Sentinel
Pennsylvania
Society of Anesthesiologists
Newsletter

Fall 2015

PRESIDENT'S MESSAGE

Bright Minds Chart Our Course

by Robert Campbell, M.D

This edition of the *Sentinel* is full of must read articles on topics of great interest to Pennsylvania anesthesiologists. Throughout my 27 years of practicing medicine in Pennsylvania, I found the *Sentinel* to be valuable enough to read every issue, cover to cover.

In my early years of practice, I read and tried to make sense of the billing, hospital, and practice regulations that would arise seemingly every year. Most of the time, my naivety was such that I did not entirely understand the predecessor rule very well, and understood the new replacement rule even less.

Almost always I felt the intrusive regulations were not resulting in improvement in patient care. If anything, it just meant doctors had to divert precious time to understand something that made little sense, had little value, and required resources to "comply." The *Sentinel* however, delivered content that was a step ahead of the confusion and chaos and explained changes in terms I could understand.

As I became more seasoned in my career, I read articles devoted to advocacy with greater clarity and understanding. There are always one or two articles on advocacy in each edition. I came to understand the machinations of physician specialty politics more thoroughly.

For the last 15 years, I have devoted some time to facilitating change in this multi-faceted landscape we travel through as anesthesiologists. Though I have heard this part of my work described as a necessary evil, I prefer to call it an essential or even an existential mission. When I first entered this profession, I was always thankful others carried that load for me. Now I am carrying the load—at least for a while. My presidential term will be ending in a few months and another volunteer will enter the office to lead this essential mission.

continued on page 4

Fall 2015

Contents

PENNSYLVANIA *society of* ANESTHESIOLOGISTS

Sentinel
Pennsylvania Society of Anesthesiologists Newsletter

Editor
Richard P. O'Flynn, M.D.

President
Robert Campbell, M.D.

Association Director
Susie Wilson

The PSA Newsletter is an official publication of the Pennsylvania Society of Anesthesiologists Inc. Opinions expressed in this newsletter do not necessarily reflect the Society's point of view. All correspondence should be directed to:

PSA Newsletter
777 East Park Drive,
P.O. Box 8820
Harrisburg, PA 17105-8820
717/558-7750 ext. 1596
www.psanes.org

2014–2015 Officers

President
Robert Campbell, M.D.

President-Elect
Andrew Herlich, M.D.

Vice President
Bhaskar Deb, M.D.

Past President
Richard P. O'Flynn, M.D.

Secretary-Treasurer
Patrick J. Vlahos, D.O.

Asst. Secretary/Treasurer
Margaret M. Tarpey, M.D.

District Director
Erin A. Sullivan, M.D.

Alt District Director
Joseph F. Answine, M.D.

Delegates to the ASA House of Delegates
Joseph F. Answine, M.D.
Joshua H. Atkins, M.D., Ph.D.
James G. Cain, M.D.
Robert Campbell, M.D.
Bhaskar Deb, M.D.
Edward H. Dench, M.D.
Michael H. Entrup, M.D.
Joseph W. Galassi, M.D.
David M. Gratch, D.O.
Andrew Herlich, M.D.
Richard C. Month, M.D.
Craig L. Muetterties, M.D.
Richard P. O'Flynn, M.D.
Margaret M. Tarpey, M.D.
Thomas A. Witkowski, MD.D

Alternate Delegates to the ASA House of Delegates
Albert A. Belardi, M.D.
John J. BianRosa, M.D., J.D.
Robert F. Early, Jr., M.D.
Lee A. Fleisher, M.D.
Randy E. Lamberg, MD.D
A. Joseph Layon, M.D.
Philip Mandato, D.O.
Donald E. Martin, M.D.
Kristin M. Ondecko-Ligda, M.D.
Shailesh Patel, M.D.
Mark J. Shulkosky, M.D.
Anthony T. Silipo, D.O.
Kevin F. Slenker, M.D.
Patrick J. Vlahos, D.O.

Delegate, Pennsylvania Medical Society House & Speciality Leadership Cabinet
Donald E. Martin, M.D.

Alternate
Kristin M. Ondecko-Ligda, M.D.

Carrier Advisory Representative
Donald E. Martin, M.D.

In This Issue

Commentary by Richard O'Flynn, M.D., *Sentinel* Editor

As we are going to press, the Presidential election is still over a year away, but the action is already heating up. While the multitude of Republican candidates are offering the most interest and sound bites at this time, the Democratic side has its own issues playing out. Obviously, the field will narrow over the upcoming months, and we will see if a physician makes it to the final cut.

On a local level, we have one of our own, Phil Mandato, D.O., running for the position of Montgomery County Coroner. This race was recently highlighted in the *Philadelphia Inquirer* and Dr. Mandato was interviewed for that article. If you are from Montgomery County, I encourage you to check out Dr. Mandato's campaign.

In this edition of the *Sentinel* you will find many must-read articles.

PSA President Robert Campbell, M.D., in the final report of his term, stresses the importance of participation and volunteerism. The PSA Board of Directors is an all-volunteer group and is always looking for new members who are interested in shaping the future of our organization and specialty.

Be sure to read Dr. Answine's article on the "surgical home and enhanced recovery after surgery" initiatives. While the buzzwords are enticing, implementation is much more involved than most realize.

Charlie Gerow, of Quantum Communications, reports on the legislative activity in Harrisburg. Representative Jim Christiana has introduced House Bill 1277, the bill to put physician supervision of anesthesia into law. This is identical legislation that successfully passed the House last session. PSA and Z-PAC are your voice in Harrisburg. Know your legislators and contribute to Z-PAC in order to assure safe anesthesia care.

Dr. Donald Martin reports on the initiatives impacting anesthesiologist practice. His report gives an update from the Pennsylvania Medical Society Specialty Leadership Council. Our District Director, Erin Sullivan, M.D., reports on ASA activities.

Our attorney, Mr. Robert Hoffman reviews the Mcare refund process and the steps required to obtain the refund. His report adds clarity to who is eligible for the refund and how various employment models need to be considered when accepting or assigning the refund. The Mcare refund came about after years of legal maneuvers headed by the Pennsylvania Medical Society. It is one of the many benefits of organized medicine — with numbers there is strength. For those who are not members of PAMED, seriously think about whether this battle would have been won if everyone decided membership was not important.

Another very valuable and informative article in this edition is about QCDR and what is required for participation. Richard Dutton, M.D., ASA Chief Quality Officer and Executive Director of the Anesthesia Quality Institute and Matthew Popovich, Ph.D., ASA Director of Quality and Regulatory Affairs explain the process. Be sure to check the article in order to better understand this complex process. I thank Anesthesia Billing Consultants, LLC, for permission to reprint this article, which first appeared in the *Communiqué* newsletter.

For anyone traveling to San Diego, Oct. 24-28, for the annual meeting, I encourage you to come to the PSA membership lunch and meeting. This is an excellent time to socialize with fellow PSA members and meet your board members. Details about the meeting will be emailed to all members as the date gets closer.

Legislative Update

by Charlie Gerow, Quantum Communications

While the media has focused on the protracted budget battle between Governor Tom Wolf and the legislature, we have been focused on building support in the House of Representatives for House Bill 1277. The bill will codify language requiring physician supervision of the administration of anesthesia, which already exists in state Health Department regulations — in the Medical Practice Act.

It is the position of Pennsylvania Society of Anesthesiologists (PSA) that physician supervision protects patient safety by ensuring that the most highly trained medical professional is on hand, especially in the event of an emergency during surgery.

Our legislation, which was introduced in June by Rep. Jim Christiana, is identical to the legislation that passed the House last year, only to die in the Senate Public Health and Welfare Committee.

Once again, we anticipate strong opposition to HB 1277 from organizations supporting certified registered nurse anesthetists (CRNAs). As the legislature returns to Harrisburg this fall, we will need the support of every member of PSA to contact their legislators and tell them why retaining physician supervision is critical to the safety of the patients you serve.

We can't emphasize enough how important it is for your legislator to hear from you.

We are also monitoring several other bills that could impact the scope of practice of CRNAs. They include:

SB 481 (introduced by Sen. Pat Vance) and HB 764 (introduced by Rep. Brian Cutler) would amend the Professional Nursing Law to provide a definition of "certified registered nurse anesthetist." PSA says these bills do not clearly define what CRNAs can and cannot do. (*SB 481 is in Senate Public Health and Welfare Committee; HB 764 is in House Professional Licensure Committee*.)

SB 717 (introduced by Sen. Pat Vance) and HB 765 (introduced by Rep. Jesse Topper) are similar to the first two bills in that they would amend the Professional Nursing Law, but these would provide a definition of "certified nurse practitioner." (*SB 481 is in Senate Public Health and Welfare Committee; HB 764 is in House Professional Licensure Committee*.)

SB 553 (introduced by Sen. Daylin Leach) would amend the Health Care Facilities Act to add a chapter on "hospital patient protection." There are several references to nurse-to-patient ratios for anesthesia services that we will be watching (*SB 553 is in Senate Public Health and Welfare Committee*).

SB 729 (introduced by Sen. John Wozniak) would amend the Dental Law to require that the state dental board "shall not limit the eligibility of dentists to use a hospital or other medical facility for anesthesia services or to receive payment for services rendered at a hospital or other medical facility" (*SB 729 is* in *Senate Public Health and Welfare Committee*).

PRESIDENT'S MESSAGE

continued from page 1

I would encourage all who read the *Sentinel* to take inventory of where you currently are on your professional journey. Are you early in your career and trying to make sense of some of the material in this publication? Are you more seasoned and finding you might be able to offer some suggestions for where we need to go?

The Pennsylvania Society of Anesthesiologists relies on its members who volunteer to pay dues annually. We listen to the needs and questions of each and every member. Relevance is never assumed but, proven every year. The leadership of our society is also an all-volunteer group that carries the load for all of us. Leadership ranks must always be replenished. If you are reading this and you are just starting out, you may not feel you have the time or skill set to contribute yet. Nonetheless, over time, you should acquire these skills.

When you think you are ready to step forward and carry the load for a few years, it will enrich all of those in our profession. You will learn so much from the experience. We are always in need of bright minds to chart our course.

The Mcare Refund Process: Tips for Anesthesiologists

by Robert B. Hoffman, Eckert Seamans Cherin and Mellot, LLC

The process to distribute $139 million in MCARE refunds to physicians, hospitals, and other medical providers will begin this fall with a notice from Mcare listing a physician's refund amount on a year-by-year basis (and is some cases, more frequently) for the years 2009-12 and 2014. Indeed, a hospital or your practice may already have contacted you asking you to sign your refund over to it. Both the Pennsylvania Medical Society and Mcare have established websites with substantial information — www.McareRefund.org and http://www.insurance.pa.gov/Pages/Mcare-Assessment-Refund.aspx#.VgANc99VhHw — on the refund issues and process. The process is more complex than you would probably imagine, primarily because of an issue discussed below. If you have questions, you should visit those websites before acting.

This article does not try to restate the extensive content found at those sites. Instead, it highlights, and briefly describes, an issue that will likely be of importance to anesthesiologists: do you (or, more accurately, the practice in which you work) have a claim to someone else's refund or does someone else have a legitimate claim to yours?

That question arose because many if not most physicians did not pay their own Mcare assessments. Instead, hospitals typically paid the assessment for employed physicians, and anesthesia practices typically paid for their partners/members and employed anesthesiologists. The Mcare Settlement Agreement itself made it clear that it did not impact any obligation that an Eligible Health Care Provider may have to remit a refund to another provider or entity that may have funded the Eligible Health Care Provider's assessment payment. In implementing the refund process, a process was established to allow those "assessment payors" to assert their claim to have the refund paid directly to them.

Here's how it generally plays out for anesthesiologists.

Hospital-employed Anesthesiologists:

Many anesthesiologists, particularly at academic centers, are hospital employees. Hospitals will almost certainly contact their employed anesthesiologists, including formerly-employed anesthesiologists, asking that the hospital, not the doctor, receive the refund. Indeed, the contact might come from a hospital that wasn't even the employer but has, through mergers or other actions, assumed the rights and responsibilities of the employer hospital.

continued on page 6

continued from page 5

The Settlement gives hospitals two mechanisms by which it can obtain a physician's refunds. First, it can ask physicians to assign their rights to the refund, using a specially- approved form. Second, even if the physician (if asked) declines to assign the refund, the hospital can file a claim to the refund with Mcare. If it does so, Mcare will include that information in its 'Notice' to the physician, and the physician will be directed to go to a special website. The website will ask the physician to agree or disagree with the hospital's claim, and Mcare will pay the refund as the physician directs. The hospital, if it disagrees with the physician's decision, can sue the physician.

In general, the logic behind a hospital's claim to the refund is that the employment contract, or benefit handbook, required the hospital to "provide" or "maintain" professional liability insurance coverage for the employed physician, whatever its cost turned out to be. Here, the cost turned out to be less than originally thought. The hospital should get the benefit of that downward adjustment, just as it would have borne the higher costs if the Mcare assessment were higher than predicted.

This analysis is subject to an important caveat: that the physician's compensation plan did NOT effectively charge the professional for all or part of the assessment. If it did, in whole or in part, the hospital would not be entitled to any, or all, of the refund.

There are many kinds of compensation models, and some use separate formulas for "base salary" (*e.g.*, a firm number) and "bonus" (profit-based analysis). If some or all of your compensation formula was based on "net income," in which professional liability coverage costs were among the deductions, then you paid your Mcare assessment, in full or in part, and are entitled to the refund in the same proportion.

Complicating the analysis, the formulas may have changed over time, or if you left employment with one hospital system for another, or if a fixed salary component for one year may have been based on the extent of profitability, i.e., after expenses, in the prior year. References in a compensation formula to "direct expenses," "direct fixed expenses," "general practice expenses," or similar terms are an indication that the compensation formula took into consideration liability insurance premiums. If you think that is the case for you, recalculate the bonus using the refund numbers (or ask the hospital to do it). If you don't have the documents you need, ask for them, and don't agree to an assignment or claim until you are satisfied. If it turns out that you and the hospital should share the refunds, you should try to work out an agreement. It is not possible to assign part of a refund or to agree to part of a claim.

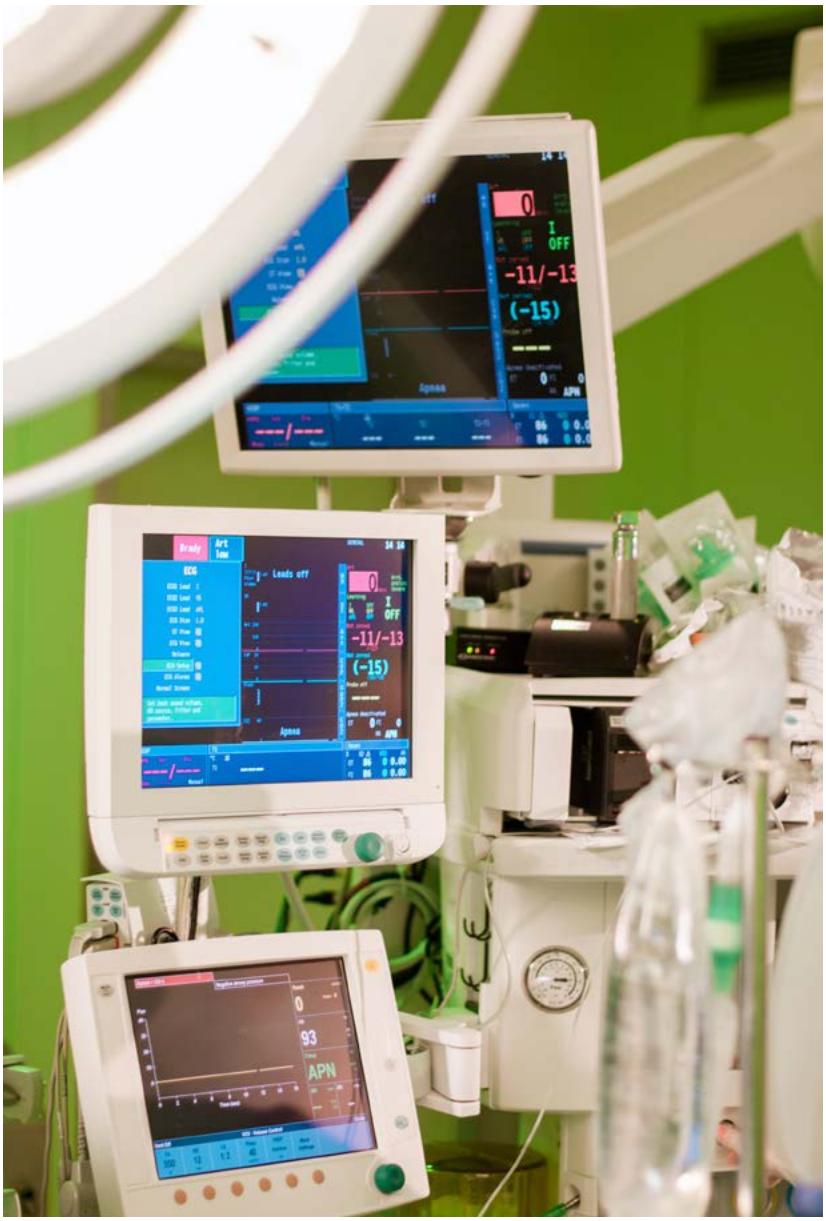
Anesthesia Practices:

The process described above pretty much applies to an anesthesia practice, substituting "practice" for "hospital." In that setting, the issue primarily relates to the refunds due to anesthesiologists who have left the practice or who were employees, not partners or members, at the time the assessments were paid. Depending on a practice's size and rate of turnover, that can be a small or substantial number. But the practice might, as a matter of uniformity, decide to recoup all refunds, allowing the practice to use them for firm purposes as it determines. Doing so would be relatively easy for existing practice members, less so for those who are no longer with the practice.

In addition to the issues discussed here, there are tax consequences of assigning or accepting the funds. In general, accepting the funds results in taxable income while assigning them before receipt does not. These tax issues, as well as the "assignment and claim" issues discussed in this article, are more fully discussed at http://www.mcarerefund.org/SiteCollectionDocuments/QuickConsult-Mcare.pdf (written by the author of this article and Michael Herzog, a tax lawyer). I recommend you, or your practice administrator read it.

QCDR Made Simple—Ha!

This article first appeared in Anesthesia Billing Consultants, LLC, Communique and is reprinted with permission.



The fact is, folks, that the Qualified Clinical Data Registry (QCDR)—and pay for performance reporting in general— is ridiculously complex. And the rules are changing every year. This article will lay out some of the basics, using simple lists and bullets, in the hope of making the options more intuitive. Let's begin with some Q&A:

Do I have to participate in performance reporting?

Leaving aside the local advantages of an effective quality management program, external performance reporting is already required for hospital and ambulatory surgery center accreditation. Performance reporting at the federal level is also required for every "eligible professional" (EP)—physician, certified registered nurse anesthetist (CRNA) and anesthesiologist assistant (AA)—paid by Medicare, or else payments will be docked. The penalties at this moment are small, but the government is committed to increasing them to as much as 10 percent of total payments over the next five years. Many anesthesiologists have already received letters from Medicare noting their failure to participate in performance reporting in 2013, and informing them that their payments will be decreased in 2015.

When?

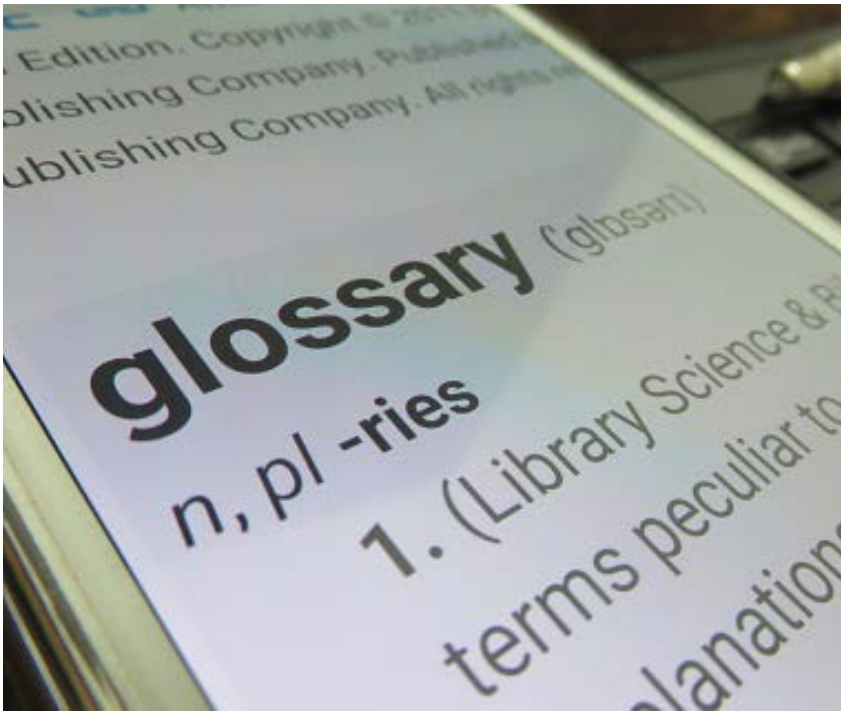
Sooner than you think. For practices with minimal Medicare billing, the financial penalties for not reporting will be small at first. But Medicaid will soon follow, and private insurers likely after that. One way or another, every practice will need to measure and report on quality if it wants to stay in business for the next decade.

What are my options?

Sixty-one percent of anesthesiologists in 2012 reported quality measures to the Physician Quality Reporting System (PQRS). Most anesthesiologists report via the claims-based reporting option. This requires appending a code to each case billed to Medicare, saying that the antibiotics were given on time, that you washed your hands before placing the central line, or that the patient was normothermic when they hit the Post- Anesthesia Care Unit (PACU). (These were three of the five measures most commonly reported by anesthesiologists in 2012.) In 2014 reporting these measures successfully yielded a

continued on page 8

continued from page 7



0.5 percent (half of one percent!) incentive from Medicare, but beginning in reporting year 2015, satisfactorily reporting will only prevent a -2.0 percent penalty. Worse still, the number of measures that must be reported has increased from the current three up to nine, with required inclusion of at least one cross-cutting measure for claims-based and "traditional" qualified registry reporting. And yes, the average anesthesia provider currently has only a few measures to choose from when using these mechanisms and no outcome measures or cross-cutting measures. More on this below.

There are alternatives to the individual claim reporting mechanism, as Medicare attempts to phase it out. One is the Group Practice Reporting Option (GPRO), which allows groups to present their data through an aggregation service. Often involving the same measures but through a different mechanism, it allows for EPs to receive the 0.5 percent incentive in 2014 while attempting to avoid penalties in the future. Another alternative is to be part of an Accountable Care Organization—a consortium of physicians and facilities accepting a risk- and/or savings-sharing payment from Medicare—in which case you are probably a salaried employee of an HMO like Kaiser or a large university system, and can safely stop reading now—you're most likely covered.

The final, and newest, alternative is the Qualified Clinical Data Registry (QCDR), intended to give eligible providers credit for participation in external benchmarking for quality improvement. While the reporting mechanism is similar to other reporting mechanisms described above, the set of measures that can be reported is much broader. Medicare has given these approved registries in each specialty the autonomy to define their own important quality metrics, in exchange for doing the data capture, analysis and reporting that Medicare used to have to do itself. We can expect Medicare to continue to promote registries in order to offload the data management burden onto private entities.

I'm already lost—Help!

OK, let's look at a glossary. Here is a handy list of the critical acronyms:

CMS—The Centers for Medicare and Medicaid Services. In round numbers about 1/3 of all healthcare payments in the US are from Medicare, with another 1/6 through Medicaid. So about 50 percent of all healthcare is bought by the federal or state government. It's a little less than that for anesthesia, but this is still a big hunk of our business.

P4P—Pay for Performance. What the government intends to do, instead of paying for quantity or service or time. The burden of *demonstrating* performance is on us.

PQRS—The Physician Quality Reporting System. The first steps toward P4P—in reality, Pay for Reporting and not for Performance in the sense of "outcomes" for practitioners by CMS. Now about eight years old, the program began as a scheme of incentive payments to eligible providers who reported either performing or not performing one or more approved quality improvement measures.

EP—Eligible Professional. Any individual who bills CMS for their professional clinical services to a patient. This includes anesthesiologists, CRNAs, AAs and others.

NQF—The National Quality Forum. A not-for-profit, membership-based organization created to endorse measures for use by CMS and others for quality reporting. Highly bureaucratic—approval of a measure through NQF can take years of effort and costs hundreds of thousands of dollars. CMS-approved measures often form a subset of all NQF-approved measures.

VM—The Value-Based Payment Modifier. The CMS companion program to PQRS, just getting started. Uses the same set of measures and combines PQRS and QCDR measures with outcome and cost measures. EPs not satisfactorily reporting PQRS will be penalized under the VM program cumulatively; this money will fund an incentive pool for those who meet all of the requirements. The VM system is already active in 2014, with results to be applied in 2016.

MAV—The Measure Applicability Validation process. Groups and providers using the claims-based or "traditional" qualified registry reporting mechanisms who cannot find enough applicable measures to report are subject to the MAV test, which assesses whether more measures would have been available. Assuming CMS agrees that there were none, the EP will not be penalized under PQRS.

QCDR—The Qualified Clinical Data Registry. A new mechanism for practices to report PQRS and that will, in the future, impact their VM. QCDRs are developed and maintained by medical specialty societies, and must seek to improve quality within that specialty by means of data aggregation and periodic feedback to participants (benchmarking). The QCDR can use both approved PQRS measures and its own non-PQRS measures. In 2015, the QCDR will be authorized to include up to 30 of these non-PQRS, specialty-specific measures, thus allowing any participant in a QCDR that takes advantage of this authorization to find the minimum nine that must be reported.

GPRO—The Group Practice Reporting Option. Practices can send their data to CMS as a group (all providers using one Tax Identification Number for their business). This is different from the QCDR, as the GPRO only allows reporting the existing PQRS measures and requires different minimums.

OK, I get it. I have to report performance on quality measures to CMS. What next?

Talk to your office manager and your practice management company. This is complicated material and everyone should get professional advice. Then consider your exposure—the percent of cases your eligible professionals bill to CMS. Then decide what your practice posture will be. Do you want to do everything possible to earn VM incentives? Or are you satisfied with avoiding penalties? Do you have an existing system to capture clinical data, or are you starting from scratch? Once you've answered these basic questions, you should check out the following publicly available resources:

What are my options?

CMS—The definitive source, but not always easy to understand! http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html

The AQI website—Information on the QCDR. http://www.aqihq.org/PQRSOverview.aspx

The ASA website—https://www.asahq.org/For-Members/Quality-Management/QCDR.aspx (requires member log-in).

ABC weekly e-Alerts on PQRS, VM and QCDR topics—http://www.anesthesiallc.com/publications/anesthesia-industry-ealerts

continued on page 10

continued from page 9

What measures can I report on?

The following currently approved PQRS measures apply to most anesthesiologists. These measures can be reported through any mechanism: claims-made, group-reporting or through the QCDR. When reviewing the measures, EPs should pay attention to the CPT Codes in the denominator of the measures. If the specified denominator codes for a measure are not included on the patient's claim (for the same date of service) as submitted by the individual eligible professional, then the patient does not fall into the denominator population, and the PQRS measure does not apply to the patient.

#30—Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics (this measure has been 'retired' by CMS, and can no longer be reported to PQRS in 2015)

#44—Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery

#76—Prevention of Catheter-Related Bloodstream Infections (CRBSI): Use of a Central Venous Catheter (CVC) Insertion Protocol

#130—Documentation of Current Medications in the Medical Record (the denominator codes do not include anesthesia codes)

#193—Perioperative Temperature Management—For General anesthetics > 60 minutes, the percentage of patients reaching the PACU at greater than 36 degrees, or in whom active warming devices were used

#226—Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (non-anesthesia codes)

#342—Pain Brought Under Control within 48 Hours of admission to palliative care (non-anesthesia codes)

#358—Patient-Centered Surgical Risk Assessment and Communication: The Percent of Patients who Underwent Non-Emergency Major Surgery Who Received Preoperative Risk Assessment for Procedure-Specific Postoperative Complications using a Data-Based, Patient-Specific Risk Calculator, and who also Received a Personal Discussion of Risks with the Surgeon (non-anesthesia codes).

How do I report?

This is the question you should ask your practice managers. The short version is that someone (possibly including the provider at the point of care) indicates in the medical record that the patient is eligible and the measure has been met. Someone else abstracts this information from the medical record or the billing documentation and turns it into a code. That code is reported directly to CMS with the bill for the case (under claims made) or to the GPRO or QCDR. Performance on the measure is calculated at the end of the year, based on the rate of successful reporting over all eligible cases.

What's different about the QCDR?

EPs participating in the QCDR report their performance on a case-by-case basis just as they would to CMS under claims made. The QCDR then analyzes performance and reports on the EP's behalf to CMS. The difference is that the QCDR may measure other elements than those reported to CMS (it's a real registry, not just a billing mechanism). The QCDR will provide regular feedback to the provider throughout the year. And—most important—the QCDR can provide reporting credit for non-PQRS measures.

Aha! That's how I can find nine measures to report!

Exactly! Here are the 11 non-PQRS measures available in the ASA-QCDR (the National Anesthesia Clinical Outcomes Registry, or "NACOR") for 2014. Even more will be added in 2015.

- Anesthesiology: Post-Anesthetic Transfer of Care Measure: Procedure Room to a Post Anesthesia Care Unit
- Post-Anesthetic Transfer of Care: Use of Checklist or Protocol for Direct Transfer of Care from Procedure Room to Intensive Care Unit (ICU)
- Prevention of Post-Operative Nausea and Vomiting (PONV)— Combination Therapy (Adults)
- Prevention of Post-Operative Vomiting (POV)—Combination Therapy (Pediatrics)
- Composite Anesthesia Safety— The percentage of all patients who complete a scheduled procedure without a major complication
- Immediate Perioperative Cardiac Arrest Rate
- Immediate Perioperative Mortality Rate
- PACU Reintubation Rate
- Short-term Pain Management
- Composite Procedural Safety for Central Line Placement
- Composite Patient Experience

OK, I know this is important, and I have to do it. How much is it going to cost me to prevent penalties or earn incentives?

Costs will depend on the current sophistication of your practice information technology and on your billing or quality capture vendor. Talk with them first! Participation in NACOR is open to any anesthesia practice in America and is free to ASA members. The ASA-QCDR service is also free to ASA members participating in NACOR. Non-member EPs (i.e. your nurse anesthetists and AAs) can use the ASA-QCDR service for $295 per EP per year, with discounts available for large groups. This is likely a fraction of the penalty and incentive money at risk, but each group will need to make this assessment on their own.

Can I still participate in 2015?

Yes, although you need to get moving. CMS has threshold levels of reporting required under each mechanism, so you will need to have your data flowing soon. For the QCDR, EPs using the QCDR option will need to report at least nine measures covering at least three National Quality Strategy domains for at least 50 percent of their patients seen during 2015.

The AQI is here to help you manage federal performance reporting in our brave new world of healthcare quality. Complicated, yes. But you can do it!

Authors:

Richard P. Dutton, MD, MBA - *Chief Quality Officer, American Society of Anesthesiologists Executive Director, Anesthesia Quality Institute, Schaumburg, IL*

Matthew T. Popovich, Ph.D. - *Director of Quality and Regulatory Affairs, American Society of Anesthesiologists, Washington, D.C.*

ERAS and the Perioperative Surgical Home: A Great Idea but an Implementation Nightmare

by Joseph F. Answine, M.D.

A smooth, complication-free surgical experience with a very satisfied patient postoperatively is not something new to medicine. It is, and has been our goal with every patient. Implementing new ideas, protocols and procedures to achieve such a goal has been studied for decades. However, now that there is a significant amount of money tied to lowering complication rates, hitting certain healthcare benchmarks, having satisfied patients and having quicker discharges; even more emphasis is placed on developing perioperative patient care systems. That is the motivation behind the "Perioperative Surgical Home" (PSH), developed and touted by the American Society of Anesthesiologists (ASA); and using protocols such as "Enhanced Recovery After Surgery" (ERAS) which is a surgical delivery pathway utilized as part of the PSH.

There are many "moving parts" in these perioperative patient care protocols that will directly involve the anesthesia team, such as less restrictive preoperative fasting, a regime for a pain-free postoperative course with minimal narcotics, aggressive multimodal management of nausea and vomiting, active intraoperative warming, restricted/goal directed fluid management, early feeding (as early as the PACU) and early ambulation— all aiming toward an early discharge and a more satisfied and healthy patient. These individual goals may have minimal impact on patient outcome however.

Every step through the perioperative process, including the anesthetic and the postoperative course, is considered vitally important. However it all starts and ends at the beginning.

The "beginning" is when the patient is identified as a surgical candidate. Truthfully, getting the patient from that point to the operating room may be the most difficult portion of the process and has the most impact on the success of this new perioperative plan. A major emphasis on cooperation and coordination of care is the glue that holds the process together. This is easier said than done with many providers involved such as primary care doctors, surgeons, preoperative nurses, anesthesiologists, PACU nurses, floor nurses and rehabilitation specialists, to name a few. A closed hospital system and a completely employed staff may make it easier to coordinate the protocol's implementation, especially the preoperative workup and instructions, in order to get the patient to the operating room quickly and safely. However, throughout the rest of the medical world where there are numerous surgeons from numerous groups working with a large number of primary care doctors, anesthesia groups and hospital systems; this has proven to be utter chaos.

The first problem is that each member of the team is usually not educated on the needs and expectations of other members of the team. A primary care doctor may know his patients, but likely knows little about particular technical challenges and risks of the surgical procedures being performed, or the expectations of the different surgeons and anesthesiologists. Therefore, to be asked to assess perioperative risk based solely on the patient's health history, and decide on further work up and medication optimization is very difficult.

The surgeon, on the other hand, knows the patient's

needs in relation to the surgical pathology but probably knows very little about the patient's overall health and medical history. All in all, even with an informed, involved, and educated patient with a strong knowledge of his/her health, much can easily be missed through the process. This lack of "knowledge coordination" leads to delays, cancellations and, most importantly, a potential decline in overall patient safety.

A coordinated effort between the primary and surgical teams based on data driven decision-making will match the appropriate patient and procedure to the appropriate perioperative care protocol, but one size does not fit all in this situation. A sick, debilitated patient is not going to do well with an ERAS-type protocol regardless of the good intentions of the medical providers. A primary care provider who is knowledgeable about the patient history, surgical pathology, surgical and anesthesia risks and proposed postoperative care plan will be able to make an educated decision about the likelihood of success. Furthermore, a primary care provider with this level of knowledge will be able to provide enough information to the patient to begin the process of stress avoidance and preoperative anxiety alleviation known to improve outcomes and patient satisfaction. All of this is not taught however during the primary care physician's residency, and is not already integrated into their practice.

Another area of potential difficulty is the need for a coordinator of all this perioperative care. "Who" should however, be that individual is the question. The ASA feels strongly that it should be the anesthesiologist, or more appropriately, named as per our society, the "perioperative physician." An anesthesiologist, I agree, would be the most logical choice with knowledge of medical management, surgery, anesthesia, pain control and nausea avoidance. However, other providers involved, especially the surgeon, a person used

continued on page 14

ERAS AND THE PERIOPERATIVE SURGICAL HOME: A GREAT IDEA BUT AN IMPLEMENTATION NIGHTMARE

continued from page 13

to being called "the captain of the ship," may have great difficulty giving up overall control of the patient. Furthermore, the perioperative physician coordinator will have to aid the other providers as they move the patient through the process—from the primary doctor and the surgeon to the floor nurses and rehabilitation specialists. He/she will have to identify protocol deficiencies and breakdowns, and have the intellectual and political strength to identify that point in the process and team member involved in order to correct the problem.

The coordinator would also be responsible for team member education and reeducation during the initiation of the system and as the system is changed to fit the needs of the team and patients. For us, as anesthesiologists, to take on this responsibility is daunting since our role as an intraoperative anesthesia provider is already a full time job. This will likely mean that the "perioperative physician" may have to lessen his/her role in the intraoperative care. Again, this may be easier for a closed healthcare system to separate a physician or group of physicians from intraoperative responsibilities, but difficult for a private group, especially since as of now it will mean a loss of income for those individuals. Some of this "financial pain" may be alleviated by subsidies from a healthcare system that sees the overall value of such a program and the keys to its success; however, it is another potentially painful part of the process.

To add to the workload, a successful PSH requires a process of "time and effort consuming" continuous data collection and evaluation. The perioperative physician leader with the insight and "intestinal fortitude" as stated above will have to alter the system based on analysis of the data in order to grow and improve the process.

Lastly, how many protocols are tolerable? Thinkers have a love/hate relationship with protocols. A well thought out and data-supported protocol does help with coordination of care, however it can make the situation mindless and robotic. As anesthesiologists, we are inundated with protocols; insulin, beta blocker and antibiotic administration, temperature control, etcetera. I find that the biggest problem with protocols is that if you decide, based on your clinical judgment, to step away from one or change it, the system breaks down and a paradoxical state of confusion occurs among the others involved.

So, when your hospital administration asks you and a small group of other providers to meet and put together a perioperative care process that lessens complications, improves patient satisfaction, shortens hospital stays, and saves money; kindly tell everyone to pack a lunch because they will be there for a while.

Pennsylvania Society Of Anesthesiologists' 2015 Nominating Committee Report

Committee Members: Robert F. Early, M.D. (Chair), Dave Gratch, M.D., Donald E. Martin, M.D., Craig Muetterties, M.D., Kristin Ondecko-Ligda, M.D., Tom Witkowski, M.D.

The PSA Nominating Committee held a meeting on Tuesday, May 5, 2015, and after follow-up telephone calls and e-mail correspondence, the work of the committee was successfully completed. All nominations are for the 2015-2016 term.

The following members are nominated for PSA officers (1 year term except where noted):

President
Andrew Herlich, M.D.

President-elect
Bhaskar Deb, M.D.

Vice President
Richard Month, M.D.

Past President
Robert Campbell, M.D.

Assistant Secretary/Treasurer
Meg Tarpey, M.D. (2-year term)

The following members are nominated for Delegate to ASA (3 year term):

Joseph Answine, M.D.
David Gratch, D.O.
Andrew Herlich, M.D.
Richard Month, M.D.

The following members are nominated for Alternate Delegate to ASA (1 year term):

Al Belardi, M.D.
John BianRosa, M.D.
Robert Early, M.D.
Lee Fleisher, M.D.
Shannon Grap, M.D.
Randy Lamberg, M.D.
A Joseph Layon, M.D.
Philip Mandato, D.O.
Donald Martin, M.D.
Kristin Ondecko-Ligda, M.D.
Shailesh Patel, M.D.
Mark Shulkosky, M.D.
Anthony Silipo, D.O.
Kevin Slenker, M.D.
Patrick Vlahos, D.O.

The following members are nominated for PSA Delegate to PMS and Representative to PMS Specialty Leadership Cabinet (1 year term):

Delegate
Donald Martin, M.D.

Alternate Delegate
Robert Early, M.D.

The following members are nominated for PSA Representative to the Carrier Advisory Committee (1 year term):

Representative
Jim Cain, M.D.

Alternate Representative
Shailesh Patel, M.D.

PSA Annual Meeting Luncheon

The Hilton Bayfront Hotel San Diego

Saturday October 24, 2015

Cobalt Level
Room 520
12:00 Noon - 1:15PM

Invitation to all members, residents and their guests.

Initiatives Impacting Anesthesiologists' Practice

by Donald E. Martin, M.D., Pennsylvania Medical Society Specialty Leadership Cabinet Member

PENNSYLVANIA
society of
ANESTHESIOLOGISTS

To help anticipate the rapid changes in health care in the next decade, the Pennsylvania Medical Society has conceived and implemented **the PACT program**, designed to enhance the engagement of physicians in their health systems. The program provides tools to identify elements within a health system's culture which support physician involvement. It then uses this information to improve organizational culture, physician engagement, and the effectiveness of clinical teams in that system. Initial system and physician assessments are conducted online, and the program staff then recommends best practices to engage physicians in the operation and management of their health system. Health systems in both Pennsylvania and other states are participating in this innovative program. The program can be found online at http://www.PACTpath.org.

Physician General Priority – Prescription Opioid and Heroin Abuse in Pennsylvania

In a discussion with the Specialty Leadership Cabinet, Dr. Rachel Levine, Physician General of Pennsylvania, highlighted the problems associated with opioid abuse in the state:

- 2,400 deaths occur annually, or seven each day.
- The number of heroin-related deaths has nearly quadrupled in the last decade.
- 45% of heroin abusers also abuse prescription opioids.
- 7.3 to 8.4 kg of prescription painkillers are sold for each 10,000 people in the state annually.

The state government and the Department of Health are responding in several ways:

- Formulating pain management guidelines for use in emergency departments
- Designing physician education programs
- Instituting prescription drug monitoring programs which provide better access for physicians and healthcare providers to current information regarding prescriptions for opioids written and dispensed within the state
- Encouraging naloxone administration by first responders to prevent deaths from respiratory depression

Coincidentally prescription opioid abuse will likely be part of the ongoing discussion between PSA members and the Pennsylvania Patient Safety Authority, led by Joshua Atkins, M.D., PhD.

Regulatory and Legislative Issues

CR NP Independent Practice

Senate Bill 717 and House Bill 765, which provide for independent APRN practice without a collaborating physician, are still in their respective House and Senate committees. **The House Professional Licensure Committee has scheduled a hearing on House Bill 765 for Thursday, October 22, at approximately 9:00 – 11:00 AM in Room 60 in the East Wing of the Capitol. Anesthesiology, as well as other medical specialties, need to have a strong presence at this hearing, with at least 10 physicians present from each specialty. Let Dr. Martin know at dmartin1@hmc.psu.edu if you can attend, especially if you live and practice near Harrisburg.**

Physicians within Pennsylvania are pointing out to citizens and legislators alike the weaknesses and limitations of some of the assertions of the Pennsylvania Coalition of Nurse Practitioners. PCNP claims that Senate Bill 717 would increase access and reduce healthcare costs in Pennsylvania; whereas physicians assert that physician-led teams are the most effective way to increase access and reduce healthcare costs in Pennsylvania.

Physician-led teams are the most effective way to increase access to physicians across the state, especially in medically underserved areas.

continued on page 18

INITIATIVES IMPACTING ANESTHESIOLOGISTS PRACTICE

continued from page 17

Medical Marijuana

Senate Bill 3 passed the Pennsylvania Senate on May 12 and is currently in the House Rules Committee for the drafting of compromise language acceptable to both chambers.

State Board of Dentistry

The state Dental Board plans to issue regulations in the near future updating the standards for administration of general anesthesia, deep sedation, conscious sedation, and nitrous oxide use within dental offices. PSA will likely play an active role in commenting on these regulations, to promote consistency with current standards of anesthesia patient care and patient safety.

MCare Refund to Physicians

The implications of the MCare refund of a portion of MCare liability premiums to physicians are outlined in detail at: http://www.mcarerefund.org/Pages/default.aspx#sthash.GKo0r5nO.dpuf

This resource provided by the Pennsylvania Medical Society includes answers to issues important to employed physicians and to members of large groups, or groups which have since been dissolved or sold, regarding when the refund may legally go to the physicians as individuals. Mailings from the state regarding this refund will be sent in September. Employed physicians may have already received requests to assign their refunds to their employers.

Welcome New PSA Members

Effective May 23, 2015 to August 13, 2015

ACTIVE

Susan Michelle Dashow, D.O.
Zabiullah Latif, D.O.
Henry Liu, M.D.
Rafik Tadros, M.D.
Thomas R Walther, M.D.
Sno E. White, M.D.

AFFILIATE

Christopher Assaid, PhD

RESIDENT

Mansoor Mohammad Aman, M.D.
Snigdha Ancha, M.D.
Nicklaus Paul Atria, M.D.
Marshall Patrick Bahr, M.D.
Richard Allen Barnhart, D.O.
Mark Walter Berguson, M.D.
Michael William Block, M.D.
Ryan Budwany, M.D.
Philip Charles Carullo, M.D.
Surmeet Singh Chhina, M.D.
Jillian A. Dibiase, D.O.
Joseph Dichiara, D.O.
Mark A. Dobish, M.D.
Philip Ofosu Eck, M.D.
Kristen Fenocchi, M.D.
Mark P. Fullenkamp, M.D.
Laura Liss Gershon, M.D.
Lindsay A. Gibeault, D.O.
Eric Jean Yves Guelaff, M.D.
Nathan Steve Hoaglund, M.D.
Lyndsay M. Hoy, M.D.
Hayden E. Hundley, M.D.
Andrea J. Ibarra, M.D.
Brandy Nicole Johnson, M.D.
Patrick James Kennedy, M.D.
Michael Robert King, M.D.
Evan Edward Lebovitz, M.D.
James Finney Lincoln M.D.
Rammurti McKenzie, M.D.
Courtney A. Mechling, M.D.
Levi Ocken, M.D.
Abraham Oommen, M.D.
Chidimma Michelle Osigwe, M.D.
Shawn Palmeri, M.D.
Vishal M. Patel, M.D.
Sanket R. Pathak, M.D.
Velvet M. Patterson, M.D.
Ashwin Vilas Rangavajjula, M.D.
Mohammadreza Rasouli, M.D.
Aaron Hunter Relic, D.O.
Poovendran Saththasivam, M.D.
Adam Joseph Setren, M.D.
Nirmal B. Shah, D.O.
Jordan Smoker, M.D.
Brandon Patrick Staub, M.D.
Elise Marie Strickler, D.O.
Gokul Thimmarayan, M.D.
Jahzreel Allardice Thompson, M.D.
Talinn Hoory Toorian, M.D.
Tuan Trinh, M.D.
Ranjani Venkataramani, M.D.
Chau My Vu, M.D.
Chelsey L. Woodrum, M.D.

PENNSYLVANIA
society of
ANESTHESIOLOGISTS

777 East Park Drive
P.O. Box 8820
Harrisburg, PA 17105-8820

Follow PSA on Facebook

To sign up for a new account, enter your name, birthday, gender and email address into the form at https://www.facebook.com. Then pick a password.

After you complete the sign up form, Facebook will send an email to the address you provided. Just click the confirmation link to complete the sign up process.

How do I follow PSA on Facebook?

First, sign in to your Facebook account. At the top of the screen, in the "Search for people, places, and things" box, type "**PA Society of Anesthesiologists**" and press "Enter." This will take you to the PSA Facebook page.

On the PSA Facebook page, click "Like" under the cover photo. Doing this will add you to the list of PSA followers, so to speak, and through your Facebook account, you will be alerted about any activity or updates made to the PSA Facebook page.

Follow PSA on Twitter

Visit https://twitter.com/signup to create a Twitter account.

Twitter will send a confirmation email to the address you entered on sign up. Click the link in that email to confirm your email address and account.

How do I follow PSA on Twitter?

First, sign in to your Twitter account. At the top of the screen, in the "Search" tab, type "**@PSAnesth**" and press "Enter." This will take you to the PSA Twitter page.

On the PSA Twitter page, click "Follow" under the cover photo. Doing this will add you to the list of PSA followers, so to speak, and through your Twitter account, you will see all of the new items posted by PSA.