FSA Today

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Who Will Be Your Doctor?

Kurt W. Markgraf, M.D., FSA President

"As anesthetists become relatively abundant, as advance practice nurses insist on recognition as doctors, as healthcare dollars become scarcer, the push to a lower standard of care will continue. Anesthesiologists will be marginalized."

With my first letter (*see FSA Today*, Summer 2007), I tried to emphasize how much the legislative process governs our professional lives and how others are continually trying to expand their scopes of practice through legislative change. My second letter (Fall 2007) emphasized the accomplishments of the FSA and how you can support your profession by either dedicating your personal time, which is difficult for most, or by supporting the PAC's that represent you. With the New Year upon us, I would like to look to the future of our profession. I find it difficult to imagine that we will not be faced with significant changes in the way we practice. I only hope that we as physicians will remain an integral part of that picture.

Let's look to our training programs. Since 1994, Medicare has reduced payment by 50 percent per case if a teaching anesthesiologist works with two residents (need I say physician?) concurrently, even if for a minute. A teaching surgeon, as do other specialists, continues to receive 100 percent per case while teaching two residents. Strong opposition from the American Association of Nurse Anesthetists (AANA) was instrumental in blocking legislation that would have corrected this inequity. The AANA argued that it would have favored physician education to the detriment of nurse education. A significant distinction is that physician training programs are heavily regulated and capped, whereas graduate nurse training programs are not. Physician and nurse training programs also have distinct funding. Since 1994, approximately 30 academic anesthesiology programs have closed. Here in Florida, the anesthesiology program at South Florida will most likely close. The number of accredited nurse anesthesia programs, however, has rapidly expanded to nine.

As we look to the future, who will be your doctor? I have previously given examples of certified registered nurse anesthetist (CRNA) leaders publicly stating that they cannot envision any need for an anesthesiologist, and others who have compared an anesthetist's education to that of an anesthesiologist's. I would like to include a few comments posted on *Forbes.com* ("Who Will Be Your Doctor?") from the dean of Columbia University School of Nursing, which pioneered the Doctor of Nursing Practice (DNP):

continued on page 3

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Unless otherwise noted, all articles are the opinions of the contributors, and the FSA does not agree, disagree or endorse any services or products.

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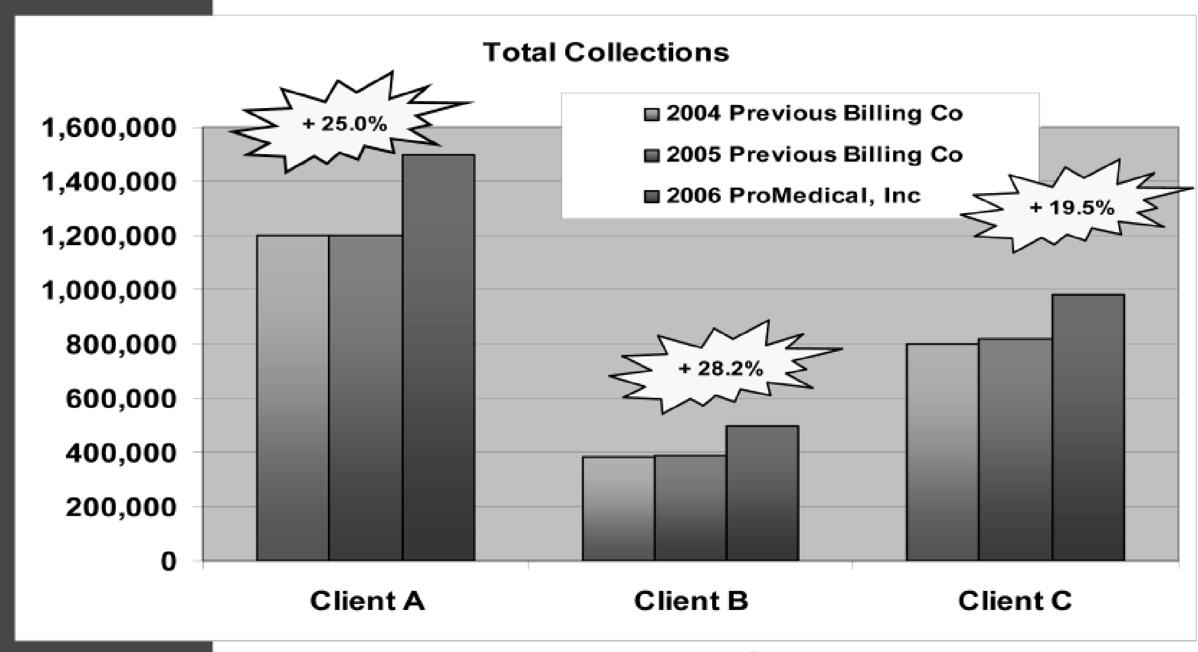

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Who Will Be Your Doctor?, from page 1

> *Rather than a physician, [your] comprehensive-care provider may very well be a nurse—who also happens to be a doctor. This doctoral degree enables advanced-practice nurses to gain the knowledge and skills necessary to practice independently in every clinical setting. These clinicians are peerless prevention specialists and coordinators of complex care. In other words, as a patient, you get the medical knowledge of a physician, with the added skills of a nursing professional. Along with a doctorate and the title of "doctor," …*

I would further like to examine how student nurse anesthetists are utilized. By way of disclosure, the hospital where I work has a long history of providing clinical sites for many allied health programs in our county. We recently agreed to provide a limited number of positions for a local nurse anesthetist training program. Our objective was to recruit these individuals for future employment. To my knowledge, the only monies involved are a small stipend to those CRNA's in our group who act as clinical site coordinators. More importantly, these student nurse anesthetists are paired with a CRNA at all times. Unfortunately, more and more clinical sites are driven by economics to utilize student nurse anesthetists in place of CRNA's and to pronounce this the safe practice of anesthesia!

Do we expect the economic picture to get dramatically better in the near future? Due to the tireless efforts of the ASA Economics Committee, ASA PAC and others, we did achieve an unprecedented increase from Medicare, but reimbursement remains inadequate. The number of anesthesia groups being subsidized nationwide is as high as 70 percent. That number may be conservative in areas with proportionally more Medicare patients. Depending upon the services the hospital requires and its patient population, these subsidies can be millions of dollars. How long can this be sustained?

As anesthetists become relatively abundant, as advance practice nurses insist on recognition as doctors, as healthcare dollars become scarcer, the push to a lower standard of care will continue. Anesthesiologists will be marginalized.

You may think that I exaggerate; you may characterize me as a Chicken Little. I once suspected some fellow FSA board members of excessive paranoia. But again and again, I have been shown otherwise. I now recognize that too many physicians have their heads in the sand. Sit up and take notice. FSA

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Tallahassee Report

Bleak Revenue Forecast May Hold Silver Lining for Anesthesiologists

by Jon Johnson, FSA Legislative Consultant

Targeted Medicaid Increases Could Benefit Specialists

Florida's revenue outlook, like that for much of the country, is facing a sharp downturn. The tone of the first committee week in Tallahassee was overshadowed with dire budget predictions and competing economic plans as to how to stimulate our state's economy.

Overall, the budget forecast for next fiscal year will be $4 billion below the FY2007-2008 budget. This year's budget has already been reduced twice since the last legislative session, which ended in May 2007. During the most recent general revenue estimating conference held last November, we saw recurring general revenue reduced by $1.1 billion. At that time, the forecast for the remaining year was also reduced. Unfortunately, general revenue collections continue to come in below the estimate, and since the November conference, the state has collected almost $100 million less than anticipated.

A key factor exacerbating the downturn in Florida's economy is the decline in the housing market. In previous years, Florida's real estate prices rose sooner, faster and longer than the rest of the nation's, and now are falling faster and harder. Other factors impacting the economic forecast include rising unemployment, high energy prices, decline in population, uncertainty in the credit market and the increasing probability there will be a national recession. This downturn in Florida's economy is projected to last through 2008 and into 2009, indicating that severe budget cuts will have to be taken in the base budget, with no consideration for potential funding increases in essential services such as Medicare.

Because of these economic factors, the Legislature is working on targeted Medicaid increases instead of a broad Medicaid reimbursement rate increase. These targeted increases could be beneficial to specialized practices such as anesthesiology.

Another issue we will follow closely for anesthesiologists is the FMA's priority legislation addressing managed care reform. The FMA is supporting legislation sponsored by Representative Bill Galvano (R-Bradenton) and Senator Don Gaetz (R-Fort Walton Beach) that would require managed care companies to accept a valid assignment of benefits, place a fair time limit on the "look-back" provisions in the prompt payment law and prohibit silent PPO's. Unlike most other professions, physicians must deal with the increased hassles that come from managed care organizations. These legislative reforms will reduce the "hassle factor" faced by physicians.

News You Can Use

Medicaid Survey

The following is a letter from Dr. Andrew Agwunobi, AHCA secretary, to the Florida Society of Anesthesiologists. The FSA urges each member to participate in the survey located at the link indicated within Dr. Agwunobi's letter.

Dear Partners:

As secretary of the Agency for Health Care Administration, one of my priorities has been to improve our level of customer service. The agency is now surveying Medicaid providers to gain their feedback, and identify areas that need improvement. The survey will be open from January 8 through February 8. Your members' opinions are important to us, and we want to ensure their voices are heard.

This is our opportunity to hear directly from your members, healthcare professionals working daily to provide quality healthcare to Medicaid beneficiaries. Please help us by publishing the link below in your emails, newsletters, bulletins or other publications to your members.

http://ahca.myflorida.com/Medicaid/provider_survey/index.shtml

I look forward to personally reviewing the results of the survey, and working with you and your members as partners in our journey toward excellence.

Sincerely,

Andrew C. Agwunobi, M.D.

ASA Director's Report

Measurement, Decision Making and Outcomes Data Registries

by Jerry A. Cohen, M.D., ASA Director, Florida

It is a well believed principle that you can't improve what you cannot measure. Those of us who have spent much of our careers struggling with meaningful ways to improve the quality of medical practice are becoming increasingly concerned about how data are used to drive decisions and payment for services. In a utopian world, physicians, hospital administrators, healthcare regulators and insurers would all agree on what needs to be measured, how it should be measured and how the outcomes measured should drive changes to improve performance, outcome and cost. Unfortunately, all of these entities have different perspectives and purposes in using data to leverage change. It is also unfortunate that not all of the motives for using the data are enlightened and pure, and the changes that are leveraged may not accrue to the interest of patients or their physicians.

My personal observation, and to be fair, I must label it as such, comes from my past experiences as associate chief of staff for quality management in my hospital and my tenure as ASA's representative to the Joint Commission. Physicians have long been, at minimum, skeptical of the motives behind the measurement of their performance. Long before the Joint Commission, the CMS, the AMA and other organizations began their various, and not always consistent, reasons for performance measurement, there was an interest in performance improvement for its own sake. The biggest problem physicians had with these earlier efforts dating from the 1980's was that they were based on industrial models, whereas medicine is more akin to a repair business—meaning that it did not have generally agreed upon indicators of outcome, did not have consistent, reproducible ways to obtain high-quality data about a defined set of outcomes and that hospitals were not willing to bear the cost of meaningful quality improvement. Hospitals, for their part, were unwilling to invest in the infrastructure (e.g., electronic medical records – EMR) to accurately measure the critical elements of patient care without assurance that there would be a return on their investments. Coupled to that, hospital administrators were acquiring greater control of their medical staffs during that time and were wary of decisions driven by data they did not control. As a result, strategic management decisions have been based to a greater extent than desirable on clusters of anecdotes, budgetary data and a few overly simplistic quality improvement demonstration projects designed to impress Joint Commission surveyors. There has been little success in formulating a mechanism for systematically organizing patient care data in a way that supports healthcare improvement and institutional planning. This is to a great extent a result of the great costs of investing in EMR without a national standard, a lack of agreement on what is most important to measure and the continued suspicions of the use to which data derived from these records would be put. Add to this the forces driving less expensive healthcare financing, and there is more than enough cynicism to go around.

The house of medicine in general and the ASA in particular have thought it important to be engaged in keeping control over various initiatives of outcomes measurement, be it for the purpose of pay for performance (P4P) or purely for supporting quality and improving performance. The ASA has recognized the need to base standards, guidelines, practice parameters and advisories on hard data and now is moving to require data, rather than relying on a structured review of the literature and surveys of practitioners. I am greatly oversimplifying how this process has been implemented and how it will be improved, which is documented in detail in the appendix of any of the ASA practice parameters and guidelines. Still, it is accurate to say that it would be a more valid, straightforward and perhaps less expensive process if it were driven by a central database registry of aggregated outcomes data. If developed and controlled by physicians, it would have the side benefit of being useful in helping us focus on improving quality as well as driving fair payment.

And so, the ASA has become very dedicated to a series of actions needed to help us implement a data registry and in advocating anesthesia-related performance measures. In the last several columns, I have discussed this issue more from the perspective of P4P and the ASA's efforts to make sure that anesthesia-related indicators used to maximize pay are properly designed to be valid and not merely to "redistribute payment from physicians in one

specialty to those in another" (see, ASA House of Delegates Resolution 7, 2007). There has been a lot of discussion, often animated, about which indicators are best and how best to measure them. The latest measures proposed by the ASA Committee on Performance and Outcomes Measurement were published in the proceedings of the House of Delegates and were posted in late December 2007 on the ASA website for your review and input (see, *www.asahq.org/news/news122707.htm*). The committee and the ASA's leadership are quite cognizant that these measures will have to be carefully perfected in order to be accepted in a form we like by the Physicians Consortium on Performance Improvement and the CMS, but it is a starting point.

We have an ASA taskforce to address the process by which outcomes measures will be advanced (see also, House of Delegates Resolution 7, 2007, "Resolved that the American Society of Anesthesiologists develop a specific process concerning pay for performance in anesthesiology …"). The taskforce will report before the winter ASA board meeting. It will also address concerns expressed in Resolution 8 that an outcomes database registry might support performance improvement more effectively than P4P. The two resolutions complement each other. While perfecting our administrative mechanism for advancing P4P measures, we must also pursue the development of data registries to support the development of valid measures independently of their use for P4P.

Having laid down a process by which these measures are formulated and approved, the greater concern will be the extent to which the AMA or the ASA and other specialty societies can control the process by which these measures are perfected and the form in which they are finally adopted. It is of great concern that government and industry are pushing for the development of measures not so much because they want a more valid way to drive the allocation of resources, but rather for the primary purpose of reducing cost. This is a perversion of the process and akin to an economic rearranging of the deck chairs on the Titanic. The world of outcomes measurement seems rife with conflicts of interest and something akin to agitprop. The AMA may be losing ground in the battle for physician control, and this is very worrisome, if true.

It is, therefore, a very positive thing for the ASA to pursue the development of a data registry. It has the positive benefit of having a chance of becoming the *de facto* standard, could have immense power if we are able to integrate our efforts with those of other organizations, such as the Anesthesia Business Group, and might become an important way of focusing on performance improvement for its own sake, independent of pay. Currently, the Committees on Information Management, Performance and Outcomes Measurement, and Electronic Media and Information Technology are making a coordinated effort to explore how an ASA data registry would look and how organizations might participate. The details are complex and include definitions of terms, completion of a data definitions dictionary, protocols for properly defining numerators and denominators of care, risk adjustment, additional reporting codes, cost, relevance sufficient to sustain interest and engagement of ASA members, HIPAA compliance and issues yet to be addressed. Despite the complexity, it is essential that physicians take the initiative in developing and controlling how and what we measure. Some efforts by other organizations have been dramatically unsuccessful, but there are also successes that we can use as a model (see, STS National Database and Outcomes program for more on a successful program). If we will not take the initiative, and regulatory agencies and/or insurance companies measure our outcomes for us, they are likely to put a system in place that resolves healthcare cost in their favor at the expense of healthcare quality.

Other readings on this subject:

Robert S. Lagasse, M.D., chair, Committee on Performance and Outcomes Measurement, ASA Newsletter Vol. 16, No. 11; How Should a Specialty Society Use Process and Outcomes Measurement? (www.asahq.org/Newsletters/2003/11_03/lagasse.html)

Panel: Who Defines Performance Measures? – PowerPoint Presentation at 2005 ASA Annual Meeting by Robert S. Lagasse (*www.asahq.org/Washington/PanelWhoDefinesPerformanceMeasurespdf.pdf*)

The Society of Thoracic Surgeons STS National Database and Outcomes Program Participation Manual (*www.sts.org/documents/pdf/Database_Manual_11.3.2006.pdf*)

Meeting Synopsis

Highlights of the Florida Society of Anesthesiologists Board of Directors' Meeting • December 8, 2007

1. Legislative Update

The FSA will promote the FMA agenda, which includes:

- HMO Reform
- Phantom PPO – In this circumstance, an insurer buys access to a contract that you have negotiated with another insurer. In other words, insurer XYZ demands the rates that you have negotiated with insurer ABC. The FMA seeks to limit or end this practice.
- Assignment of Benefits – This aims to eliminate the practice of the HMO sending money for a non-contracted doctor's services directly to the patient.
- Medicaid Update – Medicaid is proposing increasing fees for a few specialties that do not have enough doctors signed up as providers. The FMA will lobby for across-the-board increases.

2. Communications

The movie *Awake* was recently released. Information concerning awareness is available on the FSA website for members who have inquiries from the public, hospital administrators and media.

3. Legislative Update

The board is considering strategies to deal with the Board of Nursing's sedation policy. The FSA is working to ensure that the R.N.'s sedation policy is consistent with the ASA's Sedation and Patient Safety Standards and is consistent with existing rules and regulations (i.e., does not expand scope of practice).

4. Executive Committee Update

- Financial – The society is operating in the black.
- Annual Meeting Update – Profits are dwindling. The Annual Meeting Committee will consider strategies to keep the meeting profitable.
- The board adopted a Conflict of Interest Policy and an Expert Witness Policy that mirror the ASA's policies.
- The FANA president has requested a meeting with Dr. Markgraf. The concerns were discussed.

5. CAC

Dr. Lubin emphasized that if members have payment issues related to Florida's Medicare intermediary (First Coast Options Services), they should inform the FSA board, which will refer the issue to Dr. Lubin. He will then address these payment issues directly with First Coast.

6. FSA Newsletter

Efforts will be made to convert the FSA newsletter to electronic form and to charge a small fee if members want a mailed copy.

7. Recycling Proposal

Proposal to the ASA to adopt a policy that the ASA recycle all of its annual meeting materials and binders.

8. Legislative Days

In lieu of Florida legislative days, board members will be asked to go to Tallahassee on an as-needed basis.

9. Quarterly Meeting

The board will not have a quarterly meeting in August 2008. Instead, a meeting will be conducted during this year's ASA meeting in Orlando. FSA

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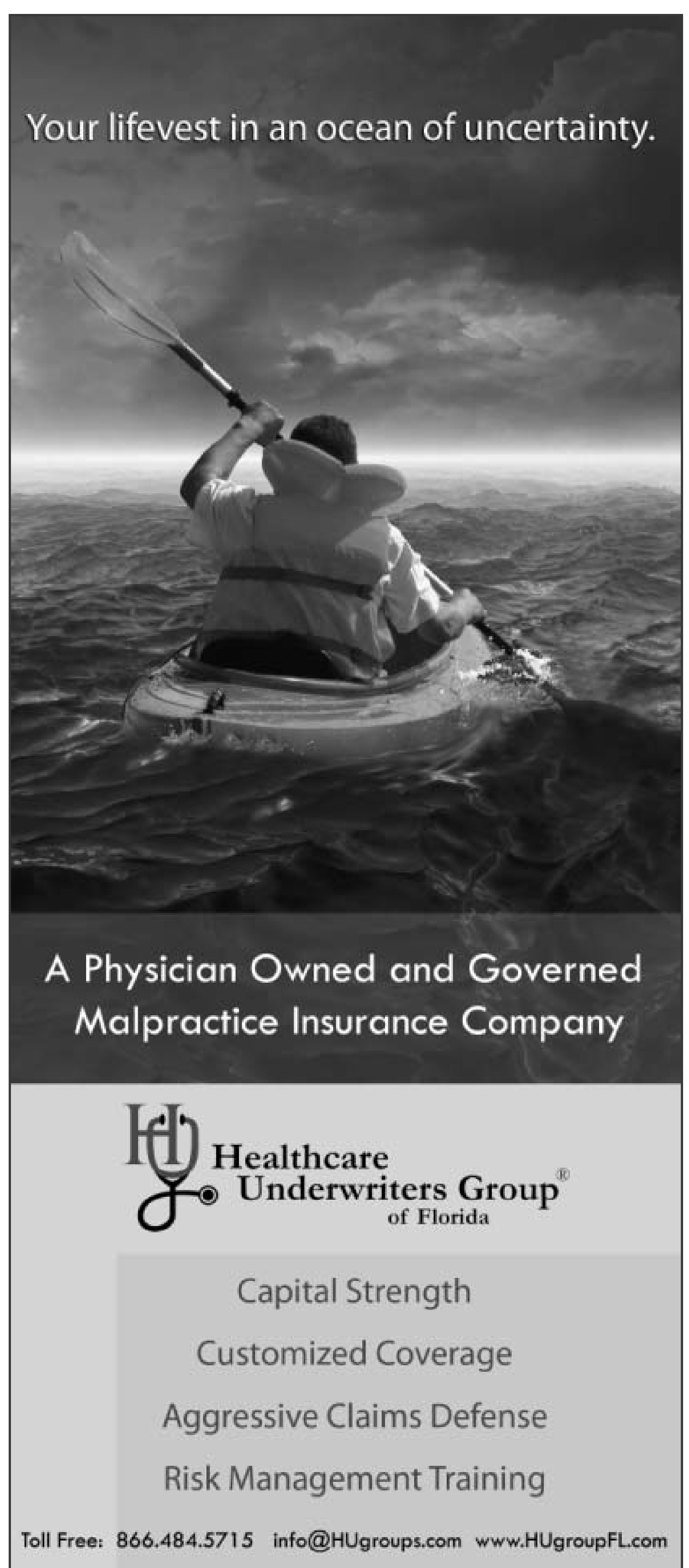
High Springs

Miguel Santos, M.D.
Miami

Robyn Stacey Weisman, M.D.
Miami

AFFILIATE

James F. O'Neill, Jr., M.D.
St. Petersburg



Calendar

March 15, 2008
11:00 a.m. – 3:00 p.m.
FSA Board Meeting
Orlando, Florida

June 9-11, 2008
ASA Legislative Conference
Washington, DC
More details at www.asahq.org

June 27, 2008
(Time TBD)
FSA Board Meeting
The Breakers Resort
Palm Beach, Florida

June 27-29, 2008
FSA Annual Conference
The Breakers Resort
Palm Beach, Florida

July 31-Aug. 3, 2008
FMA Annual Meeting
Orlando, Florida

October 2008
(Date & Time TBD)
FSA Board Meeting
Orlando, Florida
(in conjunction with ASA annual meeting)

October 18-22, 2008
ASA Annual Meeting
Orlando, Florida

October 19, 2008
6:00 – 8:30 p.m.
Annual Florida Reception
Orlando, Florida
(in conjunction with ASA annual meeting)

Florida CME Events
The American Society of Anesthesiologists sponsors CME courses throughout Florida. For a complete listing of ASA educational opportunities, visit http://events.asahq.org.

2007-2008 Florida Society of Anesthesiologists

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ASA Delegate 15 At Large
A. Joseph Layon, M.D.

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