



PRESIDENT'S MESSAGE

In The Crosshair

Bhaskar Deb, M.D.
PSA President

Previously I discussed the topic of Balance Billing and legislative attempts to limit or outlaw billing by out-of-network physicians. Legislation has now come to Pennsylvania. Several weeks ago, Senator Schwank of Berks County introduced Senate Bill (SB) 678. The bill has the support of Governor Wolf, Insurance Commissioner Teresa Miller, whom in fall of 2015 proposed curbing any “surprise balance billing” by any out-of-network Pennsylvania physicians providing either emergency or elective services within in-network hospitals. SB 678 is also co-sponsored by the Senate Banking and Insurance Committee.

This bill essentially directs out-of-network hospital-based physicians to bill a patient's insurer rather than a patient for their services. The amount the insurer pays is defined as “the out-of-network amount due under the health insurance policy”, an



amount determined unilaterally by the insurer. The bill also requires notification of patients before a hospital admission if out-of-network physicians will likely provide any of their care.

SB 678 addresses almost all specialties who may provide services at hospitals, rehab facilities, ambulatory surgical facilities or clinics. It would not be out of the realm to see extension of such rules to all physicians, even those with only outpatient private practices.

PSA opposes this bill. It does little to attack the real causes of rising patient out-of-pocket costs, narrow insurer networks and the market power of Pennsylvania's four major insurers who hold us all hostage with rising costs and decreased coverage. Total healthcare spending in 2010 was approximately \$8,425 per person, and in 2015 it was \$10,028 per person—an increase of 26%. From 2013-2017, the average monthly insurance premium for families has increased 140% and their average deductible has increased 97%. SB 678 limits insurer incentives to maintain adequate networks and access to both in-network and out-of-network physicians. This increases the market power of insurers by giving them the ability to set out-of-network physician payments instead of basing charges and payments on market-driven prospective charge and

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As we enter the summer vacation season, PSA continues to be active in Harrisburg.

Out-of-network billing (Balance or Surprise Billing)

This continues to demand the full attention of the PSA Executive and Insurance Committees, our attorney and lobbyists. Kevin Harley of Quantum Communications, our lobbying partner, reports on all current legislation of importance to our practices.

PSA is working with representatives of the emergency physicians, radiologists, pathologists and hospitalists to educate our State Representatives in order to prevent a physician-unfriendly bill from becoming law. President Bhaskar Deb reports on this in detail in his President's Message.

Charles Artz, Esq., PSA's attorney explains in detail the Physician Drug Monitoring Program (PDMP) and what is and is not required of anesthesiologists to be in compliance with this law. His

summary and conclusions clearly list his interpretation of the requirements under this law.

Drs. Answine and Moorewood, in separate articles, present forward-looking views of the future of anesthesiology and medicine.

Common to both articles is the belief that change is inevitably coming to the practice of anesthesiology and medicine.

Our District Director, Erin Sullivan, M.D. reports on the very successful ASA legislative Conference. Dr. Sullivan completes her term as Chair of the Committee on Governmental affairs this October and has helped guide our membership through the VA nursing handbook initiative.

Also in this edition, Lucy Guevara describes her experience as a female physician and the all too common inaccurate assumption that all females are nurses.



This mis-identification has been reported all too often by other female physicians in various specialties.

Finally, we bring back the practice management section with thoughtful insight from Mark Weiss, Esq. Mr. Weiss who presents guidance on protecting your practice, compensation models and leadership, setting a forward looking strategy and valuing your worth.

**I look forward to your
comments or suggestions
on topics in this edition.
Letters to the Editor should be
addressed to Editor@psanes.org.**



Are Anesthesiologists Legally Required to Query the Physician Drug Monitoring Data Base In the Hospital Peri-Operative Anesthesia Process?

by Charles I. Artz, Esq.
PSA General Counsel

Several months ago, a PSA member anesthesiologist in private practice was told by an administrator at a large hospital system that anesthesiologists were required by law to access the Physician Drug Monitoring Program (“PDMP”) data base preoperatively. The anesthesiologist contacted PSA, and the PSA Board of Directors undertook a detailed analysis of the issue.

This article will summarize the background of the PDMP, articulate PSA’s Policy Statement describing anesthesiologists’ responsibility to assist in the reduction of illicit opioid abuse, summarize the issue, and analyze the applicable law.

Background

The Achieving Better Care by Monitoring All Prescriptions Program (“ABC-MAP”) Act was established by Act 191 of 2014. The ABC-MAP Act created the Physician Drug Monitoring Program (“PDMP”) database. The ABC-MAP Act technically took effect June 30, 2015; however, the Department of Health did not implement the Act until August of 2016. The ABC-MAP Act was amended by Act 124 of 2016, which took effect January 1, 2017.

PSA POLICY STATEMENT

The Commonwealth of Pennsylvania’s prescription medication abuse crisis continues to escalate. Many health care organizations including the Pennsylvania Society of Anesthesiologists will take steps to assist in the reduction of availability of the illicit use.

Controlled medications, including opioids, are a critical component of anesthesia and sedation in many circumstances. Anesthesiologists must continue to use opioids in order to safely anesthetize their patients in the operating room, the gastroenterology and procedural suites, the labor floors, and the intensive care units as examples. Surgery and invasive procedures by their very nature cause pain. The use of local anesthesia with regional nerve blocks, including spinal and epidural anesthesia may be helpful or appropriate for certain procedures only. Consequently, anesthesiologists must provide patients with pain relief, avoidance of awareness, and a calming milieu to promote the best outcomes for patients. In many cases, there are no alternatives to these medications, the medications are insufficient or contraindicated for anesthesia care.

In the peri-operative and critical care settings, anesthesiologists almost never write opioid prescriptions for ambulatory use. Anesthesiologists are hypervigilant to the abuse potential and use every measure possible to use these medications appropriately in their peri-operative practice. PSA’s physician anesthesiologist colleagues who specialize in treatment of severe and chronic pain do prescribe these medications for patient use but are most careful about the extent and frequency of the prescriptions.

As physician anesthesiologists, expert in opioid pharmacology and well-versed in the abuse potential, anesthesiologists are fully committed to provide the safest, highest-quality, and most patient-centered care possible to each and every patient. PSA is committed to using its expertise to help the Commonwealth and hospitals, clinics, and health systems to implement appropriate measures to reduce the risk of opioid abuse, dependency, or patient harm; however, PSA remains deeply concerned that application of well-intended legislation, designed to draw heightened sensitivity to the risks of opioid prescriptions and use by patients outside of the hospital or procedural setting, to the peri-operative or critical care setting creates an unintended and potentially harmful barrier to appropriate opioid therapy.

Issue

Some large health systems in Pennsylvania are interpreting state law to require anesthesiologists to query the PDMP database to satisfy what has been construed as a mandatory and initial query even though anesthesiologists are not issuing prescriptions for controlled substances, opioids or benzodiazepines to patients throughout the anesthesiologist's involvement in the patient's surgical encounter.

Analysis

Section 2 of the ABC-MAP Act establishes the purpose of the PDMP, as follows:

This Act is intended to increase the quality of patient care by giving prescribers and dispensers access to a patient's prescription medication history, through an electronic system that will **alert medical professionals to potential dangers for purposes of making treatment determinations.**

35 P.S. §872.2 (emphasis added). Any purported mandatory query must be read in this context, i.e. as a function of alerting physicians to potential dangers for making treatment determinations. Any query that does not alert a physician to a potential danger in the context of making treatment determinations does not advance the purpose of the Act.

Section 8 of the ABC-MAP Act establishes a series of mandatory requirements for "prescribers", as follows:

(a) System query. – **A prescriber shall query** the system:

(1) for each patient the first time the patient is **prescribed** a controlled substance by the prescriber for purposes of establishing a baseline and a thorough medical record;
(2) if a prescriber **believes or has reason to believe**, using sound clinical judgment, that a patient may be **abusing or diverting drugs**; or
(3) each time a patient is prescribed an opioid drug product or benzodiazepine by the prescriber.

(a.1) **Query not required.** – If a patient has been admitted to a licensed health care facility or is in observation status in a licensed health care facility, the prescriber does not need to query the system **after the initial query under subsection (a)(1)** as long as the patient remains admitted to the licensed health care facility or remains in observation status in a licensed health care facility.

35 P.S. §872.8(a)(1)-(3), §872.8(a.1) (emphasis added).

The ABC-MAP Act defines "prescriber" as follows:

A person who is licensed, registered or otherwise lawfully authorized to distribute, dispense or administer a controlled substance, other drug or device in the course of professional practice or research in this Commonwealth. The term does not include a veterinarian.

35 P.S. §872.3. There is no question anesthesiologists are "prescribers."

The legal issue is whether anesthesiologists are subject to the mandatory PDMP database query when they provide pre-operative anesthesia services, intra-operative administration of anesthesia, and care for the patient in the post-anesthesia care unit ("PACU"). The provision of anesthesia services pre-operatively, intra-operatively and in the PACU will be referred to as the "peri-operative anesthesia process."

Anesthesiologists must continue to use opioids in order to safely anesthetize their patients in the operating room, the gastroenterology and procedural suites, the labor floors, and the intensive care units as examples.

Some large hospital systems have interpreted the ABC-MAP Act as mandating anesthesiologists to query the PDMP database prior to the initiation of the peri-operative anesthesia process. An anesthesiologist, however, like any other physician or provider satisfying the definition of "prescriber" under the Act, is subject to the mandatory query obligations only if one of the three scenarios set forth in Section 8(a)(1)-(3) quoted above occur. Each scenario will be analyzed separately.

Section 8(a)(1) mandates the PDMP database query "for each patient the first time the patient is **prescribed** a controlled substance." The triggering mechanism under the Act is the

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verb “prescribed.” The action verb “prescribe” obviously requires a “prescription.” The ABC-MAP Act does not define the terms “prescribed” or “prescription.”

The Pennsylvania Controlled Substance, Drug, Device and Cosmetic Act (“the Drug Act”) addresses the Commonwealth’s policy regarding controlled substances. 35 P.S. §780-101 et seq. The ABC-MAP Act is designed to alert physicians with respect to controlled substance treatment determinations, and to aid regulatory and law enforcement agencies in the detection and prevention of fraud, drug abuse and the criminal diversion of controlled substances. 35 P.S. §872.2. There is no question that the ABC-MAP Act and the Drug Act relate to the same persons or things and to the same class of persons and things, i.e. the proper use of controlled substances. Therefore, the two laws are in pari materia. 1 Pa.C.S. §1932(a). Thus, the two laws must be construed together as one statute. 1 Pa.C.S. §1932(b).

The Drug Act defines “prescription” as follows:

“Prescription” or “Prescription Order” means an order for a controlled substance, other drug or device for medication which is dispensed to or for an ultimate user but does not include an order for a controlled substance, other drug or device for medication which is

dispensed for immediate administration to the ultimate user (e.g. an order to dispense a drug to a bed patient for immediate administration in a hospital is not a prescription order).

35 P.S. §780-102 (emphasis added). The Department of Health’s Hospital regulations adopted a virtually identical definition of “prescription” at 28 Pa. Code §25.51.

The threshold legal question is the impact of the triggering verb “prescribed” under §8(a)(1) of the ABC-MAP Act. Throughout the entire peri-operative anesthesia process, an anesthesiologist determines and administers the medication necessary to facilitate the surgical procedure without the patient being awake or feeling pain. The anesthesiologist’s orders throughout the peri-operative anesthesia process involve dispensing drugs for immediate administration. Therefore, as a matter of law, the anesthesiologist’s orders during the entire peri-operative anesthesia process are not prescriptions. Accordingly, an anesthesiologist does not “prescribe” a controlled substance throughout the peri-operative anesthesia process.

Section 8(a)(3) mandates a physician to query the PDMP database each time a patient is **prescribed** an opioid drug product or benzodiazepine by the prescriber. Once again, the triggering mechanism is the active verb “prescribed.” For the reasons outlined above, an anesthesiologist is not required as a matter of law to query the PDMP database for any opioids or benzodiazepines ordered for

immediate administration in the hospital facility during the peri-operative anesthesia process.

The third mandatory requirement for a physician to access the PDMP database arises if the prescriber **believes or has reason to believe**, using sound clinical judgment, that the patient may be abusing or diverting drugs. The “believes or has reason to believe” standard is by definition subjective. Throughout the entire peri-operative anesthesia process, the anesthesiologist has no independent clinical facts upon which to use clinical judgment to arrive at the subjective decision that a patient may be abusing or diverting drugs.

Based on the foregoing analysis, anesthesiologists do not have any legal obligation to access the PDMP database for their patients throughout the entire peri-operative anesthesia process.

Act 124 of 2016 amended the ABC-MAP Act to add Section 8(a.1) quoted above. 35 P.S. §872.8(a.1). Under §8(a.1), if a



patient has been admitted to a licensed health care facility (which includes hospitals, ambulatory surgery centers, etc.) or is in observation status in the hospital, the prescriber does not need to query the system **after the initial query under subsection (a)(1)** as long as the patient remains admitted or in observation status. Some hospital systems apparently have interpreted the phrase “after the initial query” as a mandatory facility query and imposed these obligations on anesthesiologists. We are concerned that some of these large hospital systems have not properly considered the prepositional phrase “under subsection (a)(1).” That is, nothing in the ABC-MAP Act absolutely mandates an initial query **unless the triggering event under subsection (a)(1) has occurred**. For the reasons set forth above, however, there are no circumstances under which the three triggering mechanisms apply to anesthesiologists engaged in the peri-operative anesthesia process.

In an effort to serve its membership, PSA is in the process of seeking clarification through either an amendment to the ABC-MAP Act or interpretive guidelines published by the Department of Health confirming that anesthesiologists who administer controlled substances, opioids or benzodiazepines directly to patients throughout the peri-operative anesthesia process are not mandated to query the PDMP database.

Summary and Conclusion

PSA’s interpretation and application of the ABC-MAP Act includes the following:

1. A controlled substance, opioid and benzodiazepine ordered by an anesthesiologist and dispensed for immediate administration to a patient in a hospital is not a “prescription” as defined under the Drug, Device and Cosmetic Act at 35 P.S. §780-102 and the Department of Health’s regulations at 28 Pa. Code §25.51.
2. Controlled substances, other drugs or medications administered throughout the peri-operative anesthesia process in a surgical case do not trigger the mandatory query to the PDMP database by an anesthesiologist.
3. Anesthesiologists are “prescribers” of medication, but do not “prescribe” medication in the context of the peri-operative anesthesia process.
4. The intent of the ABC-MAP Act is to have an impact on the physician’s prescriptive treatment decisions, not anesthesia orders implemented by direct administration of medication throughout the peri-operative anesthesia process.
5. Although the Department of Health’s Frequently Asked Questions interpretive document indicates the PDMP database must be queried once when the patient is in the hospital, nothing in the FAQs or any published Department of Health policy statement requires anesthesiologists ordering and administering controlled substances, opioids or benzodiazepines during the peri-operative anesthesia process to query the database.
6. The purpose of the ABC-MAP Act is to alert the prescribing physician to potential dangers and to guide opioid prescriptive treatment decisions; and to prevent abuse or diversion.
7. Physicians ordering and administering controlled substances throughout the peri-operative anesthesia process have no reason to create a baseline in the medical record, which is the purpose of the mandatory query under Section 8(a) (1). Information contained in a mandatory query by an anesthesiologist whose only role is medication administration is clinically unrelated to preventing abuse or diversion.

PSA will keep its membership apprised of any developments on this important issue.



The Rise of Peri-Operative Medicine

by Joseph Answine, M.D.



Webster's Dictionary states that a specialty is something that a person is known for doing very well. It is an area of study that a person has special knowledge of.

Whether by patient comorbidities, the insult of the surgical procedure, the stress response involved, medications administered, or a combination of all; anesthesiologists alter the patient's usual state of health and well-being during the peri-operative period. Therefore, a medical specialty concentrating on patients as they move through the peri-operative process is a necessity.

As anesthesiologists, peri-operative medicine is truly our specialty. For many reasons, we need to embrace this as our own. Due to changing payment

models, to thwart off the attack of mid-level providers, and most importantly for better care of our patients; this is our future. For us, as it has been for the surgeons, care of our patients must start weeks before the procedure and end weeks after. The days where we meet the patients the morning of the procedure, and spend up to a few hours with them for which most of the time they are rendered nearly or totally unconscious are over.

What can we do other than administering an anesthetic that makes us specialists in peri-operative medicine?

Let's start with preoperative care. We meet our patients at the time surgery is scheduled in our "surgical optimization clinic". We do a focused pre-anesthetic history and physical examination. Based on the patient's health and the procedure scheduled, we stratify risk. Comorbidities are not the only way to predict operative outcome. Studies on the ASA physical status have proven that. For example, is a sickly elderly person having a cataract removal truly at greater peri-operative risk than a healthy 50-year-old having an asymptomatic cerebral aneurysm clipped?

It is an art to utilize all the available patient information with an understanding of the currently known data to determine risk; and then put together an appropriate preoperative work-up and optimization plan, a patient-

specific tailored anesthetic, and a postoperative pathway that will lead to the best possible outcome—a care plan that would allow the patients to be as good or better than they were before surgery.

The next step as mentioned above is to "optimize". Again, based on the available data, we implement a preoperative regimen of studies and patient-specific processes such as exercise and strengthening for pulmonary maximization, diabetes management, smoking cessation programs, treatment of anemia, cardiac prehabilitation, etc. We next educate the patients on what is ahead of them and what is expected of them over the next few weeks. Patients are now expected to be active participants in their care. We then communicate all that we have done and all that we have learned to the intraoperative team.

Now we use our skills for the intraoperative care. We take everything we have learned to produce the optimum anesthetic. It truly encompasses varying combinations of hypnosis, analgesia, amnesia and muscle relaxation utilizing the best available medications, techniques and monitors to allow for the smoothest transition to the next phase of care; the postoperative period.

The postoperative period for the new age of anesthesiology continues through discharge. During that time, we will be providing pain management using a multimodal approach while controlling postoperative



complications such as nausea and vomiting. We will use our knowledge to allow for early recognition and mitigation of other postsurgical complications in order to minimize patient mobility. This obviously means that the peri-operative team rounds on these patients are done in a routine fashion and is contacted as the primary service.

Imagine “postoperative chest pain” in the middle of the night. Who immediately evaluates the patients will determine their clinical path. It will determine work up, the procedures ordered, and where they go next, whether that be the intensive care unit, the catheterization lab, or stay on the floor. A good understanding, even in the middle of the night, of who the patients are and what they have been through could thwart unnecessary tests, and most importantly, risky maneuvers that may negatively affect the patients’ overall health even though the goal was just the opposite.

And now we become involved with something totally new to us; post-discharge care. With our specific skills, we can assure

that patients stay on a healing path and avoid unnecessary readmissions. Instead of a primary care physician getting a call a few days post discharge and having little understanding of the patients’ recent course, therefore likely referring them to the emergency room, we can handle the concern, possibly have a team member visit them at home, and hopefully avoid the trip to the hospital. We then, in a time-appropriate manner, transfer care back to the primary physician.

How often do we meet that one patient the morning of surgery that has some comorbidities, but not presenting any acute distress? Little time, therefore, is spent “optimizing” over the weeks from scheduling to surgery. We are talking about that slightly elevated creatinine, that mild COPD, that underlying type 2 diabetes, and that slightly out-of-control blood pressure. And, of course that beer belly that was earned from mastering the art of being a couch potato. The patient isn’t perfectly prepared, but nothing seems to strongly indicate cancellation. A quick care plan for a cookie-cutter

general anesthetic is put together, and the surgery is performed for that routine knee replacement. The patient does reasonably well, and surgery occurs uneventfully.

Postoperative day 1, a fever is noticed, oxygenation is impaired, a right lower lobe pneumonia is diagnosed and the patient spends the next couple of days in the intensive care unit with IV antibiotics and supplemental oxygenation by mask. Intubation is avoided but secondary atrial fibrillation requires some extensive workup and treatment. Control of hypertension along with administration of anti-arrhythmics puts the patient back in sinus rhythm and he is back on the floor in a day or two. The patient is discharged on post-op day 8, but isn’t ready to return home, so a couple weeks in a rehabilitation hospital is ordered. His blood glucose levels are elevated and due to his debilitated state, he gets a wound infection and spends a couple more days in the hospital for IV antibiotics. He is sent back to the rehabilitation center and then eventually home with a few liters of oxygen and a PICC line. He does recover slowly, but he now has a creatinine above 2 and his hgbA1C is still close to 9. He has a brand-new knee but is now too sick to use it.

We have all met this patient. Now, let us do a “what if”. “What if” we saw him weeks before surgery, did the appropriate work-up based on the history, and obtained the appropriate lab work. We determined that his kidneys aren’t bad but they are not perfect, therefore we could use the input of a nephrologist. His diabetes is not as controlled as he states, therefore we request the expertise of an endocrinologist

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The Rise of Peri-operative Medicine

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to optimize control. Furthermore, his primary care doctor optimizes his blood pressure. They will follow him while hospitalized. Prehabilitation is started. Patient education occurs. All of this is passed on to those involved with the intraoperative care days before surgery. Based on the patient's medical history, a regional technique is employed and multimodal pain management is instituted. Based on his history, pulmonary optimization occurs immediately postoperatively, he ambulates postoperative day 1, and is taking PO well. He is discharged postoperative day 3 to home. However, two days after

discharge, there is concern about his incision, and the peri-operative team member assigned to his post discharge care is contacted. The incision is evaluated at home and PO antibiotics are started. Eventually, a direct sign off occurs with the primary care physician. His postoperative laboratory values are unchanged from those noted preoperatively. He eventually loves his new knee.

Think about the patient morbidity avoided and the obvious time and money saved because of the care of the peri-operative medical team. Furthermore, think about the resources that are saved which are difficult to quantify such as a few years of dialysis, home oxygen therapy as pulmonary function continues to deteriorate,

as well as end-of-life care possibly a few years later due to the health issues we acutely worsened during his surgical care.

Studies over the years continue to show that a clinical path such as this driven by education, advanced technology, and always updated data improves outcomes and resource utilization.

If, due to our skills, we avoid all of this peri-operative insult; is that not the definition of a true medical specialty?

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Reformation of the U.S. Healthcare System: The Rubber is About to Hit the Road

by Gordon Morewood, M.D., MBA, FASE

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This spring I bought a new car. The experience was truly miserable.

I went to a new type of dealership. I order both a windshield and a pair of windshield wiper mechanisms from the glass department, front and rear bumpers from the bumper department, and leather seats from the upholstery department. The process became rather complicated once it reached the drivetrain. I found that the individuals providing the axels did not communicate well with my contact in the transmission department, and the engine specialist simply seemed angry every time I entered his shop. I was required to return to the dealership eight different times to meet with all of the required sub-contractors—on two of these occasions simply to complete paperwork.

Finally, one day in early May, the car was ready to be picked up. At 6:05 AM the next morning I slipped into the driver's seat and turned the key. Nothing happened. No gentle purr of the engine. No sputtering ignition. Not even a sad whine from the starter motor. I Uber'd my way to the hospital and called the dealership as soon as they opened at 9:00 AM.

"What is the problem?" the receptionist asked.

"It won't start" I replied.

"Why won't it start?" she said, her thinly veiled exasperation seeping through.

Without any attempt to hide my aggravation I responded "I don't know.

I turn the key and nothing happens!"

"I can't possibly direct you to the correct department unless you can tell me exactly what sort of problem the car is having..." and the dial tone abruptly droned in my ear.

Four weeks later, the completely useless car still sitting in my driveway, I received an itemized bill from the dealership. There were five pages of excruciatingly detailed part listings and assembly charges, almost none of which I could comprehend. The total amount I owed for the car? \$127,999.

Few would dispute the inevitable failure of this business model. Fatal flaws include an opaque pricing structure, little coordination between content specialists, and the lack of a single entity accountable for the overall product. The net result is an experience that few consumers would voluntarily repeat. The analogy to fee-for-service medical care should not be lost on currently practicing physicians, particularly those working in the area of institutionally-based invasive procedures.

When Medicare Part A (hospital) insurance was introduced in 1966 it was initially structured as a "cost-plus" system (1). Hospitals carefully accounted for the costs associated with

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each hospital admission and billed Medicare Part A for their costs plus a margin to support growth and future investment. The most rational institutional behavior under such an economic system was to maximize services (ie: costs) to provide the greatest net margin at year's end. The resulting unsustainable growth in the cost of hospital care prompted Congress to pass the Social Security Amendments Act of 1983 (2). That legislation established the Prospective Payment System (PPS) for inpatient hospital reimbursements under Medicare. The PPS provided a single fixed payment to hospitals according to a patient's Diagnosis-Related Group (DRG) code at the time of admission. This system of fixed payments transferred the onus for efficient resource utilization to hospitals and resulted in a significant reduction in the growth of Medicare Part A spending (1,3). In 2000, the Medicare Outpatient Prospective Payment System (OPPS) was introduced by Congress and provided similar fixed bundled payments for outpatient procedures.

The same legislation that authorized the OPPS, the Balanced Budget Act of 1997, also enacted the Sustainable Growth Formula (SGR) that would haunt US physicians for the next 20 years (4). The SGR was a congressional initiative to control Medicare Part B (physician services) spending. A complex formula was deployed which linked spending increases to the rate of growth of the US Gross Domestic Product (GDP). Part B spending limits were enforced

by reducing overall rates for billable physician services when the growth in total spending exceeded the growth in GDP. The prescribed reductions in physician reimbursement proved politically untenable and, starting in 2003, Congress passed legislation each year suspending the required reductions in the physician fee schedule. This action resulted in compounding discrepancies between actual reimbursement rates and those dictated by the SGR until 2015 when a 21% cut in Medicare payments was due to take effect. The legislation that finally and permanently repealed the SGR was the Medicare Access and CHIP Reauthorization Act (MACRA) which was signed into law on April 16th, 2015 (5).

MACRA was a bipartisan omnibus bill which addressed a number of healthcare related issues. However, its most important underlying purpose was to begin the permanent transition away from simple fee-for-service payments to physicians. Under MACRA, those physicians who participate in certain Alternative Payment Models (eg: Bundled Payment Models, Accountable Care Organizations) will receive annual bonus payments and higher fee schedule updates beginning in 2019. On the other hand, those physicians who operate mainly under the basic fee-for-service system will receive no increase in their fee schedule from 2020 through 2025 with only 0.25% annual increases thereafter. Furthermore, fee-for-service physicians will have their reimbursements adjusted according to their annual Merit-Based Incentive Payment System (MIPS) score. Each physician's MIPS score will be a composite derived from quality measures, their use of information

technology, reported practice improvement activities, and total cost of care. Adjustment to fee-for-service payments according to a physician's MIPS score will begin with a maximum range of +/- 4% in 2019 and grow to +/- 9% by 2022. The net effect of these changes will be to slowly starve the fee-for-service system and to provide growing incentive for physicians to work in a more integrated fashion with their healthcare systems.

Separate from the MACRA legislation, both private payors and the Medicare administration continue to aggressively move toward bundled payments for discrete resource-intense episodes of care (eg: most hospital based procedures). In the fall of 2017 CMS will inaugurate the Episode Payment Models (EPM) initiative in 1100 hospitals and across 83 metropolitan regions (6). This initiative will implement retrospective bundling for all patient care associated with one of three admitting diagnoses: coronary artery bypass grafting, acute myocardial infarction, or hip fracture. Under the retrospective bundling system, hospitals will be awarded bonuses or assigned financial penalties based on the total Medicare cost per patient from the date of admission through 90 days post-discharge. Total cost per patient for the EPM program will include all hospital charges, physician fee-for-service billing, and post-acute (rehabilitation or home care) services. Under this initiative, only those hospitals that are able to build strong partnerships with their physicians and streamline their systems of care will succeed.

Despite all of the sound and fury in recent years surrounding political efforts to repeal the

Affordable Care Act, the true work of healthcare system reformation is proceeding unabated. The unsustainable growth of healthcare spending in the US is driving regulators and third-party payors to experiment aggressively in order to derive better value for the number of dollars spent. There is no political will to alter the course of these efforts and it remains doubtful that a viable healthcare system can be fashioned without them.

However, there is something tangibly different about the current changes being implemented. Past efforts to reform healthcare and decrease cost or increase quality required no more than an arms-length involvement of individual physicians. Payment reforms were contested at the state or national level by our professional organizations. Demonstration of the meaningful use of information technology or tabulation of a spectrum of process metrics in the name of quality could both be accomplished by administrative staff.

In contrast, eliminating high-cost low-value components of our current care pathways, bringing essential aspects of care to the time and location where they are needed most, and engineering mechanisms to implement high-impact but presently unreimbursed interventions for our patients will require the active engagement of all clinical staff. Many physicians will see their scope of practice expand and will be asked to accommodate to new challenges. Participation in the management of healthcare delivery systems will become as much a part of every physician's medical practice as the management of an individual patient's needs.

How will these changes play out in anesthesiology practices across the State of Pennsylvania? It is impossible to predict the future with certainty, but some outcomes are both more likely and more desirable than others. One purpose of our professional organization should be to guide our specialty to the most advantageous future state possible through the dissemination of critical information and sharing of practical experiences.

To be continued... (in the next issue of the Sentinel)

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4. Balanced Budget Act of 1997, Title IV, Subtitle F, Chapter 1. Services of health professionals.
5. Medicare Access and Chip Reauthorization Act of 2015, Title I. SGR repeal and Medicare provider payment modernization.
6. Medicare Program; advancing care coordination through episode payment models (EPMs); cardiac rehabilitation incentive payment model; and changes to the comprehensive care for joint replacement model (CJR). *Federal Register* 2017;82(1):180-651.

Welcome New PSA Members!

(Effective February 9, 2017 – May 4, 2017)

Active

John Adler, M.D.
Lauren Archer, M.D.
Lauri Bernstein, M.D.
Cheryl Crhisty, M.A.
Robert Keeney, D.O.
Igor Lawler, M.D.
Chandresh Miller, M.D.
Lumei Oh, M.D.
John Semenov, M.D.
Dong Shah, M.D.

Residents

Shane Barre, D.O.
Sean Baskin, D.O., M.A.
Leah Bess, M.D.
Daniel Borna, D.O.
Mohamed Christian, M.D.
Brittany Farrag, MBBCH, MSC
Lavra McCann, M.D.
Devin Zeidan, M.D.

Medical Students

Gabrielle Castella
Andrew Goodman
Dae Kim
Andrew Beck
Brendan Gallagher
Herman Singh
Robert Oravets
Heidi Skimmer
Samuel Acquah
Uyen Nguyen
Rolfy Perez Holguin
Sandra Boty
Opetomi Seriki
Danielle Pilarte, D.O.

2017 Summer Legislative Update

by Kevin Harley

Quantum Communications



The Pennsylvania General Assembly is in full budget mode as negotiations between the House and Senate leaders and Gov. Wolf attempt to close a projected \$1 billion-dollar deficit by the June 30 constitutional deadline. Their challenge is finding new revenue to fill the budget gap without raising personal income tax or sales taxes. The two likely sources of revenue are expanded gaming and additional liqueur privatization. While the three parties may agree on expanded gaming there, is not agreement on liquor privatization.

Conventional wisdom in Harrisburg is that the budget will pass by the June 30 deadline because it benefits both Gov. Wolf's Republican majorities in the House and Senate and the reelection efforts.

Department of Health Consolidation

It appears that the governor's plan to consolidate the departments of Health, Aging Human Services and Drug and Alcohol Programs will pass the legislature.

Gov. Wolf has said if his legislation passes, he will name current Insurance Commissioner Teresa Miller as the secretary of the combined cabinet-level agencies. Secretary of Health Karen Miller has announced that she is resigning effective June 30.

How this consolidation affects the ongoing review by the Department of Health of its hospital regulations as they relate to nurse anesthetists is something that PSA and Quantum are monitoring closely.

Supervision

We continue to build support in the House for the supervision bill (HB 789) introduced by Rep. Jim Christiania. The bill places into the Medical Practices Act the Department of Health regulation that a physician must supervise the administration of anesthesia.

The legislation has the support of both the Republican and Democratic chairmen of the House Professional Licensure Committee and we are in discussions with them on legislative strategies to move the bill. We are also working on building support for the supervision bill in the Senate.

Balance Billing

The issue of balance billing or out-of-network payment is an active legislative initiative of PSA. Sen. Judith Schwank has introduced a bill (SB 678) that has been referred to the Senate Banking and Insurance Committee. Likewise, in the House, Rep. Matt Baker is expected to have his own version of balance billing legislation introduced in the near future.

The Schwank bill as it is currently written, favors the insurance industry and does not address the real issue—narrow networks. Quantum, along with Dr. Don Martin and the PSA insurance Committee, have been actively engaged in building coalitions with other specialty practice groups and the Pennsylvania Medical Society.

We are working with Sen. Don White, the Republican Senate chairman of the Banking and Insurance Committee, letting him know PSA's position.

The balance billing issue is one that is being fought not only in Pennsylvania but throughout the United States, and PSA is working closely with the ASA.

CRNA Titling Bill

There has been no movement on CRNA titling in the House, and PSA remains opposed to the bill as it is currently written. PSA is open to supporting the bill if it is amended to include scope of practice and proper supervision provisions.

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Highlights Successes and Prepares for Future Challenges

by Erin A. Sullivan, M.D., D.ABA

ASA Director from Pennsylvania and the Chair of the Committee on Governmental Affairs



It has been an epic year for the protection of safe care for our patients and for the continued stewardship of our specialty! It was such an inspiration to be surrounded by so many consummate professional citizens at LEGISLATIVE CONFERENCE 2017, held in our Nation's capital on May 15-17 at the Hyatt Regency Washington Capitol Hill. With over 600 ASA members in attendance, of which

more than 20% were residents, this year's conference gave us the opportunity to congratulate one another on our successes, while building relationships and honing our advocacy skills to prepare for the future challenges that will impact our patients and our specialty across all levels of government.

LEGISLATIVE CONFERENCE 2017 featured presentations on several topics of continued importance to physician anesthesiologists and our patients. The Interactive Workshop on State Advocacy highlighted a variety of legislative and regulatory issues that affect ASA members at the state level. In addition to special skill-based presentations focused on developing traits to engage state and local lawmakers, attendees learned about current legislation

in several states pertaining to attempts to remove physicians from the care team and out-of-network payment issues.

Physician-Led, Team-Based Care for Veterans Protected, Preparation for Future Challenges

Last year's conference focused squarely on ASA's top advocacy priority – preserving safe care for America's Veterans within the U.S. Department of Veterans Affairs (VA). LEGISLATIVE CONFERENCE 2017 had a different focus—celebration of a hard won campaign to that end. In December of last year, VA's final rule was published in the Federal Register after a record-breaking comment period. Largely due to your tireless efforts, the final rule states that VA will maintain its current physician-led, team-based model for care under which physician anesthesiologists and nurse anesthetists work together to provide high-quality and safe anesthesia care—a win for our nation's Veterans.

I was proud to lead the Committee on Governmental Affairs (CGA) during both of these comment periods. Together, our CGA Committee members helped mobilize all ASA Committees to encourage 100 percent participation in submitting comments to the Federal Register.

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Members of the Pennsylvania Society of Anesthesiologists at the ASA Legislative Conference Meeting.

Highlight Successes
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It was a unique honor to help lead ASA's advocacy efforts that resulted in more than 100,000 comments submitted in support of physician-led anesthesia care for Veterans. Starting at ANESTHESIOLOGY 2015, members of CGA, and an amazing number of ASA members, were mobilized to take action on this important issue, a pillar of the work of my committee.

It was inspiring to hear from some of our strongest supporters on Capitol Hill about this campaign and others. Among them were The Honorable Phil Roe (R-TN-01), Chair of the U.S. House of Representatives Committee on Veterans Affairs, and Co-Chair of the House GOP Doc Caucus, and The Honorable Andy Harris (R-MD-01), member

of the U.S. House of Representatives Committee on Appropriations, co-chair of the House GOP Doc Caucus, and the first ever physician anesthesiologist elected to Congress. Both are one of only 15 members of the House of Representatives who are physicians, and their hard earned expertise and

dedication played a huge role in the success of the campaign to Protect Safe VA Care.

But, with these laurels distributed, every speaker was quick to remind the attendees that there will always be new challenges to face. There's a reason the motto of ASA is

"Vigilance". Special thanks to ASA President Jeffrey Plagenhoef, M.D. and ASA's strong leadership for inspiring attendees toward the pursuit of continued improvement and advancement, while heartily congratulating everyone for their hard work.

This success featured prominently in attendees' visits to legislators as well. In a near record, there were over 150 individual visits reported. This facetime is invaluable, as it takes the minutiae of policy and replaces it with you, the attendees—real people and their experiences. Several supportive legislators received



Left, ASA President Jeffrey Plagenhoef, M.D. talking with PSA's Rich O'Flynn, M.D. at the Advocacy Champions Thank You Reception.

commemorative certificates of appreciation to thank them for their efforts to protect safe VA care. Still others received invitations for continued dialogue to protect safe, physician-led, team-based care that America's Veterans have earned and deserve.

MACRA's Second Birthday

A continued topic of interest is the implementation and guidance for the Medicare Access and CHIP Reauthorization Act, or MACRA, which replaced the Sustainable Growth Rate (SGR) formula. This new program includes two pathways for participation: the Merit-based Incentive Payment System (MIPS) and Advanced Payment Models (APMs). Other upcoming advances include a movement toward greater interoperability requirements and improved health information technology.

During the second day of the conference, attendees were fortunate to hear from ASA Vice President for Professional Affairs, Stanley Stead, M.D. and ASA Past President Alexander Hannenberg, M.D., on important aspects of the evolving regulatory story of this impactful legislation. Issues

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included whether physicians who participated in PQRS in 2016 would be held harmless for their transition to MIPS and whether physicians would be able to pick their pace to assure that their transition was smooth. Equipped with this information, attendees can now be more effective. Their voices will be crucial to the process going forward. Centers for Medicare and Medicaid Services (CMS) Program Director Molly MacHarris also walked attendees through MIPS.

Knowing where physician anesthesiologists stand, and where this specific law is taking the specialty, is essential for the future of our work on behalf of patients. ASA anticipates continued advocacy and engagement with CMS officials and lawmakers on this issue in the upcoming years.

Addressing the Continuing Epidemic of Opioid Abuse

Combatting the prescription opioid abuse epidemic remains a major focus for our specialty, and ASA continues to work in tandem with stakeholders to support legislation, education programs and research initiatives that help curb prescription drug misuse, abuse and diversion. Physician anesthesiologists are in a uniquely qualified position to act as signals of expertise on this issue.

It was an honor to hear from Asokumar Buvanendran, M.D., Chair of ASA's Committee on Pain Medicine, as the epidemic grows in public awareness. Dr. Buvanendran also currently serves as the President of the American Society of Regional Anesthesia and Pain Medicine (ASRA).

With the expertise of Dr. Buvanendran, attendees were better equipped to inform their legislators about a path forward:

there needs to be better patient access to, and physician education of multimodal and multidisciplinary pain management tools and techniques, above and beyond safe and effective opioid prescribing, while also encouraging new research and safe storage and disposal procedures.

We know this is no small or quick challenge. But with the continued enthusiasm and engagement of ASA members on this issue, we anticipate continued partnership with private and public organizations to make great strides in curbing opioid abuse, misuse and diversion in the upcoming year.

Collaborative and Innovative Legislative Advocacy, Health Care Reform, and Recognizing Excellence

One of the most popular new additions to the program were the breakout sessions which included opportunities to meet congressional experts of ASA's Advocacy Division, hearing from residents who are active and effective budding professional citizens discuss their advocacy efforts, and speaking with experts about the new APRN compact. A new tool available through the Grassroots Network provided an easy digital method for attendees to report their congressional visits, of which there were over a hundred.



Left to right: Cecilia Leatham, M.D., Resident-Drexel University; Elizabeth Quill, ASA Senior Regulatory Specialist; James Light, M.D., Resident-Temple University; Alejandro Rodrigues, M.D., Resident-Allegheny Health Network; Donna Kucharski, M.D., Cardiac Anesthesia-Allegheny Health Network; Representative Mike Doyle, PA-14th District; Roshawanda Brown, M.D., Resident-Temple University.

With the debate over healthcare reform still roiling, ASA empowered attendees in preparation for their visits with lawmakers. Wherever this may lead, ASA and our members continue to be deeply involved in tracking and analyzing legislation and the potential impact on our practices. ASA has a set of principles we would like to see incorporated into the healthcare reform legislation:

- Maintenance of access to affordable health care services for all Americans, including those with pre-existing conditions;
- Assures access to anesthesia and pain services by preserving coverage of essential benefits;
- Recognizes the value of physician directed care and of consumer choice with regard to doctor, insurer, and plan from that insurer, all across America;

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Highlight Successes
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- And ensures adequate funding for Medicaid and children's health services.

This year, ASA honored The Honorable Johnny Isakson, Senator from Georgia, with the Excellence in Government Award in recognition of his exemplary work advocating for patient safety and influencing health care policies. Every year, ASA gives the Excellence in Government Award to an elected official who has gone above and beyond to protect patient safety and the future of the specialty of anesthesiology.

Additionally, Kraig de Lanzac, M.D., was recognized with the Bertram W. Coffey, M.D., Excellence in Government Award for his innovative efforts, especially on behalf of Safe VA Care initiative. He was a cornerstone of the foundation that propelled ASA and our members to such an outstanding success last year. As the award's namesake, Bertram, "Bert," W. Coffey, M.D. said, "If you rest—you rust." And if one thing is clear, Dr. de Lanzac was absolutely tireless in propelling ASA's legislative,

political and regulatory priorities.

Each year, the LEGISLATIVE CONFERENCE helps us to assess where we are and where we are going. To be sure, we have much success to celebrate. But I really love this conference because it serves as an important reminder that we must continue sharing resources and working together in order to secure the future of anesthesiology. Thank you to you, the attendees, for giving your valuable time and energy to advocate for our patients and our specialty. I look forward to seeing this high level of engagement continue through the coming years, when surely advocacy will be even more critically important to secure best practices and patient safety.

Thank you to the hundreds of ASA members who participated in LEGISLATIVE CONFERENCE 2017. While this year's LEGISLATIVE CONFERENCE is especially bittersweet, as it is my last year as Chair and Emcee, I look forward to continue working with you all and to seeing many of you at LEGISLATIVE CONFERENCE 2018 on May 14-16, 2018. Thank you for a memorable and inspiring conference.



ASA President Jeffrey Plagenhoef, M.D. presents PSA's Erin Sullivan, M.D. with an award of appreciation for her term as Chair of the Committee on Governmental Affairs.

Speakers Training

Annually the ASA convenes the Legislative Conference in Washington DC to allow membership an opportunity to gather, exchange information and hear updates on the ASA legislative efforts to move the interests of the anesthesia community forward in the setting of continued regulatory changes. Effective delivery of the message to our Representatives and Senators requires planning and foresight. In an effort to prepare members for this task the ASA Communications department has offered speaker training at the onset of the legislative conference each year.

This year the Monday morning lectures were reinforced by a practical session of taping and critique.

The importance of knowing your audience, self-identification, learning to effectively deliver an idea were discussed as imperatives for effective advocacy. Targeted discourse and dialog for unified message requires planning to deliver the message at hand.

The following techniques were presented and should be considered for any member speaking with the press, city, state,

and federal officials to whom you are delivering a message.

- 1) Identify yourself as a Physician Anesthesiologist in order to differentiate yourself from a nurse anesthetist.
- 2) Use the term “anesthetize the patient” rather than put the patient to sleep.
- 3) Be certain to emphasize the concept of “Physician-lead Patient Centered team based care” for continued and improved patient safety.
- 4) Use simple stories of physician lead care to illustrate the foundation of the physician anesthesiologist as the team leader.
- 5) Learn to bridge the conversation to refocus to the discussion and deliver your message.

Every member is encouraged to participate in the speaker training sessions at some time since the opportunity to speak about the profession will undoubtedly present itself. Information about the program is available on the ASA website or through the ASA Public Relations Department. Please plan early as the sessions are filled every year.

President’s Message continued from page 1

payment data from all insurers in a geographic area collected by an independent database.

PSA has been successful in aligning with four other Pennsylvania hospital-based specialties. All five specialties have submitted comments to the Senate Banking and Insurance Committee. PSA also intends to launch a public education campaign. ASA and other national organizations will also be involved in providing resources for this public education effort.

Seen on a coffee mug belonging to a CRNA:

**ANESTHESIA: Where
the most ambitious
nurses share a
profession with the least
ambitious physicians**

What is this you ask, and where is this coming from? For those of you unaware, such sentiment is being driven by the APRN Compact. The APRN Compact approved May 4, 2015, allows an advanced practice registered nurse to hold one multistate license with a privilege to practice in other states. This is under consideration in multiple states and will become effective with enactment in 10 states (currently enacted in three). The APRN Compact legislation states: “An APRN issued a multistate license is authorized to assume responsibility and accountability for patient care independent of a supervisory or collaborative relationship with a physician.”

What is the nursing rationale behind this?

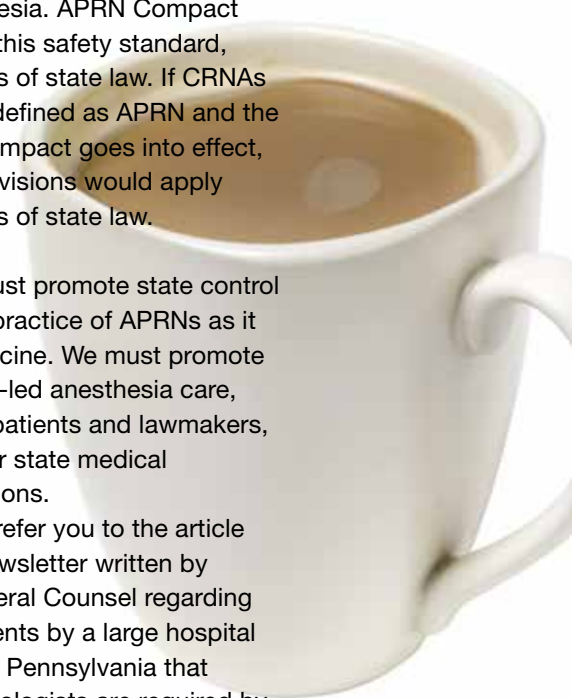
- Increases access to care by allowing APRNs to cross state borders
- Allows telehealth by APRN
- Cost effective for nurses and organizations
- Facilitates states’ responsibility to protect the public
- Increases access to health care, protects patient safety and reduces costs while supporting state-of-the-art health care delivery, today and in the future.

APRN Compact eliminates state patient safety standards requiring physician involvement in anesthesia and other medical care. 46 states and Washington D.C. require physician involvement during administration of anesthesia. APRN Compact removes this safety standard, regardless of state law. If CRNAs become defined as APRN and the APRN Compact goes into effect, these provisions would apply regardless of state law.

We must promote state control over the practice of APRNs as it is in medicine. We must promote physician-led anesthesia care, educate patients and lawmakers, alert other state medical organizations.

I also refer you to the article in this Newsletter written by PSA General Counsel regarding requirements by a large hospital system in Pennsylvania that anesthesiologists are required by law to query the Physician Drug Monitoring Data Base.

Happy reading. I hope I’ve shed some light on some key state and national issues.



“Are You My Nurse?”

by Lucy Guevara

I was recently on an off-service rotation and one morning as I entered the room of a patient who had been admitted to our service, I overheard the patient quickly tell the person they were talking to on the phone “Hey, can I call you back? My nurse just walked in to talk with me.” For a moment, I was confused and actually turned around to look for his nurse behind me. Alas, the patient was in fact referring to me—the person in the long white coat with a stethoscope around her neck and a large badge that had the word “PHYSICIAN” written in big letters. As some of you read this many of you might be thinking that I am being too sensitive to this misidentification. If this had been the first or even the tenth time this had happened, I might agree. However, that has not been the case and I have been called a nurse more often in my (very) short career as a physician than I care to count.

Please do not misunderstand; I respect the profession of nursing to the highest degree. Without nurses, we as doctors would be lost. Nurses have been by my side since day one in the hospital as a frightened medical student and have been an asset to me ever since with their incredible intuition and endless wisdom. When it comes to caring for the intricate needs of each of their patients, nurses have a special skill set that is different from the skill set physicians



develop in medical school. Yet being mistaken for a nurse is a far too familiar feeling amongst my fellow female colleagues and one that is not an issue encountered by my male peers.

History was made one day in October of 1846, when the first successful surgical anesthetic was used by Dr. John Collins Warren at Massachusetts General Hospital. A few years later in 1849 the first female physician, Elizabeth Blackwell, received her medical degree. Although there were no female physicians when anesthesia was initially used successfully, by the 1900s anesthesiology was one of the few specialties in which women were in the majority.

It was a combination of social and economic factors that contributed to women being

selected in the specialty of anesthesia. Initially, the majority of male physicians stayed away from anesthesia due to decreased compensation and the unfortunate label that anesthesia had earned as being submissive and secondary to the surgeon in the operating room. It was noted that females were superior to their male counterparts in the role as anesthetists because of their ability to play the role of subservient and were more easily controlled by surgeons. This notion was best summed up by a quote from a British anesthesiologist, Dr. Frederic Hewitt, in 1896, in which he stated “Anesthesia was born a slave; and she has ever remained the faithful handmaid of her master surgery.”

Social growth and the breaking of stereotypes during the twentieth century have nearly abolished the notion that women are subservient or inferior to men in the field of medicine. After almost over two centuries, female medical school graduates now outnumber their male counterparts. Despite this milestone, female physicians are still under-promoted and receive less pay when compared to men in medicine, including anesthesiology. A recent RAND Corp. study conducted on the “Glass Ceiling Effect” found that women are closing the gender gap in medicine and specifically the specialty of anesthesia by sheer representation, especially for the younger age groups.

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How To Prevent Your Medical Group From Getting Robbed Of Its Staff

by Mark F. Weiss, J.D.

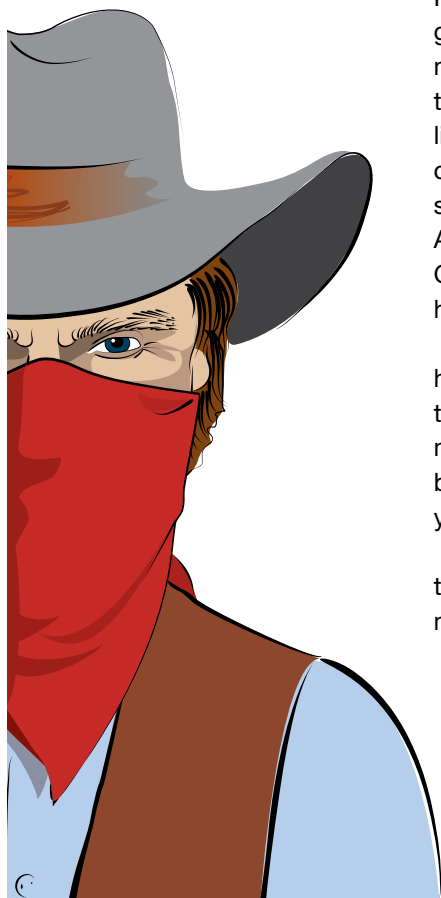
Ever watch those old black and white B-movie Westerns?

The bad guys would ride into town and rob the bank.

"Hands up! Give us all the money!" And then off they'd ride, carrying bags of cash.

What if the writers had put a different twist on how the bad guys robbed banks? Instead of grabbing all of the money and riding off with it, what if they just forced the banker out of the bank and took over the business? First Citizens Bank of Tumbleweed? No! First Bad Guys Bank of Tumbleweed? Yes!

Ha ha, someone is laughing. That's ridiculous, they say.



Unfortunately, it's not at all ridiculous. It happens all the time, except not at banks where it would be a crime but to medical groups, where it's just good business.

A hospital informs the emergency medicine group that's been providing services to it for the past 15 years pursuant to an exclusive contract that the contract won't be renewed next August. Instead, the group's physicians will be offered jobs with the hospital controlled medical group.

Or, a national group takes over the anesthesia contract at St. Mark's Community Memorial Hospital and tells the local group that it will employ all of its members, well, not exactly all, those who don't make the cut, like the local group's executive committee members, should start looking for jobs elsewhere. Again, what's bank robbery in the Old West is "just business" at the hospital.

But that doesn't mean that you have to make it easy for someone to drop a neutron bomb on your medical group, mooting your business structure and "liberating" your employees.

Groups interested in protecting their business (and note that this means both local groups as well as regional and national groups which are by their nature setting themselves up for the same danger) must

assess both internal and external strategies to defeat being robbed.

This includes things like covenants not to compete, the creation of fiduciary duties, placement fees, and nonsolicitation provisions.

Of course, there's another category of protection to consider. That's action taken over an extended period of time to reduce the chance that your group will ever be targeted for elimination.

No, the possibility can't be completely obviated. It's still the Wild West out there. But you can at least remove the "rob me" sticker that's on your back.

Is Your Medical Group Stealing From Its Future?

You get what you pay for.

If you try to get it without paying for it, you won't get much of it, at least not of high quality.

And you are probably stealing. The irony is that you are stealing from yourself, from your future.

Medical Group Compensation Plans

What does your medical group's compensation plan compensate for? The usual answer is "productivity," whether measured in units or minutes or by some other standard.

If your group compensates for X, you will get more of X. So if X is

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How to Prevent

continued from page 21

units, your group's physicians will be motivated to maximize their production of units.

But if your group compensates for X and also wants Y, you will get a lot of X and not very much, if any, Y.

For many medical groups, Y is leadership. They want their group leaders to lead, but their compensation plans incentivize only the production of units.

Is it any surprise that the "leadership stuff" is relegated to the wee hours of the night or even to the wee hours of never? Is it any surprise that there's no actual leadership, only "consensus?" Is it any surprise that the leaders schedule business meetings at 7 pm or on weekends, signaling amateur status?

If you don't pay for leadership, you won't get much, if any, of it. You will create tension. You will create resentment. But you will not create leadership.

You'll be stealing from the leaders – either from their ability to generate units or from their time for themselves or with their families.

And, as a result you will get a very weak form of leadership, one that results in your group stealing from its own future in the form of poor decisions and lost opportunities.

You've got great plans to take over the region or to simply protect your position at one facility. You expect your leaders to achieve that goal. Yet you've incentivized them away from your goal. Don't blame them when you never get there. Blame yourself.

It's time to make sure that your group's compensation plan is in

synch with your group's business strategy and future.

When You Fail To Set Strategy

The jellyfish of the highway. You've seen them, too. Plastic shopping bags traveling a few feet off the ground, propelled by the wind of passing cars.

Without a purposefully developed strategy, a medical group is like one of those plastic bags. Pushed this way, then that, by outside forces. The hospital. The economy. The government.

Strategy is your entity's intended destination. It's setting the "to where" the business, just like those cars, is heading.

Most medical groups have no strategy. They're on the road of the plastic bag, their destination set by someone else. Their existence is patient by patient. Their existence is reactive to the hospital and to referral sources. Most won't survive.

We're at a point of unprecedented change in healthcare. Hospitals are struggling for survival. Many hospitals see mergers with other facilities and the rolling up of physician practices as solutions. But, at the same time, advances in technology threaten the not-so-distant future viability of hospitals and of traditional medical practice, both those aligned with hospitals and those remaining independent. Most hospitals and most medical practices will not survive in their present guise.

So, what are you going to do?

1. Get clear. Accept the truth of your current situation.
2. Correct the defects in your organizational structure, especially in regards to governance.

3. Permit the entity's leaders to lead. Allow them to set strategy, not just hold a worthless strategy retreat, and then direct its implementation.
4. Allow the entity's leaders the freedom to fail as long as they correct course. If they don't get the group headed in the right direction, then replace them with other leaders and give them the same freedom to try.

Speaking of freedom, you do have another choice: Let the wind of someone else's forward progress determine where you'll blow.

"Physicians, Lower Your Expectations" And Other Manipulation

The so-called expert said something like, "In the new economy, physicians need to lower their income expectations."

Why? To enable hospitals to hire you for less and increase their profit? So that payors can refuse to increase reimbursement? Because you are really a sacrificial lamb on the altar of patient care, set to be beaten to death by guilt?

"Lowered expectations" and "fair share" and "reasonable compensation" are concepts designed to allow someone else to steal from you. So, too, is, "Just practice medicine while we run the business."

Raise your expectations. Not because you are entitled to receive more for less or even for the same thing. But because by raising your expectations you'll look for, and implement, ways to expand your business opportunities, deliver more value, and increase your income.

Most of you won't do it. The world is filled to the brim with people who actually believe that their future is smaller, with people

who will, indeed, lower their expectations.
But that's OK, because you'll need someone to work for you.


Mark F. Weiss is an attorney who specializes in the business and legal issues affecting physicians and physician groups on a national basis. He served as a clinical assistant professor of anesthesiology at USC Keck School of Medicine and practices with The Mark F. Weiss Law Firm, a firm with offices in Dallas, Texas and Los Angeles and Santa Barbara, California, representing clients across the country. He can be reached by email at markweiss@advisorylawgroup.com. Complimentary resources are available at advisorylawgroup.com.

Are you my nurse? continued from page 20

Yet despite the increase in representation, there still exists a discrepancy when it comes to pay, promotion, and research funding.

I am proud to write that women have fractured the ceiling of this previously dominated male field, however I still cannot say I feel secure in my role as a female physician. Being called a nurse constantly reminds me of the continued issues I have yet to face. Overpowering the glass ceiling and subsequent gender gaps will take much more than outnumbering men in the field.

As I continue to learn and practice I realize that I will experience these issues often. However, I also realize a couple of key things that will make my career as a female anesthesiologist as successful and fulfilling as possible. While being called a nurse is incorrect, because I am in fact a doctor, I should realize that the vast majority of interactions between colleagues and patients will be mutually respectful, fulfilling and rewarding, and this will only improve with time. Finally, and most importantly, increasing the number of women in medicine, especially in leadership and faculty positions, is critical for providing role models that will contribute to a diverse and well-balanced healthcare provider team. And at the end of the day, our ultimate goal as health care providers, regardless of whether that is as a physician, nurse, medical assistant, or pharmacist, is to work as a team that provides the best healthcare for all patients.



ASA® Fellow Designation Criteria Checklist

Becoming a Fellow of the American Society of Anesthesiologists® (FASA™) is a prestigious honor in the specialty as it indicates a superior level of service, leadership, advocacy and education – setting those apart from their peers. The criteria required for earning the FASA designation demonstrates a candidate's commitment to advancing the practice and securing the future of anesthesiology.

The criteria required for all candidates include the following elements:	
✓	ASA member for immediate past 5 years
✓	ASA state component member for immediate past 5 years
✓	Unrestricted medical license(s)
✓	Board certified by the American Board of Anesthesiology or American Osteopathic Board of Anesthesiology
✓	Two letters of endorsement from an ASA Active Members
✓	CV and optional bibliography

The additional criteria enable the candidate to demonstrate their dedication in three areas – professionalism and leadership, advocacy, and education and scholarly activities. Candidates must meet six total requirements, with at least one from each of the categories. Selected requirements must have occurred within the past 5 years.

Professionalism and Leadership	
Leadership or participation in ASA, ASA components, ASA committees or other ASA entity	
Participated in local/community leadership position/activities	
Held a hospital/practice location leadership position	
Held a leadership position with a subspecialty or any medical society	
Involvement in the ASA Foundations	
Held a Military/government leadership position	
Demonstrated medical volunteerism	

Advocacy	
Attended LEGISLATIVE CONFERENCE	
Active participation in state-level advocacy efforts	
Active participation in ASA advocacy efforts	

Education and Scholarly Activities	
Active involvement in teaching or mentoring activities	
Conducted research in anesthesiology	
Published in journals, web content or teaching materials	
Served as a board examiner, exam program development	
Involved in education program development (print, live, digital)	
Held a faculty position for ASA or other educational programs or meetings	
Served as an editor for publications	
Subspecialty or other medical board certification	
Participant in the Maintenance of Certification in Anesthesiology	

Application fee \$350 (one-time)
 *The Fellow designation only applies to ASA Active Members in good standing with ASA and the component society. If membership lapses greater than one year, reapplication is required.



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Nurse Independent Practice

The Nurse Independent Practice Bill (SB 25), which does not include CRNAs, passed the Senate but there has been no movement in the House.

Advocacy

PSA board member Dr. Andy Boryan of Summit Health recently hosted Sen. Rich Alloway, a member of Republican Senate leadership team, at the Chambersburg Hospital to learn what anesthesiologists are doing to help prevent opioid abuse. Dr. Boryan gave the senator a brief tour and then explained to him the team approach to anesthesia. Sen.



Sen. Alloway's visit with Dr. Boryan to the Chambersburg Hospital.



Alloway also met with the entire Summit Health anesthesia team.

Hospital visits like the one with Dr. Boryan are the most effective method to educate lawmakers. They learn first-hand the role you and your colleagues perform in

patient safety.

Please let us know if you would like to arrange a hospital visit with your senator or representative, and we will schedule it for you. Call us at 717-213-4955.