Who will represent you?

GSA examines the 2014 Congressional & Senate Candidates.
**National practice news**

**Quality data impacts practice quality**

From AQI Staff Reports

This kind of national quality management... can have substantial positive effects on anesthesia practice.

The National Anesthesia Clinical Outcomes Registry (NACOR) was launched on January 1, 2010 with six early adopting practices. Data is now available to support academic and health policy research in collaboration with physician scientists in any AQI-participating practice. NACOR now includes over 1.1 million cases from 151 fully-contributing groups. NACOR includes data from almost 9,000 anesthesiologists, or about 25% of the active practitioners in the U.S.

AQI released the Participant User File (PUF) in early 2013: an aggregated, de-identified, cleaned version of selected NACOR data fields. This data is already being studied by more than a dozen investigators, and several papers are in the works which will provide us a new and comprehensive understanding of the nature of anesthesiology in the United States. The AQI is using this information internally to provide high-level dashboards of summary data for ASA societies and state-society leaders, anesthesiology subspecialty societies, and important ASA committees. Information and instructions for accessing AQI data can be found on the AQI website http://aqihq.org/qaui-inquiry.aspx.

While intrusive, this is sensible as a counter balance for new models of payment that incentivize cost effectiveness.

AIRS: The Anesthesia Incident Reporting System is growing. Currently we have more than 800 serious adverse events, unsafe conditions, and near misses. Transparent national outcome reporting is essential to assure the public that physicians and hospitals are not skimping on necessary and indicated care.

While CCP and AIRS are positive examples for our specialty, one of the largest national gaps in anesthesiology is the generation and reporting of systematic data on adverse outcomes from every case, every day. An estimate from the 275 groups participating in the National Anesthesia Outcomes Registry (NACOR) is that no more than half have a system for collecting this kind of data, while fewer than 25% are able to report clinical outcomes to NACOR on a routine basis. This number has been increasing steadily, and will soon reach a critical mass where true national benchmarking of adverse outcomes is possible.

Continued on Page 5
The OIG commented in the new advisory opinion that: “The Proposed Arrangement appears to be designed to provide the Psychiatry Group (the referring physician practice) to do indirectly what it cannot do directly that is, to receive compensation, in the form of a portion of Requestor’s successful payments, in return for the Psychiatry Group’s referrals of ECT patients to Requestor.”

Unlike Advisory Opinion 12-06, the new advisory opinion involves a hospital that forced its lengthened hours on patients, a practice that amounted to “requesting” to agree to a come-on-to-its-own-otherwise-unwilling patients to Requestor for anesthesia services.

The OIG concluded: “The Proposed Arrangement therefore presents the significant risk that the remuneration Requestor would provide to the Psychiatry Group—i.e., the opportunity to generate a fee equal to the difference between the amounts the Psychiatry Group would bill and collect for its anesthesia services, and the per diem amount the Psychiatry Group would pay Requestor—would be in return for the Psychiatry Group’s referrals to Requestor. We discern no safeguards in the Proposed Arrangement that would minimize this risk. Therefore, for the combination of reasons stated herein, we cannot conclude that the Proposed Arrangement would pose no more than minimal risk of fraud and abuse under the anti-kickback statute.

Significantly, the OIG went beyond the scope of PSA’s legal opinion request and explored separate concerns with respect to both the hospital’s relationship with the Psychiatry Group, to the extent that the hospital was providing the Psychiatry Group with a benefit in exchange for the Psychiatry Group’s referrals to the hospital’s anesthesia group (and b) the hospital’s relationship with the Psychiatry Group, to the extent the anesthesia group agreed to the Additional Anesthesiologist Services, to do indirectly what it cannot do directly that is, to receive compensation, in the form of a portion of Requestor’s successful payments, in return for the Psychiatry Group’s referrals of ECT patients to Requestor. The proposed arrangement would present the significant risk that the remuneration Requestor would provide to the Psychiatry Group—i.e., the opportunity to generate a fee equal to the difference between the amounts the Psychiatry Group would bill and collect for its anesthesia services, and the per diem amount the Psychiatry Group would pay Requestor—would be in return for the Psychiatry Group’s referrals to Requestor. We discern no safeguards in the Proposed Arrangement that would minimize this risk. Therefore, for the combination of reasons stated herein, we cannot conclude that the Proposed Arrangement would pose no more than minimal risk of fraud and abuse under the anti-kickback statute.

The complaint further alleges that “Vanderbilt designed, created, and maintained electronic data and image management systems that provide template treatment records to support patient-specific billing practices. For purposes of documentation to anesthesia services, Vanderbilt’s software provides physicians with only one choice for describing the level of treatment: “medically directed.” The software does not permit physicians to select subcategories or levels of payment, such as ‘medical supervision,’ even though various forms of anesthesia care may be performed.”

Although the case is in an early stage and no decision has been issued, the allegations in the case serve as a reminder of:

1. The complicated nature of anesthesia billing.
2. The need to comply with the rules when billing for medical direction.
3. The need to document compliance with medical direction.
4. The need to assess carefully immediate availability issues.
5. The need to address billing compliance concerns that employers raise.
6. And finally, whether or not the government chooses to intervene.

The podcast describes the investigation of the UC Irvine case and how the authorities determined the claim by going on-site to the hospital and looking at the distances involved. The follow-up from the transplant point: immediate availability issues, not properly listing the services (personal services vs. medical direction or medical supervision), and insufficient documentation to support the services billed.

After reviewing selected numbers of Medicare and Medicaid claims, we found that anesthesiologists oversee multiple procedures, in different buildings or on different floors, where they may not immediately know what services anesthesiologists and other physicians made. Anesthesiologists also incorrectly billed Medicare and Medicaid, indicating that they had personally performed the services instead of medically directing them. The services, and finally, there was insufficient documentation to support the services billed.

Based on the results of the OIG 2013 work plan, the OIG Advisory Opinion No. 12-06 that should assist anesthesia providers to benefit from their referrals by having their anesthesia services as a target area of review.

Although it is not a new development, anesthesiologists should be aware that the OIG 2013 work plan identifies personally performed anesthesia services as a potential area of review.
Jack Kingston is a former state senator and is now running for the U.S. Senate. He is a conservative who believes in limited government and has opposed Obamacare. He is running against incumbent Senator Saxby Chambliss. Kingston is known for his conservative views and his opposition to government spending. He has been a strong critic of the Affordable Care Act, which he believes will lead to higher taxes and decreased freedom for patients. Kingston believes that the Affordable Care Act will lead to higher premiums and decreased access to health care for many Americans. He has also opposed the establishment of health care exchanges, which he believes will increase the power of insurance companies and decrease patient choice. Kingston has also been a vocal critic of the Obama Administration’s policies on energy and the environment. He believes that the United States needs to increase its domestic energy production and reduce its reliance on foreign oil. Kingston is a strong supporter of the U.S. military and has been a vocal advocate for increased defense spending. He has also been a strong supporter of the war on terrorism and has been a critic of the Obama Administration’s policies on the war in Afghanistan. He is running in a very competitive race, and the outcome of the election will likely determine the balance of power in the Senate.
What we asked...

**Question 1**
Do you believe that there is a correlation between physician-led health care and patient safety and medical errors? Please explain.

**Question 2**
In what circumstances, if any, do you believe that someone other than a physician should lead a patient care team? Why or why not?

**Question 3**
Should physician anesthesiologists be available to every patient who undergoes surgery? Why or why not?

**Question 4**
If you support the role of physicians as the highly-trained and highly-skilled providers of health care, would you support the expansion of scope of practice for non-physician providers? Why or why not?

**Question 5**
Do you believe that there is a correlation between physician-led health care and patient safety and medical errors? Please explain.

**Question 6**
Do you believe that the government should play a role in the provision of health care? Why or why not?

**Question 7**
If you support the role of physicians as the highly-trained and highly-skilled providers of health care, would you support the expansion of scope of practice for non-physician providers? Why or why not?

**Question 8**
Do you believe that the government should play a role in the provision of health care? Why or why not?
Do you believe that there is a correlation between physician-led health care and patient safety and medical research? Please explain.

Question 2 - In what circumstances, if any, do you believe that someone other than a physician should lead patient care? Why or why not?

Question 3 - Do you believe that there is a job overlap between physician-led health care and medical research? Please explain.

Question 4 - Should a physician anesthesiologist be available to every patient undergoing surgery? Why or why not?

Question 5 - Should a physician anesthesiologist be available to every patient undergoing surgery? Why or why not?

Question 6 - Should physicians remain at the forefront of patient care? If you support the role of physicians as the highly-trained and responsible leader of the patient care team, how do you propose to ensure physician leadership in the oversight of the patient care team?

Question 7 - Should physicians remain at the forefront of patient care? If you support the role of physicians as the highly-trained and responsible leader of the patient care team, how do you propose to ensure physician leadership in the oversight of the patient care team?

Question 8 - Should physicians remain at the forefront of patient care? If you support the role of physicians as the highly-trained and responsible leader of the patient care team, how do you propose to ensure physician leadership in the oversight of the patient care team?

Question 9 - Should physicians remain at the forefront of patient care? If you support the role of physicians as the highly-trained and responsible leader of the patient care team, how do you propose to ensure physician leadership in the oversight of the patient care team?
Question 1 Response

There is no way the physician and the patient can be in a direct relationship with the patient and, therefore, the patient has the health and wellness as their primary/geriatric concern. Government involvement will end up being onerous and limiting the care costs further.

Question 2 Response

I would support Congressman Tom Price's plan. I believe the system is broken due to the bureaucracy created by the government. I believe the system is too large, and the administration is working to destroy the system.

Question 3 Response

Yes, a physician would be the only one to lead in healthcare decisions. The only exception would be if the patient is an incapacitated patient, where another individual would have the control.

Question 4 Response

No, the health care system does not need regulatory oversight. The answer is yes, if the personal physician is the attending physician. As such, the best outcomes are determined by that relationship, not third party payers, or bureaucrats. I can't think of any reason for a bureaucrat, or anyone other than a physician should lead patient care. A Patient’s autonomy should be respected. Individually, their family and doctor make decisions together. Even in the case of an incapacitated patient, where another individual would have the control.

Question 5 Response

The answer is yes, a physician would be the only one to lead in healthcare decisions. There needs to be lessened. Patients should become involved in the planning and decision making process.

Question 6 Response

Insurance is a threat to the traditional, effective model of health care. For instance, because of the ObamaCare mandate, the plan is the health care policy that is the cause of the inefficiency in the American health care system. The answer is yes, if the personal physician is the attending physician. As such, the best outcomes are determined by that relationship, not third party payers, or bureaucrats.
Question 1 - Do you believe that physicians are the natural leaders of patient care; or should another profession or field of study take a lead role in patient care? Why or why not?

Question 2 - Do you believe that a physician anesthesiologist can be the lead physician in a patient care team? Why or why not?

Question 3 - Do you believe that there is a correlation between physician-led health care and patient safety and medical necessity? Please explain.

Question 4 - Do you support the role of physicians as the highly-trained and qualified leader of healthcare for patient safety and medical necessity? Why or why not?

Question 5 - Do you agree with the physician role in the management of the healthcare system? Why or why not?

Question 6 - Should a physician anesthesiologist be available to every patient who undergoes surgery? Why or why not?
Dr. Puri elected AMA delegate

Medical College of Georgia Resident Dr. Suvikram Puri has been elected by his peers to serve as the alternate delegate to the AMA in 2014 and delegate in 2015. He campaigned for and won the election during the ASA Resident House of Delegates in San Francisco, CA, in October.

“I was given the opportunity to serve as resident delegate to the American Society of Anesthesiologists and was privileged to represent the State of Georgia and MCG,” Dr. Puri said. “By participating, I have developed a unique insight into the future of anesthesiology during my conversations with several current and future ASA leaders. Dr. Puri will serve multiple roles. He will work alongside the ASA board of directors and become part of the delegation to the American Medical Association. In addition, as a member of the ASA resident governing council and in collaboration with the AMA resident leadership, he will represent over 5,500 anesthesiology residents from over 130 programs. Other responsibilities include significant involvement with the ASA-PAC, grassroots lobbying, and educating anesthesiology residents about healthcare policies.

“The ASA is a very active and powerful organization and I am extremely proud to be in a position to serve. I am grateful to both the anesthesiology department at MCG (especially Drs. Manuel Castresana, Mary Arthur, and John Blackburn) and the GSA (especially Dr. Jay Johansen and Jet Toney) in their wholehearted support and constant encouragement of my effort to be elected,” he said.

Grateful, respectful, anxious

Continued from Page 2

I had the pleasure of speaking with Dr. Neeld and I asked what we can do to help win this war and continue to provide our patients with the highest quality care. His response was multi-faceted and started with appreciation of the gravity of the situation. He asserted it is imperative that we stay abreast of efforts to undermine our role in patient care. The amazing staff at GSA Headquarters and Cornerstone Communications makes this easy to do through relevant, informative GSA e-news updates delivered via e-mail to members.

Support candidates who recognize and embrace the physician-led model as the gold standard for patient care.

Dr. Neeld said physicians must be aware of our allies in the government arena and pledge support to these individuals. This is the theme of this edition of scOpe as we examine the candidates who are vying in the coming elections to represent our state at the federal level. It is imperative, perhaps now more than ever, that we support candidates who recognize and embrace the physician-led model as the gold standard for patient care in the perioperative period.

Finally, Dr. Neeld emphasized that we must encourage ASA’s leadership to fund outcomes studies. Such studies could arm our allies with the necessary ammunition to counter the attacks on our specialty and patient quality of care. Each one of us must actively participate in these studies by providing outcomes data. The Anesthesia Quality Institute exists for the purpose. The mission of the AQI is “to develop and maintain an ongoing registry (NACOR) of case data that will become the primary resource for anesthesiologists looking to assess and improve patient care.” By providing data to the AQI, we equip the ASA to prove our value and preserve our leading role in patient care.

“Although it is the heart of what we do, it is no longer sufficient that we only provide the best possible care for our patients,” Dr. Neeld said. “We must follow his and others’ examples by tirelessly working to preserve our specialty in this new era of healthcare. We all have a role to play, and we simply cannot afford to be inactive. Each one of us must actively participate in these studies by providing outcomes data.

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January 11-12, 2014 | 18th Annual GSA Winter Forum | January 11-12, 2014 | Atlanta Perimeter Center Marriott Hotel

Target Audience: Physicians, Retired Physicians, Residents, Anesthesiologist Assistants (AA), CRNAs, Medical Students, Business Managers

Activity Co-Directors: Justin Ford, MD Northside Anesthesiology Jay Kher, MD Northside Anesthesiology

Register at www.gsahq.org

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American Society of Anesthesiologists

American Society of Anesthesiologists, Inc.

Anesthesia Today

CURRENT ISSUES AND MULTIDISCIPLINARY UPDATES

Friday, January 10, 2014

3:00 – 6:00 p Registration - Grand Foyer

4:30 – 6:30 p Board of Directors Meeting - Madison

5:00 – 9:00 p Exhibitor Set Up - Presidential Ballroom

6:30 – 7:30 p Welcome and Hospitality: Registrants, Exhibitors and Guests - Roosevelt

7:30 p Dinner on your own with family and friends

7:45 p Board of Directors and Faculty Dinner

Saturday, January 11, 2014

6:00 a Exhibitor Set Up - Presidential Ballroom

6:30 – 7:20 a Registration/Breakfast with Exhibitors - Presidential Ballroom

7:25 a Introductions - Winter Meeting Activity Co-Directors: Justin Ford, MD, Northside Anesthesiology Consultants, LLC and Jay Kher, MD, Northside Anesthesiology Consultants, LLC

Jay Johansen, MD, PhD - GSA President

Introductions - Winter Meeting Activity Co-Directors

John Rowlingson, MD - University of Virginia

COS: Girish Joshi, MBBS, MD, FFARCSI

8:30-9:25 a How Pain Mechanisms Direct Pain Management

John Rowlingson, MD - University of Virginia

Cosmo A. DiFazio Professor of Anesthesiology

9:30-10:00 a Break with Exhibitors - Presidential Ballroom

10:00-10:55 a Non-Opioid Anesthesia

Robert Thibe, MD, University of Virginia

Assistant Professor of Anesthesiology

9:30-12:00 p Resident Section Meeting - Salon E

10:00-10:55 a Intraoperative Goal Directed Therapy (GDT)

Thibe, MD, University of Virginia

Assistant Professor of Anesthesiology

11:00a-11:55 a Intraoperative Goal Directed Therapy (GDT)

Thibe, MD, University of Virginia

Assistant Professor of Anesthesiology

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

1:00-1:55 p Basics of TEE for the Non-Cardiac Anesthesiologist

Julie Hullmeyer, MD

University of Virginia

Assistant Professor of Anesthesiology

2:00-2:55 p The Perioperative Surgical Home from Concept to Reality

Arthur Boudreaux, MD

University of Alabama at Birmingham

Chief of Staff & Clinical Professor

3:00-3:30 p Break with Exhibitors - Presidential Ballroom

3:30-4:25 p Utilizing Performance Improvement Techniques to Improve Clinical Practice

Arthur Boudreaux, MD

University of Alabama at Birmingham

Chief of Staff & Clinical Professor

4:30-5:25 p Anesthetic Considerations of the Complex Spine Case

Jeffrey Gonzales, MD, MA, Duke University Department of Anesthesiology

Clinical Director of Surgical Spine Services & Assistant Professor

5:30 p Meeting Adjourns

6:00-7:00 p Mix with Family and Friends - Great Room

7:00 p Dinner on your own with family and friends

Sunday, January 12, 2014

7:30 a – 12:00 p Workshop: Ultrasound Guided Regional Anesthesia – Pavilion

Ultrasound Workshop: Instructors: Michael Ashmore, MD, Howard Hong, MD, Jay Kher, MD and Douglas Stewart, MD

Workshop attendees will rotate through four ultrasound stations, following the below schedule:

7:30 a - 8:25 a Ultrasound Session 1

8:30 - 9:25 a Ultrasound Session 2

9:30 - 10:00 a Break

10:00 - 10:55 a Ultrasound Session 3

11:00 - 11:55 a Ultrasound Session 4

10:00a-1:00 p GAAA Board of Directors Meeting – Tyler

1:00-1:55 p Ultrasound Guided Regional Anesthesia Session 5

2:00-2:55 p Ultrasound Guided Regional Anesthesia Session 6

3:00-3:30 p Ultrasound Guided Regional Anesthesia Session 7

3:30-4:25 p Ultrasound Guided Regional Anesthesia Session 8

4:30-5:25 p Ultrasound Guided Regional Anesthesia Session 9

5:30 p Meeting Adjourns

6:00-7:00 p Mixer with Family and Friends - Great Room

7:00 p Dinner on your own with family and friends

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

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. Faculty members and planners must disclose any commercial relationships with any ACCME-defined commercial interest that might create a potential conflict of interest (COI) with this CME activity. Faculty members must also disclose any off-label, experimental, or investigational uses of drugs or devices in their presentations.

This activity has been planned and implemented in accordance with the Essential Areas and Standards of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of The 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.

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

Accreditation Statement:

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.

Credit Designation:

The American Society of Anesthesiologists designates this live activity for a maximum of 4 AMA PRA Category 1 Credits™ and the January 11th live activity for a maximum of 2 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Cancellation Policy:

Calculations and other changes in registration or participation in all or any portion of the Winter Meeting must be made by January 4, 2014. To qualify for refund, cancellations must be received at Georgia Society of Anesthesiologists, Inc. by January 10, 2014. After January 10, 2014, refunds will not be provided.
Arthur Boudreau, MD
University of Alabama at Birmingham, Chief of Staff, Clinical Professor
The Perioperative Surgical Home: From Concept to Reality
At the conclusion of the presentation, the learner should be able to:
• Describe the major components of the perioperative surgical home (PSH).
• Identify gaps in current practice that have to be filled to offer a PSH service.
• Emphasize need for collaboration and teamwork and for the local political obstacles of a PSH.
• Discuss the potential funding sources for PSH development.

Jeffrey Gonzalez, MD, MA
Duke University, Department of Anesthesiology, Clinical Director of Surgical Spine Services, Assistant Professor
Anesthetic Considerations of the Complex Spine Case
At the conclusion of the presentation, the learner should be able to:
• Describe the standard this associated with spine surgery.
• Discuss the safety aspects of spine surgery.
• Evaluate use of noninvasive techniques for blood management in spine cases.
• Discuss future goals of hospital care in spine patients with regard to CMS/hospitality changes.

John Rowlisting, MD
University of Virginia, Department of Anesthesiology, Cooso A. Zafra Professor of Anesthesiology
How Pain Mechanisms Direct Pain Management
At the conclusion of the presentation, the learner should be able to:
• Highlight the mechanisms by which the pain transmission system is activated.
• Present the rationale for utilizing mechanism-targeted therapy.
• Discuss contemporary advances in pain treatment.

Mixing Sharp Needles with Thin Blood
At the conclusion of the presentation, the learner should be able to:
• Highlight recommendations from leading guidelines.
• Discuss the pharmacology of modern-day antiplatelet drugs.

Robert Thiele, MD
University of Virginia, Department of Anesthesiology, Assistant Professor of Anesthesiology
Non-Opioid Anesthesia
At the conclusion of the presentation, the learner should be able to:
• Identify the effect of intraoperative opioids on postoperative care.
• Describe alternative, non-opioid “MAD” reducing agents.
• Learn which anesthetic agents can reduce postoperative opioid utilization.

Intraoperative Goal-Directed Therapy (GDT)
At the conclusion of the presentation, the learner should be able to:
• Compare the “goal-directed” hemodynamic management to traditional strategies.
• Review the means of achieving hemodynamic goals.
• Discuss hemodynamic monitors utilized in GDT.
• Discuss GDT as a component of Enhanced Recovery after Surgery (ERAS) protocols.

Ultrasound Workshop Instructors
Michael Ashmore, MD
Northside Anesthesiology Consultants, LLC, Anesthesiologist
Howard Hong, MD
Northside Anesthesiology Consultants, LLC, Anesthesiologist
Jay Khed, MD
Northside Anesthesiology Consultants, LLC, Anesthesiologist
Douglas Stewart, MD
Northside Anesthesiology Consultants, LLC, Anesthesiologist
Workshop for Ultrasound Guided Regional Anesthesia
At the conclusion of the presentation, the learner should be able to:
• Identify the use of ultrasound for transverse abdominal plane blocks.
• Explain the use of ultrasound for paravertebral blocks.
• Recognize relatable and absolute contraindications to the use of TEE.
• Discuss TEE views to obtain for use in noncardiac surgery.

Julie Huffmeyer, MD
University of Virginia, Department of Anesthesiology, Assistant Professor of Anesthesiology
Basics of Transesophageal Echocardiography for the Non-Cardiac Anesthesiologist
At the conclusion of the presentation, the learner should be able to:
• Explain indications for use of transesophageal echocardiography (TEE) and transthoracic echocardiography for patients undergoing noncardiac surgery.
• Recognize relative and absolute contraindications to the use of TEE.
• Discuss basic TEE views to obtain for use in noncardiac surgery.

Accommodations
For hotel reservations, please contact the Atlanta Marriott Perimeter Center Hotel at 1-404-880-2451 and request the Georgia Society of Anesthesiologists room block.
To book online, please visit: http://www.marriott.com/hotels/travel/atlpc-atlanta-marriott-perimeter-center/
To book online, please visit: http://www.marriott.com/hotels/travel/atlpc-atlanta-marriott-perimeter-center/

Register at www.gsahq.org

Questions? Contact Kristin Andriss, GSA Member Services Manager: 404-249-9178 x 6 | kristin.strickland@politics.org

By Joy Rushmell, AA-C
GAAA President

With the Georgia Academy of Anesthesiologist Assistants (GAAA) and Georgia Society of Anesthesiologists (GSA) joint membership program up and running, we wanted to take an opportunity to share what advocacy & safety in anesthesia looks like an Anesthesiologist Assistant (AA) perspective.

To advocate is simply defined as the act of showing support or concern for a cause or proposal. However, to an Anesthesiologist Assistant, advocacy is the cornerstone of our practice. Our practice involves a unique relationship between the AA, Anesthesiologist, and patient. We have chosen a healthcare profession that holds the belief that the interests of patient safety are best served with an anesthesiologist’s involvement with the delivery of every anesthetic. Advocating for our patients’ safety, interest, and well-being are paramount to our ethical standards of conduct.

The AAs in Georgia are honored to be partnered with the anesthesiologists of the GSA.

As we are facing challenges in medical service reimbursement, the demands to save money are being placed on all providers. Patients and anesthesiologist should not be sacrificed throughout this process. There is no increase in cost to patients when receiving an anesthesiologist through the Anesthesiologist Care Team (ACT) model, and there is a significant increase in safety over non-physician sole anesthesia providers. Along with this increase in safety, comes the inherent cost savings associated with avoiding increases in complications.

AAs are proud to be a part of the scientifically proven elevation in safety... utilizing the ACT model.

The Silber Study (Anesthesiology, 2000) clearly demonstrated that there were 2.5 times more deaths and 6.9 times more complications overall in cases when anesthesiologists were not involved in patient care. AAs are proud to be a part of the scientifically proven elevation in safety record amongst anesthesiologist utilizing the ACT model. We advocate actively for the anesthesiologist-led team approach and are the only mid-level anestheologist providers that do so.

GSA ’s management team to serve AAAA

Comerstone Communications Group, Inc. has been selected by the American Academy of Anesthesiologist Assistants to manage the organizations’ administrative and government affairs. Cornerstone currently provides association management, activity planning and government affairs services to the GSA and will continue in that role. AAAA will transition their operations from Richmond, Virginia to Cornerstone’s Atlanta offices on January 1, 2014.

“This firm is proud of our continued association with GSA, “James E. ”Jed” Toney, founding principal, said. “GSA and Cornerstone have grown together, and the experience earned during our 22 year relationship has prepared us to offer many of the same services to the AAAA leadership and members.”

Toney will serve as executive director of the AAAA while remaining executive secretary of the GSA. Kristin Andriss, GSA’s member services manager and associate director of scoPe will have similar but expanded responsibilities for the AAAA. GSA’s financial services manager, Leann Johnston, will manage all of the GSA’s books and e-commerce transactions. Cornerstone will expand its personnel to better serve both organizations.

At its July 2013 meeting, the GSA Board of Directors voted unanimously to endorse Cornerstone’s bid for the AAAA contract.

Educating our patients, physicians, and fellow healthcare colleagues about the AA profession and physician-led anesthesiologist team is necessary for the sustainability of the ACT model of patient care. The AA profession was established at Emory University in 1969 by Anesthesiologists that were concerned with the safety of the anesthesia workforce in the United States. They created a profession that is centered on patient safety in perioperative care. Again, we are the only non-physician anesthesia provider that allows for this practice model.

Through the joint membership program, the GAAA has placed advocacy and safety at the pinnacle of our partnership. We believe that a unified voice of GSA Anesthesiologists and GAAA Anesthesiologist Assistants provide a platform that can be utilized to highlight the importance of anesthetic delivery under a physician-led model which will further the growth of our professions. As a team, the Anesthesiologist and Anesthesiologist Assistant are highly efficient and provide exceptional patient care through complex environments. The AAs in Georgia are honored to be partnered with the Anesthesiologists of the GSA. We will continue to promote the Anesthesiologist as the leader of the care team, and we look forward to the continued support of the AA profession by the Anesthesiologists in Georgia.
In May 2013, Goldman Sachs entered the market in November 2012 (formed with Westin Carson, Associates and Mid-Florida Anesthesia in December 2012; and Phyx Healthcare Group, among other anesthesia practices. The strategy evolved. The “strategics” (anesthesia practices) that answer continues to questions regarding the anesthesia community. The decision is an individual assessment partially funded by the Medicare Part B providers. The auditor says that the staff “came

This is the step right one for a private anesthesia group to take? It may still be too early to know if these sales will benefit the anesthesia groups that practice at hospitals for less than what they charge. One refrain is one that is often heard at hospita-! Sis on technical assistance to assist covered entities to comply. Importantly, over two-thirds of the data breaches involved lost or stolen PHI, not deliberate efforts to misuse the PHI. The settlements are not just with large covered entities, but also with small physician practices and nonprofit entities. For example, in April 2021, a small physician practice agreed to pay a $100,000 fine in connection with a HIPAA violation. The common themes of the OCR enforcement actions are:

Amends the definition of a data breach so that any impermissible use or disclosure of protected health information (“PHI”) is a breach no matter whether it covered entity (the physician practice) or business associate (such as a hospital). He demonstrated that there is a low probability that the PHI would be misused. The penalty for each noncompliance is $100.00. The risk assessment is an assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic PHI. Additional guidance on the protocol is available at http://www.hhs.gov/ocr/privacy/hipaa/understanding/ securi tyrule/rahajinjaalaindopdfs.pdf. The bottom line is that HIPAA compliance will save you some money, but failure to comply will take even more time and cost far more money.

Judy is an attorney in private practice in Washington, D.C. As counsel to ASA and anesthesiology practice associations, she has had extensive experience in business and the related issues of broad anesthesia. Judy has written or co-authored ten practice management monographs in the ASA Practice Management series, as well as other articles on anesthesi-ology. Judy was named one of the 25 most influential women in medicine in 2013 by the American Medical Women’s Association. She was a Fulbright Scholar at the University of Toronto in 1992-93. Judy is an attorney in private practice in Washington, D.C. As counsel to ASA and anesthesiology practice associations, she has had extensive experience in business and the related issues of broad anesthesiology. Judy has written or co-authored ten practice management monographs in the ASA Practice Management series, as well as other articles on anesthesi-ology. Judy was named one of the 25 most influential women in medicine in 2013 by the American Medical Women’s Association. She was a Fulbright Scholar at the University of Toronto in 1992-93. Judy is an attorney in private practice in Washington, D.C. As counsel to ASA and anesthesiology practice associations, she has had extensive experience in business and the related issues of broad anesthesiology. Judy has written or co-authored ten practice management monographs in the ASA Practice Management series, as well as other articles on anesthesi-ology. Judy was named one of the 25 most influential women in medicine in 2013 by the American Medical Women’s Association. She was a Fulbright Scholar at the University of Toronto in 1992-93. Judy is an attorney in private practice in Washington, D.C. As counsel to ASA and anesthesiology practice associations, she has had extensive experience in business and the related issues of broad anesthesiology. Judy has written or co-authored ten practice management monographs in the ASA Practice Management series, as well as other articles on anesthesi-ology. Judy was named one of the 25 most influential women in medicine in 2013 by the American Medical Women’s Association. She was a Fulbright Scholar at the University of Toronto in 1992-93. Judy is an attorney in private practice in Washington, D.C. As counsel to ASA and anesthesiology practice associations, she has had extensive experience in business and the related issues of broad anesthesiology. Judy has written or co-authored ten practice management monographs in the ASA Practice Management series, as well as other articles on anesthesi-ology. Judy was named one of the 25 most influential women in medicine in 2013 by the American Medical Women’s Association. She was a Fulbright Scholar at the University of Toronto in 1992-93.