WINTER 2014

THE NORTH CAROLINA SOCIETY OF ANESTHESIOLOGISTS

the beacon for patient safety in North Carolina

IN THIS ISSUE

[FROM THE PRESIDENT]

BRYANT MURPHY, MD

President's Column

Now that the election cycle is behind us, and the holidays are here we can return to watching football and basketball, and the airwaves will be free of campaign ads. While they can potentially serve a good purpose, the constant cycle of campaign advertising during this most recent election was either barely helpful, or downright dirty and nasty. Conventional wisdom says that campaign ads (and especially negative advertising) do not do anything to significantly change the minds of committed voters, and only have a minimal effect on undecided voters. Occasionally the opposite can occur and negative advertising can actually hurt a candidate. One of the best videos of the year was that of a young child in North Carolina who sent a video message to Senator Hagan and Thom Tillis asking them to stop the negative campaigning. This video went viral and certainly gave the young lady her five minutes of fame. I only hope that the candidates saw it.

Having said that, the NCSA has always prided itself on being a bi-partisan organization having the goals of Anesthesiologists and the larger house of medicine as a priority. This stance has caused us to give support to candidates on both sides of the aisle who have recognized the importance of the issues that we believe in. Former State Senator Eric Mansfield (D) was very helpful in the battle for tort reform, and newly elected Senator Thom Tillis (R) was also helpful in that same fight. The point is that whether you believe in Red or Blue, it is more important to carefully examine the issues in play, and determine how those issues are evaluated (and voted on) by the candidates that you support. NCSA has had that stance for years, and it has contributed to the success and status that we enjoy at the General Assembly. In addition, the personal relationships that we share with many of our elected officials place us in the position of being trusted advisors

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Changing Times and Federal Issues

[FROM THE ASA DIRECTOR]

GERALD A. MACCIOLI, MD, FCCM

Once again the NCSA had a very large delegation at the ASA Annual meeting and a solid presence at the Reference Committee hearings. Thank you to everyone who served as either a Delegate or Alternate Delegate and to those of you who make their presence possible in your respective practices. For this edition of our newsletter, I am going to focus on our specialty and Federal policy issues.

SGR

Just this week, the Congressional Budget Office updated their scoring for the SGR. One of the key observations is the cost of SGR repeal with a freeze has slightly decreased from $131 billion over 10 years to $118.9billion. In addition, the cost of the bipartisan reform bill with 5 years of updates of 0.5% and other payment reforms has slightly increased from $138B to $140B, mostly because the "misvalued" codes provision that saved about $5 billion was enacted in March's patch bill and is already law. Also, the cost of a 9-month patch has dropped dramatically from about $20B to $13.6 billion, and a 21-month fix now "only" costs $36B instead of approximately $40B. (These scores do not include the so-called Medicare extenders: therapy cap, rural hospital payments etc. that are historically attached to SGR packages.) What does this mean for the house of medicine? I think, bottom line, we see continued volatility in CBO's estimates but the dramatically lower cost of temporary patches makes that solution more palatable. While ASA opposed HR 4015/S2000 (SGR Repeal and Medicare Provider Payment Modernization Act of 2014) this past spring, I believe we may want to think about grassroots action to encourage SGR repeal. We need to end the annual kabuki dance over the 'doc fix' and finally get down to serious solutions.

MedPAC

On 7 November 2014 following the elections, MedPAC staff presented their research on two new payment policy proposals which promote the use of services based on clinical evidence, consolidated payment codes and bundling. MedPAC staff asked Commissioners to consider assessing flexibility of Medicare Advantage plans and ACOs to apply approaches, contemplate whether the status quo for fee for service (FFS) policies results in FFS beneficiaries not obtaining best value, and to evaluate FFS approaches that aim to motivate selection of lower-cost products and generate price competition between products: LCA policies, consolidated payment codes, Bach bundled payment approach, and United HealthCare approach. MedPAC is really pushing the concept of developing payment policies to promote the use of services based on clinical evidence. Anesthesiologists as downstream providers will probably not feel much impact from this approach but may experience a shift in procedures if this comes to fruition.

2015 Medicare Final Rule

Herein are a few highlights from the 2015 Medicare final rule that pertain to some of the items of interest to our specialty:

- Imaging guidance remains bundled within the epidural injection codes (62310, 62311, 62318).
- CMS waived the co-insurance and deductible for anesthesia provided for screening colonoscopy, recognizing the value that anesthesiologists bring to this important screening test.
- Surgical global periods remain on-schedule to transition to 0-days (by 2017 for current 10-day; by 2018 for current 90-day). The mechanism of valuation of unbundled global period remains unknown, although a hint from CMS: since the current rate-setting methodology already assumes particular numbers of visits, MedPAC suggested that CMS should reduce the RVUs for the 10- and 90-day global services based on the same assumptions currently used to pay for these services (referred to as "reverse-building block," since CMS has increased RVUs for these services

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[FROM THE NCSA ASSISTANT EDITOR]

ROBERT ROYSTER

Hard Reboot

"What a caterpillar calls the end of the world we call a butterfly."—Eckhart Tolle

Several weeks ago, I woke up in the morning with severe neck and shoulder pain. I worked through the pain on steroids for a week without noticing my right triceps muscle had almost no strength. An MRI confirmed a herniated disk at C6-7 crushing the nerve root. Within two days I was a surgical patient presenting for an ACDF performed by a neurosurgeon I know personally, to be anesthetized by my partners. I have never had surgery before. And on the morning of surgery, my thoughts are something like this:

I am certainly going to die. The steroids have blown me up like a tick over the previous two weeks, and my already-generous neck looks and feels like a Michelin tire. There is no way my partners are going to be able to ventilate me, let alone intubate. If I survive the induction, it will be due to an emergency tracheostomy. My colleagues have graciously chosen one of my most experienced senior partners, who also happens to be the hospital Chief of Staff, to anesthetize me. My neurosurgeon friend is going to be so nervous he is sure to have a seizure during the most delicate moment of the procedure. So a C6 cord transection means I will still be able to breathe, though without the use of my accessory muscles, and I'll be able to shrug my shoulders and bend my wrists, though my hands and lower extremities will be paralyzed. Cool. Sign me up.

I don't want to give the impression that I was not confident in my care team. I knew first-hand that I had chosen a skillful surgeon, and that I would be hard-pressed to find a more skillful anesthesiologist or CRNA elsewhere. I similarly had great confidence in the quality of the hospital where I work. The thought to go outside my hospital to avoid the "MD Hex" only played briefly in my mind before it was dispelled for the above reasons.

Of course, the surgery went great. I woke up a couple hours later in the PACU with no pain. My triceps muscle was mostly recovered already. I was hoarse (for which my neurosurgeon still hangs his head to this day), but alive and happy to be so. I proceeded home to begin my recovery.

I have no idea how many patients through the years have told me they were "slow to wake up" because it took two weeks for their "anesthesia" to wear off. I have always discounted their concerns this way: "You received Des/Sevo/Isoflurane, which would have been out of your system pretty much immediately after your operation. Your foggy feeling was likely due to the pain medicines you were receiving." So, through a great stroke of Karma, my own experience in the weeks following my operation was exactly such. I was off all meds except Tylenol and Decadron by post-op day #2. I was getting plenty of sleep and daily exercise. But I was definitely "in a fog" for at least two weeks post-op. Conversation was difficult and slow. Words and names eluded me that I use nearly on a daily basis. I was having emotional swings regularly (e.g. tears running down my face on daily walks while smiling uncontrollably at the same time). What a sight I must have been. I could not understand why I felt this way. I have been on steroids in the past without this type of side effect. Oh, man, I must be one of those patients who is "slow to wake up!"

I decided that if my brain is a super-computer, it had undergone a "hard reboot" under general anesthesia. For two weeks, my operating system was booting up and initializing. All my regularly-used programs were similarly being restarted as I needed them. Although this was a disconcerting experience, it was primarily positive. As my mind wandered, I found easy, clear answers to puzzles in my life that have eluded me for years. It was as if those programs had been frozen. I could practically see the wheel on my desktop spinning and spinning for years like the Energizer hamster. All it took was to shut them down and re-open them in order to move on.

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[LEGISLATIVE AND REGULATORY UPDATE]

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

2014 ELECTION RESULTS

The 2014 mid-term elections were the most expensive in North Carolina history. In fact, the United States Senate race between Kay Hagan and Thom Tillis was the most expensive Senate race in American history. Over $110-million was spent by the candidates and their allies. In addition, significant independent expenditures were made in North Carolina legislative races, with the five most expensive state legislature races in history all occurring this year.

While Senator Hagan and her allies outspent Speaker Tillis, their spending was not enough to overcome the national environment, which favored Republicans. Hagan attempted to tie Tillis to an unpopular Legislature, while Tillis tied Hagan to an unpopular President Obama. The end result was a 45,000-vote victory for Thom Tillis out of 2.94-million ballots cast. Senator-Elect Tillis has been a strong supporter of the North Carolina medical community and was supported in his election bid by the ASA PAC.

Republicans also increased their majority in the North Carolina Congressional Delegation. Republican David Rouzer won the open North Carolina 7th District vacated by retiring Mike McIntyre. As a result of Congressman Rouzer's victory, the GOP now holds a 10-3 majority in the North Carolina Congressional Delegation. In addition, Democrat Alma Adams easily won the open seat in the 12th Congressional District. Both Adams and Rouzer have proven track records of supporting patient safety legislation and were supported early on by the ASA PAC.

At the state level, Republicans maintained their supermajorities in the North Carolina Legislature. Despite millions of dollars in independent expenditures against Republican incumbents, the Senate GOP Caucus expanded its majority by one seat. The 2015-16 Senate will consist of a 34-16 Republican majority. On the House side, the GOP lost four seats, while gaining one, resulting in a net loss of three seats. As a result, the GOP will have a 74-46 majority in the North Carolina House during the 2015-16 Session. Both the House and the Senate will retain GOP supermajorities allowing them to override a gubernatorial veto.

The NCSA lost a strong supporter in Representative Tom Murry (R-Wake), who was defeated by nurse practitioner Gail Adcock. Additionally, NCSA supporter Tim Moffitt (R-Buncombe) lost his re-election bid. These losses were partially offset by the victory of Larry Yarborough (R-Person), who is married to a physician and has a brother who is an anesthesiologist.

The North Carolina Supreme Court elections resulted in Republicans retaining a 4-3 majority on the Court. Republican Justice Mark Martin won re-election as Chief Justice. Democratic Justices Robin Hudson and Cheri Beasley won re-election. Court of Appeals Judge Sam ("Jimmy") Ervin also won election to the Supreme Court.

2015 LEGISLATIVE PREVIEW

Following the elections the House and Senate Republican Caucuses will meet to determine legislative leadership for the 2015-16 Session. In the Senate, President Pro Tem Phil Berger and Majority Leader Harry Brown are expected to retain their respective positions. In mid-November, the House GOP caucus nominated Rep. Tim Moore (R-Cleveland) as its nominee for Speaker. Two years ago, Rep. Moore was one of the lead sponsors of HB 181 (physician supervision of CRNAs). The caucus also nominated Rep. Skip Stam (R-Wake) for another term as Speaker Pro Tem, and Rep. Mike Hager (R-Rutherford) as Majority Leader.

On the policy front, Medicaid reform is expected to again be a hot topic for legislators. House and Senate members met this fall to discuss reorganizing the Division of Medical Assistance ("DMA"), which oversees the Medicaid Program. Additionally, legislators continue to

debate whether to include out-of-state managed care companies in a Medicaid reform plan with provider-based accountable care organizations. The scope of eventual Medicaid reform may hinge on whether DMA is able to bring Medicaid expenditures in under budget this fiscal year.

Certificate of Need ("CON") reform is also likely to be debated by House and Senate members. During the last legislative session, orthopaedic surgeons and ophthalmologists pushed for a new law to eliminate CON requirements for single-specialty ambulatory surgery centers ("ASCs"). Similar legislation is expected to be introduced in 2015. The NCSA has joined the Hospital Association and radiologists in past sessions to oppose radical changes to the CON laws in order to avoid cherry-picking commercial patients away from community hospitals.

As always, the NCSA will remain vigilant to protect North Carolina's existing legal requirement that CRNAs providing anesthesia services must do so under the supervision of a physician. Other states in recent years have confronted omnibus legislation seeking to grant independent practice to all advanced practice nurses, including CRNAs. It is unclear whether the nursing lobby will seek to introduce such legislation in North Carolina this year.

NORTH CAROLINA MEDICAL BOARD

In late October, Governor McCrory appointed NCSA President Bryant Murphy to serve on the North Carolina Medical Board. Dr. Murphy was one of the top nominees recommended by the North Carolina Medical Board Review Panel. Dr. Murphy joins a long line of NCSA members who have served on the Medical Board, including most recently Dr. Art McCulloch and Dr. Tom Hill. One of the issues the Medical Board will be asked to address in 2015 is the development of regulations governing reporting of physicians to the Medical Board by the Controlled Substance Reporting System ("CSRS"). The NCSA will work to ensure that such proposed rules capture improper opioid utilization but do not undermine legitimate pain practices.

POLITICAL UPDATE

On behalf of the NCSA staff, thank you to the North Carolina anesthesia practice-based PACs that were active in 2014. These practice-based PACs supported candidates of both parties who promote policies that bolster patient safety and access to care.

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

[SPECIAL REGULATORY UPDATE]

JULIAN D. ("BO") BOBBITT, JD AND PERRIN W. JONES, MD

CASE STUDY: MAXIMIZING THE ANESTHESIOLOGIST'S ROLE AND REIMBURSEMENT IN AN ACO

I. INTRODUCTION

The three keys to any physician's success in an Accountable Care Organization "ACO") are (1) determining that the ACO will likely be successful (and thus have a substantial savings pool "pie"); (2) maximizing their value contribution (thus maximizing their slice of the pie); and (3) contracting to protect their interests. It is no different for anesthesiologists. The following is a case study of how to maximize the anesthesiologist's role in an ACO. Successful ACOs quickly learn that the complex patient with multiple co-morbidities consumes disproportionate ACO population dollars and that there are significant opportunities for savings. This priority ACO initiative is ripe for anesthesiologist value-add.

II. OVERVIEW OF A COMPLEX CARE MANAGEMENT PLAN

Before teasing out the anesthesiologist's role, we need to know what is involved. The following is an overview of a well-done complex care management plan:

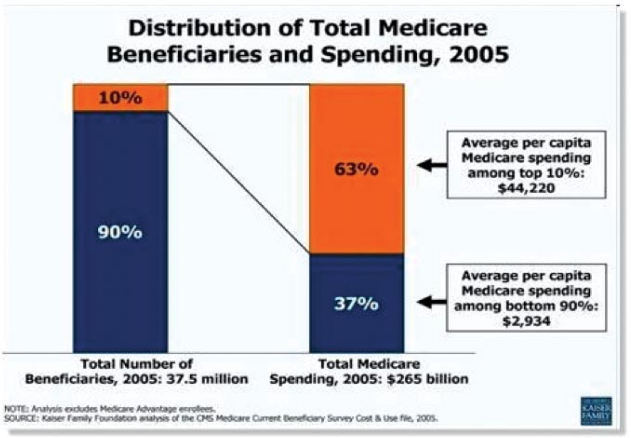
- **What Is Complex Care Management?** There are several types of care management interventions, but in essence, complex care management programs are those "in which specially-trained multidisciplinary teams coordinate closely with primary care teams to meet the needs of patients with multiple chronic conditions or advanced illness, many of whom face social or economic barriers in accessing services."[1]
- **Why Care?** Usually a small percentage of a typical patient population, these "super utilizers"—say 5% to 20%—frequently consume 50% to 70% of total costs. "For many health systems, a small group of highly complex patients create a large portion of the overall costs of care. If you want to manage health system costs, that means managing their health."[2]

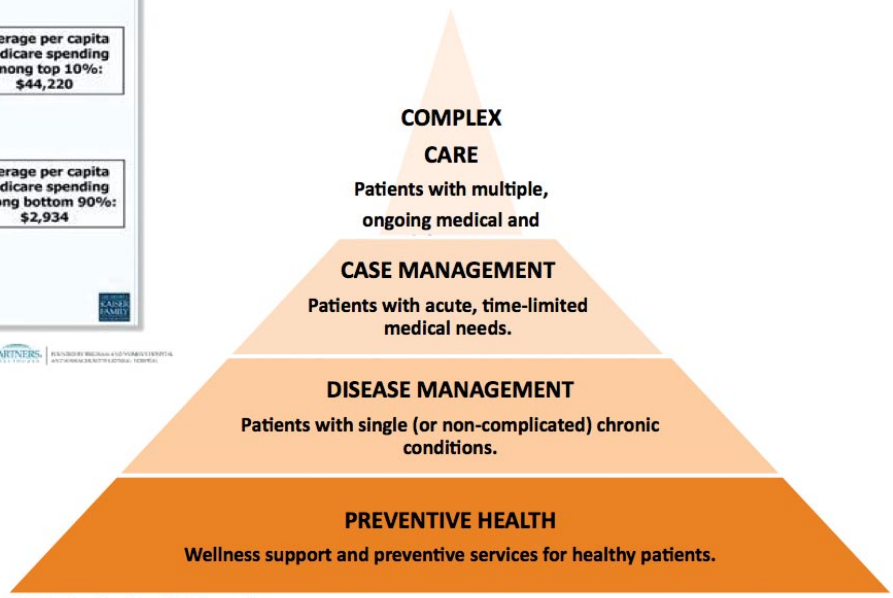
California Quality Collaborative

- **Elements of a Successful Complex Care Management Program.**

1. **Identify Business Case for ACO** – Confirm existence of "super utilizers" and extent of utilization. How will you know you are addressing key issues (i.e., rate of ED usage, admissions).
2. **Identify Patients** – Perform a patient stratification via data analytics, plus clinical input, functional states, and social support. One simple yet effective technique is to ask your physicians this question: Who are the patients who you would not be surprised if they were in the ED in the next six months?
3. **Develop Care Plan/Care Team** – "The composition of the CCM care team must be tailored to the target population and constructed to effectively deliver the desired outcomes." Teams frequently are configured around one or more primary care managers, usually nurses or social workers embedded in a primary care patient-centered medical home. Other team roles include care manager, community resource contact, behavioral health provider, pharmacist, clinician specialists depending on the disease state(s), and administrative and analytic staff. The care plan considers existing resources.
4. **Evolve Skills and Caseload of Care Manager** – The care manager can assume responsibilities and case load over time. Developing a process for intake, assessment, stratification, and care transition support should be prioritized.
5. **Develop Data Plan** – This would include alerts and data sharing across the care continuum. Remote monitoring allows tracking of stable patients.
6. **Specialist Support of Primary Care Medical Home** – Patients need to be treated by the provider best able to handle their care. Once a care protocol is established, patients can be stratified based upon presence, absence, and severity of disease. Healthier patients may be most

10% of Medicare patients account for nearly 70% of spending





California Quality Collaborative

appropriately seen by a midlevel provider, while remotely supervised by a physician. Sicker patients may require direct treatment by a primary care physician. Patients with multiple complex clinical issues frequently require physicians with subspecialty clinical training. The key questions for the primary care physician, however, involve what constitutes a legitimate referral and when it should be made. For these situations, it is helpful for the primary care physician to enlist the help of subspecialists in creating specific, objective referral criteria as well as a method for having access to current best practice protocols, open lines of communication, and either real-time or near-time subspecialist contact.

7. **Transition/Coordination with Primary Care** – "To perform their key role of coordinating patients' care, critical care teams must ensure that all providers share information, secure smooth referrals, and help patients find needed resources in health systems and communities." An inherent advantage of population management is coordination among providers regarding patient transitions. Complex patients frequently see multiple specialists, emergency departments, inpatient admissions, and post-acute care facilities. In fact, experts say this is the most wasteful aspect of the American health care system and, in turn, the area of greatest value opportunity for ACOs. Every provider and facility needs to coordinate with the medical home, and close-to-real-time information to the medical home is needed on admissions, emergency department visits, and discharges. Actionable data needs to be shared along the continuum of care. Weekly 15-minute huddle calls are recommended. Create a system of best practice sharing support.
   - **Co-Management Agreements** – Once a shared care protocol for a complex patient is determined, it is useful to draft a written agreement for co-management. It helps assign responsibilities, efficient use of personnel, and the crucial role of the care navigators.
   - **ACO Affiliation Agreements** – Sometimes, the core ACO physicians will determine which providers and facilities provide the highest value and are most cooperative. Usually sufficient is a simple "handshake" of provider referrals to them if they follow the ACO's protocols. Affiliation agreements documenting that tighten the relationship. This moves to active participation status, with entitlement to savings distributions in proportion to contributions for the specialists demonstrating meaningful contributions.
8. **Patient Engagement** – The first care management visit should be face-to-face. Management can be primarily telephonic for lower acuity patients. All specialists and hospital and post-acute care providers need to be on the

same page and actively involved in supporting patient engagement and self-management. Reinforce through motivational interviewing.

9. **Develop Measures** – These are internal to assist management of the population, not for external reporting. Examples include: hospital and emergency department utilization, daytime emergency department use, readmission rates, diabetic control, blood pressure control, depression screening, medication adherence, patient experience survey results, percentage of patients receiving outreach calls within 48 hours, percentage of patients with primary care visits within seven days of discharge.

III. THE ROLE OF THE ANESTHESIOLOGIST

The ACO subject of this case study is 100% primary care. It had no real linkage with specialists or facilities. However, ideally, anesthesiologists should be leaders and core members of ACOs. In this case study, an anesthesiologist served several vital roles:

- **Knowledge Manager** – Subspecialty clinical knowledge needed to be pushed upstream, as it were, to the primary care physician and patient. An anesthesiologist is experienced in process management and working with multiple specialties. The anesthesiologist knew how to develop standing protocols, timely referral prompts, access points, and a network of applicable subspecialists the primary care physician could call on.
- **Transition Coach** – The anesthesiologist designed a process for timely information sharing, coordination, and patient navigation—for use once the patient is referred or admitted. It is a natural role, akin to the anesthesiologist's role as perioperative process manager. This role is heightened for anesthesiologist leadership in the admission handoff from the medical home to the hospital for a procedure and upon discharge.
- **Meaningful Financial Gain** – It is too early for actual savings determinations for this case study example. However, a predictive modeling of a similar initiative recognized the savings distribution entitlement of the anesthesiologist as second only to the medical home primary care physician.

IV. CONCLUSION

Experts note that ACOs are already evolving to ACO 2.0 which involves more specialists, bundled payments, and post-acute than first generation ACOs. There is significant potential for anesthesiologists to contribute to and benefit from these changes by understanding their potential as knowledge managers and transition coaches, particularly for complex patients requiring care from multiple subspecialties.

[1] The Commonwealth Fund, *Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?*, Pub. 1764, Vol. 19, p. 1 (Aug. 2014).

[2] The Advisory Board Company Care Transformation Center Blog, *The High-Risk Patient Care Partner ACOs Are Working With,* www.advisory.com/research/care-transformation-center, (Oct. 8, 2014).

According to Ron Miller's Holy Bible of Anesthesia, the primary mechanism of inhaled anesthetics is to disrupt the transmission of nervous impulses, principally at the synaptic or axonal plasma membranes of nerves. General anesthetics interrupt transmission of nerve impulses in the central nervous system, notably the reticular formation of the brainstem as well as the cerebral cortex and hippocampus. This to me sounds a lot like a hard reboot, where the power to a computer is shut off, the electrical impulses running through the central processor cease, and the computer starts from a powerless state. Notably in a hard reboot, the operating system performs a "Power-On Self-Test (POST)." Maybe that's what my head was up to for two weeks. There is also such a thing as a "warm reboot," where the power is not disrupted, and the POST is not performed. It could be many patients undergo a warm boot under GA and don't experience the extended fog.

In any case, whether this theory is right or wrong, my system is up and running at full speed again, and I'm considering asking my partners to put me under on a yearly basis for about an hour just to reboot. Is there a CPT code for that?

Regarding what this personal vignette has to do with the NCSA, I simply hope it may provide insight or at least amusement to some. Even as the practice of Anesthesia has advanced many miles from its humble beginnings, it still is much of a black box. At the least, the next time one of my patients tells me it took them two weeks to wake up from surgery, I will believe them.

Have any of you undergone surgery and had a similar post-op experience? I would be interested to know. We can discuss this or any other topic you'd like to discuss on our Linkedin page. This has been up and running for nine months now, and 77 of our members have joined so far. To this point, it has been used solely as an informational tool, but it can be so much more with member participation. If you read an article that you feel our members can benefit from, please post it on this site. If you have a question for NCSA leadership and/or our political power team, and you feel other members may benefit from the answer, please post that as well. If something concerning is happening within your practice or in your hospital or community, post it and see if others are experiencing the same thing. I would like to see this tool used to the utmost of its capabilities in a way that will improve communication and expand the influence of our society. The NCSA Linkedin group is private, meaning only members may participate, and any comments posted there may only be seen by other members. If you have difficulty finding the site to sign up, please email me at robroyster@mac.com, and I will be happy to send you an invite.

I wish you and your family a blessed Holiday season and a Happy New Year!

[FROM THE ASA DIRECTOR] CONTINUED

proportionate to the number of E/M services assumed to be included in the postoperative period, for the sake of relativity, the RVUs attributed to the visits can be fairly removed in order to value the new 0-day global codes.)

- Interventional Pain malpractice assignment remains that of anesthesiologist---not of surgery: "given that the commenters did not provide sufficient rationale to support that MP risk for interventional pain management is similar to interventional radiology or to a comparable surgical specialty, we will crosswalk interventional pain management to anesthesiology as proposed."

Value Based Payment Programs

The AMA has expressed significant concern about the combined impact that various overlapping Medicare incentive programs are having on physicians and their practices. These programs, with often incomprehensible, conflicting requirements and flawed implementation processes, are all entering their penalty phases and pose a risk to the stability of the Medicare program that many policymakers do not seem to appreciate. The AMA and others have called on the Centers for Medicare & Medicaid Services (CMS) to synchronize and simplify the requirements for avoiding these penalties, and to reverse its proposals to raise total penalties from these programs to 10 percent or more in the foreseeable future. Overall six different programs have been created by congress in what often appears to be complete disregard for other program requirements. The PQRS and Value-Based Modifier programs especially burden anesthesiologists. While the ASA's AQI now has Qualified Clinical Data Registry certification (QCDR) and has now provided a mechanism for anesthesiologists to meet the reporting requirements this still represents a burden in some ways, especially to smaller practices.

OIG Work plan 2015

The Office of the Inspector General has published its 2015 work plan and once again, has anesthesiology in its sights. They review Medicare Part B claims for personally performed anesthesia services to determine whether they were supported in accordance with Medicare requirements. They will also determine whether Medicare payments for anesthesia services reported on a claim with the "AA" service code modifier met Medicare requirements.

So, as a profession, medicine continues to have a lot on it's plate and anesthesiology, as a specialty, has more than its share of hurdles. The NCSA, however, has always been at the forefront of advocacy and as a Society we are more than up to facing these challenges.

As always thank you for the privilege and opportunity of serving as Director of the premiere component society of the ASA.

[FROM THE PRESIDENT] CONTINUED

when health care matters come before the General Assembly. The American Society of Anesthesiologists has also recognized the importance of our Practice Based PAC system, and frequently asks our component society for advice, instruction and support on issues that have national consequences.

To go one step further, I will continue to make my pleas for everyone to make a contribution to the ASA PAC. I know that we all contribute in other ways, but it is important that we increase our participation level in the **ASA's national** PAC. If you sit down and think about all of the ways that the ASA helps to make it possible for us to practice the way that we do, an annual contribution is a small price to pay.

Lastly, I would like to thank everyone for their assistance and support during my year as President. As I mentioned a year ago, this is your organization and I was just given the task of caring for it for one year. There are too many people to name, but Dana, Kara, and Bo always kept me straight, and they are truly the best Association Management Group in the world. I would also like to thank many of my NCSA "mentors" who helped me when I was a young enthusiastic resident, and let me tag along to the meetings. I hope that I can do the same for the young anesthesiologists who will come behind me.

Have a Merry Christmas and Happy New Year.

The North Carolina Society of Anesthesiologists

ANNUAL MEETING

Anesthesia's Value Proposition

NC society of
ANESTHESIOLOGISTS
THE BEACON OF PATIENT SAFETY

P.O. Box 1676
Raleigh, NC 27602

DATES TO REMEMBER

Note – all NCSA members are invited to the executive committee meeting. If you plan to attend, please RSVP to kweishaar@smithlaw.com

Executive Committee Meeting
Sunday, December 14, 2014 at 10am at the Grandover (Greensboro, NC)

Executive Committee Meeting
Sunday, February 15, 2015 at 10am at the Umstead Resort & Spa (Cary, NC)

Executive Committee Meeting
Monday, May 4, 2015 at the City Club of Washington in conjunction with the ASA Legislative Conference (Washington, DC)

ASA Legislative Conference
May 4 – 6, 2015 (Washington, DC)

Annual Business Meeting
Sunday, September 27, 2015 at the Grove Park Inn in conjunction with the Annual Meeting

NCSA Annual Meeting
September 25 – 27, 2015 at the Grove Park Inn (Asheville, NC)

ASA Annual Meeting
October 24 – 28, 2015 in San Diego, CA

Executive Committee Meeting
Sunday, December 6, 2015 at 10am at The Proximity Hotel (Greensboro, NC)

NC Anesthesia Practice Managers Association (NCAPMA)

The NCAPMA is a group of practice managers from academic and independent (physician owned) anesthesia practices and anesthesia billing companies across the state. The Association meets in conjunction with the NCSA, the NCMGM and also conducts semi-annual billing issues meetings. Practice managers enjoy the opportunity to discuss payer and management issues specific to anesthesia with their colleagues across North Carolina. The NCAPMA always welcomes new members. If you or your practice manager have any questions or would like to attend an upcoming meeting of the NCAPMA, please contact Lisa Starnes, President, at (828)274-3477 or Lisa.Starnes@allcareclinical.com.