FSA Today

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The Anesthesia Company Model – Frequently Asked Questions

In October of 2013, the FSA filed a complaint against several Florida corporations and physicians, citing their alleged participation in company model arrangements. Earlier this month, the complaint was unsealed. Your FSA leadership has made available an informational document outlining the details and history of the complaint and answering frequently asked questions. The document is available on the FSA website – **CLICK HERE** to access the document.

Nominations for the 2016 FSA Distinguished Service Award

Dear FSA members,

As the current Chair of the Judicial committee, which is charged with identifying our 2016 Distinguished Service Award recipient, I need your assistance. The DSA recipient can be any individual who has contributed significantly to anesthesiology in the state of Florida. If you have someone you would like to nominate for this prestigious recognition, please submit your nomination by clicking **HERE**.

Thank you so much for your help!

Sonya Pease
Chair, FSA Judicial Committee

From the FSA Task Force on Professional Diversity

Rosemarie Garcia-Getting, Chair

The FSA Task Force on Professional Diversity encourages FSA members to participate in the **ASA Mentoring Program**. The purpose of the program is to "foster diversity within ASA through mentorship" according to the website. This is accomplished through Mentor/Mentee pairs who develop a project "oriented to scientific or clinical research, or an educational, political advocacy or organized medicine endeavor." The mutually agreed upon project must "have the goal of enhancing the professional career, leadership potential, and active involvement of the mentee within the ASA." The ASA Mentoring Program awards up to $5,000 in funding for selected projects.
Mentors should be leaders in the ASA and established clinicians who are willing to volunteer their time advising and guiding their mentee throughout the project, which may range from one to three years.

Mentees should be ASA members of diverse racial, ethnic or gender backgrounds seeking career development, growth of leadership skills, and further involvement in ASA. Medical students, anesthesiology residents/fellows, junior faculty members, or new graduates in private practice may apply as mentees.

Mentors/mentee pairs must complete and submit their application to the ASA Mentoring Program by **June 30, 2016**. More information can be found HERE.

MOCA 2.0: What You Need To Know

by Brenda G. Fahy, MD FCCP MCCM

The American Board of Anesthesiology® (ABA) launched its Maintenance of Certification in Anesthesiology Program® (MOCA®) in 2004 to assure the public that physicians were dedicated to improving clinical outcomes and patient safety. The program was designed based on standards set by the American Board of Medical Specialties (ABMS) and adopted across all of its 24 Member Boards.

In 2011, as the ABA considered its strategic plans, the Board of Directors decided to investigate incorporating technology and adult learning theory into the MOCA program. The goal was to take a more innovative approach to promoting lifelong learning and knowledge retention. Last year, the ABMS issued its latest Maintenance of Certification (MOC) Standards, which provided greater flexibility for Member Boards to incorporate innovation into MOC programs, thus complementing the ABA's vision.

These developments, coupled with significant input from our diplomates, led the Board to redesign the MOCA program. The redesigned program, known as MOCA 2.0™, launched in January 2016. The most significant and welcome change, according to our diplomates, is replacing the once-every-10-year MOCA Exam with the MOCA Minute™ pilot to satisfy the MOCA Part 3: Assessment of Knowledge, Judgment, and Skills requirement.

MOCA Minute provides physicians with access to multiple-choice questions similar to the ones that previously appeared on MOCA Part 3 Exams. The questions may be accessed 24/7 from a laptop, mobile device or desktop computer, offering greater flexibility for physicians whose time is limited by growing administrative, regulatory and

practice demands. MOCA Minute also allows the Board to quickly introduce diplomates to new topics related to research, clinical practice or public health threats, potentially expediting the time it takes to educate clinicians about issues likely to impact medical practice.

MOCA Minute was designed to help physicians retrieve and retain their medical knowledge more effectively. Research has shown that when information is presented and repeated over time, that information is more likely to be retained.[1] This new approach to assessment not only helps the ABA determine if diplomates continue to meet certification standards, but also provides diplomates with a self-assessment tool that can help them identify and fill knowledge gaps.

The ABA sends diplomates weekly reminder emails with a link to access MOCA Minute questions. Additionally, diplomates can get to their questions through their portal accounts or via a MOCA Minute mobile application. Diplomates answering MOCA Minute questions immediately receive the correct answer, a rationale and links to reference materials. This feedback encourages diplomates to learn more about a topic whether they answered the question correctly or not. The goal is to ultimately improve patient care by engaging the entire corps of MOCA participants in self-assessment and learning throughout their careers.

Diplomates participating in MOCA 2.0 must answer 30 MOCA Minute questions per quarter (120 per year). In addition to answering the questions, the Board also asks diplomates to report how confident they are in their answers and how relevant the question topics are to their practice. The confidence question determines how quickly diplomates will see similar concepts again to improve knowledge retention and retrieval. The relevance question will help the Board determine if question topics remain germane to medical practice over time.

Making the MOCA components more meaningful was a motivating factor for the redesign. Diplomates told the Board that we could do better. In addition to criticizing the high-stakes exam, many diplomates reported that the Part 4: Improvement in Medical Practice requirements – which included completing a simulation course – did not improve their practice. Based on this feedback, the Board has made simulation an optional activity in MOCA 2.0. While the ABA believes courses offered through ASA-endorsed simulation centers provide valuable educational experiences, we understand that for some diplomates these courses are inconvenient and costly based on the associated travel expenses and time away from practice. With that said, Florida has two ASA-endorsed centers – one in Gainesville and one in Miami – and one nearby in Birmingham, AL, for diplomates are who interested in this Part 4 option.

To make Part 4 more accessible and relevant, the Board has expanded the list of Part 4 options, giving diplomates more choices. Last summer, the Board surveyed MOCA participants, asking them to share activities they believed could improve their medical practice and deserved Part 4 credit. The Board used the survey results to expand its Part 4 list to include what diplomates have told us are more meaningful options. For instance, physicians may now get credit for point-of-care learning or learning that occurs when doctors do research to refresh their knowledge or gather new information to manage a case. The ABA has implemented a Part 4 point system, assigning points to activities based on the time and effort associated with their completion. Diplomates must

earn 25 points for each five-year period in the 10-year MOCA cycle (50 points over 10 years).

Additionally, the Board has moved from a $2,100 MOCA fee that diplomates paid every 10 years to a $210 annual fee, which many diplomates have told us is more palatable. While the ABA has adapted new technology to make MOCA more convenient and meaningful, we have tried hard not to increase the program's fees, which have not changed since 2012.

Additional program enhancements are expected in 2017, when the Board will launch MOCA 2.0 for subspecialties. This will give ABA diplomates certified in critical care medicine, pain medicine and pediatric anesthesiology an opportunity to tailor their MOCA Minute questions to their subspecialty. Diplomates with subspecialty certificates in hospice and palliative medicine and sleep medicine will need to continue taking certification examinations through the American Board of Internal Medicine as the ABA does not have the question banks to support MOCA Minute for these subspecialties.

In 2017, the ABA will also launch new MOCA 2.0 features, including a dashboard to help diplomates identify knowledge gaps and track their progress through the program, and search functionality to help diplomates identify continuing medical education (CME) that can help them close knowledge gaps. The Board will also create a document repository where physicians can upload, store and email certificates, licenses and other important documentation often requested by credentialing agencies and employers.

The ABA is hopeful that MOCA 2.0, particularly replacing the MOCA Exam with MOCA Minute, will make the program more attractive to non-time-limited (NTL) certificate holders for whom participation is voluntary. Aside from MOCA Minute, most NTLs are likely already completing the other program components, which include holding a current unrestricted license to practice in the U.S. or Canada (Part 1), completing 250 Category 1 CMEs every 10 years (Part 2) and participating in a series of activities designed to improve medical practice (Part 4).

The Board believes MOCA 2.0 is a better approach to maintaining certification, one that can help physicians retain their knowledge and improve their practices in meaningful ways. However, we understand there is always room for improvement. We will continue to partner with our diplomates to evolve the program to meet their needs, the ABMS standards and the Board's mission of advancing the highest standards for the practice of anesthesiology.

Ultimately, our goal is to ensure that board-certified anesthesiologists continue to be well equipped to provide the highest quality of care to our patients. If we work together, we believe we can accomplish this goal.

If you have questions or need additional information, please visit the About MOCA 2.0 page on the ABA website. Alternatively, you may call or email the ABA Communications Center at 866-999-7501 or Coms@theABA.org.

Dr. Fahy is the division chief and associate chair of Critical Care Medicine at the University of Florida, where she also serves as a professor of Anesthesiology and the program director for Critical Care. She is also the vice president of the American Board of Anesthesiology.

1. B. Price Kerfoot, MD, EdM "Brain Science Provides New Approach to Patient Safety Training, Patient Safety and Quality Healthcare, November/December 2013

RESIDENT'S PERSPECTIVE

Nothing Else Really Matters (report from ASA Legislative Conference 2015)

by Keya Locke, MD

When I stepped off that plane in our nation's capital for my very first American Society of Anesthesia Legislative Conference I was ecstatic, invigorated, energized, and ready to change the world; it was a feeling akin to when I stepped into my first medical school classroom. It was like a family reunion and I was the third cousin, or so I felt if only for a moment. Before I could find a corner and start reading before the activities began, in walked Dr. Young, my senior fellow resident at The University of Florida-Jacksonville, and as I would soon discover so very much more. She took me by the arm, welcomed me and got right down to business. She introduced me to Dr. Jerome Adams, Member of the ASA Professional Diversity Council, who welcomed me with a hug and offered advice on how to become more involved with the council. Dr. Young then whispered "He is also the Indiana State health Commissioner", and we moved on to Dr. Crystal Wright, Dr. Fitch, Dr. Dombrowski, Dr. Diez and countless others. As I took my first small steps into this political world of advocacy for the specialty I love, for the right of the best of care for our veterans, and for expanding professional diversity I was honored to have Dr. Young guiding me with her years of wisdom, and by example. The conference continued with enthusiastic speeches from ASA members, senators, congressman, and physician congressman!

Before I knew what was happening I was holding up the wall and laughing with the president of the FSA while he joked about my chairman Dr. Lewis. I sat beside the former ASA president and the current ASA vice president and had breakfast. I felt in every moment the great responsibility that brought us all here together and the pride with which they looked upon me for taking up the fight and I was humbled.

By the second day I felt like part of that family and was treated as such. We were all there for the same reason, to advocate for our specialty, to advocate for Physician-led Anesthesia care teams as the future of Anesthesia. We were there to make our voices heard and to keep abreast of what those who would have us silenced had been busy doing in a concerted, well-funded, and organized fashion. The message hit home, and hit home hard when Dr. Brady, president of the ASAPAC, played a video in which a congressman in support of the CRNA's stood at a podium on Capitol Hill and said "CRNA's are the future of Anesthesia". And to quote president of the ASA J.P. Abenstein, the CRNA's are not simply calling for the right for midlevel provider independent practice, they are calling for "the elimination of the Anesthesiologist." The current proposed VA Nursing handbook would mandate CRNA's to practice independently and is in direct conflict with the current VA Anesthesia handbook. This Handbook is the single most important national issue threatening our specialty today.

We stand at a precipice. Either we stand up donate generously to the ASAPAC, as they are our soldiers on the ground, or pack up and go home. To do nothing would abandon not only our profession, but in a more immediate sense, we abandon our sickest

patients, the honorable men and women who have served to protect our freedoms. To them we say, all you deserve is nursing care, while our NATO mandates that their Italian, and British soldiers receive ONLY physician anesthesia care.

On our last day in Washington DC, we visited and made our case heard before our congressmen. Again I was in awe of Dr. Young and Dr. Lewis. The conviction in the message we brought to the Hill was undeniable. As the day wrapped up, and I sat on the plane reflecting, a single thought occurred to me: the physicians lobbying for the future of physician-led anesthesiology will be the ones least affected. They showed up in record numbers for us, the residents, "the future of Anesthesia". How can I sit idle and not advocate for my own future? In truth, we are busy perfecting our craft, waking up early and going to bed late, studying for the ever looming boards, preparing research projects, and keeping our attendings happy. We do this so that we can finally claim that prize at the end of the rainbow, when we finally get to practice in our chosen areas. But, if we do not step up now, donate to the FSAPAC and ASAPAC, stay active, spread the word and make our voices heard, we will be eliminated. In all honesty, nothing else really matters…

Keya Locke is a 3rd year Resident in the Department of Anesthesia at the University of Florida-Jacksonville

Report from ASA Practice Management 2016 *by Micah David Gaar, MD*

Transitioning from residency training into a new practice is an intimidating step in a young anesthesiologist's career. The typical resident fear of being alone and on call for the first time is only one of many anxiety provoking concerns considered while looking onward to post-training life. Simply understanding the different anesthesiology practice types, how the new group or employer addresses risk management issues, becoming familiar with quality performance and how it relates to the practice's bottom line, this new important concept of medical direction, and how this all wraps into the billing process are vast and extremely important domains that are often not emphasized during residency training. Thankfully, I had the opportunity to attend the American Society of Anesthesiologists' Practice Management 2016 conference, which offers a Resident Track specifically tailored to residents and fellows nearing the end of their training in order to get an early foothold on these foundational, yet complex, concepts.

The conference was held in San Diego, on a typically pleasant Saturday. Glancing through my lecture schedule revealed some timely and relevant topics such as Employment Contracts, Employer Expectations, Budgeting with a Larger Paycheck, and an introduction into the Perioperative Surgical Home, which I had heard in passing during my clinical duties back home in Miami. We were seated in a large conference hall, at round tables, which allowed residents and fellows from across the country to introduce themselves and discuss each other's programs and plans for the future. This may sound like business as usual at a conference for the more seasoned anesthesiologist, but it is surprisingly rare for an anesthesiology resident to meet residents from other programs, much less at such an important time at the end of training.

The lectures were delivered in a concise and effective format by experienced practice leaders and professionals. The conference schedule was kept on track and we were able to submit questions via text or email, which were addressed in a Q&A session

offered at regular intervals throughout the day. Each lecture had plenty of additional references or sources to pursue if an attendee wished to delve deeper into a topic. We were also given the option to have a copy of all the lectures mailed to our homes so we could focus more on the presentation and less on vigorously scrawling notes. Brief roundtable discussions between presentations allowed us to discuss how this new information would assist us in our transition into practice, and it was a great relief to find how many others had the same concerns and faced similar obstacles as myself.

An unexpected benefit of attending the Resident Track was simply engaging in conversations with practice leaders on the convention floor and during lunch. I don't know of any other forum that would allow a resident to meet and discuss the details and nuances of various practices so openly and efficiently. A wealth of insight can be gained by simply asking various groups, "What are you looking for in a potential new partner?" or "What advice would you give me while I am just starting out?" These interactions, after a day of focused presentations and roundtable discussions, cemented an eye-opening experience. The American Society of Anesthesiologists' Practice Management Resident Track is a valuable opportunity to break away from the day-to-day life of residency to meet peers and future colleagues and learn about the challenges we face as we venture into practice.

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