MSA Minnesota Society of Anesthesiologists

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NEWSLETTER

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President's Message

By Adam D. Niesen, MD
Mayo Clinic
Rochester, MN

Never in my wildest dreams did I ever consider that a farm kid who grew up tinkering on Farmall tractors and milking cows would be the president of anything, much less a group of physician anesthesiologists. During this year, it has been truly amazing to be a part of such a dedicated and enthusiastic group of colleagues. It is clear the MSA is a vibrant and engaged organization, well positioned for the present and future of anesthesiology. However, during a discussion with some of my colleagues in the operating rooms, one fellow anesthesiologist asked me, "What does MSA do for its members?" At the heart of this question is something that is frequently discussed in healthcare today: value. While it would not be possible to list every way that the MSA provides value to our members, I would argue that at its core, the MSA is an educational institution.

1. Practicing Physician Education – The MSA provides two education programs per year (one in the spring, one in the fall) at no additional charge for our members. These sessions regularly feature nationally and internationally recognized experts presenting the most up-to-date information relevant to current practice. In addition, the fall meeting typically includes workshops for hands-on practice of techniques, such as airway management, ultrasound guided regional anesthesia, and echocardiography, just to name a few. These offerings have evolved with feedback from you, our members. Most recently, the fall meeting included the use of problem based learning discussions (PBLDs), and our upcoming spring meeting is scheduled to include presentations on practice management. The MSA has also worked to develop reciprocity agreements with neighbor states, which allows our members to attend those states' meetings at no charge (and vice versa).

2. Resident Physician Education – As the future leaders of the specialty, the MSA is dedicated to the development of excellent physician anesthesiologists. The advisory board includes representation from both of the state's residency programs, aiding the growth of these representatives into peer leaders. The MSA also provides support to the Midwest Anesthesia Residents' Conference, as well as funding support for resident attendance to both the ASA Practice Management and Legislative Conferences.

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2019 Spring Legislative Update

By Nate Mussell
Lobbyist, Lockridge Grindal Nauen
Minneapolis, MN

Hans Sviggum, MD
Mayo Clinic
Rochester, MN

As the legislature moves into the heart of the session in March, the pieces are beginning to fall into place on both the budget front and on the scope of health policy issues that will be moving ahead the remainder of the legislative session. Governor Walz released his initial budget recommendations in mid-February setting up the framework for budget discussions with the House and Senate over the next two months. Although the Governor is required to release his budget by mid-February, those recommendations will have to be revised following a reduction in the February budget forecast with the budget surplus going from $1.5 billion dollars as of November, down to just over $1 billion dollars at the end of February. The Governor has already given indications that he will be going through his budget line-by-line to determine where to make any adjustments from his initial recommendations. As expected, the Governor's budget recommendations were very ambitious matching many of the themes from his election platform. On the health care front, the two items that are sure to generate the most interest include the continuation of the provider tax and the Governor's MinnesotaCare buy-in proposal. Both proposals are likely to run into significant opposition from Senate Republicans making for an interesting budget debate at the end of April into early May.

There are a couple of interesting bills to highlight that we are watching that might be of interest to MSA members as the legislative session goes on. The first bill – HF557/SF350 – is authored by two of the physician legislators – Rep. Alice Mann, M.D. (D – Burnsville) and Sen. Scott Jensen, M.D. (R – Victoria). The bill would prohibit physician non-compete provisions and make them unenforceable. Again, this bill has come up in the previous legislative sessions but will be interesting to follow as the session progresses. The bill did have its first hearing in the Senate but hasn't yet been heard in the House. Interesting to note that in previous years the scope of this bill was limited to only primary care physicians, but this year the language would apply to all physician non-compete provisions.

The other bill of interest – HF1651/SF1338 – authored by Sen. Jim Abeler (R – Anoka) and Rep. Glenn Gruenhagen (R – Glencoe) is called the "unconscious persons bills of rights." The bill would require that upon a patient or patient's representative's request, a hospital, ambulatory surgery center, or health clinic, would be required to record a patient's surgery by mounted video camera and keep that video as part of a patient's medical record. More interesting, the bill also goes on to say that a patient or patient representative could request and receive a copy of any incident or accident report compiled by the hospital, surgical center or health clinic and that report could be admissible in court. Finally, the patient would also be able to request of list of the names of each individual that was part of that patient's health care team and what role they played. While the bill is not likely to get a hearing in the House, it certainly creates extremely far reaching precedent and directly impacts anesthesia practice in each of these health care settings.

President's Message continued from page 1

3. Legislative Education – The MSA has been tirelessly working on behalf of anesthesiologists and our patients in Minnesota, through legislative efforts at the state level. These efforts involve educating our elected representatives about the contributions and value physician anesthesiologists provide to our patients and communities. During this legislative session in Minnesota, we were involved in efforts regarding the APRN Multistate Licensure Compact (did not make it out of committee due to efforts), opioid prescribing limits, and non-covered emergency services language. We have worked hard to engage other medical specialties for collaborative support of mutual issues, as well as continuously educating legislators on the role of anesthesiologists in safe patient care.
4. Education of Lay Public – Continued education of patients and the public at large regarding the importance of physician anesthesiologist involvement in their perioperative care is crucial to demonstrating the value of our contributions. As part of these efforts, the MSA continuing to grow our social media presence to more effectively distribute information to our members, elected representatives, and the general public. If you haven't already, follow the society on Facebook (www.facebook.com/msaconnect) and Twitter (@MSAphysicians).

It has been an honor and pleasure to serve you as president for this past year. Our greatest strength as a Society is our members. If you are interested in learning more, I would encourage you to participate! Contact an advisory board or executive committee member for more information, or drop me a message at niesen.adam@mayo.edu.

MSA Spring 2019 Conference Preview

By Kyle Bohman, MD
Mayo Clinic
Rochester, MN

Dear Colleagues,

The Minnesota Society of Anesthesiologists Spring Meeting is quickly approaching. This year's Spring Meeting will be held on May 4, 2019, at the Radisson Blu Mall of America in Bloomington. We have organized a high-yield agenda for the meeting with a variety of emerging concerns in the field of anesthesia and perioperative care.

Based on MSA member feedback, we are including practice management topics at the Spring Meeting. Dr. Jay Mesrobian, a widely-known expert in practice management from Medical College of Wisconsin, will be sharing his perspective at the meeting. Closely entwined with practice management issues is the legislative process, and we will have a legislative update from our MSA lobbyist Nate Mussell from Lockridge, Grindal, Nauen, PLLP.

We take our member feedback seriously, and work hard to deliver what you have expressed interest in. We also try to detect emerging trends and issues in anesthesiology, bring them to your attention, and foster a medium for networking. The upcoming MSA Spring Meeting is no exception, and I look forward to seeing you all there!

MSA Fall 2018 Meeting Recap

By Kyle Bohman, MD
Mayo Clinic
Rochester, MN

On November 17th, 2018, we had the honor of hosting this year's Minnesota Society of Anesthesiologists Fall Conference at the Radisson Blu Mall of America. I was proud of the content offered by expert anesthesiologists from across our state.

One of the highlights of the Fall Conference was a series of interactive problem based learning discussions (PBLD's). The PBLD topics included both common concerns (such as Pediatric Emergencies, Post-Dural Puncture Headaches, and Post-Partum Hemorrhage) and increasingly frequent concerns (such as Adult Congenital Heart Disease, Pulmonary Hypertension, and ECMO). We intend to continue to offer a variety of educational formats including interactive offerings like PBLD's to meet the needs and preferences of our members.

We are indebted to our many expert speakers, discussion facilitators, participants and exhibitors who made our Fall Conference such a success. It was a pleasure to host all who attended, and I hope to meet those of you who could not attend at one of our upcoming meetings.

Resident Corner: Mayo Clinic

By Juan G. Ripoll, MD
CA-1 ASA/MSA Representative
Mayo Clinic
Rochester, MN

As we approach the end of the winter season, it is a great moment to reflect on the progress made by our residency program throughout this academic year. The CA-1s are now becoming more familiar with the dynamics of the operating room and continue to build their own technical skills to safely practice anesthesia. Meanwhile, the CA-2s are refining their abilities in the surgical sub-specialties while they eagerly await for their fellowship or job interviews. Finally, the CA-3s are mastering the supervisory role and continuing to excel in their transition into future attendings. Although every class faces its own unique challenges, I remain thrilled by the strong sense of community in our residency program that not only allows us to freely share our triumphs, but also learn from our failures.

The academic activities in our residency program remain fascinating. We benefit from highly educational Grand Rounds and Monday lectures not only from our recognized group of staff anesthesiologists, but also from distinguished visiting professors from other academic programs. These weekly events are great opportunities to spend some time with our colleagues and discuss our experiences in the operating room. Our education is also well rounded by outstanding monthly journal clubs. We recently had one at an old property of the Mayo brothers named the Mayowood Mansion. We discussed a couple of interesting manuscripts about the most recent updates in the intraoperative fluid management for major abdominal surgeries, while enjoying a delicious dinner. Certainly, it was a great learning opportunity: full of debate in a very collegial environment.

As we move into the last quarter of this academic year, we are now relieved from the stress of the ITE. However, we remain focused on our anesthesia boards while striving to maintain a good work-life balance. It is also the moment of the year where most of us are preparing our abstracts to submit research studies or medically challenging cases to the Midwest Anesthesia Conference and other conferences that will take place during the spring. We remain grateful for an exceptional mentorship program that allows us not only to be involved in research projects early in our career, but also to accomplish our academic goals.

We look forward to continuing to learn about this incredible specialty everyday while remaining humble, compassionate, and committed to excellent patient care.

Thank you to our 2019 Spring Conference Exhibitors!

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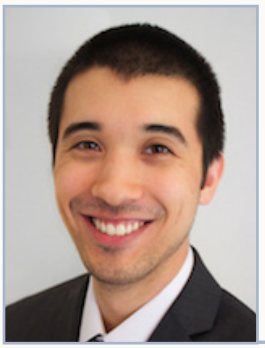


Resident Corner: University of Minnesota

By Lucas Deschenes, MD
University of Minnesota
Minneapolis, MN

Greeting from the University of Minnesota! Here in Minneapolis, snow on the ground is often a benchmark for the academic year being in full swing and as we've broken the snow record for February, we also have a number of accomplishments to be proud of. Our CA-1 residents are becoming proficient in anesthetic management of complex surgical patients as our CA-2 and CA-3 residents become adept at the many subspecialties in anesthesiology, along with preparing for fellowship training or starting their careers.

We are proud to highlight our departments involvement at this year's annual ASA conference in San Francisco where 55% of our residents, along with a number of attendings, fellows, and medical students participated in over 40 lectures, panels, PBLDs, abstracts, and presentations. Looking forward, we are excited for our entire CA-1 class who will be presenting medically challenging cases at the Midwest Anesthesia Residents Conference this upcoming April.

Our department also strives to make echocardiography a fundamental skill by the end of CA-1 year and, for the second year in a row, are on track to have all residents certified in basic Focused Assessed Transthoracic Echocardiography (FATE). Our residents also continue with a 100% board pass rate, 5 years running. Even with rigorous training, we play an active role in resident wellbeing and quality of education with multiple residents being on the Resident Leadership Council (RLC) for the University of Minnesota. This year, the RLC is co-chaired by none other than our Senior MSA Resident Representative, Dr. Sagar Navare.

Just as we are committed to providing excellent care to our patients at home, we are dedicated to teaching anesthesiology abroad. Through a partnership between the University of Minnesota Department of Anesthesiology and the Canadian Anesthesiologists Society International Education Foundation, one of our CA-3 residents, Dr. Vinayak Nadar, spent 4 weeks in Kigali, Rwanda to teach their anesthesiology residents a variety of skills both in the operating room and through simulation.

As the amount of clinical sites we cover expands, so must our residency program. Starting in 2019, our program will increase from 7 to 10 residency positions. These accomplishments cannot be undertaken without the utmost support from our individual faculty mentors, Residency Program Director, Dr. Mojca Konia and Department Chair, Dr. Michael Wall. As we look forward to what the coming years hold, we cannot forget our individual successes and failures that mold us into the physicians that we are today. Our motto is "Driven to Discover", and I cannot wait to discover what the future of anesthesiology has to offer.

ASA Update

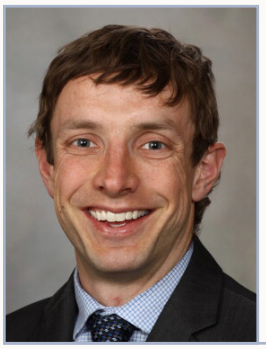
By David Martin, MD, PhD, FASA
Mayo Clinic
Rochester, MN

The March Board of Directors meeting just concluded, and ASA Committees are working on many interesting projects. We learned that drug shortages still affect a great number of anesthesiology practices across the country. One approach to easing the burden is to decrease the number of formulations required so that manufacturers can focus their efforts on fewer product lines. ASA is working with several other groups to drive consensus on standardization of drug concentrations. And the ASA drug shortage registry has been an effective tool for promoting our cause. When you experience shortages, please report them at the following website: https://form.jotform.com/81783710213149

The ASA Legislative Conference is rapidly approaching — a highlight of ASA advocacy efforts. The Legislative Conference will take place in Washington, DC, May 13-15. Key messaging will focus on anesthesiologists helping find solutions for the opioid crisis, and continued emphasis on solving anesthesia drug shortages. We'll also lobby for just solutions to "Surprise Medical Bills" when patients are out of network, and well as rural passthrough payment rules. Finally, we will also hear more about "Medicare For All" and other forecasts for payment reform. Stay tuned, for an update.

The ASA annual meeting will be Orlando, Florida, October 19-23. In addition to being the specialty's foremost professional gathering, this year is also a great destination to bring the family. And to help anesthesiologists who find it difficult to take time away from work, the meeting has been reorganized so that the vast majority of the educational sessions will conclude on Tuesday. The House of Delegates, however, will still meet on Wednesday morning. I hope to see you there!

As always, please reach out to me if you have any questions or suggestions.



MSAPAC and ASAPAC Update

By Hans Sviggum MD
Chair, MSA PAC Committee
Mayo Clinic
Rochester, MN

Dear Members,

Both the Minnesota Society of Anesthesiologists and the American Society of Anesthesiologists have political action committees (MSAPAC and ASAPAC, respectively) that aim to improve working conditions for anesthesiologists, and ultimately the care we provide our patients. These PACs are a bipartisan voice advocating on behalf of our specialty. The PACs are able to support legislative candidates and law makers at the state (MSAPAC) and federal (ASAPAC) level.

The PACs allow us to help elect lawmakers, from all political parties, who understand and demonstrate their commitment to patient safety and quality of care. Most laws prohibit associations like the MSA from involving themselves in the political process, only PACs can participate.

PAC contributors recognize the challenges facing our profession including underfunded Medicare payments for anesthesia services, a burdensome regulatory/legal environment, and attacks on physician-led anesthesia models. They understand that political involvement is critical to facing these challenges. They know that the MSAPAC and ASAPAC are effective political voices for our profession.

Please consider becoming a MSAPAC and ASAPAC contributor today!

Get to Know a Physician: Kevin Jenner, MD, MBA, Anesthesiologist and Pilot

By Kevin Jenner, MD, MBA
CentraCare Clinic Anesthesiology
Saint Cloud, MN

"Long stretches of boredom, broken up by brief periods of excitement." This was the way flying was explained to me by an experienced pilot, and one of my first flight instructors. Some may think the same would be an accurate description of our medical specialty, anesthesiology. There are many parallels between flight and medicine, and this is perhaps one of the reasons so many physicians try their hand at earning a pilot's license.

I began my life as a pilot in 2005, during my senior year as an undergraduate student at the University of Iowa. After reading a magazine article about the Sport Pilot licensing process, all it took was a quick phone call to the local municipal airport and a small fee, and I was flying in a single engine Cessna airplane with a Certified Flight Instructor on my "Discovery Flight." A Discovery Flight is the first step for most civilian pilots towards earning their license. I quickly decided that the limitations on a Sport Pilot's license were too great, and pursued a Private Pilot license instead.. Six months of time, 10 hours of ground school, and over 50 hours of flight time (including over a dozen hours of solo flight time without an instructor), and I had earned my private pilot's license in the summer of 2006.

That is similar to the timeframe most people should expect for earning a license today, with costs ranging from $6,000 to $10,000 for the entire process. Learning to fly is like a miniature residency: you're expected to study in your downtime, be able to accurately quote important regulations and aircraft characteristics before and during flight, know the "lingo" to communicate with other pilots and air traffic controllers, react quickly and appropriately in emergencies, and generate your own flight plans and emergency backup plans to avoid emergencies. Eventually, you are given the privilege to complete an FAA written knowledge exam followed by a "checkride" with an FAA flight examiner, similar to taking the written and oral boards for anesthesiology.

Since I was a small child, I had dreamt of flying, and having earned my license, I found new degrees of freedom as an adult - not just from gravity, but from connectivity. Flying a small airplane requires total focus without distractions. I mute my cell phone and focus entirely on the process: the routine of the aircraft checklists, the feel of the airplane controls, the sound of the engine and radio traffic, and the view outside, always looking for other aircraft or changing weather conditions. It provides a break from the "always on" connectivity of my smartphone and I find other thoughts or concerns fade into the background as my full attention turns to the task at hand, just as it does when focusing on a patient's care in the operating room.

It is a freeing experience, and one that adds a new perspective, both literally and figuratively, to my life. If you have an interest in flying, contact your local municipal airport - Minnesota has more than 100 airports! - and see if they have a flight school. Call around until you find one that does, then sign up for a "Discovery Flight." Your flight instructor, much like your attendings during residency, will take it from there. Some useful websites include:

Airplane Owners and Pilots Association: www.aopa.org

SkyVector Flight Planning: www.skyvector.com

AirNav Airport Information: www.airnav.com

News from the ASA
All Press Releases Reprinted from asahq.org

ASA Says "No" to Medicare as a Benchmark for Out of Network Payments

On September 7, ASA joined several physician organizations in a formal communication to provide feedback on the Centers for Medicare and Medicaid Services' (CMS) request for information on price transparency. The communication stressed that Medicare should not be used as a benchmark for reimbursement of out-of-network providers. It also recommended that "the best measure of standard charges is the usual and customary physician charge ("U&C charge") procured from a not-for-profit, independently owned and operated entity."

The CMS request for information provided in part, CMS' concerns that "challenges continue to exist for patients due to insufficient price transparency. Such challenges include patients being surprised by out-of-network bills for hospital-based physicians, such as anesthesiologists and radiologists, who provide services at in-network hospitals, and patients being surprised by facility fees and physician fees for emergency room visits."

Out-of-network payment, also commonly termed "surprise bills" or "balance billing" is a high-level issue of concern for ASA, state component societies, large group practice entities, and a growing number of stakeholders including medical specialty organizations, insurers, patients and consumer groups, and others. Out-of-network payment occurs when a patient receives a bill for the amount remaining between the out-of-network provider's fee and the amount contributed by the patient's insurer after copay and deductibles. In most cases, balance billing is the result of a large gap between what the insurer chooses to pay and the physician's billed charge. Indeed, ASA believes a more accurate term for the occurrence is "surprise insurance gaps."

The coalition's letter answered CMS' five main questions, including how physicians, CMS, and insurers can better assist consumers in making the best choice for their health and safety:

We believe that it is the responsibility of payers, including CMS, to clearly provide information to consumers about the potential costs of seeking care under their particular coverage. Clinicians can participate by helping patients interpret or help decipher, as best they can, their patients' cost-sharing responsibilities, particularly in- and out-of-network out-of-pocket costs, but ultimately, the onus should be on insurers to make these costs transparent to patients. Hospital based clinicians often are not aware of the patient's particular insurance terms and conditions, secondary or tertiary insurance, or the carriers' policy on coordination of benefits.

Other groups who joined the communication included the American College of Emergency Physicians, the American College of Radiology, and the American Society of Plastic Surgeons. For additional information about out-of-network payment, please contact advocacy@asahq.org.

California Governor Signs Dental Anesthesia Legislation

In 2015, six year old Caleb Sears was given anesthesia in a dental office under the single operator model where the oral surgeon performing the surgery was also administering the anesthesia and monitoring Caleb's vital signs. Soon after the procedure began, Caleb stopped breathing while under general anesthesia and subsequently passed away. Since that time, the Sears family has lobbied state lawmakers in an effort to change the law and prevent other small children from the same fate as their son. The result of this effort is Senate Bill 501 which was initially stalled in 2017 but was amended and pushed forward during the 2018 legislative session.

On September 29, 2018, California Governor Jerry Brown signed CA SB 501. This legislation makes several changes to current dental anesthesia and sedation statutes, the majority of which will affect pediatric dental patients and which will become effective January 1, 2022. The notable changes are outlined below and the full bill text may be viewed here. The bill requires dentists to possess a pediatric endorsement of their general anesthesia permit in order to administer deep sedation or general anesthesia to patients younger than seven years old. A licensed surgeon or physician may also administer deep sedation or anesthesia if various requirements are met, including holding a general anesthesia permit. The bill also requires dentists to be present in the dental office setting during both the ordering and administration of deep sedation or general anesthesia. For patients younger than 13, the operating dentist and at least two additional personnel must be present for the procedure, and certain personnel must be certified in pediatric life support and airway management. In addition, onsite inspections and evaluations of licensees are required.

All references of "conscious sedation" are replaced with "moderate sedation" and a dentist may administer or order the administration of moderate sedation to a dental patient receiving outpatient care if specific criteria are met, including completion of appropriate training. If a dentist orders moderate sedation for a patient, the dentist must be physically present in the facility while the patient is sedated. If a patient is younger than 13, the operating dentist plus two additional personnel must be present during the procedure, with one of the additional attendees dedicated primarily to monitoring the patient.

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Regarding minimal sedation, a dentist is authorized to administer or order the administration of such sedation on a patient younger than 13 if the dentist has specific licensing credentials and remains physically present in the treatment facility, among other things. In addition, a dentist shall have the training, equipment and supplies to rescue a patient should he or she fall into an unintended deeper level of sedation. Finally, the bill also requires the Dental Board of California to maintain data on all adverse events pertaining to dental anesthesia and sedation for at least the past 15 years.

Although the signed bill does not incorporate all of the changes the California Society of Anesthesiologists (CSA) initially hoped for, including the fact that the bill language does not mandate that one of the additional personnel be a fully qualified physician anesthesiologist, CSA does commend the California State Legislature and the Governor for this new law. It strengthens the training and continuing education requirements for anesthesia permits, and puts the terminology defining different levels of anesthesia and sedation in-line with standard medical terminology as defined by the ASA.

Reminder to the State Components

With the legislative sessions having concluded in most states, state component societies are reminded that the work to protect patient safety by ensuring physician-led anesthesia care is far from over. Administrative agencies are continuing to consider ideas for and propose/adopt regulations that could help or hurt patients. Additionally, lawmakers and their staff are developing language for 2019 legislative introductions.

Now is the time to ensure participation at medical, nursing, dental, health, and insurance board meetings. If not able to attend these meetings for the sake of being resource, then at minimum review upcoming meeting agendas (most are on-line). If a board meeting agenda item is on-point (i.e. discussion or rule proposal that would impact the practice of anesthesiology and the patients it serves), then ensure the presence of a physician anesthesiologist at the meeting to provide insight.

Rules are proposed by each of these boards, so ASA members are encouraged to review the proposal, discuss with your state component society leadership, and submit written comments as appropriate. At the state legislative level, ensure relationships are maintained with local lawmakers.

Now is an opportune time to meet with lawmakers and/or their staff to share with them the extensive medical education, training, and background required to become and continue as a physician anesthesiologist. Please contact grassroots@asahq.org for guidance pertaining to any upcoming lawmaker meetings.

The ASA's Department of State Affairs serves as a resource to the state component societies for their state level advocacy initiatives. State Affairs is happy to help to the extent requested by the state and can be reached at advocacy@asahq.org.