experience of another.

The AQI believes the time is ripe for a national system for reporting critical events in our specialty. The US aviation system has had such a system in place since 1976. Called the Aviation Safety Reporting System, it is funded by the Federal Aviation Administration and administered by NASA. Blinded data gathered from reported incidents is available on the FAA website, in the Aviation Safety Information Analysis and Sharing system, and is available for public research.

History

Similar efforts have occurred elsewhere around the world. The Australian Incident Monitoring System (AIMS) was created almost 20 years ago to capture serious events and near misses in the operating room. Reporting was via paper forms, sent to a central office. This registry spawned numerous academic papers up until 2005, when it became a victim of its own success. The system was expanded to include any in-hospital adverse events (losing its focus on anesthesia) and was then expanded internationally (losing its focus on local practice). With these changes, anesthesia providers stopped contributing to it, and AIMS ceased to be a useful tool for anesthesiologists. However, the need for such a system did not go away. The Australian and New Zealand Tripartite Anaesthetic Data Committee was formed in 2006 to reintroduce national anesthesia event reporting using the tools of the Information Age. This system, now active throughout Australia and New Zealand, uses anonymous web-based reporting to gather events.

The Critical Incident Reporting System (CIRS) was created in Switzerland in the 1990s to fill a similar role, and is still in use by Swiss anesthesiologists today. With the recent publication of the "Helsinki Declaration" proposing universal professional standards for anesthesia QM, there is thought of expanding this system across all of Europe. Similar systems are in place in Great Britain, Scandinavia, and locally at several US medical centers. And after decades of disinterest, the US government has recently provided some support: The US Patient Safety and Quality Improvement Act of 2005 authorized the creation and accreditation of Patient Safety Organizations (PSOs) as a means of aggregating healthcare quality data across multiple institutions. These regulations were completed in 2009, and have spawned a number of national quality registries based in hospital corporations, state governments and professional associations.

Development of AIRS

In January, 2010, even as the AQI was launching NACOR, the AQI Board requested a plan for an incident reporting system. Since that time we have researched incident reporting systems in other countries, conversed with dozens of experts in the US and abroad, and conducted a detailed analysis of the legal issues such a system would raise. The AQI was designated as a Patient Safety Organization in September, 2010. We formed the AQI-AIRS Steering Committee, and recruited a select group of experts to advise us on the best approach to building the system. Ably led by James Caldwell, M.D., of the University of California, San Francisco, and Patrick Guffey M.D. of the University of Colorado, this volunteer committee of subject matter experts defined the scope of incidents we would seek, the data we would solicit, and the uses we would make of the results. Members of the Steering Committee are shown in Table 1.

A prototype of the online reporting tool was developed this spring, and evaluated by the Committee. After several rounds of revision, a beta-test version of AIRS was launched in May, for use by the Committee members themselves and by practices already participating in NACOR. We've captured dozens of incidents in the past few months (one of which is presented as a teaching case elsewhere in this Newsletter) and we've ironed out the kinks in the system. Now it's time to make AIRS a truly national resource.

Complete article at www.gsahq.org

GEORGIA
SOCIETY OF
ANESTHESIOLOGISTS, INC.

1231 Collier Road, NW
Suite J
Atlanta, Georgia 30318
(404) 249-9178 Fax (404) 249-8831
www.gsahq.org

Protecting Patients, Practice in a New Healthcare Era

GSA 2012 Winter Forum

REGISTER NOW!

Fees reduced for GSA Members


Dr. Zarse


Dr. Dozier

January 21, 2012

The Westin Atlanta Perimeter North
Atlanta, Georgia

CME Activity Co-Directors:
Ginger Zarse, MD & Heather J. Dozier, MD

Register NOW @ www.gsahq.org