HOSPITAL IN REVIEW

The VA Boston Healthcare System, the largest consolidated facility in VISN 1-VA New England Healthcare System, encompasses the 3 main campuses and 4 outpatient clinics within a 40-mile radius of the greater Boston area. The consolidated facility consists of the Jamaica Plain Campus, located in the heart of Boston’s Longwood Medical Community; the West Roxbury Campus, located on the Dedham line; and the Brockton Campus, located 20 miles south of Boston in the City of Brockton. In addition to the 3 main medical centers, 5 Community Based Outpatient Clinics (CBOCs) located in Framingham, Lowell, Quincy, Causeway Street (Boston), and Plymouth make up VA BHS.

VA Boston Healthcare System

Jamaica Plain Campus, located in the heart of Boston's Longwood Medical Community

ANESTHESIOLOGY

Today, our staff is comprised of 14 faculty attending anesthesiologists, 9 nurse anesthetists, 3 anesthesia technicians, 2 administrators, 3 rotating anesthesia residents, 2 rotating fellows and 6 anesthesia interns. Despite a diversity of backgrounds and training, the anesthesia team remains a harmonious group with similar interests in improving patients' well-being, providing the best educational experience for our trainees, and investigating innovative ideas to further enhance the services offered to patients.

(continued on page 12)

REPORT OF COUNSEL

NURSE ANESTHETISTS SEEK INDEPENDENT PRACTICE

Edward J. Brennan, Jr., Esq.

Under the guise of allowing advanced practice nurses, including nurse anesthetists, to practice to the “fullest extent of their education and training,” nursing advocates are pushing for independent practice.

As reported earlier this year, The Massachusetts Association of Nurse Anesthetists has joined with the Massachusetts Coalition of Nurse Practitioners to file H. 2009 and S. 1079. The bills, if passed, would eliminate the statutory

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Standing Committees of the Executive Committee:

Constitutional Committee:
Selina A. Long, MD, Immediate Past President
Betty L. P. O'Brien, MD, Treasurer

Standing Committee on Nominations:
Fred Shapiro, DO-Chair (2014), Ruben Azocar, MD, Selina Long, MD (2015)

Standing Committee on Rules and By-Laws:
Lee Perrin, MD-Chair, Corey Collins, DO, Mary Kraft, MD, Ruben Azocar, MD, Roman Schumann, MD

Standing Committee on Residency Affairs:

Standing Committee on Ethics and Standards:

Standing Committee on Governmental Affairs:

Standing Committee on Public Education:

Standing Committee on Publicity:
Selina Long, MD (2015), Lawrence A. Simons, MD (2016), Angela M. Mckee, MD (2017)

Standing Committee on Special Projects:
Jeffry B. Brand, MD (2014), Michael Barnett, MD (2015), Chaithanya Pinni, MD (2016), Brian O'Gara, MD (2017)

Standing Committee on Research:
Lee S. Perrin, MD-Chair, Corey Collins, DO, Mary Kraft, MD, Ruben Azocar, MD, Roman Schumann, MD

Standing Committee on Mergers:
Fred Shapiro, DO-Chair (2014), Ruben Azocar, MD, Selina Long, MD (2015)

Standing Committee on Publications:
Selina A. Long, MD (2015), Mary Ann Vann, MD (2016), Brian O'Gara, MD (2017)

Standing Committee on Hospital Affairs:
Selina A. Long, MD (2015), Mary Ann Vann, MD (2016), Brian O'Gara, MD (2017)

Standing Committee on Continuing Education:
Fred Shapiro, DO-Chair, David Stahl, MD (2016), Michael Barnett, MD (2017)

Standing Committee on Special Projects:
Jeffry B. Brand, MD (2014), Michael Barnett, MD (2015), Chaithanya Pinni, MD (2016), Brian O'Gara, MD (2017)

Standing Committee on Research:
Lee S. Perrin, MD-Chair, Corey Collins, DO, Mary Kraft, MD, Ruben Azocar, MD, Roman Schumann, MD

Standing Committee on Nominations:
Fred Shapiro, DO-Chair (2014), Ruben Azocar, MD, Selina Long, MD (2015)
EDITOR’S REPORT

A NOTE FROM YOUR EDITOR, RICHARD D. URMAN, MD, MBA

Welcome to the 41st edition of the MSA Record! Our goal is to keep you informed of what is happening in the world of anesthesia – both in Massachusetts and on the national level. I’m honored to continue serving as Chair of Publications Committee and MSA Anesthesia Record editor. It has been a year since our last newsletter, and a lot has happened that directly impacts our specialty and our patients. In this edition, we describe recent events and activities of a very busy year. As you will see, MSA has been active on the political, membership, and educational fronts as demonstrated in the reports by our MSA President, ASA Director, Legal Counsel, and Committee Chairs. Highlights include nurse anesthetists seeking independent practice in Massachusetts, healthcare payment reform, prescription monitoring program and its impact on anesthesia practice, changes to MSA bylaws, news about Lifebox challenge, and the Anesthesia Quality Institute update. In addition, you will find a description of CME educational opportunities, Dr. Suciu’s report from the resident (CORA) component, and Dr. Philip’s ASA Director update. As usual, we highlight a local anesthesia practice, and we have selected VA Boston as our feature article.

Over the year we further developed our website (www.massanesthesiology.org) to better serve the needs of our members. Visit it often for latest news, meeting and education updates. The good news is that our membership numbers are up, and MSA remains a strong force advocating for our specialty both locally and nationally.

We would like to thank our immediate past MSA president, Dr. Selina A. Long for her extraordinary leadership and welcome our new president Dr. Michael R. England, as well as the newly elected Executive Committee and ASA Delegation. I hope that this edition will highlight ample opportunities to participate and inspire you to become more involved with the MSA, ASA, and their respective PACs. We have listed all current officers and committee members, so feel free to contact any of them with questions.

Finally, please mark your calendars so that you can participate in many exciting upcoming events including CME courses, MSA Annual Meeting, ASA Legislative Conference and our regular MSA Executive Committee meetings to which all members are invited. I hope that you enjoy reading this edition of the MSA Anesthesia Record. If you have any comments or interested in contributing an article, please contact me. ~

ASA Annual Meeting
ANESTHESIOLOGY 2013
October 12-16
New England Caucus Meetings

Saturday 3:00 - 4:30 pm, Yerba Buena 14-15
Tuesday 3:00- 5:00 pm, Pacific H
San Francisco Marriott Marquis
On May 23, 2013, I had the honor of taking the reigns of the Massachusetts Society of Anesthesiologists from Dr. Selina Long. I was truly humbled, for I felt a feeling of smallness trying to fill her shoes. She had done an excellent job of positioning the society for the storm that we all see (and saw) just over the horizon. The field of anesthesiology as well as the profession of medicine is under “attack” to reinvent itself. Physician extenders of all varieties are trying to redefine what their practice is and should be, with or without the belief that they need to be “supervised” by physicians. Society in general, with the passage of the Affordable Care Act, wants access to medical care. The quality of that care is secondary to gaining access to care.

Exactly how this will play out in the coming years is unclear. The relationship between anesthesiologists and nurse anesthetists is being constantly challenged, despite the clear difference in training, decision making ability and expertise. How quality will change is the issue. Dissolving the anesthesia care team model is the intent of many non-physician providers of anesthesia care. As one nurse anesthetist told me “why should the Board of Registration in Medicine tell me (a nurse) how to practice?”

In taking on the challenge we face in Massachusetts, immediately after being given the gavel from Dr. Long at the annual meeting, there was a heated discussion on the direction the MSA should travel to oppose the current bill in the Massachusetts Legislature for independent nursing practice. Some in the audience felt that we should use all of our resources to hire a lobbying firm to present our case to elected officials. That was countered by the realization that we have an excellent person who is doing an outstanding job at the State House keeping his ear to the ground protecting our best interests in Mr. Edward Brennan. It was also pointed out that this effort on the part of the nurses is a marathon and not a sprint and that the high costs of a separate firm, could lead us to bankruptcy.

After a time it was decided to make moves slowly and not rush to hire a commercial firm, rather plan to work closely with the Massachusetts Medical Society hand in hand to defeat this initiative and not make this just an “anesthesia” issue. Indeed, it is in fact not just an anesthesia issue. The legislation would apply to nurse practitioners as well. A similar bill would grant independent practice to psychiatric clinical nurse specialists. Shortly after the annual meeting, I sat down with Mr. Brennan and Mr. Bill Ryder of the MMS to see what that organization could offer us in the way of sage advice and planning a strategy with them. Mr. Ryder noted that MMS strongly opposes the bills. He noted that engaging high price lobbyists is no guarantee of success. Rather, he advised that we need to encourage all of us to get involved. We need to create a grass roots political effort. We all need to get to know our local state representative and senator. We need to take the time to go and visit them in person to make our points clear, and ask for their support. These elected officials respond to their voting constituents, not high paid lobbyists. This is the (continued on page 14)
Spiro G. Spanakis, D.O., is a pediatric anesthesiologist at University of Massachusetts Memorial Medical Center, where he is an Assistant Professor of Anesthesiology and Pediatrics. He is currently President Elect of the MSA after completing his term as Vice President.

Long active with our state specialty society, Dr. Spanakis served as a resident delegate for the American Society of Anesthesiologists Resident and Fellow Section as a first year anesthesia resident in 2003. He has continued to serve the Society in various capacities, including establishing a web site for the MSA during his residency, which he continues to oversee. Since that time, he has served on the Executive Committee, the Program Committee and as program director for several MSA continuing medical education programs, in addition to serving as alternate delegate and delegate to the American Society of Anesthesiologists.

He was recently elected to the position of Speaker of the House of Delegates for the American Medical Association Young Physicians Section. Prior to his election, he served as chair of the Massachusetts Young Physicians Section delegation to the AMA in his role as Chair of the Massachusetts Medical Society’s Committee on Young Physicians. Currently, he is the Vice Chair of the Committee on Preparedness at the Massachusetts Medical Society and is a member of its Committee on Strategic Planning. Locally, he is the Secretary of the Worcester District Medical Society.

Besides his extensive involvement in organized medicine, he divides his time between his clinical practice at several Worcester campuses, resident education and patient safety in the Department of Anesthesiology at UMASS Memorial Medical Center. Currently he is the Clinical Base Year Director for categorical residents. As the Director of Simulation, he uses high fidelity simulation scenarios to expose residents to rare critical events in the operating room. He was recently awarded an Inter-Professional Education Grant from the University of Massachusetts Medical School to bring together an interdisciplinary group of health care providers to learn crisis management techniques in the operating room. In his role as Associate Quality and Safety Officer for the Department of Anesthesiology, he organizes the department’s Quality Improvement Conferences where he promotes interdisciplinary system solutions to prevent medical errors in the practice of anesthesiology.

Dr. Spanakis attended the College of the Holy Cross where he earned a B.A. in Biology. He received his Doctor of Osteopathic Medicine degree from the University of New England College of Osteopathic Medicine in Maine. Board certified in anesthesiology, he completed his residency training at the University of Massachusetts Medical Center and his fellowship in pediatric anesthesiology at Children’s National Medical Center in Washington, DC. He currently resides in Worcester. ~
REPORT OF THE MSA SECRETARY
Sheila R. Barnett, M.D.
May 23, 2013

The active membership of the Massachusetts Society of Anesthesiologists has surpassed the 900 mark; the present count is 946 active members. This entitles the MSA to ten (10) ASA Delegates at the ASA House of Delegates, October 12-16, 2013 in San Francisco, CA.

The MSA is working towards re-listing of members by home address and eliminating MSA’s hospital districts in favor of organizing MSA districts along with congressional districts in order to better identify constituents for legislative activity and for the future the ability to vote on-line via the website.

Membership totals as of May 23, 2013

<table>
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<tr>
<td>Active</td>
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<tr>
<td>Affiliate</td>
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<tr>
<td>Resident</td>
<td>490</td>
</tr>
<tr>
<td>Retired</td>
<td>193</td>
</tr>
</tbody>
</table>

A moment of silence for our deceased members
Harry E. Bowen, M.D.
Abdel Mehtio, M.D.
Joseph L. Murphy, M.D.
Joan Peterson, M.D.
Samuel Winer, M.D.
PAST PRESIDENT’S ANNUAL REPORT - MAY 2013

The conclusion of my year as the president of the Massachusetts Society of Anesthesiologists likewise concludes the busiest year for advocacy, membership improvements and education in the Society’s history. Allow me to elaborate below.

Most of the Society’s energy went into advocacy advances this year:

1) In July, I submitted testimony regarding proposed amendments to regulations of the Division of Health Care Finance and Policy regarding the adoption of actual time units for MassHealth anesthesia services, and called for MassHealth to adopt payment Modifiers 25 and 59, which I am pleased to say have been implemented.

2) In August, Governor Patrick signed Chapter 224 of the Acts of 2012 (health care payment reform) into law, which became effective in November. We have been closely watching the evolution of accountable care organizations (ACO’s), the cap on medical spending to the gross state product (GSP) and medical malpractice reform. The MSA will continue to monitor the implementation of Chapter 224 to ensure that quality anesthesia and pain management services are not adversely affected as Massachusetts transitions into new payment methodologies and systems.

3) In October, the House of Delegates of the American Society of Anesthesiologists affirmed through four resolutions that:
   c) regional anesthesia is the practice of medicine,
   d) OR medications should be safely secured,
   e) delineated the differences in training between anesthesia assistants and CRNAs,
   d) provided guidelines for deep sedation by non-anesthesiologists.

4) In November, Alex Hannenberg, MD, Ed Brennan, Esq. and I met with Health and Human Services representatives in Massachusetts to clarify anesthesia billing for MassHealth patients. We proposed that MassHealth adopt Medicare rules and Modifiers for anesthesia services which recognize medical supervision.

5) In January, House Bill 2009 and Senate Bill 1079 were filed to petition for expanding the scope of practice for all advanced practice nurses, including CRNAs. If passed, it would effectively eliminate supervision and the care-team model of anesthesia practice, allowing independent practice. The MSA vigorously opposes this legislation, and moreover it was the impetus for several membership developments that will allow us to better motivate, organize and mobilize the Society in opposition. The ASA has been very supportive of the many states where scope of practice legislation is pending, and I participated in several conference calls with other state society presidents regarding their similar activity. Because developments in this area were fast-moving and required leadership consensus, Mike England, MD, your President-Elect, and Spiro Spanakis, DO, your Vice-President, and I initiated weekly conference calls to discuss developments and strategy.

6) In March, I submitted written testimony to Dr. Lauren Smith, the interim Commissioner of Public Health, regarding the burdens proposed by regulations that implementing the “Prescription Monitoring Program” would place upon our specialty practice, and requested that perioperative anesthesiologists be exempt from the program as we do not typically prescribe any medications upon or after a patient’s discharge. Further information regarding this issue is contained in the Report of Counsel.

7) The ASA Legislative Conference met in late April in Washington, DC, which focused on federal issues:
   g) truth and transparency for healthcare providers,
   h) easing of drug shortages,
   i) maintaining scope of practice and the care-team model,
   j) a permanent SGR fix.

As you can only imagine, these developments required the MSA to update many Society “fixtures” of the past so that we

(continued on page 11)
Comparison of House and Senate Health Care Payment Reform Bills

(continued from page 1)
provisions requiring these nurses to practice under the supervision of a physician, and removes the Board of Registration in Medicine from its current role in jointly regulating the scope of practice of CRNAs and NPs with the Board of Registration of Nursing. The scope of practice of CRNAs and NPs would be left solely with the Nursing Board. This is tantamount to independent practice.

The bills would eliminate the longstanding standard of care requiring a nurse anesthetist to administer anesthesia under the supervision of a qualified physician and therefore compromise the safety and care of patients in the Commonwealth.

Because the bill’s language fails to place any statutory limitations on scope of practice, the legislation could dramatically expand nurse anesthetists’ scope of practice into areas that consist of the practice of medicine; such as, chronic pain and cancer pain. Not only is a nurse anesthetist’s education and clinical training much shorter than an anesthesiologist’s training, it does not include any significant time studying and training in the diagnosis and treatment of these conditions.

The bills have been assigned to the Legislature’s Public Health Committee, and hearings are likely to be scheduled later this year or the beginning of 2014. MSA is vigorously opposing the bills, as is the medical society and other medical specialty societies. It is vitally important, however, that anesthesiologists speak up for patient safety, and tell legislators that when seconds count, having an anesthesiologist or qualified physician immediately available, working with and overseeing the CRNA reduces risk and ensures the safe delivery of quality anesthesia care.

In the coming weeks, MSA will be calling all members to action and asking you to contact your state representative and senator. When those calls come, please stand up for your patients and contact your legislators.

Nursing Board Proposes New Regulations for APRNs Scope of Practice

The Nursing Board has proposed new regulations for advanced practice nurses (APRNs), including nurse anesthetists, which eliminate longstanding physician supervision requirements over all aspects of APRN practice, except for prescribing medications. Under current law, a CRNA can order tests and therapeutics and prescribe medication under the supervision of a physician during the immediate perioperative period of care, which is defined as “day prior to surgery and ending upon discharge of the patient from post anesthesia care.” The proposed regulations do not accurately reflect statutory provisions requiring physician supervision for the ordering of tests and therapeutics or administering medications where a CRNA does not have prescriptive authority (DEA number). Nor does it reflect statutory provisions requiring physician involvement in jointly promulgating regulations involving the ordering of tests and therapeutics and prescribing medications. At a hearing before the Nursing Board on August 7, MSA president, Michael England, M.D., testified in opposition to the proposed regulations, reminding the Nursing Board that it needs to follow the applicable statutory provisions governing physician supervision of CRNAs. The medical society and other medical specialty associations also opposed the regulations.

Truth and Transparency for Health Care Providers

MSA is supporting S. 1035 which would require all health care practitioners to conspicuously post and communicate to patients and the public the practitioner’s specific licensure. A health care practitioner would be required to wear a photo identification name tag during all patient encounters, which would include the practitioner’s name and type of license. The name tag must be of sufficient size to be visible and apparent to all patients. S.1035 is before the Public Health Committee. A hearing on the bill has yet to be scheduled.

Prescription Monitoring Program

An outside section of the final FY’2014 state budget amends the Prescription Monitoring Law to make clear that physicians are required to check the Prescription Monitoring Program only when prescribing a schedule II or III narcotic to a patient for the first time (giving a patient a written prescription to be filled at a pharmacy). Prior to the passage of this provision in the budget, the Department of Public Health (DPH) was working on regulations that would have required physicians to utilize the PMP for every new patient, regardless of age, diagnosis or intent to prescribe a scheduled medication. This could have been construed to require an anesthesiologist to check the PMP for every patient undergoing anesthesia. The MSA will monitor the regulatory process necessary to implement the new revised law. Enforcement of the law will not begin until the regulations are in place.

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It is my pleasure as your Director to give you an update on the national Anesthesiology issues. ASA and MSA advocate for the interests of you, our members.

Our society’s annual meeting, ANESTHESIOLOGY 2013 will be held in San Francisco in October. An exciting program of educational, scientific and advocacy activities is being readied to address the interests of all attendees. The Opening Session will be “Chasing Zero”, a presentation by Charles Denham, MD, Editor-in-Chief of the Journal of Patient Safety, with actor and patient safety advocate Dennis Quaid. The APSF Ellison C. Pierce Lecture on Patient Safety will feature Alan F. Merry, MD, and Massachusetts’ own Jeffrey B. Cooper, PhD will receive the ASA Distinguished Service Award for his achievements improving anesthesia patient safety. Check out the meeting website http://www.asahq.org/Annual-Meeting/ and plan now to attend!

MSA leadership and our resident representatives participated in the annual ASA Legislative Conference in Washington DC. Appropriate payment for our services is always important to ASA members, and we addressed several Medicare payment issues. We reminded our legislators about anesthesiology’s uniquely low payment from Medicare at 33% of private payment rates, and therefore advocated that anesthesia should be “held harmless” for further payment cuts through the Medicare SGR (Sustainable Growth Rate) formula cuts. We were able to show our legislators that according to the Congressional Budget Office, anesthesiology services are not driving volume or growth in Medicare spending. This year, House committees have released a concept proposal to replace the SGR with a quality-based program, and have sought input from stakeholders including ASA to refine it; the future of this initiative is uncertain. ASA also advocated for repeal of the non-elected Independent Payment Advisory Board (IPAB), which would have sweeping powers to mandate added payment reductions on top of SGR cuts. Support for this repeal is growing, with bills introduced in both House and Senate this year (H.R. 351 and S. 351).

ASA is also proactively addressing the changing health care system with its increased focus on care coordination and reduction of unnecessary services, to help ASA members find productive opportunities. With our legislators in Washington, we reinforced ASA’s concept of the Perioperative Surgical Home, where anesthesiologists would serve as the medical coordinators of the entire peri-operative patient care process. The Perioperative Surgical Home can provide strategic and financial support for the anesthesiologist as the Perioperative Physician. ASA’s Committee on Future Models of Anesthesia Practice, which includes your Director, is actively preparing the detailed components of this model, including monetization, so that ASA members can use this structure to develop their own practices.

Many types of providers are involved in health care today, including physicians, technicians, nurses, physician assistants and other allied providers. Increasingly, the training programs provide doctoral degrees within their specialty, allowing them to be called “Doctor”, and recent studies confirm increasing patient confusion. There is a heightened need to make sure that patients have adequate information to make wise and cost-conscious health care choices and decisions. To address this, legislation has been introduced in the House to improve transparency in the identification of health care providers and in health care provider-related advertisements and marketing (H.R. 1427). ASA actively supports this legislation.

Shortages of critical intravenous drugs continue. Central nervous system drugs, which include drugs used by anesthesiologists, are the class of drugs most frequently affected by shortages. The causes of drug shortages are specific and unique to each drug, and include: legislative and regulatory factors; a lack of contingency plans for critical drugs that are vulnerable to shortages; manufacturing factors such as noncompliance with FDA Good Manufacturing Practice regulations; business and market factors such as consolidation of firms and lack of business incentive to enter a specific product market; market price pressure; and distribution factors such as just-in-time inventory. Because the causes of shortages are multi-factorial, a variety of solutions will be needed to alleviate drug shortages. The Food and Drug Administration Safety and Innovation Act (FDASIA) passed last year newly requires manufacturers to report expected interruption or discontinuance of critical drugs’ manufacture, leaving time to develop alternatives. ASA and FDA are frequently in contact about the evolving drug shortages issues.

(continued on page 19)
might be more nimble in navigating the course ahead. These include:

1) Clarifying and making the officer nomination process more transparent and egalitarian through by-laws changes to be voted on at the 2013 Annual meeting,

2) Outsourcing CME programming to the Massachusetts Medical Society to better concentrate our office resources on membership advances,

3) Website improvements - members only area with log-in protection and a link to the state anesthesiologists PAC website for donations,

4) Re-listing of members by home address and elimination of former MSA “districts” in favor of organizing MSA districts along with congressional districts in order to better identify constituents for legislative activity,

5) Engaging and strengthening our connections with both the State’s academic and private practice leadership through informative meetings and social events,

6) Acquiring Officer’s and Director’s insurance.

In fulfilling our educational mission, we have offered several popular courses each year (for example: ultrasound guided regional anesthesia, difficult airway management, update in sedation and analgesia), and continue to support and develop the New England Anesthesiology Residents Conference, held this year at the Brigham and Women’s Hospital.

I continue to be grateful for the “seasoned” advice of Dr. Alex Hannenberg, the past president of ASA, the legal counsel of Mr. Edward Brennan, the secretarial support of Ms. Beth Arnold, and YOU.

Selina A. Long, M.D.

President 2012-2013
Hospital in Review-continued

VA Boston Healthcare System-continued

(continued from page 1)

to our veteran patients by promoting new research discoveries in clinical investigation. In addition, the anesthesiology staff, surgeons, OR nurses and support staff have formed a close-knit group that enjoy working and socializing together. Our rotating trainees frequently comment on this culture of professional and friendly coexistence between the OR services. VABHS is proud to have been elected to the top of the Boston Globe '100 best employers' list and this is mirrored by very high work satisfaction by members of the anesthesia team.

The Anesthesiology, Critical Care and Pain Medicine Service provide a range of clinical, educational, and research activities throughout the health care system. Clinical services include anesthesia care both in the operating room suite and at specialized sites throughout the hospital, critical care and medical direction in the surgical intensive care units, pain management for chronic and acute pain symptoms as well as liaison with the emergency department, and emergency response via code calls and airway management coordination. Hence, anesthesiologists in our group are specialty-trained in critical care medicine, cardiac anesthesia, regional anesthesia, thoracic anesthesia, patient safety, and pain medicine.

We provide training in anesthesiology, critical care, pain management, regional anesthesia and preoperative assessment. Anesthesia residents, pain fellows and anesthesia interns rotate through VHBHS from Massachusetts General Hospital (MGH), Beth Israel Deaconess Medical Center (BIDMC), Brigham and Women’s Hospital (BWH) and Boston Medical Center (BMC). Medical students from Boston University School of Medicine and Tufts University also receive opportunities to join the anesthesia team during mandatory and elective rotations. Furthermore student registered nurse anesthetists (SRNA) from Northeastern University and St. Joseph’s Hospital, RI have an established educational presence at VABHS. Our educational opportunities include clinical training for all levels of trainees under close supervision, simulation experiences, didactic and small group sessions including weekly multidisciplinary anesthesia, cardiology, cardiac surgery and vascular surgery rounds.

Research areas range from basic science such as pain and anesthetic mechanisms through clinical studies. Specifically in the realm of perioperative care, our goals include providing the highest quality anesthetic and surgical services, identifying ways to increase operating room efficiency, improving patient outcomes through earlier rehabilitation and superior pain control, and minimizing postoperative complications in the intensive care unit and hospital wards. VABHS has been the pioneer for the National Surgical Quality Improvement Program (NSQIP), the Veteran Affairs Surgical Quality Improvement Program (VASQIP) and now is actively joining a national VA anesthesiology group to create the Veterans Affairs Anesthesia Quality Improvement Program (VAAQIP). VAAQIP is planned to establish a database from Anesthesia Record Keeping (ARK) systems of every VA hospital in the nation as well as receive and utilize data from other currently existing VA databases. Furthermore, VABHS anesthesiologists actively participate in a VHA’s National Center for Patient Safety lessons learned project.

Pain Medicine

The VABHS Pain Clinic is an interdisciplinary clinic composed of Board Certified Pain Management physicians, behavioral medicine psychologists, and advance practice nurses. Pain clinic’s priorities are, 1) patients with neuropathic pain (examples: diabetic neuropathy, trigeminal neuralgia, post herpetic neuralgia), 2) pain related to cancer or cancer therapies, 3) pain related to traumatic brain injuries and polytrauma, and 4) patients who may be helped by interventional procedures. The overriding goal is to help patients become as functional as possible while relieving as much pain as possible. The clinic is designed to do a thorough pain assessment, develop a plan of care, and either implement that plan of care or make recommendations back to the referring provider. Pain service recognizes that chronic pain can often be reduced but seldom completely eliminated. To maximize improvement the Pain Clinic uses medications emphasizing non-narcotic strategies, physical rehabilitation, mental hygiene and interventional procedures when indicated. Patients are encouraged to play an active role in their therapy.

We also provide consultation on the inpatient wards for patients with cancer pain, neuropathic pain and patients with polytrauma injuries. ~
Health Care Payment Reform Bills-continued

(continued from page 9)

**Health Care Payment Reform**

The comprehensive health care payment reform law, Chapter 224 of the Acts of 2012, is being implemented. A new state agency, the Health Policy Commission, has been formed and is charged with implementation. The Commission will set the annual health care cost growth benchmark (the amount health care spending will be allowed to grow, which for 2013 is 3.6%); certify new payment methods and care delivery models (ACOs and Medical Homes); oversee the publishing of cost and quality data and the development of a state health plan to determine the future medical capital needs of the Commonwealth every 5 years; and monitor and review the impact of changes in the health care system.

Other state agencies established by Chapter 224 are taking form. Among these is the Health Information Technology Council, which will oversee the development of interoperative health information exchanges that will allow for the secure electronic exchange of health records among all providers in Massachusetts by 2017.

MassHealth (Medicaid) has begun the Chapter 224 mandated transition toward a global payment system based on delivery of care through medical homes in which primary care providers will be coordinating care. MassHealth has set a goal that 25% of its covered lives would be under global payments by July, 2013; 50% by July 2014; and 80% by July 2015.

The Massachusetts hospital market continues to consolidate through mergers and affiliations, as provider networks develop to take on risk through global payments and alternative payment methodologies.

In June, the Legislature enacted a law which brings Massachusetts into compliance with the Affordable Care Act. The Commonwealth Health Insurance Connector, the state entity created as part of the Massachusetts health care access law of 2006 to help the uninsured find health insurance, will be the Exchange for the state under the ACA.

MSA will continue to monitor implementation of Chapter 224 and the rapidly changing health care market in Massachusetts very closely. ~

Dr. Michael England pictured with Mary Muchenda, CEO, Kijabe Hospital, Kijabe, Kenya, with Dr. Mark Newton, on his recent visit.
President’s Report—continued

MSA Plans for the upcoming year - continued

(continued from page 5)

tactic that our nursing counterparts are taking. We have to get involved. So, what is the MSA planning?

1. Updating our membership lists to include all member’s voting zip code that will be linked to their state senator and representative.

2. Calling upon you, our members, to speak out on behalf of patients and the need to maintain anesthesia safety by contacting legislators with the message: “When seconds count, having an anesthesiologist immediately available, working with and overseeing a nurse anesthetist reduces risk and ensures the safe delivery of quality anesthesia care.”

3. Encouraging all residents to be politically involved and knowledgeable of the impact that nurse independent practice may have on their career.

4. We received a grant recently from the ASA to partially fund our efforts. We will discuss the possibility of directing these funds to engage a firm to properly strategize our “campaign” to maximize the impact of our message.

5. Work closely with the MMS in formulating a concise strategy during the upcoming legislative hearings (to be held in December or January) on scope of practice.

6. We have testified before the Board of Registration in Nursing when they had a public comment session on their new regulations regarding advanced practice nurses. It was pointed out clearly that the new proposed regulations do not conform to the state statute requiring physician supervision in the ordering of tests, therapeutics and prescribing of medications. I also pointed out that Nursing regulations have to be jointly promulgated with the Board of Registration in Medicine on these matters. This was not their plan!

This promises to be a most interesting and busy year! ~
Respectfully submitted

Michael R. England, MD
MSA President 2013-2014

Pictured above, incoming MSA President, Dr. Michael England and MSA Treasurer, Dr. Daniel O’Brien at the MSA Annual Meeting in May.

EXECUTIVE COMMITTEE MEETING DATES FOR 2013-2014

Thursday, Sept. 12, 2013
Thursday, Oct. 3, 2013
Thursday, Nov. 21, 2013
Thursday, Jan. 16, 2014
Thursday, Mar. 6, 2014
(All members are welcome)

* note-date change, November and January meetings, same location.
COMMITTEE ON PROGRAMS ANNUAL REPORT - MAY 2013

The Program Committee oversaw a number of successful programs in the past year. The Abdel Mehio Ultrasound Guided Regional Anesthesia course, held, December 1, was popular as usual. New topics included complications of regional anesthesia as well as the use of continuous catheters for blocks. The 3rd Annual Winter Meeting in Puerto Rico, again presented interesting speakers in a gorgeous tropical locale and was enjoyed by a small but enthusiastic group; the number of registrants doubled this year.

The NEARC Subcommittee of the Program Committee has been instrumental in ensuring continuation of the New England Anesthesia Residents Conference. This annual meeting, intended to be run by residents and for residents, was held April 18 at Brigham and Women’s Hospital. It was a resounding success and the Program Committee hopes interest in the meeting will remain strong and that the CORA residents will eventually take on a major leadership role for NEARC.

Upcoming meetings include the Airway Meeting, which was postponed until the Fall at a date to be determined. We are also happy to coordinate again with the New England Society of Anesthesiologists for their 56th Annual Fall Conference September 19-22 in the Berkshires. The Program Committee is currently working on a new program designed to assist members with understanding the requirements for MOCA, as well as offer some MOCA-approved CME credits. This program will be offered this winter at a date to be determined.

As always, the Program Committee is always seeking interested members to help with planning and steering the meetings of the MSA. Please contact Cristin McMurray with questions or comments.

SAVE THE DATE

MSA 7TH UPDATE IN SEDATION & ANALGESIA

Saturday, April 12, 2014

Waltham Woods Conference Center, MMS Headquarters
Waltham, MA

The Third Annual Winter Conference was held at the El Conquistador Resort in Las Croabas, Puerto Rico, January 18-21, 2013. Speakers from left to right, Drs. William Camann, Keith Ruskin, Program Director Cristin McMurray and Fred Shapiro, enjoying the picturesque view.
COMMITTEE ON BYLAWS ANNUAL REPORT - MAY 2013

Chair
2012-2013

Lee S. Perrin, M.D.

A number of different Bylaws related items were referred to the Committee. Below are bylaw changes recommended by the Executive Committee during the past year. It is required by our Bylaws that once recommended by the Executive Committee of the MSA that the proposed changes be mailed to the members of the Society thirty days prior to the Annual Meeting. This report constitutes that notice.

1. Updating our parliamentary reference. “Sturgis” is no longer being published. The most recent version by many of the same editors of the 4th edition of Sturgis is now called the “American Institute of Parliamentarians Standard Code of Parliamentary Procedure”. The changes are available on the American Institute of Parliamentarian’s web site. This bylaw change was recommended by the EC on September 6, 2012.

11.1 PARLIAMENTARY AUTHORITY


2. During a previous bylaws “cleanup”, we missed removing “Bachelor of Medicine” from the qualification for the retired membership category. There was some confusion as to whether someone with the Bachelor of Medicine was able to become a member of MSA or ASA. ASA’s interpretation of the language is that the terms “Doctor of Medicine or Doctor of Osteopathy” refers to the type of physician and NOT to a particular degree. Therefore, ASA accepts anyone with a DEGREE that is equivalent. This bylaw change was approved and recommended by the EC on September 6, 2012.

3.3.4 Retired

3.3.4.1 A Doctor of Medicine or Doctor of Osteopathy who has been a continuous active member of this Society or another component society for ten (10) years or more and who is eligible for retired status in The American Society of Anesthesiologists, Inc., and who has retired completely from professional activity; provided, however that the Executive Committee may at its discretion modify the time upon resumption of professional activity.

3. When we amended our bylaws to allow membership in the component based on either where you lived or where you worked we neglected to include that choice in section 3.6. Section 3.6.2 does limit the member to belonging to only one component at a time. It should be noted that section 3.6.2 (not included here) says that an individual can only belong to one component society. This bylaw change was approved and recommended by the EC on September 6, 2012.

3.6 MAINTENANCE OF OTHER MEMBERSHIPS

3.6.3 Members of The American Society of Anesthesiologists, Inc., upon transfer of their location of professional activity or residence to the Commonwealth of Massachusetts shall apply for membership in this Society within 180 days unless they are a member of another component society.

4. Earlier this year there was a discussion regarding the nominating, balloting and ballot counting process. It was suggested that we change our procedure. We also do not have a satisfactory mechanism for breaking a tie on the mail ballot. These questions were discussed at the November 29, 2012 and January 10, 2012 meetings of the Executive Committee and these bylaws changes approved and recommended at the January meeting.

8.2.7 Committee on Nominations

8.2.7.3 Duties

To prepare a list of nominees for each office which is to be vacant in this Society and to forward their recommendations to the Executive Committee by March 1. The Committee shall solicit the membership for nominations in December and close the period for receiving nominations on February 1.

(continued on next page)


Annual Reports-continued

Committee on Bylaws Annual Report-continued

(continued from previous page)

4.3 ELECTION

4.3.1 Nominations Approval

Nomination of officers will be made from the recommendations of the Committee on Nominations. The Executive Committee may amend the report of the Committee on Nominations by a majority vote of the voting membership of the Executive Committee present and voting.

4.3.2 Ballot Distribution

Election shall be by the members of this Society by ballot distributed by mail forty-five days prior to the annual session by the Secretary of this Society using instant runoff voting. The voted ballots must be received by the Secretary prior to the annual session at a date specified by him/her. Nothing in these Bylaws shall preclude a member from casting a ballot for a write-in candidate.

4.3.3 Ballot Counting and Results

The ballots will be counted by the Secretary and two tellers appointed by the President and approved by the Executive Committee. A tie will be broken by a coin toss by the Secretary as witnessed by the tellers. The results will be announced at the Annual Meeting of the Society.

5. Review of the Bylaws disclosed that, unlike most associations, the MSA does not have a policy or bylaw regarding the indemnification of the volunteers who serve on our committees, our officers or our employees. The proposed bylaw below was crafted by MSA legal counsel and the Bylaws Committee chairman. It was presented at the January 2013 Executive Committee meeting and recommended for approval at that time. This will become a new section of the bylaws in the Miscellaneous section of our bylaws.

1.1.1.1 INDEMNIFICATION AND INSURANCE OF OFFICERS, EXECUTIVE COMMITTEE MEMBERS, COMMITTEE MEMBERS, EMPLOYEES, AND OTHER AGENTS

11.4.1 Officers, Executive Committee Members and Committee Members. Each Officer, Executive Committee member and committee member of the Society in each instance, whether or not then in office, shall be indemnified by the Society against all charges which may be reasonably incurred or paid by him in connection with any claim, actual or threatened action, suit or proceeding (civil, criminal or other, including appeals) in which he or she may be involved by reason of his or her being or having been such officer or committee member, made or brought against him by reason of any act or omission, or alleged act or omission by him in any or each such capacity, and also against all charges which may be reasonably incurred or paid by him (other than to the Society for its account) in reasonable settlement of any such claim, action, suit or proceeding.

11.4.2 Employees and Other Agents. The Executive Committee may, by general vote or by vote pertaining to a specific employee or agent or class thereof, authorize indemnification of the Society’s employees and agents, other than those officers and persons referred to in Section 11.4.1 above, to whatever extent they may determine, which may be in the same manner and to the same extent provided in Section 11.4.1 above.

11.4.3 Definition of “Charges”. As used in this Section 11.4 the term “charges” shall include, without limitation, judgment awards, settlement awards, awards by other tribunals or bodies, attorneys’ fees, costs, fines, penalties and other liabilities.

11.4.4 Limit upon Indemnification. Indemnification under this Section 11.4, whether under Section 11.4.1 or Section 11.4.2, shall not be made, and no person shall be entitled to indemnification, in any case where such claim, action, suit or proceeding shall proceed to final adjudication and it shall be finally adjudged, nor shall any settlement be determined reasonable if it is found, that such officer, Executive Committee member, committee member, person, employee or agent (a) is or was delinquent in the performance of his or her duties in connection with the alleged acts or omissions giving rise to such claim, action, suit or

(continued on page 19)
We greatly appreciate the continued efforts of our doctors who volunteer and take the time from their busy schedules to visit the community and educate the public about the vital role of the anesthesiologist in the perioperative setting.

The revised MSA Website enabled various MSA Committees to merge their efforts and creativity. The Public Education committee has joined the Committees on Publication and Website in a combined effort with Drs. Urman and Spanakis to design a section that specifically addresses the educational opportunities MSA can provide for both its members and the community. They have developed a link on the MSA website for the public to submit inquiries about our profession.

Dr. Shapiro has been a member of the Executive Board and chairman, Public Education Committee since 2001, Past President of the Massachusetts Society of Anesthesiologists and current Chair, Committee on Governmental Affairs. ~

The committee oversees the publication of the MSA Record (Newsletter) once a year, usually in the summer following the Annual meeting. The content is based on Committee reports, plus additional contributions from the editor and members. The Record is distributed to the entire MSA membership via regular mail and is also available electronically.

Email blasts (eBlasts) -- the committee supports the use of selective eBlasts to the entire MSA membership that convey major developments of regional and national importance. The Committee will work with the rest of the MSA and, the legislative council to prepare and distribute as needed.

The Committee Chair proposed an idea of forming a loose affiliation with an academic journal in a way that would benefit MSA members. We will explore various options and report back to the Executive Committee.

The MSA website is constantly evolving and is overseen by the Subcommittee on Website Development. Dr. Spanakis has led the effort. ~

Respectfully submitted,

Richard Urman, MD, MBA
Opt-out pressure continues. This year, there has been legislation filed in several states to create de facto independent practice for nurse practitioners, including nurse anesthetists. This legislation is active in Massachusetts. Specifically, the legislation will eliminate the statutory requirement that such nurses function under the supervision of a physician pursuant to regulations developed jointly by the Board of Registration of Nursing and the Board of Registration in Medicine. Please read the detailed discussions about this by our counsel, Edward Brennan, Esq.

There are many active issues facing anesthesiologists now. To address them, we need the support of every anesthesiologist. It is important that we all contribute now to MSA-APAC and ASAPAC, to support our state and our national legislative efforts. Each of us knows members of our respective departments who are not members of MSA and ASA. Please join in the challenge to get them involved.

I am privileged to serve you as your ASA Director from Massachusetts. I especially thank the MSA Executive Committee and you the MSA members for your help and support. If you have any questions or comments, or needs that could be addressed, please do contact me at MSA.

Respectfully Submitted,

Beverly K. Philip, MD
Director

Pictured above, left to right; Dr. Ruben Azocar, Dr. Fred Shapiro, Dr. Beverly Philip, ASA Director, and Dr. Selina Long at the Annual Meeting in May 2012.

Committee on Bylaws Annual Report-continued

(continued from page 17)

proceeding, or (b) has not acted in good faith in the reasonable belief that his or her action was in the best interests of the Society. Neither a judgment or conviction nor the entry of any plea in a criminal case shall of itself be deemed an adjudication that such officer, Executive Committee member, committee member, employee or agent was derelict of the performance of his or her duties if he or she acted in good faith, for a purpose which he or she reasonably believed to be in the best interests of the Society, and had no reasonable cause to believe that his or her conduct was unlawful.

11.4.5 Other Remedies. The rights of indemnification herein provided for shall be severable, shall not be exclusive of other rights to which any officer, Executive Committee member, committee member, employee or agent may now or hereafter be entitled, shall continue as to a person who has ceased to be such officer, Executive Committee member, committee member, employee or agent, and shall inure to the benefit of the heirs, executors and administrators of such a person.

11.4.6 Insurance. The Society shall have power to purchase and maintain insurance on behalf of any person who is or was an officer, Executive Committee member, committee member, employee or other agent of the Society, or is or was serving at the request of the Society as a Director, officer, employee or other agent of another organization, in which it has an interest, against any liability incurred by him in any such capacity, or arising out of his or her status as such, whether or not the Society would have the power to indemnify him against such liability.
COMMITTEE ON RESIDENT AFFAIRS ANNUAL REPORT - MAY 2013

The Committee on Resident Affairs (CORA) had a successful year. Among current members, we have remained very involved in anesthesia events and issues over the past year. Residents from many different institutions participated as resident delegates at the annual ASA meeting in Washington D.C. this past October. In addition, resident representatives from Brigham and Women’s Hospital, Beth Israel, Massachusetts General Hospital and Tufts anesthesia residencies. $1500 was raised from this event.

Another endeavor that we have taken a larger role in relates to philanthropy. Dr. Hannenberg has been a fantastic proponent of Lifebox, and has been a valuable advisor for us. On March 2nd, anesthesia residents from across Massachusetts celebrated the completion of the annual in-training exam. Over 100 residents from across the state attended a social mixer hosted in honor of Lifebox, a charity that donates pulse oximeters to developing countries. Over 77,000 operating rooms around the world lack this equipment that is so vital to our everyday lives. This event is a part of the ongoing Lifebox Challenge, a fund raising competition between Boston University, Brigham and Women’s Hospital, Beth Israel, Massachusetts General Hospital and Tufts anesthesia residencies.

The annual NEARC was held this year at Brigham and Women’s Hospital, and with the help of Dr. Roman Schumann, CORA has tried to become more involved. Bev Chang has spent a great deal of time attempting to create a framework that allows CORA members to help organize future events. Ultimately, the goal will be for CORA members to regularly update a website that will host information that all member institutions can view. This will help them stay informed with important news and information regarding the NEARC. In addition, CORA members will be instrumental in reporting important information to different resident institutions through various contact resources and maintaining a constant communication with the NEARC steering committee.

Our presence as a committee of residents that works under the MSA to promote resident involvement for the improvement of our specialty and ultimately for better care for our patients has shown. We are currently holding elections, and applications from residents to various positions on CORA have doubled this year. I have received numerous emails from residents that want to get involved. Our fundraising efforts resonated with faculty and residents, indicating that we are not just a group of residents that sit on the sidelines, but can also make a difference for patients in areas with more minimal resources.

This upcoming year, we have a fantastic group of residents that will be leading CORA. In addition to continuing the above endeavors, we have other goals. Personally, I would like to see an easier system of communication, where all CORA announcements (elections, Hannenberg scholarship, ASA resident delegate applications, etc) are transparent and easily communicated across the state to residents. I would also like to see CORA take on a larger role of encouraging 100% involvement in the ASAPAC from all member institutions in Massachusetts. The MSA has been very supportive of us this year, and we look forward to another great year of resident involvement with the MSA. ~

CORA Officers for 2013-2014

Chair: Brian O’Gara, M.D., Beth Israel Deaconess MC
Vice-Chair: Beverly Chang, M.D., Brigham & Women’s Hospital
Secretary: Roya Saffary, M.D., Boston Medical Center
Treasurer: Michael Kim, M.D., Boston Medical Center
Social Chair: Richard Pedro, M.D., Boston Medical Center
Social Chair: Veronica Crespo, M.D., Boston Medical Center
This past year, NEARC received national attention when the subcommittee chair was contacted by Tom Cooper, on behalf of the Board of Trustees of the International Anesthesia Research Society (IARS). The IARS Executive Director informed us of an outstanding opportunity for NEARC participating residents. For its 2013 annual meeting in San Diego in May 2013, the IARS would sponsor the 2 residents who would win top abstract at NEARC in 2 categories to then compete in a national selection of best abstracts from all regional anesthesia resident conferences. The event represents an additional, exciting incentive for residency programs to participate in NEARC, and it is hoped that IARS will continue this new format for residents for its subsequent meetings.

On April 13, 2013, a well attended 7th annual NEARC was hosted at BWH in Boston. The host organizers, BWH program director Rob Lekowski, MD, CA II resident Beverly Chang, MD and their administrative support staff offered a delightful program that included an overview of healthcare reform (Richard H. Gregg, MA, MBA), life in the real world (Terence K. Gray, DO) and OR emergency management checklist use (William R. Berry, MD, MPH, FACS). More than 40 abstracts by residents from many NE institutions were submitted this year. A sophisticated abstract scoring system using ASA abstract judging criteria was implemented this year to ensure proper selection of the winning abstracts for IARS sponsorship. Faculty judges from 5 institutions (UMASS, BIDMC, BWH, MGH and TMC) volunteered to determine the winners in several phases with a final call following the abstract presentations on the day of the conference. The host for the 8th annual NEARC has yet to be determined.

The subcommittee’s outreach effort to encourage even wider program participation occurred in several phases and included written, phone and e-mail information to of all NE anesthesia program directors as well as to every NE anesthesia state society president. This outreach proposed the establishment of a NEARC steering committee to formalize content, schedules and future direction of the conference. At this time, the MSA NEARC subcommittee leads the transition into this NEARC steering committee at the MSA. A core group of interested anesthesiologists have offered to collaborate in the steering committee, which should begin its work shortly. It has become evident, that as a conference by residents for residents, such a steering committee will include MSA residents’ component members (CORA) with specific responsibilities for NEARC. The subcommittee wishes to thank Beth Arnold of the MSA for her unfailing administrative assistance during the past year.

New England Anesthesia Resident Conference (NEARC)
Spring 2014
Baystate Medical Center
Go to MSA website link for details
SUMMARY OF THE ASA GUEST SPEAKER PRESENTATION, DR. JANE FITCH

Another political battleground for anesthesiologists has been over proposed inclusion of independently practicing nurse anesthetists in the field of interventional pain management. On this particular subject Dr. Fitch seemed elated to relay that states such as AZ, MA, OK, LA, and TN all had enacted legislation either defining the practice of pain management as the practice of medicine, or limiting the performance and supervision of fluoroscopy based injections around the spinal cord to physicians only. In 2013 both IL and IA joined this list of states who found that only pain physicians should be responsible for the interventional care of the chronic pain patient. Central to these scope of practice decisions were efforts made by both the Pain Care Coalition and the ASA to inform both patients and legislators of the paramount importance of patient safety and the integral role played by anesthesiologists in ensuring safe care. Dr. Fitch then went on to describe the presence of the anesthesia assistant (AA) and their introduction into new areas of the country. Currently there are 1800 AA’s practicing in 17 states, Washington D.C., and the VA healthcare system. Various state societies including recently Colorado and Connecticut have played a key role in helping to expand the educational programs available to AA’s so that they may become a valuable part of the anesthesia care team.

As the national healthcare reform process moves forward, there has been an increasing focus on the provision of both quality and safe care to all patients. Dr. Fitch cited the leading role played by our nation’s anesthesiologists as a reason why our profession will be chosen as an example of how to incorporate quality and safety into everyday practice. With the introduction of the perioperative surgical home model, anesthesiologists stand at the forefront of ensuring excellent patient care and effective multidisciplinary com-

(continued on next page)
munication throughout the entirety of the perioperative period from pre-admission to discharge. The ASA affiliate Anesthesia Quality Institute also serves as an example of how anesthesiologists are uniquely suited to ensure best practices on a national level.

After this brief discussion regarding the relevant national issues facing anesthesiologists, Dr. Fitch then transitioned into discussing the ASA’s specific legislative advocacy efforts with regards to the ongoing reform of Medicare physician reimbursement and better oversight of national drug shortages. Highlights from the recent efforts by ASA delegates on Capitol Hill included advocating that reducing reimbursements to anesthesiologists based on SGR models did not make economic sense, as many independent studies have shown that anesthesia costs have been below the SGR rate for well over a decade, whereas radiology and minor procedure costs have exploded. Advocacy efforts by our ASA delegates and Congressman Dr. Andy Harris (R-MD) continue to oppose payment oversight by the proposed Independent Payment Advisory Board (IPAB), fighting for representation by physicians in the discussion of how Medicare payments should be made. Finally, in June 2012 President Obama signed into law the FDA Safety and Innovation Act. Provisions advanced by ASA members aided in the inclusion of stipulations that drug companies must notify the FDA of any anticipated interruptions or halts in the production of drugs specifically used by anesthesiologists, as well as encouraging the FDA’s authority to reverse or mitigate any production problems of these important agents. The inclusion of our profession in national health care reform legislature has been through the important work of the ASA delegates and groups like the ASA’s Health Policy Research Division, as well as lobbying efforts by the ASAPAC, which last year raised over $1.8M.

In addition to the ASA’s tireless efforts fighting for anesthesiologists’ fair representation in national healthcare reform, our national society also provides for a bevy of educational and career advancement opportunities on a national scale. Dr. Fitch cited the ASA annual meeting, as well as separate national meetings regarding patient safety, quality, and education all as examples of what the ASA staff works on to aid in the professional and intellectual growth of every anesthesiologist. Additional educational modules such as the ACE program and Practice Performance Assessment and Improvement, as well as the newly customizable Education Center on the ASA home page all enable anesthesiologists to learn and perform at the highest level.

In the next section of her lecture, Dr. Fitch then moved on to describe the makeup of the ASA’s constituents, budget and leadership. In 2012 the number of ASA members increased to over 50,000 members, representing an over 3% increase from the year prior. This increase in membership stands out amongst political societies in the medical field, as most other national societies are struggling to maintain their numbers, let alone see annual growth. Despite our growing constituency, the percentage of anesthesiologists who are members of the ASA is disappointingly low, especially in the state of Massachusetts. Increasing this percentage will be incredibly important going forward. The ASA’s annual operating expenses are around $1.8M, with the largest fractions spent on governance, advocacy, and education.

When contrasted with revenues of over $40M, nearly half of which is made up of dues, this means the year 2012-2013 will allow for the ASA to add to its reserves. The remainder of the revenue is made up of corporate support, exhibit sales at meetings, as well as advertising in meetings and publications.

To conclude her lecture on how ASA “works for you,” Dr. Fitch focused on the charitable and international outreach programs supported by the ASA. These include the ASA Charitable Foundation, the Hope for the Warriors program, and Lifebox. These serve as shining examples of the anesthesiology community’s interest in providing not only excellent patient care but also in providing much needed support for our veterans and underserved communities both at home and abroad. Dr. Fitch’s discussion wonderfully elucidated how the ASA strives to embody the core values of every anesthesiologist, and how our national society works to ensure that the practice of anesthesiology is well represented throughout the world.

MARK YOUR CALENDAR FOR NEXT YEAR’S
MSA ANNUAL MEETING
Thursday May 22, 2014
MIT Endicott House, Dedham
(All MSA members are invited to attend)
LIFEBOX CHALLENGE

On March 2nd, anesthesia residents from across Massachusetts celebrated the completion of the annual in-training exam. Over a hundred residents from across the state attended a celebratory social mixer hosted in honor of Lifebox, a charity that donates pulse oximeters to developing countries without this resource. Over 77,000 operating rooms around the world lack this equipment that is so vital in our everyday lives. This event is a part of the on-going Lifebox Challenge, a fund raising competition between Boston University, Brigham and Women’s Hospital, Beth Israel, Massachusetts General Hospital and Tufts anesthesia residencies. A total of $10,000 was raised by 100% resident donations, which raised over 40 lifeboxes. Please show your support for our residents by considering getting involved or donating in the name of the residency of your choice. Every $250 buys a pulse oximeter. Donations can be made at http://www.lifebox.org/donations. Please be sure to write in the name of the residency you are donating for under the information box. For more information, please contact Beverly Chang at bchang5@partners.org.

Dr. Beverly Chang, Chair-elect of MSA Committee on Resident Affairs

Dr. Brian O’Gara, Chair of MSA Committee on Resident Affairs, pictured above promoting the Lifebox Challenge Golf Tournament that was held in June 2013.
Selina A. Long M.D.
President
Massachusetts Society of Anesthesiologists
318 Bear Hill Road
Suite 4A
Waltham, MA 02451

Via email: MSABOX@verizon.net

February 5, 2013

Dear Dr Long,

I am writing with sincere thanks from everyone at Lifebox for your Society’s very generous donation of $1,000 in memory of Dr Richard Browning of Rhode Island.

This gift will help make a life-changing difference to health workers striving to deliver safe treatment in environments where resources, support and training are scarce.

Lifebox is slowly and steadily closing the 70,000+ pulse oximetry gap. We won’t stop until every operating room and recovery setting worldwide has access to this essential equipment, and the training to make sure that it is used effectively.

So far, we have:

- sent 4100 pulse oximeters and education kits to facilities in 75 lower-resource countries worldwide.
- supported local training for over 2000 anaesthesia providers
- introduced these to the World Health Organization’s Surgical Safety Checklist, proven to reduce surgical complications by more than 30 percent and mortality by nearly 50 percent
- worked in collaboration with local organizations, membership groups and ministries of health to foster the communication and collaboration that is the only way to make a permanent, positive change in the quality and safety of care.

Thank you – we are truly grateful for your support.

Yours sincerely

Pauline Philip
Chief Executive
Lifebox Foundation
What’s New in Anesthesia Quality Management?

An Update from the Anesthesia Quality Institute (AQI)

Richard P. Dutton, M.D., M.B.A., Executive Director

Quality management is an important function of any anesthesia practice. Individual clinicians have a professional obligation to think about the patient care they provide and attempt to improve it. On the practice level, assessing outcomes allows for identification of system problems that can be resolved by changes in policy or group practice. For example, measurement of the rate of postoperative nausea and vomiting (PONV) in the PACU can identify patient populations at higher risk. A policy of providing prophylaxis in the OR for these patients can reduce the overall rate of PONV. On the national level, aggregation of data on rare complications (e.g. postoperative visual loss) can lead to appreciation of problems too rare to be studied at the local level. Once identified as a recurring problem, detailed review of cases can suggest common features and targets for improvement. This kind of national quality management, based only on clinical anecdotes, can nonetheless have substantial positive effects on anesthesia practice. This principle is illustrated by the case series published by the Anesthesia Closed Claims Project (CCP) in the scientific literature, and by the individual case vignettes from the Anesthesia Incident Reporting System (AIRS) which appear each month in the ASA Newsletter.

While CCP and AIRS are positive examples for our specialty, one of the largest national gaps in anesthesiology is the generation and reporting of systematic data on adverse outcomes from every case, every day. An estimate from the 275 groups participating in the National Anesthesia Clinical Outcomes Registry (NACOR) is that no more than half have a system for collecting this kind of data, while fewer than 25% are able to report clinical outcomes to NACOR on a routine basis.

The good news is that this number is increasing lately, and will soon reach a critical mass where true national benchmarking of adverse outcomes is a possibility. The Figure shows the cumulative number of cases in NACOR with associated reporting of clinical outcomes (out of 11.2 million total cases) reported by the month and year when the outcomes were entered in the registry. Further good news is shown in the Table, which shows the rate of occurrence of selected major and minor outcomes from the practices that get this data to NACOR.

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ASA News-continued

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Anesthesia Quality Institute-continued

A Q I  B o a r d  o f  D i r e c t o r s

8/23/2013

NACOR Outcomes

The data presented are rough aggregates of what is collected in NACOR, based on a minimum number of practices which report that outcome. Definitions vary from practice to practice, especially in the “minor” category. The rates presented are not risk adjusted in any way.

* Not all practices report all outcomes. This creates varying denominators for rate calculations. Consequently, some outcomes might have a higher count (N) but a lower rate (%) as compared to others.

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<td>any PONV</td>
<td>144141</td>
<td>9.660</td>
</tr>
<tr>
<td></td>
<td>Blood - Vascular</td>
<td>154</td>
<td>0.036</td>
</tr>
<tr>
<td></td>
<td>Central Line/IV Problem</td>
<td>196</td>
<td>0.032</td>
</tr>
<tr>
<td></td>
<td>Dental/Oral/Tooth/Mouth</td>
<td>790</td>
<td>0.043</td>
</tr>
<tr>
<td></td>
<td>Dural/Wet/Headache</td>
<td>580</td>
<td>0.037</td>
</tr>
<tr>
<td></td>
<td>Equipment/Monitor</td>
<td>471</td>
<td>0.054</td>
</tr>
<tr>
<td></td>
<td>Eye/Ocular/Corneal</td>
<td>2291</td>
<td>0.133</td>
</tr>
<tr>
<td></td>
<td>Hemodynamic instability</td>
<td>53499</td>
<td>3.700</td>
</tr>
<tr>
<td></td>
<td>Inadequate postoperative pain control</td>
<td>52142</td>
<td>5.805</td>
</tr>
<tr>
<td></td>
<td>Neuro - any</td>
<td>570</td>
<td>0.067</td>
</tr>
<tr>
<td></td>
<td>Regional Anesthesia Problem</td>
<td>342</td>
<td>0.035</td>
</tr>
<tr>
<td></td>
<td>Respiratory - Pulmonary</td>
<td>809</td>
<td>0.073</td>
</tr>
<tr>
<td></td>
<td>Reversal Narcotics</td>
<td>262</td>
<td>0.065</td>
</tr>
<tr>
<td></td>
<td>Reversal NMBAs</td>
<td>806</td>
<td>0.129</td>
</tr>
<tr>
<td></td>
<td>Unanticipated upgrade of care</td>
<td>1658</td>
<td>0.129</td>
</tr>
<tr>
<td></td>
<td><strong>Total MINOR</strong></td>
<td><strong>263204</strong></td>
<td><strong>20.283</strong></td>
</tr>
<tr>
<td>MORTALITY</td>
<td>Mortality</td>
<td>577</td>
<td>0.033</td>
</tr>
<tr>
<td></td>
<td><strong>Total MORTALITY</strong></td>
<td><strong>577</strong></td>
<td><strong>0.033</strong></td>
</tr>
</tbody>
</table>
The outcomes shown in the Table are aggregated from multiple practices, based on a variety of measure definitions and data capture mechanisms ranging from paper forms to electronic records. This heterogeneity is a barrier to accurate benchmarking at present, and why the data in this table should be taken with an appropriate grain of salt. AQI took a step towards improving this situation in April, when we convened a conference of anesthesia quality management experts and electronic record vendors to recommend common definitions for the outcomes of greatest interest. The consensus document produced from this conference (Anesthesia Outcomes of Interest) can be downloaded at http://www.aqihq.org/qualitymeasurementtools.aspx.

Currently just short of 9,000 anesthesiologists participate in NACOR, or 20-25% of clinically active anesthesiologists nationwide. This number continues to grow, as more practices and facilities recognize the need for registry data and external benchmarks. In addition to providing a measuring stick for judging and improving the quality of patient care, registry participation will be increasingly important for meeting federal regulatory requirements and the demands of non-federal payors. The Center for Medicare and Medicaid Services (CMS) has released draft rules for public comment on the definition and certification of Qualified Clinical Data Registries (QCDRs), as a mechanism for meeting incentive requirements for Meaningful Use of Healthcare Technology, hospital Pay for Performance, and individual provider participation in the Physician Quality Reporting System. Similar language has appeared in several other federal writings in the past 6 months, including proposals for new healthcare payment models contained in the draft House legislation repealing the Sustainable Growth Rate formula. It is clear that registry participation is a desired outcome of healthcare reform. While intrusive, this is sensible as a counterbalance for new models of payment that incentivize cost effectiveness. Transparent national outcome reporting is essential to assure the public that physicians and hospitals are not skimping on necessary and indicated care.

NACOR data is now available to support academic and health policy research by physician scientists in any AQI-participating practice. AQI released the Participant User File (PUF) in early 2013: an aggregated, de-identified, cleaned version of selected NACOR data fields. These data are already being studied by more than a dozen investigators, and several papers are in the works which will provide us a new and comprehensive understanding of the nature of anesthesiology in the United States. The AQI is using this information internally to provide high-level dashboards of summary data for ASA and state-society leaders, anesthesia subspecialty societies, and important ASA committees. Information and instructions for accessing AQI data can be found on the AQI website (www.aqihq.org) under the ‘PUF’ header.

AQI is also participating in a pair of new quality initiatives launched by ASA. One is the inaugural Anesthesia Quality Management meeting, scheduled for November 2013 in greater Chicago. This weekend course is intended for anesthesia department quality management officers, and is designed to teach the basics of quality management in an anesthesia practice. More information can be found on the ASA website at http://education.asahq.org/qm2013.

A second initiative is the development, with ASA’s Quality Management and Departmental Administration (QMDA) Committee, of a ‘Quality Consultation’ program intended to provide high-functioning anesthesia practices with overall national benchmarking of their efforts, documentation of clinical performance, and suggestions for further improvement. The consultation is based on a review of practice structure, NACOR data, personal interviews and a 1 day site visit by a team of practicing—and experienced—anesthesiologists. More information on this program, including the kind of documentation that can be shared with hospital leadership or external agencies, can be obtained by emailing the author directly at rdutton@asahq.org.

Richard P. Dutton, M.D., M.B.A., Executive Director, Anesthesia Quality Institute
NEW BOARD REGS BRING NEW CME REQUIREMENTS

On February 1, 2012, a revision to 243 CMR 3, a portion of the Board’s regulations, will take effect. Two changes to the regulations involve CME requirements. Physicians renewing their licenses after February 1 must have completed 3 hours in effective pain management, identification of patients at high risk for substance abuse, and counseling patients about side effects, and the addictive nature and proper storage and disposal of prescription drugs. This is a statutory requirement that was enacted by the Legislature in 2010.

A free online resource to obtain the necessary credits is available at www.opioidprescribing.com. If your license is due to expire between now and February 1, the Board encourages you to take the online course, or obtain credit from another program, as soon as possible. The 3 credits will qualify as either Category I or II credits, and they may be counted as risk management credits.

The revised Board regulations also include a new requirement for 2 CME credits in end of life care. There are a number of programs offering end of life care CME, among them the Massachusetts Medical Society (www.massmed.org).

The end of life care requirement also takes effect on February 1, and the Board similarly encourages physicians with license expiration dates between now and February 1, to obtain the necessary credits as soon as possible. End of life care CME credits also qualify as Category I or II, and may be counted as risk management credits.

The revised 243 CMR 3 can be found here:


If you have questions, please email Charlene Morelli at: Charlene.morelli@state.ma.us
ABA Releases Online Tutorial on MOCA® Program

RALEIGH, N.C. (October 27, 2011) — To enhance its ongoing effort to provide clarity on the Maintenance of Certification in Anesthesiology (MOCA) program, The American Board of Anesthesiology, Inc. (ABA) has developed an online tutorial to address frequently asked questions and concerns of constituents.

The Maintenance of Certification (MOC) concept originated with the American Board of Medical Specialties (ABMS) in 1999 as a professional response to the need for public accountability and transparency of practice improvement initiatives by physicians. The ABA recognized the importance of this initiative and developed the MOCA program to help board certified anesthesiologists demonstrate to society their lifelong commitment to quality clinical outcomes and patient safety.

The ABA designed this tutorial to familiarize viewers with the pathway to ABA certification and maintenance of certification as well as educate them on their specific MOCA program requirements.

Subjects covered by the tutorial include:

- Pathway to Maintenance of Certification
- Evolution of Certification Process
- MOCA Program Requirements
- Entering Requirements in ABA Portal Account

“We hope our diplomates and future diplomates will find this tutorial useful as we make transparent the road to board certification and the Maintenance of Certification in Anesthesiology program,” said David L. Brown, M.D., Secretary of the ABA Board of Directors.

“This tutorial is just one more way that the ABA is providing information to our diplomates on MOCA,” said Dr. Brown. “This video will supplement other resources we have made available on the ABA website, such as the Frequently Asked Questions section and MOCA requirements by certification year.”

To view the MOCA tutorial go to:
http://www.theaba.org/Home/Videos
MEMBERSHIP CHANGES  8/12 to 7/13

New Active
Kathryn Aberle, MD, BWH
Ajita Amin, MD, BIDMC
David August, MD, MGH
Aranya Bagchi, MD, MGH
Magdelenas Bakowitz, MD, Baystate MC
Susan R. Banaj, MD, Guardian Anesthesia
Antje Barrevedell, MD, Newton Wellesley
Maxim Bashkirov, MD St. Ann's Hosp
Paula Bokesch, MD, St. Elizabeth's MC
Andrew R. Bond, MD, BWH
Katherine Bourne, MD, Melrose Wakefield
Meredith Brown, MD, AAM
Peter Calkin, MD
Manelly Capriales, MD, Holyoke MC
Malaka Cayer, MD, Mass E&E
Do W. Chan, MD, Sturdy Memorial
Christopher Chen, MD, BWH
Lucy Chen, MD, MGH
Fred Cobey, MD, Tufts MC
Christopher Conley, MD, AAM
Frederick Conlin, MD, Baystate MC
Martha Cordoba-Amoroco, MD, BWH
Kimberly Al Cox, MD, Brockton Hosp
Joseph Craver, MD, CHMC
Duane Dixon, MD
Elizabeth Eastburn, MD, CHMC
Nasser El-Mallah, MD, Mercy Hosp
Daniel Ellis, MD, Cambridge HA
Brian Engles, MD, So. Shore Hosp
Arie Farjci-Cisneros, MD, St. Vincent
Keith Fargoza, MD, MGH
Brian Ferla, MD, BIDMC
Devan M. Flaherty, MD, BWH
Ross Frohn, MD, EMCARE
Carolyn Furuya, MD, Holy Family Hosp
Jennifer Gerstle, MD, BIDMC
Amir Gholami, MD, AAM
Alexandra Gordon, MD, AAM
Stefan Ianchulev, MD, Tufts Medical Ctr
Oluwaseun Johnson-Akeju, MD, MGH
Vesela Kovacheva, MD, BWH
Bhargavi Krishnan, MD, MGH
Sanjeev Kumar, MD, RI Hospital
Sara LaFleur, MD, MGH
Jeanette L. Lee, MD, Norwood Hosp
Michael Leeman, MD, MGH
Ivan Lesyuk, MD, Lawrence General Hosp
Mazen Maktai, MD, Mass General Hosp
Ashish Malik, MD, Baystate MC
Parag Mathur, md, Anesthesia Assoc. of MA
Melissa Matos-Auerbach, MD, Mercy Hosp
Mark McKeen, MD, MGH
Dennis McNichol, MD, BWH
Marc Mercoli, MD, BIDMC
Vikram Narayan, MD, Lowell General
Emily Nelson, MD, BWH
Michael Nguyen, MD, BWH

Steven Nguyen, MD, Berkshire MC
Teresa Ning, MD, Baystate MC
John J O'Connor, MD, BIDMC
Christy Paiva, MD, St. Anne's Hosp.
Pirawan Pan, MD, Brockton Hosp.
Raymond Park, MD, CHMC
Deevia Patel, MD, Mercy Medical Ctr
Solvaz Pirzaden, MD, Holy Family Hosp
Amy Reed, MD, BIDMC
Gary Roark, MD, Beverly Hospital
Jennifer Rodges, MD, BIDMC
Gretchen Rohrs, MD, Holyoke Hospital
Derek Rosner, MD, Baystate MC
Nirav Shah, MD, Tufts MC
Monica Sidor, MD, Baystate MC
Victorija Smith, MD, UMass Memorial MC
J. William Sparks, MD, CHMC
Thomas Sung, MD, Tufts Medical Ctr
Scott Switzer, MD, Baystate MC
Mingham Tsay, MD, BIDMC
Cynthia Tung, MD, CHMC
Vladimir Volson, MD, Lowell General
Dongdong Vau, MD, BWH
Cassandre Victor-Vega, MD, Baystate MC
Cuong Vu, MD, Baystate MC
Mark Wechsler, MD, Jordan Hosp.
Alexander Wolf, MD, Baystate MC
Zhongcong Xie, MD, MGH
Joyce Yao, MD, BWH
Martin Zammart, MD, BWH
Jose Zeballos, MD, BWH
Martha Zegarra, MD, AAM

Affiliate
Tracey Cacciatore, MD, Boston VAMC
Jenny Freeman, MD
zkhei Ikeda, MD, MGH
Rina Kato, MD, MGH
Armin Maghsoudlou, MD Boston MC
Nathaniel Sims, MD, MGK

Retired
Giovanni Camerleghi, MD, Longmeadow
Daniel Dedrick, MD, NC
Dwight Gele, MD, Natick
Norman Gould, MD, Leominster
Suresh Gulati, MD, Winchester, MA
John K. Kim, MD, Andover, MA
Astrid Liland, MD, Newton, MA
Inder Malhotra, MD,
Lynda J. Means, MD, Portland, ME
Zoya Mehta, MD, Shrewsbury, MA
Rihard Mirabile, MD, Hingham, MA
Peter Silverstein, MD, Canton, MA

Deceased
Harry E. Bowen, MD
Samuel Winer, MD (8/1/13)

BOX SCORE
MEMBERSHIP TOTALS (8/1/13)
Active 989
Resident 528
Affiliate 25
Retired 193
Organizations may now submit positions directly online. Newly submitted practice opportunities will be made available on the ASA website within 24 hours of submission. All practice opportunity postings will be available for a period of 60 days. This online service has replaced the quarterly placement bulletin, which had been mailed to interested ASA members. Please note that ASA reserves the right to reject any job submission it deems inappropriate.

This new feature of the ASA website will allow your position to be made available to more than 36,000 anesthesiologists. Also, you now have the option of including a phone number, fax number and/or email address to your listing. To update your available position simply click on your posting, make any necessary changes and click on the submit button. Your changes will be updated within 24 hours. The placement service remains free of charge.

Any questions regarding the ASA Placement Service should be directed to the ASA Executive Office at (847) 825-5586 or by email at p.fitzpatrick@asahq.org.
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- Annual dividend based on overall program experience
- Annual audit assistance performed by DISNE

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- Offer flexible payment plans
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Daniel Nissi, RIA, CLU
Phone: 800.649.9111
Fax: 508.429.4010
Email: info@disneinc.com
Website: www.disneinc.com
UPCOMING EVENTS

2013 New England Residents’ Practice Management Conference
November 16, 2013
Beth Israel Deaconess Medical Center
(Leventhal Conference Room) 2nd Floor Shapiro Building
8:00 am - 4:00 pm
Topics:
ASA Update
Evaluating a Prospective Practice
ROE: getting paid for what you do
Performance Measurements for Working Anesthesiologists
Surgical Home
Hospital & Medical Staff relations
Employment Contracts, How to Interview: What's your style?
Private Practice vs Academia
Does increased OR efficiency equal patient risk?
(no charge for residents, breakfast & lunch included)
Contact info: mayes@bidmc.harvard.edu

MSA Airway Course
Feb.2014
Waltham Woods Conference Center,
MMS Headquarters, Waltham, MA

MSA 7th Sedation & Analgesia Course
April 12, 2014
Waltham Woods Conference Center
MMS Headquarters, Waltham, MA

New England Anesthesia Residents Conference
April 2014
Hosted by Baystate Medical Center,
Springfield, MA

MSA Annual Meeting
May 24, 2014
MIT Endicott House
Dedham, MA
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