GEORGIA
SOCIETY OF
ANESTHESIOLOGISTS, INC.

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www.gsahq.org

SUMMER MEETING

Details Inside!

Advances & Innovation
IN ANESTHESIOLOGY

July 18 – 20, 2014 | *The Ritz-Carlton Lodge, Reynolds Plantation*
Lake Oconee, Greensboro, Georgia

scope magazine

LET'S MAKE A CONTRACT!

Making wise choices
in a changing landscape
of medical practice.

scOpe

scOpe is the quarterly magazine of the Georgia Society of Anesthesiologists, Inc. The print version is mailed to 900-plus members, exhibitors and advertisers. The digital version is posted in the members section at www.gsahq.org. scOpe is intended to inform members of contemporary issues and opportunities in anesthesiology, pain management, peri-operative care and patient safety. Opinions expressed in this publication do not necessarily reflect the official position of the Society or its leadership. Direct correspondence to:

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Editor's Corner

Ginger Zarse, MD
Chair, GSA Communications Committee
Editor, scOpe

A lot going on with many moving parts

In considering the theme for this issue, the Communication Committee and leaders of the Society had intended for members to submit articles based on their experiences in the new practice models. Though several were invited to submit, none did.

So what conclusion is one left to derive from this missed opportunity to tell others about the pros and cons of the several modes of anesthesia practice in our state and nation? The only viable accounting is that our members are busy. I get that.

Anesthesia practitioners are busy and within our professional and personal lives are many moving parts. What is normal this year will likely be changed to a new, fleeting normal in the next. GSA members and our other readers need only scan the diversity of information in this magazine to note the pressures on our industry and challenges we face as business people. Yes, business people.

In this issue, GSA presents for the benefit of our members the educated perspectives of two notable experts/observers in the business of deciphering the good, bad and ugly in the various new practice models that are no longer on the horizon but are the terra firma under many practices – for now. A special heartfelt "thank you" goes in the direction of Attorney Judy Semo and MD/PhD John Gunderman for taking time out of their busy lives to write especially for this issue.

Many of the moving parts in our personal and professional lives are over our heads, literally. They are in the administrative offices of our facilities, the claims and contract offices of health benefit plans, the Halls of Congress, inside the White House and along the marble corridors of federal agencies which determine who gets paid how much and for what. Again, for the benefit of our members and readers, we've included brief updates on the key issues in Georgia, the nation's Capital and states across the country.

Our Society is engaged in the advocacy on many of these issues. Through our lobbyists and grassroots contacts of members, we are winding the gears of the several moving parts impacting our profession. The dollars members contribute to GSA-PAC and ASA-PAC lubricate the access our lobbyists and members need to be effective representatives of our patients and our profession. I can't imagine any practicing Anesthesiologist or AA conjuring up even a single valid reason for not contributing to these critical government affairs tools.

Finally, I point your attention to the centerfold which demonstrates that, once again, GSA is presenting for the benefit of its members one of the best CME programs available to anesthesia providers this summer. Congratulations and thanks to Summer Meeting Activity Directors Dr. Henry Heyman and Sanjay Dwarkanath, both of Georgia Regents University (MCG).

I commend this issue of scOpe to you and urge you to take just a few moments of your busy life to disengage the moving parts as you thoughtfully consider the information within.

Ginger Zarse, MD
Editor and Communication Chair

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Contact Devon at devon.bacon@politics.org or call 404-249-9178.

Decisions in a Time of Change:
Making Sense of New Practice Models

Judith Jurin Semo, J.D.
Judith Jurin Semo, PLLC
Washington, D.C. jsemo@jsemo.com

In the words of the legendary songwriter, Bob Dylan, "The times they are a-changin'." That phrase aptly captures the current state of the health care industry in general, and the anesthesia community in particular. The news carries a seemingly constant stream of announcements of sales of anesthesia practices, hospitals terminating their arrangements with their longtime anesthesia practices, health systems creating ACOs and other clinically integrated networks and insisting that their anesthesia groups participate, and hospitals moving to employ the physicians in their communities. For private practice anesthesia groups, the question is whether private practice remains an option or whether the time is ripe for them to make a change. This article will explore some of the many questions a group will want to consider when making that assessment.

What's ahead? Should we sell? So what direction is best? Will private practice survive? Can a group get top dollar now if it elects to sell? Is there a "window" in which to sell a practice and, if so, how long will it remain open? How large is the denominator (how many group owners will share in the sale proceeds) and how much will each group owner receive from a sale after group obligations are satisfied and all expenses paid? Is the chance of recouping equity worth risking the lack of control over the future?

Will our practice change after we well? Will group anesthesiologists be happy long-term as employees of a large multi-state practice? Will selling the practice provide protection for group anesthesiologists from the many market forces facing them, including hospital employment, ACO implementation, possible reduced volume, implementation of value-based purchasing, and competition from other anesthesiology practices (including other large multispecialty management companies), to name just a few? Will the group (in its new form as part of the purchaser) be able to recruit top-notch anesthesiologists if it only can offer the reduced level of income agreed upon for new physicians as part of a sale? After expiration of the initial employment agreement, will the purchaser maintain physicians' incomes at the initial level, will it increase them, or will it reduce them? Will the purchaser maintain the group's mode of practice or will it seek to change the practice, either by moving an all-physician practice to a care team model or by increasing the nonphysician anesthetist to physician ratio in the case of a care team practice?

Will group members retain any equity? What is the structure of the transaction and will group owners retain an ownership interest either in the purchaser, the new practice, or their own practice (as restructured)? Will they have a chance for a "second bite" (a chance for a further distribution) if the purchaser sells the practice after holding it for several years?

What's the fit? Is the potential purchaser a good cultural fit for the group? What is the focus of the purchaser – is it on providing high quality care or is it more focused on making money? Is the purchaser a new entrant into the market, so its focus is hard to discern? Is the purchaser a single-specialty group (anesthesia only) or is it a multispecialty group offering multiple service lines (e.g., emergency medicine, radiology, neonatology, and/or hospitalist medicine)? Will a purchaser with multiple service lines be in a better position to compete for hospital contracts?

Is the group in a unique position? Is the group sufficiently large with a diverse mix of facility clients so that the group may serve as a cornerstone practice for a new market entrant, or a cornerstone practice in a new geographic market for an existing purchaser practice? If so, might the group be able to command a premium price?

What about hospital employment? Is hospital employment an option? Will hospital employment result in stability for group anesthesiologists? Will it impede the ability of group anesthesiologists to exercise independent medical judgment? Will the hospital system continue to pay competitive compensation over time, or will it reduce compensation over time, once the group anesthesiologists have given up their private practice and infrastructure? Will the hospital treat the employed anesthesiologists in the same way it treats other employed physicians, and implement productivity–based compensation plans that may penalize anesthesiologists for inefficient ORs and out-of-OR locations and gaps in the OR schedule?

Will making a change simplify practice? Some anesthesiologists view the selling option as one that will protect group members against possible adverse market changes. Will any of the options available simplify life for group anesthesiologists and free them from needing to worry about the economics of their practice? In the case of a sale of the practice, will the buyer hold the group anesthesiologist employees accountable for the economics of their practice, with reductions in profitability resulting in a "claw back" of part of the purchase price or reduced incomes (and possibly termination of one or more anesthesiologists)?

Is it realistic to assume that the status quo will continue? A segment of the anesthesiologist community opposes selling or making changes, electing to continue their private practice. Anesthesiologists in this category may include those who view their current situation as positive, as well as physicians who are at an earlier stage of their careers who may prefer to continue on the path of private practice, rather than selling the practice. While there are many questions to be asked about the viability of the different options available to the anesthesiologist community, an equally important question that each group must assess is whether or not it is likely that the *status quo* will continue.

Continued on Page 11

Judy Semo is an attorney in private practice in Washington, D.C. As counsel to ASA and anesthesiology practices nationwide, she has had extensive experience in business and legal issues relating to the practice of anesthesiology. Judy has written or co-authored ten practice management monographs in the ASA Practice Management series, as well as other articles for anesthesiologists on practice management issues.

Should Doctors Work for Hospitals?

Richard Gunderman, MD PhD
Chancellor's Professor
Indiana University

Editor's note: At GSA's request, Dr. Gunderman created the following summation of an article published recently in The Atlantic Monthly.

Hospitals are buying up medical practices at a feverish pace. According to the American Hospital Association, the number of physicians employed by hospitals grew more than 40% be-tween 2001 and 2011, and the pace shows no signs of slackening. In reviewing its data for the past decade, a large physician recruiting firm found that in 2004 only 11% of physician searches were conducted by hospitals but by 2013 that figure had risen to 64%.

There are a number of reasons hospitals want to employ physician. A major aim is to funnel patients to the hospital's facilities. By law, it is illegal for hospitals to offer physicians in-ducements to refer patients to their facilities unless the physicians are hospital employees. A term that hospitals use to describe the referral of patients to providers and facilities outside their system is "leakage." Such leakage represents lost revenue, and by employing physicians hospi-tals hope to plug the holes.

The Federal Trade Commission has taken an interest in this trend.

Of course, there are other factors. One is the ability to hospitals to charge more for a vari-ety of procedures than independent physicians, by tacking on "facility fees." By buying a physi-cian practice, a hospital can charge more for the same test or procedure, even though it is per-formed in the same place by the same physician. In some cases, such facility fees can raise prices to Medicare by as much as 70% compared to what would be paid to an independent physician.

Another factor is negotiating clout with healthcare payers. When a hospital employs a greater proportion of physicians in a healthcare market, it can often negotiate more favorable payment rates with health insurers. The Federal Trade Commission has taken an interest in this trend, lodging complaints against hospitals for employing too high a percentage of local physi-cians. In some cases, the FTC has even filed lawsuits against such hospitals.

This is not the first time that hospitals have gone on a medical practice buying spree. Something similar took place in the 1990s, when the rise of managed care made it appear that hospitals needed to exert more control over patient referral patterns. But widespread public revolt against managed care quickly led to the opening up of such network restrictions. Moreover, as physicians became employees, their productivity fell. Before long, hospitals began divesting themselves of physician employees.

This is not the first time that hospitals have gone on a medical practice buying spree.

Hospitals hope that this time will be different. For one thing, they now have in place more sophisticated information systems, which enable them to do a better job of tracking physi-cian behavior. Even if hospitals lose money on a per-physician basis, they hope that more favor-able payment rates and control of referrals will enable them to make up the difference. If suc-cessful, they would both get more patients and generate more revenue per patient.

But there is another pitfall in physician employment – namely, that employed physicians tend to be more discouraged. It is easy to see why. When physicians become employees, they forfeit a substantial degree of professional autonomy. They are subjected to more institutional rules and regulations, feel increasing pressure to practice according to prescribed patterns, and often confront frank productivity quotas.

A related danger is a loss of autonomy on the part of the entire profession of medicine. Increasingly, physicians find themselves working for non-physicians, often individuals who never trained in the health professions or cared for the sick. As the trend toward physician em-ployment continues, the people in charge of medical practices are less likely to sport white coats and stethoscopes and more likely to be attired in three-piece business suits. Many physicians feel they are losing control of medicine.

Employed physicians tend to be more discouraged.

A recent nationwide survey showed that the single most important factor in promoting professional fulfillment among physicians is providing high-quality care to patients. Where the health of medicine is concerned, infringing on physicians' ability to care for patients as they think best can prove toxic. By contrast, one of the best tonics is ensuring that physicians can con-tinue to care for patients as they see fit.

In the short term, hospitals may reap financial rewards by employing large numbers of physicians. Over the longer term, however, the vitality of both individual physicians and the en-tire profession of medicine seems likely to decline, with deleterious consequences for patient care. To protect and promote the future health of the medical profession, we need to ensure that physicians continue to base their decisions on what is best for the patient, not what is best for the hospital.

Your thoughts?

How have new models of practice impacted your career and the delivery of patient care?
Submit your Letters to the Editor at gingerzarse@gmail.com.

Please, no anonymous submissions.

Election Update

GSA-backed candidates earn primary wins

State legislative candidates supported by GSA's political action fund, The Committee for Responsible Health Care Policy, showed well in the May 20 General Primary Elections. GSA-backed candidates won in 15 of 16 contests with three incumbents drawn into Primary Run-off elections in July.

"Congratulations to the candidates who ran quality, successful campaigns," GSA-PAC Chair Dr. Rick Hawkins said. "GSA-PAC has compiled a high-percentage "win" rate over the past 20 years by carefully selecting candidates who have demonstrated they take their legislative jobs seriously. Further, they campaign on important issues and campaign to win."

"Thanks to the GSA members, especially to the new-member AAs and Resident Physicians, who have joined our initiative to support candidates who have demonstrated their support for public policy that is protective of patient safety," Hawkins said.

GSA-PAC invested $23,500 in contributions to candidates in the May 20 election. Additional contributions will be delivered to those in run-offs. Once the run-offs are complete, GSA-PAC will determine which General Election candidates warrant support.

2014 GSA -PAC Donors

Amanda Brown, MD	$1,000	James Carlson, MD	$200	Forrest Lane, MD	$200
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				Myra Stamps, MD	$200
				John Stephenson, MD	$200
				Mark Stewart, MD	$200
				Thomas Stewart, MD	$200

Candidate Support?

To nominate a state legislative candidate for GSA-PAC contributions, please contact GSA Executive Director James E. "Jet" Toney at jet.toney@politics.org. Sooner is better than later.

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ASA Washington Legislative Conference

VA Nursing Handbook, RPT dominate agenda

GSA sent 16 representatives to the May 5-7 ASA Washington Legislative Conference where concerns for the nation's veterans dominated the agenda and the conversations – among anesthesiologists and on Capitol Hill. Also prominent was a push to raise the level of Congressional support for the Rural Pass Through legislation sponsored by Georgia Senator Johnny Isakson.

More than 400 Anesthesiologists, Resident Physicians, State Component Society executives and lobbyists, and medical students attend the meeting. The following ASA initiatives were presented, discussed and debated by ranking members of Congressional committees and top staff of federal agencies on health and human services:

Preserve Safe Anesthesia Care for Veterans
At issue: The Department of Veterans Affairs' (VA) Office of Nursing Services (ONS) has proposed a new policy document known as the "VHA Nursing Handbook" which would abandon physician-led, team-based surgical anesthesia care, and impact the care of our nation's Veterans.

Advocacy points:
• Veterans receiving care within VA are some of the sickest of patients. They have complex medical conditions that pose a heightened risk of complications during surgery. Physician involvement is critically important to ensuring that the health and lives of Veterans are not put at risk.
• Independent studies inform policymakers of better outcomes when physicians are involved in anesthesia.
• Internal and external Veteran's health stakeholders, including VA's own anesthesia experts, the VA Chiefs of Anesthesiology, and Veterans Service Organizations (VSOs), have expressed concerns to the highest leadership levels of VA about the proposed policy change.

Improve Rural Health Care Access
At issue: Expand patient access to physician anesthesiology services in rural areas.

Advocacy points:
• Low Medicare Part B anesthesia payments and low patient volume in rural areas make it difficult for rural hospitals to retain anesthesia providers.
• Current law allows some rural hospitals to use reasonable costs-based Medicare Part A "pass-through" funds to employ or contract with anesthesiologist assistants and nurse anesthetists. According to CMS, the "pass-through" arrangement cannot be used for physician anesthesiologists.
• In 2010, ASA, through formal comment, requested that CMS permit rural hospitals to use the rural pass through arrangement for physician anesthesiologists, as well as the other providers. CMS responded that it cannot permit hospitals to use the pass-through arrangement for physician services without a change in the current law.

Protect and Enhance Medicare Payments to Physician Anesthesiologists
At issue: Protect and enhance Medicare payments to physician anesthesiologists by fixing the 33% problem, repealing and replacing the SGR, reversing cuts to pain care procedures, and supporting the Perioperative Surgical Home model of coordinated care.

Advocacy points:
• Physician anesthesiologists, long recognized as the leaders in patient safety, are unfairly paid at the lowest Medicare payment rate among all health professionals at only 33% of private payment rates.
• ASA® strongly supports continued efforts to advance a permanent repeal of the current SGR formula and a replacement with a new mechanism that brings equity and stability to Medicare physician payments and a mechanism for meaningful annual payment updates that at least recognize inflation.
• Physicians treating pain face massive CMS mandated payment cuts for key procedures.
• In response to the call for alternative payment and delivery models, ASA is leading efforts to develop a coordinated surgical care model known as the Perioperative Surgical Home model of care.

(Washington, DC) – GSA members visited all 15 offices of the Georgia Congressional and Senate Delegation on May 7, 2014. Shown here (l to r): Dr. Steve Sween, Emory Resident Dr. Matt Hunter, Dr. Ginger Zarse and Dr. Steve Walsh with U.S. Rep. David Scott (center). Rep. Scott is a vocal supporter of better health care for the nation's veterans. He took the well of the U.S. House shortly after GSA's Hill visits to denounce the lack of action on the VA issue by the administration.

(Washington, DC) – The GSA team of Drs Sween, Hunter, Zarse and Walsh also visited U.S. Rep. Dr. Tom Price, an orthopedic surgeon and rising leader in the House of Representatives Republican Caucus. Price has stated his support for maintaining physician-led healthcare in the Veterans Administration health system.

Content credit: American Society of Anesthesiologists®

Washington Attendees

The following GSA members attended the ASA Legislative Conference and made Capitol Hill visits, May 5-7, 2014:

Michael Ashmore, MD	Alpheretta
Ryan Budwany, MPH	Macon
Steven Huffman, MD	Marietta
Matthew Hunter, MD	Atlanta
Matthew Klopman , MD	Sandy Springs
Bob Lane, MD	Macon
Christopher Malgieri, MD	Atlanta
Katie Meredith, MD	Atlanta
Wyn Mortimer , MD	Fayetteville
Michael Nichols, AA-C	Cumming
Suvikram Puri , MD	Augusta
Cinnamon Sullivan, MD	Atlanta
Steve Sween, MD	Atlanta
Steven Walsh, MD	Roswell
Thomas West, MD	Lakemont
Ginger Zarse, MD	Alpheretta
Jet Toney	Atlanta

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Target Audience:

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Henry Heyman, MD
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Sanjay Dwarakanath, MD
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2014 GSA Summer Meeting Schedule

Friday, July 18, 2014

3:00 – 7:00 p Registration - **Prefunction Salon II & III**

4:00 – 9:00 p Exhibitor Set Up - **Salon I**

5:00 – 7:00 p Board of Directors Meeting - **The Boardroom**

7:00 – 8:30 p Welcome Hospitality with the Exhibitors - **Salon I**

8:30 p Dinner on your own with family and friends

Saturday, July 19, 2014

6:00 a Exhibitor Set Up - **Salon I**

6:30 – 7:20 a Registration/Breakfast with Exhibitors
Salon I, Prefunction Salon II & III

7:20 a *Welcome* - **RCBR Salon II & III**
Kathy Stack, MD - GSA President

Introductions - **RCBR Salon II & III**
Sanjay Dwarakanath, MD & Henry Heyman, MD
Summer Meeting Activity Co-Directors

7:30-8:20 a ASA Update - **RCBR Salon II & III**
Jane Fitch, MD - ASA President

8:20-9:10 a *What's the Best Approach to the Interscalene Block?*
RCBR Salon II & III

9:10-9:40 a Break with Exhibitors
Salon I, Prefunction Salon II & III

9:15-9:45 a Resident Section Meeting – **Meadowlark**

9:40-10:30 a *Use of Ultrasound for Bedside Evaluation of Heart Function* - **RCBR Salon II & III**
Matthew Lyon, MD

10:30-11:20 a New Guidelines on the Management of PONV
RCBR Salon II & III
Tong J. Gan, MD, MHS, FRCA, FFARCS

10:30-12:30 p GAAA BOD Meeting - **Meadowlark**

11:30 a Meeting Adjourned/Lunch with family and friends

1:00-3:30 p *Basic Perioperative TEE, Ultrasound in Perioperative Period, and Ultrasound for Regional Anesthesia Workshop (Pre-registration required)* - **Sassafrass**
Sanjay Dwarakanath, MD
Tong J. Gan, MD
Henry Heyman, MD
Vikas Kumar, MBBS

1:00 p 14th Annual GSA Golf Tournament
(pre-registration required) - **Oconee Course**

4:00-5:00 p 11th Annual Family Ice Cream Social
(Sponsored by the GAAA) - **Tupelo**

6:30-8:30 p Evening Reception - **Reynolds Ballroom**

7:30-9:00 p Board & Faculty Dinner - **Linger Longer**

Sunday, July 20, 2014

6:30 - 7:30 a Registration/Breakfast with Exhibitors
Salon I, Prefunction Salon II & III

7:00 - 7:30 a General Business Meeting for GSA Members
RCBR Salon II & III

7:30 - 8:20 a *Postoperative Delirium and Cognitive Decline*
RCBR Salon II & III
Charles Brown, MD, MHS

8:20 - 9:10 a *Fluid Management in Surgical Patients: An Integral Part of the ERAS Strategy* - **RCBR Salon II & III**
Tong J. Gan, MD, MHS, FRCA, FFARCS

9:10 - 9:40 a Break with Exhibitors - **Salon I, Prefunction Salon II & III**

9:40 - 10:30 a *Update on Geriatric Anesthesia* - **RCBR Salon II & III**
Charles Brown, MD, MHS

10:30 - 11:20 a *Sickle Cell Disease: Modern treatment methods for an ancient disease* - **RCBR Salon II & III**
Steffen Meiler, MD

11:20 - 12:10 p *Creating a Culture of Quality in Anesthesia*
RCBR Salon II & III
Shvetank Agarwal, MBBS

12:10 p Meeting Adjourned

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

Accreditation Statement:
This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership 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

Credit Designation:
The American Society of Anesthesiologists designates this live activity for a maximum of 10 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the 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.

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 Monday, July 14, 2014, to qualify for refund. Absolutely no refunds will be issued for changes received at GSA headquarters after Monday, July 14. The cancellation policy and late registration fee will be strictly enforced.

Register at www.gsahq.org | For more information, contact Devon Bacon, GSA Associate Director, at devon.bacon@politics.org or (678) 222-4221

Director's Report

What's going on at ASA?

Howard Odom, MD

If your picture of the ASA is the Annual Meeting where 15-18 thousand people are catching up on CMEs, you can personally confirm the diversity and value of the educational opportunities provided there. But you may not be aware of some organizational aspects of ASA behind its impact on your daily practice throughout the year. Today's ASA is, in many ways, almost unrecognizable relative to when I joined as a resident. The more years I practice and have gotten involved in ASA, the more I appreciate and enjoy any opportunity to hear about the "old days." Our legacy is certainly to be treasured but now must serve as prologue for our dynamically different Society.

Today's ASA is almost unrecognizable relative to when I joined as a resident.

To perhaps fill in a few gaps in your awareness of how ASA works, here is a rundown of what's going on in a few selected organization-related items from the March ASA Board of Directors (BOD) that are a bit removed from the more familiar educational and practice topics.

ASA CEO –
Mr. Paul Pomerantz has completed his first year as CEO presiding over the unification of the Park Ridge and Washington offices, staff organization and society administration. ASA has added staff to bring us into line with current standards for professional societies. As part of his report to the March BOD, Mr. Pomerantz described the processes underway for management team development (including staff organization charts), updating infrastructure (Information Technology and facilities), developing relationships within anesthesiology and the broader medical and healthcare communities (specialty societies, ABA, and AHA), and planning for the future. Each of these is a huge leap forward that already have shown measureable progress toward meeting the service needs of members and refining the effective & accountable operation of our Society.

New ASA Headquarters Building –
The construction of the new ASA headquarters building in Schaumburg, IL is nearing completion. Not very far from the current longtime HQ in Park Ridge, ASA offices will move mid-summer and celebrate an official grand opening during the August BOD meeting. Need for a new HQ was driven by ongoing growth of Society membership, the progressive inadequacy of space for the staff needed to support Society operations and the dramatically different needs for facility function & design. GSA members John Neeld, MD, and Steve Sween, MD, have served admirably from the early stages of developing design specifications, to finding a suitable site, to now overseeing the myriad of details in design & construction. In addition to his day job and serving as ASA Speaker of the House, Dr. Sween will soon see completion of his task as Chair of the Ad Hoc Committee on Headquarters Building Construction. Thanks, Steve (and Barbara).

ASA Strategic Plan –
You may wonder if ASA is focused on maintaining (some might say protecting) the status quo or working proactively to accomplish material change in the future. The answer is, both. President-Elect J.P. Abenstein, MD, outlined a new strategic planning process that, rather than an interim annual update, begins a new three- year planning cycle with a fresh rewrite. This new strategic plan will guide ASA's efforts from 2015 through 2017. Decision Strategies International (DSI), based in Philadelphia, has been contracted to facilitate the strategic planning process. The March BOD contributed to the start of the process during a presentation by DSI where we assessed a range of critical uncertainties and discussed possible future economic, political and regulatory scenarios. The resulting final strategic plan developed by ASA leadership will provide input to the budget process for 2015. The intent is that all new initiatives and all ongoing activities will be measured against the strategic plan to assure alignment of purpose and funding across the entire society.

There is much more that could be told. Be sure to also find Dr. Sween's report from the BOD in the May issue of the ASA Newsletter. But for now, be assured that ASA is our member-oriented, volunteer-driven, staff-supported organization.

So, what's going on? ASA is engaged in every way to "Advance the Practice & Secure the Future."

The ASA is fulfilling its Mission Statement. The business of our specialty goes on due to a great deal of work done by your fellow ASA members. Thank them and join them to build a Society that focuses our combined strengths on the challenges we will meet.

(Schaumburg, IL) – The ASA will celebrate the opening of the new headquarters building at the August Board of Directors Meeting. The building will house administrative offices and the continuing medical education complex to serve member educational and re-certification needs. The greatly expanded HQ footprint will empower ASA to meet the needs of its members and stay ahead of the changing dynamics of members' professional practice.

New Practice Models...

Continued from Page 4

Will the group's primary hospital customer continue to operate in its current form or will it affiliate with another hospital system? If the latter, will the group be under pressure to combine with the new hospital system's primary anesthesia group? Will there be a change in administrators at the hospital, which may lead to a reevaluation of the hospital's contract with the group? Does the group receive financial support (in any form, direct or indirect) from the hospital and, if so, is it realistic to assume that such support will continue at the current level?

Given the significant amount of change in the health care market in general and the anesthesia services market in particular, the anticipated change in payment (so-called "reimbursement") rates and methodologies, the downward pressure on hospital compensation arrangements, and the increasingly competitive nature of the anesthesia services market, groups should not assume that the *status quo* will continue.

Note: Some groups believe that they are protected either by their size (the number of clinical staff they have) or the clinical excellence of their services. Those factors do not provide protection against change. With the advent of national anesthesia practices with larger numbers of anesthesiologists and nonphysician anesthetists, size will not preclude change, though a large size may make implementation of a change a longer process. Clinical excellence is important, but it is a prerequisite. It is not going to protect a group against needing to compete to retain its exclusive (or non-exclusive) agreement. Hospital and other facility administrators often do not distinguish among anesthesia practices on the basis of quality. Even if a group can document its quality based upon data and benchmarking, facility customers may still make a change, particularly if they have been dissatisfied with a group's service record or its cost.

What other options exist? Has the group considered all options available to it?

Can the group add new locations or new service lines? Has the group considered other options to create value for the group, such as by acquiring new practice sites, opening an office-based anesthesia practice, or exploring the pros and cons of establishing a pain medicine practice? Taking one or more of these steps will result in expansion of the group and diversification of the group's risk and ultimately should serve to strengthen the group's position.

Can the group enhance its value to customers by combining with other practices? Does it make sense for the group to consider a combination with other anesthesia practices, or perhaps with other physician specialty practices? Combining with other physician specialties may enable to the group to compete by offering a different product, particularly as payors are moving to value-based purchasing and package pricing. Combinations of all sorts, including mergers, acquisitions, or creation of a new practice entity, require careful planning and consideration of a host of issues, from internal governance to antitrust issues. They may offer a group an opportunity to increase its ability to compete.

Can the group enhance its value to its primary hospital (and ASC) customers and to patients by implementing a perioperative surgical home? The ASA has developed the concept of the perioperative surgical home as a means of providing better and more efficient care to patients. Implementation of a perioperative surgical home can enable physician anesthesiologists to use their medical skills to provide even better, more efficient, and more cost-effective care to patients; increase patient and surgeon satisfaction; and demonstrate leadership. If a group is uncertain how to move forward with such an effort, it can obtain more information from ASA and should consider attending the ASA Quality Conference and Conference on Practice Management. It may also want to consider implementing a perioperative surgical home for a specific service line (e.g., joint replacements).

Can the group decrease its costs by entering into a management services organization ("MSO") arrangement? In some markets, there has been increased discussion of creation of an MSO in order to create efficiencies and reduce costs in the provision of back-office, billing, compliance, human resources, purchasing, information technology, and other services needed to support a practice. Can the group either improve the services it is obtaining or reduce its cost to obtain such services, or possibly both, by creating or joining an MSO? It is important to appreciate that participation in an MSO typically does not involve integration of the participating practices. If physician practices are not sufficiently integrated (either through financial or clinical integration), they cannot jointly negotiate payor or facility agreements, as such joint action would violate federal antitrust laws. Antitrust restrictions need to be considered if a group is considering participating in an MSO.

Is the proposed change being considered consistent with the group's goals? Anesthesiology groups need to review carefully their own situations and the goals of their group members. Whatever path a group takes, it should consider the long-term effects of its decision and assess which of the options best fits its goals and position.

Moving forward. If the group elects not to pursue one of the structural options discussed above (sale or combination with other groups), the group should not abandon the self-examination process, but should continue it aggressively to implement changes that will enhance its value to its patients, its facility customers, and its medical staff "customers." Failing to engage in an ongoing self-assessment and improvement is likely to narrow significantly the group's options.

GSA-PAC Donors...

Continued from Page 6

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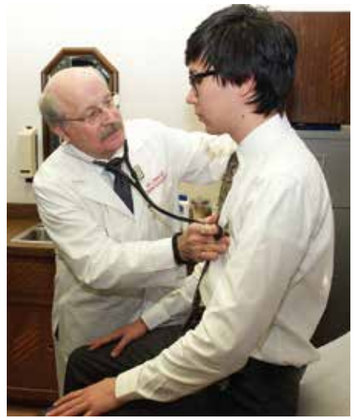
‘Capitolizing’ on DOD offer

Steven L. Sween, MD

On Tuesday, January 21, 2014 I had the opportunity to serve as the Doctor of the Day at the MAG-supported medical station at the Georgia State Capitol. I arrived at the appointed time and I was met by Ms. Ruby Butts, the nurse/coordinator, and Ms. Liz Bullock, MAG staff coordinator for this MAG service to Georgia legislators and capitol staff. They greeted me with great kindness and encouragement for the day that we were about to spend together. Orientation was quick and uneventful. Soon I would meet two of MAG's lobbyists, Mr. Marcus Downs and Mr. Ryan Larosa, both very welcoming and grateful for the day that I was dedicating to serving our lawmakers.

A few patients stopped by early, mostly to seek reassurance that their upper respiratory symptoms did not represent anything to be seriously concerned about. Another staffer had a mild conjunctivitis, again warranting reassurance.

At about 0930, I was escorted to the Senate chamber to be introduced by my senator from district 32, Senator Judson Hill. After he introduced me before the entire Georgia Senate, I was allowed to briefly address the members, expressing my thanks for their valuable service to



(Atlanta), January 21, 2014 – Dr. Steve Sween checks a patient at the Medical Aid Station at the Georgia State Capitol. Doctors from throughout the state volunteer as “Doctors of the Day” whenever the General Assembly is in session. The Medical Association of Georgia program is considered a tremendous and valuable benefit to legislators, staff and guests.

their constituents and all of the citizens of this great state. Of course, I used this opportunity to remind them of the great and noble profession and specialty that I was there to represent in their medical station. I was grateful for the photo opportunity with Lieutenant Governor Casey Cagle and Senator Hill prior to returning to the medical care office. Many of the senators greeted me directly and expressed their sincere thanks.

A little while later, I accompanied Ms. Butts to the chamber of the House, where I met and was introduced by my representative from the 52nd district, Representative Joe Wilkinson. Again, I had the privilege to be the face of medicine and to thank the members of the House for their dedicated service to all Georgians.

At the medical station, I had the opportunity to interview and treat several patients, most requiring simple reassurance and recommendations for continued conservative measures. I must admit, I was initially skeptical that serving as Doctor of the Day might be unappealing and even anxiety-provoking. That was definitely not the case. Rather, it was an extraordinary chance to demonstrate and express my gratitude to the rule makers of Georgia for the tremendous privilege and trust we hold as their members in the medical community. I am most thankful that I accepted the assignment to serve as MAG Doctor of the Day. As Representative Wilkinson stated in my introduction, "this is Dr. Sween's first time as Doctor of the Day, but it will not be his last." I am quite certain he was right.

I used this opportunity to remind them of the great and noble profession & specialty that I was there to represent.

Welcome new and returning members

Raj Arora, MD - Columbus
Guy Young, MD - Cordele
Robert Dennison, MD - Augusta
Thomas Street, MD - Valdosta
Michael Dykes, MD - Ft. Oglethorpe
Charles Tullius, MD - Savannah
Adam Everett, MD - Cordele
Ammar Divan, MD - Duluth
Okera Hanshaw, MD - Conyers
Prentiss Lawson, MD - Rome
Yatish Ranganath Siddapura, MD - Augusta
Lauren Hinds, MD - Augusta
Darren Rhinehart, MD - Atlanta
Kikelomo Olorunrinu, MD - Rome
Michael Duggan, MD - Atlanta
Nicole Carignan, MD - Atlanta
Amalachi Okafor, AA-C - Atlanta
Nancy Uhrich, AA-C - Marietta
Margaret Nguyen, AA-C - Marietta
Marlene Miller, AA-C - Marietta
Zach Mikronis, AA-C - Marietta
Nadia Meah, AA-C - Marietta
Marshall Johnson, AA-C - Marietta
Andrea Meier, AA-C - Marietta
Ashley Hall, AA-C - Marietta
Michelle Droege, AA-C - Marietta
Dana Denker, AA-C - Marietta
Kirsten Adamson, AA-C - Marietta
Michael Tolbert, AA-C - Gainesville
Jeff Brown, AA-C - Tifton
Lindsey Hopkins, AA-C - Atlanta
Mitzi Kabore, AA-C - Gainesville
April Still, AA-C - Gainesville
Michael Silver, AA-C - Gainesville
Sarah Rogers, AA-C - Gainesville
Joshua Kelly, AA-C - Thomasville
Lindsey Amerson, AA-C - Atlanta
Claire Wainwright, AA-C - Lawrenceville
Christian Allen, AA-C - Marietta
Lena Mark, AA-C - Austell
Laura Burch, AA-S - Atlanta
Jiaqi Li, AA-S - Atlanta
Lacey Landon, AA-S - Atlanta
Shawnna Joynt, AA-S - Atlanta
Lacey Landon, AA-S - Atlanta
Sharla Phipps-McGregor, AA-S - Atlanta
Christopher Helwig, AA-S - Atlanta
Sowjanya Thalanki Krishna Murthy, AA-S - Atlanta

Retired Members

Michael Murphy, MD - Atlanta
Linda Ritter, MD - Athens
Dinah Franklin, MD - Conyers

By the numbers

Total members	**1152**
Active	712
Affiliate	15
Resident	107
Retired	115
AA Educational Affiliate	141
AA Student	52
Medical Student	8

GAAA ‘Day at Capitol’ 100 STRONG

By Kris Tindol, AA-C

By all accounts the Georgia Academy’s first ever AA Day at the State Capitol was a tremendous success. The February 24th event in Atlanta was organized and executed by GAAA in conjunction with its management company, Cornerstone Communications Group, as a time to meet state legislators and educate lawmakers on the AA profession. More than 100 AA Fellows and Students attended from across the state to experience the political process in action.

Prior to arriving that Monday morning, members of the delegation had contacted their legislators well in advance to invite them to a grab-and-go breakfast and to tell the officials AAs looked forward to meeting them. The early breakfast provided a friendly forum that enabled Fellows to talk one-on-one with many members of both the House and Senate. The legislators were interested in the talking points and were appreciative of the information concerning the long history of AAs providing quality anesthesia in Georgia.

(Atlanta) – More than 100 AA Fellows and Students participated in the several activities of the GAAA’s 1st Annual AA Day at the Capitol. Legislators enjoyed a homemade biscuit breakfast and the opportunity to meet AAs from their districts who are in practice or in training.

Fellows and Students who attended AA Day left with valuable insight into the art of forging and maintaining positive working relationships with our elected officials.

One of the highlights of the day was the reading of a special Resolution on the floor of the State Senate. Georgia State Senator Chuck Hufstetler, AA-C, arranged for a visit to the floor session and sponsored a proclamation that was read to the entire governing body declaring that February 24, 2014, is officially AA Day in the great state of Georgia. GAAA leaders were invited to stand on the platform facing the chamber while the Resolution was read. President Joy Rusmisell accepted the Resolution and addressed the Senators, their staff, and gallery visitors.

(Atlanta) -- GAAA President Joy Rusmisell joined Georgia Lt. Gov. Casey Cagle (back right) and state Senator Chuck Hufstetler, AA-C, (back left) at the rostrum of the State Senate on February 24, 2014. Also participating in AA Day at the Capitol activities were Ralph Dapaah, AA-C (GAAA Director), Rick Brouillard, MMSc, ScD, (Program Director Emory University), Gina Scarboro, AA-C (Director of Academic Affairs, South University) and Brad Maxwell, AA-C (GAAA Director).

Members of the delegation also visited with their representatives while the bodies were in session by meeting them "behind the line" for photos and conversation about AA practice and issues. The legislators were especially receptive to the young, bright faces of the students from both Emory and South University and were eager to learn about their education experiences. They also listened attentively as Fellows spoke of the profession and the quality patient care provided as part of the Anesthesia Care Team.

Healthcare delivery is ever-changing, and we must be proactive in places like the legislature and the Medical Board where policy decisions are made. The Fellows and Students who attended AA Day left with valuable insight into the art of forging and maintaining positive working relationships with our elected officials so that when the time comes to protect our interests, we have the relationships in place for advocacy. GAAA extends its sincere thanks to Senator Hufstetler, Mr. Jet Toney and his entire group at Cornerstone, and to the AA Programs at Emory and South for all their work and support to make AA Day such a success.

Federal Issues Update

Isakson's 'rural pass through' bill introduced in US House

The bipartisan *Medicare Access to Rural Anesthesiology Act* by Rep. Lynn Jenkins, KS-5, and Rep. Emanuel Cleaver, MO-1, has been introduced in the U.S. House as a companion bill to S. 1444 by Georgia Sen. Johnny Isakson and Sen. Ron Wyden, D-OR. The bill reforms Medicare's rural incentive payment for all types of anesthesia providers and extends rural hospitals' access to physician anesthesiologists. Under this legislation, rural hospitals would expand access to physician anesthesiologist services and be able to more readily recruit and retain physician anesthesiologists who may want to serve their rural communities, providing greater access to physician care. Many rural areas of the country face challenges in recruiting and retaining physicians to serve rural patients.


GA Sen. Isakson

Senate committee approves ASA-supported VHA Nursing Handbook language

The U.S. Senate Appropriations Committee has unanimously approved the Military Construction and Veterans Affairs (Mil Con-VA) and Related Agencies Appropriations Act, which included ASA-supported language addressing the proposed Veterans Health Administration (VHA) *Nursing Handbook*. The report included language nearly identical to the bill that passed in the House of Representatives earlier this year encouraging the VA to engage both external and internal stakeholders in the development of the *Nursing Handbook* and requesting that the VA work to ensure that the *Handbook* does not conflict with handbooks "already in place within the VHA" - a reference to the current *Anesthesia Service Handbook*. This *VHA Nursing Handbook* report language is due to ASA's advocacy efforts in Congress, including many productive meetings on Capitol Hill during the ASA's 2014 Legislative Conference.

The report language reads:
Nursing Handbook.-The Committee understands that the VHA Nursing Handbook is currently under review. The Committee encourages the VHA to seek input from internal VA program offices and external professional stakeholders prior to possible regulatory action and submission to the Under Secretary for Health for final approval. The Committee believes all possible outreach efforts should be used to communicate the proposed changes, to gather public comment, and to collaborate with Congress, stakeholders, VA nursing staff, and external organizations. **The Committee also requests that the VHA ensure that any changes to handbooks with¬in the VHA do not conflict with other handbooks already in place within the VHA.**

MN Lawmakers Approve APRN Initiative

On May 13, Minnesota Senate file 511 became law removing existing requirements for Advanced Practice Registered Nurses (APRNs) to practice within the relationship of a physician. Under the language, collaborative management will no longer be required of nurse anesthetists providing anesthesia care.

The Minnesota Society of Anesthesiologists (MSA) fought the measure from its inception with a coalition of physician groups including the state medical society, family physicians, pain physicians, and others. The political dynamics of the legislature, weighed heavily by the state's rural geography and a vocal state school of nursing, eventually prevailed and patient safety was substituted with an "access to care" law.

To the frustration of the nurse anesthetists seeking pain medicine authority, several patient safety provisions were included in the final language. The language includes the following requirements:

•Collaboration with a physician for nonsurgical acute and chronic pain medicine

•Written prescribing agreements for treatment of chronic pain medicine symptoms

•Setting limitations for nonsurgical pain medicine services – must be performed in the same licensed health care setting as the collaborating physician.

Additionally, the new law prohibits nurse anesthetists from interpreting CTs, MRIs, PETs, nuclear scans, and mammography. These provisions of the new law go into effect January 1, 2015.

In a separate legislative measure, MSA successfully passed language directing the Minnesota Department of Health (MDH) to collect data on pain medicine procedures in the state. Specifically, the Commissioner of Health must gather the types and numbers of pain medicine procedures performed in the previous 36 months, the kinds of professionals performing the procedures, and the location/facility type where such procedures are performed. The Commissioner must submit a report with the compiled data to specified lawmakers in the House and Senate by January 15, 2015.

Senate committee approves ASA-supported VHA Nursing Handbook language

On April 1, 2014, President Barack Obama signed into law the Protecting Access to Medicare Act of 2014, a 12-month patch to avert a 24.1 percent cut to Medicare physician payment per the Sustainable Growth Rate (SGR) formula.

The law extends the previous 0.5 percent update until December 31, 2014, and includes a 0 percent update from January 1, 2015 to April 1, 2015. With passage of this law, the Medicare anesthesia conversion factor will remain $22.6765 in 2014.

The legislation also includes other provisions that typically have been included with previous SGR patch legislation, such as an extension of the geographic practice cost index (GPCI) floor. Additionally, as an inducement for physician organizations to support the proposal, the patch legislation would delay the transition to codes known as the International Classification of Diseases, 10th Edition diagnosis and procedure codes (ICD-10-CM/PCS) until October 1, 2015. The language of the bill states that, "The Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD-10 code sets as the standard for codes sets under section 1173(c) of the Social Security Act (42 U.S.C. 1320d-2(c)) and section 162.1002 of title 45, Code of Federal Regulations."

Continued on Page 15

State Issues Update

GA Med Board adopts pain clinic regs

The Georgia Composite Medical Board has adopted rules requiring licensure and regulating activities of pain clinics in state. The Board voted unanimously at its June meeting.

GSA has been intimately involved as a stakeholder in this initiative which follows the 2013 passage of pain clinic legislation. The journey towards passage of legislation to regulate pain clinics and shut down so-called "pill mills" was a five-year process.

At the request of House Speaker David Ralston, the GCMB included language to clarify that CRNAs are not prohibited from working in pain clinics within CRNA scope of practice as defined by Georgia Code. This language was initially crafted by GSA and submitted to the Board in February in response to the Speaker's request so that the language could be inserted into the proposed rule rather than the legislature re-opening the pain clinic licensure act.

GSA successfully fought an attempt by the GA Association of Nurse Anesthetists to amend the definition of "Medical treatment or services" to exclude administration of anesthesia by a CRNA acting within scope of practice as defined in code. The GSA Government Affairs Committee and the American Society of Anesthesiologists determined that the GANA amendment would, were it adopted by the Medical Board, later be used by the GANA to seek expanded CRNA scope through Nursing Board rulemaking.

The Medical Association of Georgia provided initial legal counsel on the proposed GANA amendment and has stood alongside GSA during the stakeholder process and public hearings. The GA Society of Interventional Pain Physicians and GSA overtly advocated for a regulatory solution to Speaker Ralston's concerns. Neither organization wanted to see the legislature re-visit pain clinic licensure this year.

To read the rule, visit www.medicalboard.-ga.gov.

ASA urges FTC to end state-level overstep

On April 30, the American Society of Anesthesiologists submitted formal comments to the Federal Trade Commission strongly urging the FTC to modify its current position on the application of the state action doctrine to state licensing authorities and end its related enforcement policies against those agencies.

The comments provided "The FTC has no particular expertise in regulating health care and risks inflicting serious harm on patients by adopting enforcement policies that appear intended to promote competition over quality of treatment and patient safety." ASA's comments further explained the importance of states being able to regulate health professionals, promoting competition that leads to high quality patient care and protects patient safety.

The comments were submitted in response to the FTC's March 2014 Public Workshop "Examining Health Care Competition." The purpose of the Workshop was to examine trends and activities potentially impacting competition in the growing health care industry.

The state action doctrine provides immunity for certain policy actions by state and local authorities. Historically, the FTC has honored the state action doctrine regarding health care. Unfortunately during recent years, the FTC has become increasingly more activist, seeking to interject itself in state health statutory and regulatory matters. The ASA is ensuring the FTC is aware of physician anesthesiologists' profound patient safety related concerns with the agency's expanding involvement in state-level legislative and regulatory activity.

In March, the FTC released a policy paper titled "Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses" (APRN). The paper opined that broader APRN scope of practice is good for consumers and competition.

High court to hear NC Board v FTC appeal

The U.S. Supreme Court announced it would hear arguments in North Carolina State Board of Dental Examiners v. FTC. At issue is whether the antitrust state action doctrine protects the work of state licensure boards. Previously, the ASA joined the American Medical Association, the American Dental Association, and other health care groups in a friend of the court brief in support of the North Carolina State Board of Dental Examiners' request for review of the appellate court's decision. That brief was filed November 27, 2013. Arguments for the case will likely be heard in the fall.

Truth in advertising bills signed in Utah, WV

On March 28, Utah and West Virginia's Governors signed legislation concerning truth in advertising. Utah Governor Garry Herbert (R) signed SB 137 which updates the state's truth in advertising laws to additionally require a healthcare provider to wear a badge identifying their name and license type during a patient encounter. This law goes into effect January 1, 2015. Utah already requires such information in healthcare provider advertisements.

In West Virginia, Governor Earl Ray Tomblin (D) signed SB 602 which similarly requires employees to wear an ID badge during patient encounters. Compliance is required as of July 1, 2016.

Indiana Gov signs AA licensure bill

On March 24, Indiana Governor Mike Pence (R) signed into law Senate Bill 233, which authorizes licensure for anesthesiologist assistants. This legislative success was the result of a multi-year effort by the Indiana Society of Anesthesiologists and the American Academy of Anesthesiologist Assistants. Indiana will be 17th jurisdiction to authorize anesthesiologist assistant practice. Anesthesiologist assistants are also recognized federally by the Centers for Medicare and Medicaid Services and the Veterans Affairs system.

Federal Issues...

Continued from Page 14

ASA stated its concerns about offset or "pay for" provisions related to so-called "misvalued" services. The provision directs the Centers for Medicare & Medicaid Services (CMS) to identify potentially "misvalued" procedures for changes that would result in payment reductions. ASA opposed the inclusion of this provision in the SGR Repeal legislation. Additionally, the patch legislation includes a provision that modifies the current budget sequester in 2024 to provide for a four-percent across the board cut for all of Medicare for the first six months of that year.

On Sunday, March 2, the ASA Board of Directors voted to take "no position at this time" on H.R. 4015/S.2000, the SGR Repeal and Medicare Provider Payment Modernization Act of 2014.

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