SUMMER 2016

THE NORTH CAROLINA SOCIETY OF ANESTHESIOLOGISTS

the beacon for patient safety in North Carolina

IN THIS ISSUE

[FROM THE PRESIDENT]

TIMOTHY GUNDLACH, MD, MBA

Healthcare stands at a crossroads. Implementation of the Affordable Care Act continues. The Obama Administration has made it clear that improving the quality of care provided to patients and getting control of increasing healthcare spending, i. e., bending the cost curve are the cornerstones of its policy. CHS plans to increase participation in Alternative Payment Models (APMs) with a target of 50% of federal healthcare spending being tied to APMs by 2018. Congress abolished the SGR. In its place is MACRA, with federal payments being tied to MIPS or APMs.

Increasingly, we see mergers and acquisitions in healthcare. In North Carolina one third of anesthesiologists, including my practice in Charlotte, are now employed by MEDNAX, a national company. Over the last decade, large healthcare systems like Carolinas Healthcare System and, Novant have acquired hospitals and medical practices, creating ever larger systems.

Even in areas where single or multi-specialty physician groups remain we see increasing use of clinical integration to consolidate and coordinate patriot care with the goal I of improving quality and efficiency. The world of healthcare that anesthesia residents today are preparing to enter is vastly different from the one I have worked in for the majority of my twenty plus years. It's hard to imagine what the landscape will look like for anesthesiologists in another twenty years.

One thing I am certain of, however, is that physicians, and anesthesiologists in particular, must continue to be engaged in the formation and implementation of healthcare policy. This must take place at multiple levels: individual practices and hospitals, healthcare systems, and state and federal government. The NCSA and ASA have long recognized the truth in the adage that, "if you're not at the table you're on the menu." Perhaps the best illustration of that from current events is the fight over the VA Nursing Handbook. ASA has been active and involved in advocating for patient safety through physician supervision of nurse anesthetists.

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[FROM THE ASA DIRECTOR]

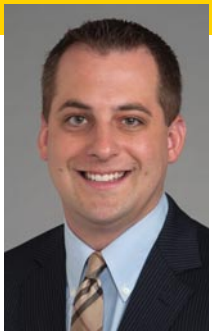
R. PAUL RIEKER, JR., MD

This is an eventful year for professional affairs affecting the practice of Anesthesiology. As you know from multiple ASA communications, the Department of Veteran's Affairs Office of Nursing Services is advancing a new policy document entitled the "Advanced Practice Registered Nurses" rule. This proposal would mandate independent practice for all APRNs, including nurse anesthetists, and would eliminate the VA's current model of physician led, team based anesthesia care. Despite the absence of any shortage of anesthesia providers or access to physician led anesthesia care, this proposal has moved forward to public comment period before a final ruling. The American Society of Anesthesiologists has strongly opposed this rule change as have the VA Chiefs of Anesthesiology, the American Medical Association, bipartisan members of Congress, and multiple other medical organizations. The ASA has supported www.SafeVACare.org to facilitate the public comments. You can also learn more from the ASA website, www.asahq.org. It should be a categorical imperative for all Physician Anesthesiologists to register their comments regarding this proposal to abandon physician led anesthesia care for our nation's veterans.

Locally, the response in North Carolina has been strong. Over 1500 public comments have been made from the Old North State. The public comment period will close on July 25, 2016. Once you have commented, please encourage your family, friends, and physician colleagues to register responses as well. This is the one of the most important issues currently facing the practice of Anesthesiology, so take action now.

The ASA remains engaged in other vital issues affecting our profession. The Centers for Medicare and Medicaid Services recently issued a lengthy rule book regarding the implementation of the Medicare Access and CHIP Reauthorization Act of 2015. MACRA will change how physicians are paid beginning in 2019. Physicians, designated as Eligible Clinicians, must be engaged in either a Merit-based Incentive Payment System or an Advanced Alternative Payment Model. Despite well intentioned analysis and descriptions of this elaborate scheme, it seems to me nobody really knows how Physician anesthesiologists will most easily comply in order to obtain full reimbursement for their services. The ASA has identified three key points for the implementation of MACRA. An appropriate timeline for implementation is necessary and delays may be required to allow for proper readiness to rules not yet understood. Proper recognition of the role of Physician Anesthesiologists in procedural and perioperative care is important and it is not necessarily clear how we can be fairly scored in a Merit based Incentive Payment System. Also, access to appropriate and important quality measures for anesthesia will be crucial for the successful implementation of MACRA. The ASA will continue to monitor the MACRA rule making process and respond to the policy makers as indicated.

There are many ongoing challenges to our profession. But do not be discouraged. Our best advocacy begins at the bedside on a daily basis. Continue doing what you were trained for as a physician and do your professional best. If you have not done so, please visit www.SafeVACare.org and comment accordingly. It will take you less time than starting the easiest IV.



[FROM THE NCSA EDITOR]

D. MATTHEWS HATCH, MD, MBA

As the VA handbook continues in its time of public comment, I am a little surprised more physicians are not publically vocal about their disagreement with what is being proposed. I wrote an article several newsletters ago describing the watering down of the term doctor and how we are all just being called providers and everyone is interchangeable. Instead of being seen as unique and valued members of a care team with specific and clear roles, health care providers (including physicians) are now in unclear roles, which can lead to extreme patient confusion. Doctors of Nursing Practice (DNP), Doctors in Pharmacy (PharmD), Doctors of Physical therapy (DPT), Doctors of Philosophy (PhD), Doctors of Optometry (OD), Doctor of Chiropractic (DC), Resident Physicians, Physician Assistants, Nurses, Nursing assistants, and Attending Physicians are just a few of the multitude of health care practitioners who a patient may meet in their hospital visit and many of these providers may introduce themselves as 'doctor'. The American Medical Association published a survey highlighting how little a patient knows about who is and is not a physician1. 35% of people surveyed thought a doctor of nursing practice was a physician, 19% were unsure. Thus over half of the people polled did not know that a DNP did not attend medical school. When patients are expecting to see a physician 'doctor' in certain roles, this survey highlights how our recent practice may be contributing to false expectation setting and unintentional confusion. It is interesting to note that in that same AMA study 20% of people polled did NOT think that an Anesthesiologist was a physician. As more institutions adopt a patient centric model of healthcare, it is more important than ever for a patient to know who is ultimately in charge of their care. The AANA itself has a stance on this, "As healthcare becomes increasingly complex, it is critical that patients are appropriately informed regarding who is providing their care. All healthcare professionals should clearly identify themselves to patients, indicating appropriate licensure and other earned credentials, whether verbally or by an appropriate mechanism for the clinical setting (e.g., name badge)"2. As educational institutions attempt to maintain their edge in a competitive market by expanding their offered degrees, the lay public has a right to know that while people may end up with a similar title, the training required to achieve that title may not be equivalent. Does saying you are "Doctor so and so with anesthesia" clearly identify an advanced practice provider's (APP) licensure and earned credentials vs. those of a physician?

So now as lines between providers become blurred (to quote Robin Thicke), the VA is proposing a rule change eliminating physician anesthesiologists from the anesthesia care team. I fully stand with the ASA and most anesthesiologists everywhere in support of the physician lead anesthesia care team, but I want to highlight that this new handbook change would not only remove physician supervision but would completely REMOVE physician involvement in anesthesia care within the VA system. This is a step backwards from the care team model approach that has proven to provide high quality and safe care and is certainly not being led by the most important people affected by this decision, the patients. I have heard lawmakers say they are sick of this debate because they see it as just a turf battle. The answer is no, this is not a turf battle which would imply equivalent training and credentials. I and every physician anesthesiologist are being told that we are no longer needed to provide anesthesia care. In my opinion this is a dangerous and unjust stance that is without merit. We are expected to be sensitive to other provider's feelings, even if patient care may be compromised, while others are allowed to pursue their political agendas under the guise of providing equivalent services. But when it comes to patient safety, it is our duty to speak up. If we know the services are not equal and have evidence to support that the physician anesthesiologist lead care team model is superior, why would

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[LEGISLATIVE AND REGULATORY UPDATE]

DANA E. SIMPSON, ESQ.
JAMES A. HARRELL III, ESQ.
KARA G. WEISHAAR

The 2016 Session of the North Carolina General Assembly opened on April 25th and completed its work on July 1st. As always, the NCSA was engaged in lobbying on a number of health policy issues and educating legislators regarding the implications of these policies on both patients and North Carolina anesthesiologists.

INDEPENDENT PRACTICE FOR NURSES

During the first part of 2016, the North Carolina Nurses Association and the North Carolina Association of Nurse Anesthetists maintained their coordinated effort to advance legislation authorizing independent practice for all advanced practice nurses ("APRNs") in the State. The Joint HHS Oversight Committee, made up of House and Senate members, heard testimony from a number of APRNs arguing for changing North Carolina law to authorize independent practice of APRNs, including CRNAs. Thankfully, the Committee did not accept a recommendation by Senate Health Committee Co-Chair Ralph Hise (R-Mitchell) to recommend independent practice legislation to the 2016 Short Session. Instead, House and Senate members agreed to continue to study the issue of APRN independent practice during the Fall of 2016 and then decide whether to recommend potential legislation to the 2017 General Assembly.

We appreciate the NCSA members who weighed in with House and Senate members to remind them of the patient safety implications of removing the requirement of physician supervision. This seemingly never-ending policy debate has been more seriously discussed in the last two years than we have seen in a long time. Accordingly, your continued education of legislators is critical.

CERTIFICATE OF NEED

Advocates for eliminating certificate of need ("CON") requirements for single-specialty ambulatory surgery centers ("ASCs") were again active in the 2016 Session. During the first six weeks of this legislative session, orthopaedic surgeons and ophthalmologists lobbied legislators to repeal CON for single-specialty ASCs. In 2015, the Senate budget included a provision to eliminate CON. While the 2016 Senate budget did not include such a provision, Senator Ralph Hise (R-Mitchell) introduced stand-alone legislation to repeal CON beginning in 2021. This legislation as discussed in the Senate Health Committee but did not receive a vote.

The NCSA once again joined the North Carolina Hospital Association, radiologists, and other hospital-based physicians in opposing these proposed CON changes. Jim Harrell led the NCSA effort to educate legislators regarding the negative effects of "cherry-picking" patients away from community hospitals. The NCSA Executive Committee remains open to working with all parties to find a compromise that improves the fairness of the CON process without harming the viability of community hospitals and their anesthesiologists.

CONTROLLED SUBSTANCE REPORTING SYSTEM MANDATE

The Senate budget adopted at the beginning of June included a requirement that the State update the technology used for the Controlled Substance Reporting System ("CSRS") database. Following the completion of this IT update, all North Carolina physicians would be mandated to both register and use the CSRS prior to prescribing a controlled substance. While the Senate budget provision included an exception for emergency

situations, it did not include an exception for prescribing a controlled substance in the perioperative process, including anesthesia.

The NCSA and the North Carolina Medical Society worked with legislators in both the House and Senate to share their concerns about the breadth of this proposed new CSRS mandate. This lobbying effort resulted in the final budget removing the mandate on using the CSRS and instead limits the budget provision to: (1) providing funding to upgrade the functionality and interface capabilities of the CSRS and (2) mandating that anyone licensed to prescribe a controlled substance must register for access to the CSRS (registering for the CSRS has been universally supported by the House of Medicine and is a much less significant burden than the initial Senate proposal to mandate the use of the CSRS before prescribing any controlled substance). The registration mandate will become effective after the upgrades to the CSRS database are completed.

MEDICAID REFORM

Following the General Assembly's adoption of groundbreaking Medicaid reform in 2015, the 2016 Session was relatively quiet on the Medicaid front. Legislators agreed to hold off on making major policy changes to Medicaid reform until the 2017 Session.

The Department of Health and Human Services presented a Waiver Request to CMS to allow North Carolina to implement the capitated Medicaid system authorized by the General Assembly last year. Under the current DHHS plan, which was submitted to CMS on June 1st, North Carolina Medicaid would move to a capitated system led by both provider-led and investor-owned managed care organizations beginning in July 2019.

The NCSA is worked with the North Carolina Medical Society, the North Carolina Hospital Association, and other provider organizations to ensure that key provider protections that apply to commercial managed care plans in North Carolina will also apply to new Medicaid managed care plans. Clarifying the applicability of such provider protections to Medicaid was not adopted this year, but will be a key priority in 2017.

POLITICAL UPDATE

The March 15, 2016 legislative primaries were eventful for the NCSA. Dr. Frank Moretz, a former NCSA President, won the Republican primary in Buncombe County and will face a Democratic incumbent in a "swing" legislative race this fall. NCSA member Dr. Scott Aumuller ran a very competitive race in an open Senate primary in Cabarrus County, but unfortunately fell short – coming in a close second in a four-way primary.

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ASAPAC Director's Note

DAVID MAYER, MD

The ASAPAC fiscal year runs from October 1 through September 30 of each year. All ASAPAC donors are listed in the Honor Roll part of the ASA Advocacy website and the membership list is updated daily. (http://www.asahq.org/advocacy/asapac/honor-roll). Many contributors find it easier to have monthly contributions charged against a credit card. This eliminates forgetting it and is very easy to set up on the ASAPAC website (http://www.asahq.org/advocacy/asapac and select More About ASAPAC).

If you are already contributing, thank you! But if you are in the 75% of anesthesiologists in North Carolina that are not, you should join your colleagues! What is holding you back? Join us in standing up for patient safety!

Dr. Greg Murphy, a Greenville urologist, was appointed to an open House seat by Governor McCrory, and will face an election challenge in the fall. Finally, former AANA and NCANA President Sharon Pearce lost her bid for election to the North Carolina House in a hotly-contested Republican primary in Davidson County.

The Fall 2016 General Election is shaping up to be very competitive in North Carolina. In addition to the presidential race, Governor McCrory will face a tough re-election battle against Attorney General Roy Cooper, while U.S. Senator Richard Burr will face a challenge from former State House member Deborah Ross. A number of long-time State legislators are retiring following the 2016 Short Session, including Senate Finance Chair Bob Rucho, Senate Rules Chair Tom Apodaca, House Speaker Pro Tem Skip Stam, and House Judiciary Chairman Leo Daughtry, among others. These retirements will mean a shakeup in the leadership of both Chambers in 2017.

As always, please do not hesitate to contact Kara Weishaar, Jim Harrell, or Dana Simpson if you have any questions regarding NCSA regulatory, legislative, or political matters.

[FROM THE PRESIDENT] CONTINUED FROM PAGE 1

Our Society has actively worked to keep Congress informed on this issue. We have worked with administrators at CMS to make sure that the importance of supervision is recognized and that supervision is required in the interest of patient safety. NCSA and other state component societies have done the same at state levels. It was not until the attempts by the administrators at the VA to remove the supervision of all advanced practice nurses, including nurse anesthetists were well underway that ASA became aware of the threat and moved into action. With the publication of the VA Nursing Handbook in May the supervision nurse anesthetists, and thereby the safety of American veterans undergoing anesthesia at VA facilities is definitely “on the menu.”

If you have not done so already, please visit the website www.SafeVAcare.org. Make a public comment asking the VA to continue to require the involvement of a physician in all anesthetic care for our veterans.

There will be continued attempts to remove supervision requirements over the coming years. Once again this spring the NC General Assembly considered removing the supervision requirement. Thanks to the commitment of the NCSA membership and individual anesthesiologists throughout the state, we were able to stop this misguided effort. But there is renewed emphasis from government agencies, lawmakers, and individuals on expanding scope of practice for mid-level providers.

Threats to anesthesiologists are not limited to scope of practice issues. As I mentioned above, CINs, ACOs, MACR and MIPS all have potential to severely alter the reimbursement to anesthesiologists. Opportunities for involvement include hospital committee work, involvement in efforts by your hospital or healthcare system to participate in APMs, and advocacy at local, state, or national levels. Even if you are have no interest or are uncomfortable in participating in these efforts, you can help by allowing others in your group to have the administrative time to do this important work. Too often I hear that the work done by NCSA leadership doesn't benefit the individual practices. I can't emphasize how short sighted and selfish that attitude is. While participation in advocacy efforts may not show up in this quarter’s balance sheet as a line item it is a long term investment in the future of the specialty.

Anesthesiologists in North Carolina have long recognized this and supported the efforts of the NCSA. As a result we have the strongest and most successful component society in the ASA. As practices across the state change it is imperative that leaders or North Carolina anesthesia practices as well as individual anesthesiologists continue to be committed to the success of your Society.

It is an incredible honor and privilege to serve as your President in 2016. Thank you for all your support. Please continue to support the NCSA staff and leadership.

[FROM THE NCSA EDITOR] CONTINUED FROM PAGE 3

we not continue to fight for the best interests of our patients? Patient safety is the key point that gets lost in this whole debate. This is and has to always be about patient safety and doing what is best for the patient. Anesthesiology as a medical profession has led the charge in putting patients first and prioritizing patient safety. Our significant training in medicine has prepared us above any other provider to be the leader of the anesthesia care team. As mentioned above, I along with the ASA, want the anesthesia care team to provide safe anesthesia care for my patients. I am arguing FOR using CRNAs in my practice in a physician lead team. I respect the CRNAs I work with and together we provide excellent anesthesia care. Yet, when changes are proposed eliminating me from that care team, it is unfortunate that some of the arguments are focused on salary instead of my role as a leader and expert in anesthesia care. Individual agendas promoting personal and professional advancement cannot take away our focus from the ultimate goal of patient safety and the patient centric approach to healthcare. Our patient's deserve the best care possible, the physician-led anesthesia care team.

1. ama-assn.org/go/tia
2. http://www.nacns.org/docs/TruthTransparencyAANA.pdf

So what do we do now? Besides showing how we lead in the anesthesia care team every day, we can do more on a state and national level through our political action committees to help elect policymakers in both parties who share our commitment to protecting patients. This part of the newsletter will explain some of the workings of the ASAPAC. It is our hope that this information will encourage you to get off the sidelines if you are not participating in the ASAPAC or to increase your contributions to an even higher level for this year. Although there are many practice based PACs in North Carolina that are highly effective, it is important to also include the ASAPAC in your advocacy efforts. The ASAPAC is a well-established and well-respected PAC that has been highly effective since its inception. In fiscal year 2015, the participation rate in North Carolina for the ASAPAC doubled to 25%. We were one of four states to earn Special Distinction in the nationwide Alabama Cup for ASAPAC involvement. Five states had over 50% participation rate with Arkansas being the highest at 57.9%. While we are thrilled with our progress here in NC, we still have three-fourths of North Carolina anesthesiologists not contributing. Hopefully the following information about the structure of the ASAPAC will be helpful so that we can really compete to win the Alabama Cup soon!

A common statement by colleagues and residents is "I thought I did that already, I am not sure why I am not on the Honor Roll." The ASAPAC fiscal year runs from October 1 through September 30 of each year. All ASAPAC donors are listed in the Honor Roll part of the ASA Advocacy website and the membership list is updated daily. (http://www.asahq.org/advocacy/asapac/honor-roll). Many contributors find it easier to have monthly contributions charged against a credit card. This eliminates forgetting it and is very easy to set up on the ASAPAC website (http://www.asahq.org/advocacy/asapac and select More About ASAPAC). Another common question is "Does the ASAPAC help with local races or only candidates running for federal office positions?" The answer is strongly "YES". The ASAPAC board uses the fund to support candidates in strategic fashion in key local/state and federal elections. During the recent March Primary, the ASAPAC helped engage in key state races in North Carolina there were important to our Society.

Lastly, a common misconception exists about political affiliations and the ASAPAC. At it's core, the ASAPAC is a bi-partisan, non-ideological political organization. It supports candidates based upon their positions on issues impacting our specialty. Issues such as patient safety, regulatory reform, MACRA, professional liability reform, scope of practice, etc. - are not party line issues or ideological issues, supporters of anesthesiology can be found along the entire political spectrum with widely differing views on issues outside of those impacting anesthesiologists. It is imperative that NCSA members understand this aspect of the PAC.

Hopefully this information will lead you to enthusiastically contribute to the ASAPAC. If you are already contributing, thank you! But if you are in the 75% of anesthesiologists in North Carolina that are not, you should join your colleagues! What is holding you back? Join us in standing up for patient safety!

Look for periodic updates in the NCSA Newsletter about ASAPAC progress and special events.

NC society of
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THE BEACON OF PATIENT SAFETY

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2016 ASA Legislative Conference