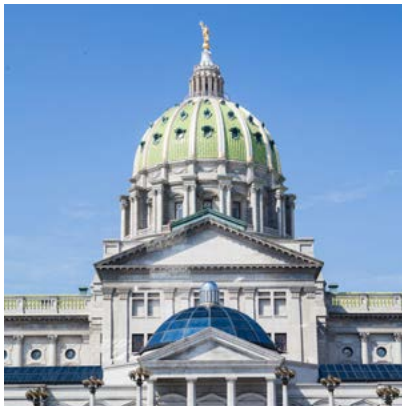
Sentinel
Pennsylvania
Society of Anesthesiologists
Newsletter

Winter 2015

PRESIDENT'S MESSAGE

Relevant to Indispensable

by Robert Campbell, M.D



My year as PSA President has been a year of transition for the society. I do not recall any year when PSA has experienced so many dramatic changes. I have always been one to embrace change, but even in the context of my experiences, this year has been extraordinary. In the context of the changes occurring in medicine overall, the timing of our transformation has the potential to serve us well.

I had the pleasure of appointing Dr. Rich O'Flynn as the new editor for the *Sentinel*. He is only the second editor of this important publication. There are not a lot of enduring legacies remaining in the world, but years from now, Rich will still be the *Sentinel* editor and Pennsylvania's anesthesiologists will be more informed than ever as a result. When you read this publication every quarter in the future and appreciate just how good it is, don't thank Rich, thank me for twisting his arm and having the insight to recognize his stellar communication skills!

Also for the first time since the founding of Z-PAC, we have a new leader, Dr. Tom Witkowski. Unlike so many in medicine, Tom recognizes the key role of PAC funds in navigating the heavy traffic at the intersection of Medicine and Politics. In today's world, our specialty and our careers will be highly correlated with the performance of our PAC. If anesthesiologists support the PAC, we will do well. If they do not, then we will not. We own our futures. We determine if our futures are going to be rewarding or dismal. Support Z-PAC and let Tom lead us to a rewarding future of generous payment for high-quality health care.

Throughout its history, PSA has been represented in Harrisburg by one lobbying firm. This year we employed the services of Quantum Communications. Quantum is a larger firm. Our goal is to be more multi-dimensional in all our advocacy in Harrisburg. To be successful in Harrisburg, PSA needs three things: an outstanding lobbying firm, a well-funded PAC, and the ability to conduct a grassroots campaign. More on this later.

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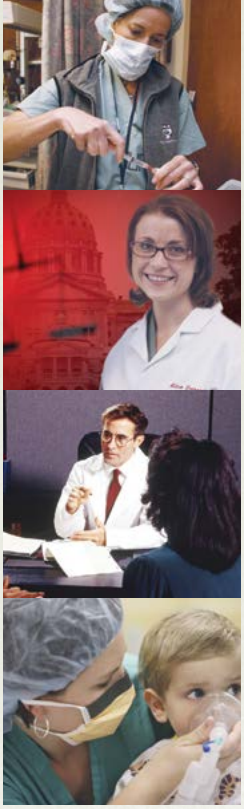

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Sentinel
Pennsylvania Society of Anesthesiologists Newsletter

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The PSA Newsletter is an official publication of the Pennsylvania Society of Anesthesiologists Inc. Opinions expressed in this newsletter do not necessarily reflect the Society's point of view. All correspondence should be directed to:

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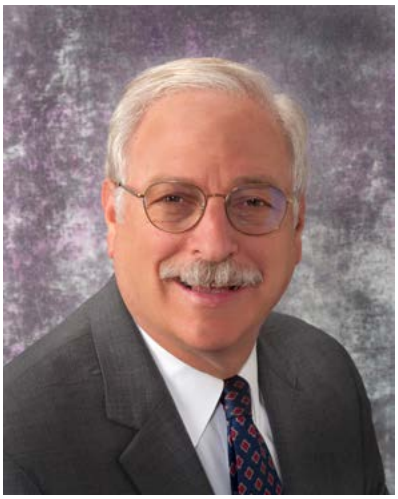
PSA Installs the 63rd President



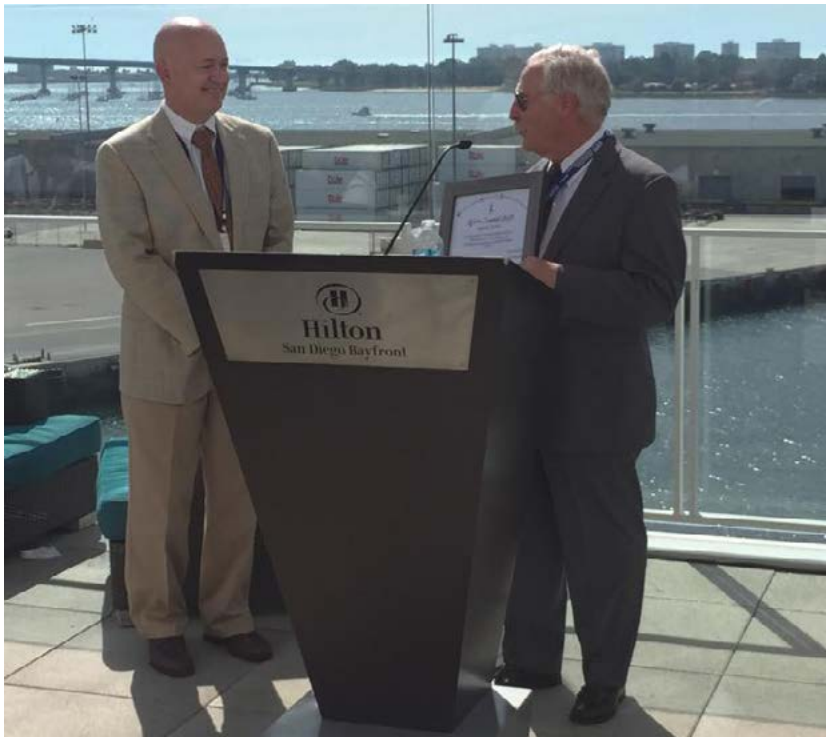
On October 24, 2015, Andrew Herlich, D.M.D., M.D., was installed as the Society's 63rd president. Outgoing President Robert Campbell, M.D., turned the gavel over to Andy at the membership lunch meeting held during the ASA Annual Meeting.

Dr. Herlich is a native Philadelphian. He trained at the Hospital of the University of Pennsylvania in Philadelphia and Mount Sinai Hospital in New York. He is fellowship-trained in both pediatric and ambulatory anesthesia.

Andy is a professor in the Department of Anesthesia at the University of Pittsburgh School of Medicine and is the vice-chairman for faculty development. His clinical practice is at UPMC Mercy Hospital where his primary interests are anesthesia for maxillofacial surgery and pediatric burn surgery.

He serves as a delegate to the American Society of Anesthesiology and as ASA liaison to the American Dental Association, the American Association of Oral and Maxillofacial Surgery, and the Dental Society of Anesthesiology. In 2011 he was awarded Honorary Fellowship in the American Association of Oral and Maxillofacial Surgeons. Dr. Herlich is also a volunteer hotline consultant for the Malignant Hyperthermia Association of the United States.

Andy has been married for 33 years to his wife, Thelma and has two grown children.



Immediate Past President, Robert Campbell, M.D., receives a congratulatory plaque for his excellent year of service from PSA's new President, Andrew Herlich, M.D., DMD, at the PSA Annual Meeting in San Diego, CA.

PRESIDENT'S MESSAGE

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Charlie Gerow, Kevin Harley, and Ken Robinson at Quantum are leveraging all of Quantum's assets on our behalf. They are also in close contact with us to both learn more about our issues, and to take advantage of opportunities in Harrisburg to achieve our goals.

Expect board members to be in touch with you as we develop a political grassroots capacity. In the past, we have occasionally had membership reach out to political leaders. It was always associated with independent nurse anesthesia care. Just as our board is implementing changes at our society's leadership level, so will you be called upon to change. We need anesthesiologists with communication skills to reach out with talking points on a more regular basis—not just when there is a crisis. If you are a communicator and you care, please call me. If you are not, then we will call you and train you.

We have had other PSA firsts this year. There are too many to mention, but I will include some here. For the first time, we implemented unified dues with ASA. As a result, we are spending less to collect dues and are collecting more dues than ever in the history of our society. For the first time, we are tweeting and now have an increasingly "liked" Facebook page. We have conducted the first ever Pennsylvania Physician Anesthesiologists Week to increase awareness of our specialty. Too many Pennsylvanians including lawmakers do not know that anesthesiologists are physicians. We have participated centrally in constructing the first PA Controlled Substance Database. For the first time we have offered CME and MOCA-eligible educational meetings in the state to enable members to acquire ultrasound skills.

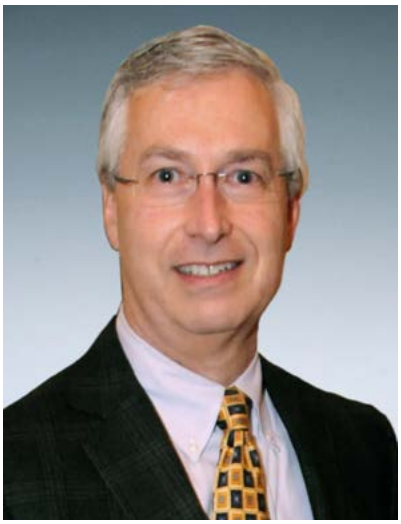
This is not all on me of course. The most important change has been a unified effort on the part of the board of directors to transform our organization. Collectively, we recognize the need to adapt to the changing landscape of anesthesia and medical practice. I think the board is doing the right thing. One thing for sure, is that if everything is dramatically changing all around you, staying the same is not an option.

We are changing with the times, but are we doing enough? PSA membership is one measure of the effectiveness of our transformation. We now have 2,037 members—an all-time high. What other changes are going to be needed to be certain that PSA membership is not just relevant but essential? We need to develop strategies that reflect the emergence of large, super-group practices, hospital employed physicians, value-based reimbursement systems, and the national emergence of anesthesiology assistants. We need to re-assess what our threats are and where our allies are in this rapidly changing and dynamic environment.

When I became president, my stated goal was to take PSA from relevant to indispensable. I regret I have fallen short. We are not there yet. But I can take some consolation in that PSA is more relevant than ever in the professional lives of anesthesiologists. There is more to do. We have incoming officers committed to making PSA indispensable and we have a board of directors which aspires to unparalleled excellence in governance. We are not content with relevance alone. This vision will take us where we need to be.

The Time Is Now

by Richard O'Flynn, M.D., *Sentinel* Editor



As I write this, we have just wrapped up the annual ASA meeting in San Diego, the elections are over and the PSA has installed its new president. It seems like it is more of the same with nothing really changing … just another November.

On the legislative front in Pennsylvania, House Bill 1277, the reincarnation of HB 1603 from the last legislative session, sits in committee with no scheduled action. As you should know, HB 1277 is simply legislation to put into statute, *i.e.*, the requirement that physicians personally administer anesthesia or supervise CRNA's in doing so. It is already required by Department of Health regulations, so really nothing changes except that statutes are harder to change than Department of Health regulations. The opponents cite uncertain future needs, the necessity to be flexible with staffing, etc., but in reality it comes down to money over patient safety. PSA will always stand on the side of safety and feel, actually expect, that our legislators would do the same.

On the federal level, there is the potential change in the "VA Nursing Handbook" that would require, **not permit but require**, nurse practitioners, CRNAs included, to practice independently. The ASA is working on multiple levels to eliminate CRNAs in this group as the operating room is an entirely different environment than the office. Anesthesia requires immediate decisions and actions; managing chronic illnesses like diabetes, hypertension or asthma does not. Again, you would expect those in charge, in this case the VA officials, to come down on the side of what is best for our veterans, but in Washington there are always outside influences.

So, what are we to do?

We can sit back and do nothing, we can be apathetic and hope for the best, or we can become active. Realize that those pushing these changes are well-motivated, well-funded and passionate about their goals. Anesthesiologists need to be the same. As has been communicated in the past, apathy is not acceptable. Think back to when you had your first clinical rotation; when you first put on your white coat; when you stood and repeated the Hippocratic Oath. You were proud and passionate about caring for patients. It wasn't simply a job— it was the desire to care for patients with patient safety at the heart of it.

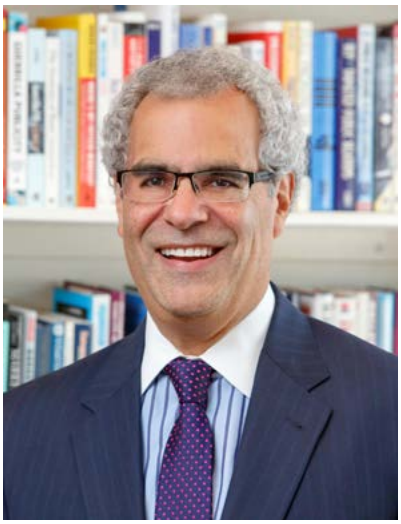
Anesthesiologists need to regain that passion. Anesthesiology is the practice of medicine, practiced in a team-based model. Physicians and CRNAs make a great team, but every team needs a leader.

PSA and ASA will not be successful if we continue to have involvement with less than 20 percent of our members. Legislators know the issues from what they hear. If they don't hear from rank and file anesthesiologists, they will obviously put less credence into what our leaders and lobbyists are telling them. They need to hear from you, their constituents. You need to have the personal relationship with your state representative and senator. You need to respond to ASA calls for outreach to your federal congressman and senator. You need to act on alerts that come from PSA and ASA. And yes, you need to contribute to both ASAPAC and Z-PAC. Our PACs support legislators and candidates who value patient safety.

It doesn't matter if you are in academic or community practice, a partner or employed physician, just out of training or nearing retirement. This issue affects us all. Remember, it is not about your job, it is about the patient. Your patient, your family and even your own future medical needs.

Legislative Update

by Charlie Gerow, Quantum Communications



The budget battle between Gov. Wolf and the legislature continues as we go to press. During the stalemate, legislative activity has stalled, but we have continued to work with members of the House Professional Licensure Committee and legislative leadership to build support for House Bill 1277.

You have been asked to contact your legislator to urge that the bill be reported out of committee and sent to the floor of the House for a vote. It is critically important as the first year in the two-year legislative session draws to a close that you make that call.

HB 1277 codifies existing state Health Department regulations requiring physician supervision of the administration of anesthesia.

Legislators need to hear from members of PSA that this is a vital issue. Physician supervision protects patient safety by ensuring that the most highly trained medical professional is on hand, especially in the event of an emergency during surgery – when seconds count.

This legislation has been our priority for many years. It's now primed for passage. Now is the time for legislators to hear from each of us!

If you are not certain who to contact, PSA's website features a legislator lookup. Go to: http://www.legis.state.pa.us/ to find your legislator's name and contact information.

Update on CRNP "Definition"

HB 765 (introduced by Rep. Jesse Topper) was the subject of a House Professional Licensure Committee hearing on Oct. 22. The bill amends the Professional Nursing Law by removing the requirement that a certified registered nurse practitioner must establish a collaborative agreement with a physician in order to practice.

It also amends the scope of law to allow a certified registered nurse practitioner to practice independently, without a collaborative agreement with a physician. Currently, the Board certifies but does not license nurse practitioners.

Quantum and several PSA members were at the hearing, but did not testify. A number of other medical specialty societies were represented at the hearing as well.

Pennsylvania Medical Society President Karen Rizzo, M.D., cautioned that the bill seeks to "eliminate the collaborative ties that exist between NPs and physicians, allowing NPs to diagnose, treat and prescribe independently and without physician involvement. In essence, this legislation would allow NPs to do everything a physician can do with equal clinical authority and autonomy, yet without the necessary education and training."

"Simply increasing the number of physicians or expanding the role of non-physician practitioners will not solve our access-to-care problems in rural and underserved communities," Dr. Rizzo continued. "Rather, policies and programs which specifically target those areas and directly address the barriers to practicing there have the most potential for success."

PSA is monitoring the bill and will advise you as it progresses.

Your continued support of the profession is especially needed right now. Please make an added effort to reach out to your legislators and friends in support of our patient safety legislation.

No Time for Complacency

The new legislative session is underway in Harrisburg and we need our legislators to take action on House Bill 1277—the bill that will put into statute physician supervision of anesthesia. In 2013-14 we had a huge victory in the PA House with a bipartisan 131-67 vote on House Bill 1603—the identical bill to HB 1277. However, HB 1603 was held up in the Senate and did not get out of committee before the session ended.

Our profession faces coordinated attacks by various parties who wish to promote the expansion of the scope of practice of nurses. They've been emboldened by the federal government and are well-funded and organized.

Z-PAC is our voice in Harrisburg. We need to support legislators who agree with our views on patient safety. In order to be successful, Z-PAC needs the financial support from all of our members, not just 20 percent of our members. Now is the time to step up. If you are a loyal contributor, consider increasing your donation. If you are not a contributor, now is the time to start. The average Z-PAC contribution is $325—less than $1 per day. Think of the impact of Z-PAC if we had double the contributors!

We need to adopt zero tolerance for not supporting physician advocacy efforts and zero tolerance for complacency. If you are a contributor, ask your partners why they are not. A few voices cannot have the impact that all of us would have speaking together. Z-PAC gives us that unified voice on our issues and concerns.

Your support is vital to our success. Do this today. You can make your donation to Z-PAC online at www.psanes.org or use your phone and scan the QR code to be taken to the Z-PAC page to contribute.

Working together, we will make a difference — a BIG difference for our patients and for our practices.

Happy Doctors

by Robert A. Campbell, M.D.

There are many articles in the news echoing the sentiment among doctors that careers are on the wrong track. Doctors are unhappy and not in control of their destiny. Current projections are that we will have 90,000 too few doctors in 2025. Maybe a better metric than total numbers is to start measuring the total number of happy doctors. Happy doctors are productive and will advance the profession and the quality of healthcare in general.

Is there a roadmap to happiness in medicine?

After being called "doctors" for over 2,000 years we are now being termed "providers". As a first step toward happiness in medicine, we should be certain to use the term "doctor" whenever we can. We have a great legacy in this noble profession and should preserve that legacy by using our correct title. There are now 48,000 applicants for 20,000 medical school spots. Those who get through this should call themselves doctors. Make it a habit.

It is also my humble opinion that the roadmap to happiness begins with changes to our medical education curriculum. There are aspects of our education, or lack thereof, that years later are responsible for widespread doctor discontent. It is easy to identify proximate causes of discontent, like long hours, decreasing incomes, night call, high-risk for litigation and the like. Just maybe there is a root cause in our education that has others at the helm while we are endlessly working the oars, unaware of even where we are going. Maybe we are not taught all the right things. Is learning the Krebs Cycle more important than some of the items left out of our physician education curriculum?

Big data is not core to medial school curriculum, but it should be.

Doctors need data skills if they wish to be at the table developing strategy for health care delivery. Access to data, and the ability to manage and interpret big data, is more important than ever in most careers in or out of medicine. Business, pharmacy, nursing, technology, and other professionals working with us all have more exposure to this skill set. We need to learn big data since those who have the skills to access and understand quantitative metrics will be making the decisions as medicine is now driven by this data. In addition to big data, we also need to include courses in information technology and statistics-driven course work.

Aside from quantitative analysis, how about some business skills being taught in medical school?

Despite the fact that health care is big business, business skills were nowhere to be found in my medical training. We need formal management, accounting and finance skills to have any hope of getting our hands on the wheel at the helm. Some doctors are attune to this and going to

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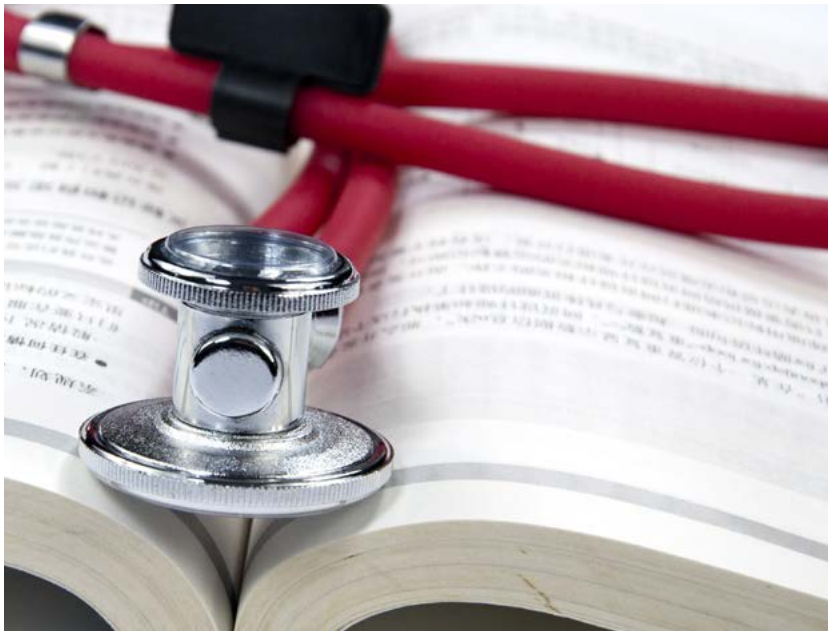
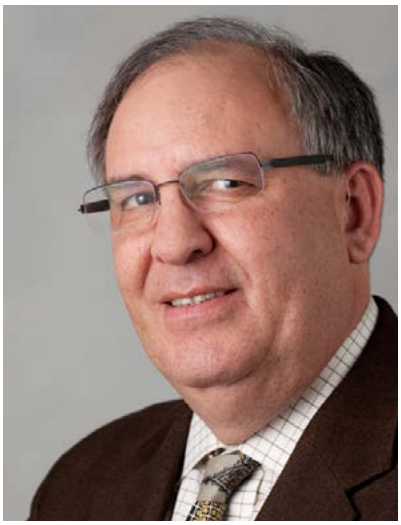


The Role of Physicians From Cradle to Grave

by Robert Hoffman, Eckert Seamans Cherin & Mellott



Normally, I write *Sentinel* articles about medical/legal issues that affect anesthesiologists, either specifically as anesthesiologists or together with physicians generally. This article breaks that tradition. Instead, it discusses two recent legal developments that relate to the actions and role of physicians generally, but with little, if any, direct impact on what anesthesiologists do. I write about them anyway because I think they are interesting. I hope, after reading this, you agree.

K.H. v. Kumar

The first development involves an August, 2015 decision of Pennsylvania's Superior Court, involving a plaintiff referred to as K.H. According to the decision — and I want to be clear that I do not know if the facts stated below are either the real facts or all of the relevant facts — K.H. was born prematurely at 33 weeks gestation in June, 2002 and spent two weeks in the NICU. On release, he suffered from respiratory, cardiac and gastrointestinal complications due to his prematurity, and was admitted to the hospital on multiple occasions in his first several months of life. During this time, a chest X-ray showed healing fractures of the fifth and sixth ribs and flattening of the vertebral bodies at T8, T9, T12, L2, L3 and L4. The radiologist, "while concerned about the potential of child abuse," concluded that the "more likely" cause of the injuries was a congenital issue secondary to K.H.'s premature birth. The pediatrician referred K.H. to a pediatric orthopedist who, after exam, accused the parents of child abuse. In early October, K.H. was seen by a gastroenterologist, who reported a rash or bruise on K.H.'s sternum and chest wall. In December, the pediatrician noted an increase in the size of K.H.'s head as well as a bruise on his forearm.

As you can no doubt guess, there is a very unhappy ending. In mid-December, K.H. was discovered unresponsive in his crib. He had sustained non-accidental injuries consistent with having been "shaken," including "contusion in the high left parietal region with surrounding edema with mass effect, interhemispheric subdural hematoma, tentorium subdural hematoma, and small left frontoparietal subdural hematoma." K.H. is alive but assertedly with multiple major disabilities. His father was convicted of the abuse and went to prison.

None of the involved physicians made a report to the State's Child Abuse Hotline.

In 2009, K.H., through his parents (his mother had remarried), filed a lawsuit. With one largely irrelevant exception, K.H. did not allege that any physician had misdiagnosed or mistreated him. Instead, K.H. alleged that the standard of care went beyond diagnosis and treatment to invoking the social services safety net and calling 800-932-0313, Pennsylvania's Child Abuse Hotline. K.H. argued that this failure prevented timely intervention, before the more serious injuries occurred, by child protective services staff. Pennsylvania's Child Protective Services Law (CPSL) includes physicians as among the persons mandated to report suspected child abuse when they have "reasonable cause to suspect that a child is a victim of child abuse."

Defendants argued that even if a physician had failed to make a report that should have been made, the CPSL did not allow a plaintiff to be awarded damages. (This is a very lawyerly argument that goes under the heading "there is no private cause of action for damages." In a somewhat analogous case in 1999, the Supreme Court ruled that a physician's failure to report a driver with failing eyesight to PennDOT for possible suspension of her driver's license, as the Vehicle Code required the physician to do, nevertheless did not allow plaintiffs to sue for damages.) The trial court agreed and dismissed the complaint.

Superior Court, in an opinion by Judge Wecht, recently elected to the Supreme Court, reversed. The issue, Superior Court held, wasn't whether the CPSL allowed for damages but whether the standard of care required the doctors to make the call independently of the CPSL. Just as the standard of care likely required K.H.'s pediatrician to refer him to the radiologist and other specialists, so, the Court held, a jury might find that the standard of care also required physicians to take steps to protect K.H. from abuse.

The Court's conclusion included this sentiment on a physician's responsibility:

> In its contemporary form, the Hippocratic Oath sworn by aspiring physicians in the United States provides, *inter alia*, that 'I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.' (This version of the Oath was apparently written in 1964 by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University.)

The Court did not itself determine what the standard of care required. Judges do not decide that. Instead, the MCARE statute requires that standard of care testimony come only from physicians practicing in the physician defendants' specialty or subspecialty and that juries resolve conflicts in that testimony. Here, the Court simply noted that plaintiffs had presented expert reports from qualified physicians who supported a broad reach of the standard of care. As the Court excerpted one expert's report: "[i]n order to comply with the standard of care a physician, particularly a pediatrician, must appropriately recognize signs and symptoms of abuse, diagnose that abuse, and report that abuse." That may or may not be a fair statement of the applicable standard of care, but it is sufficient, the Court held, to allow a jury to decide the issue.

Superior Court remanded the matter for a trial. Before that happens, the defendants have asked the Supreme Court to review the case and ultimately reverse the decision. The Pennsylvania Supreme Court over the past decade has been quite cautious in creating new liabilities for physicians, rejecting several requests that it do so. The Supreme Court has frequently cautioned that "before a change in the law is made, a court, if it is to act responsibly must be able to see with reasonable clarity the results of its decision and to say with reasonable certainty that the change will serve the best interests of society." It may well see this case as transgressing that guidance. It is also entirely possible that the changes to the Court's composition, the result of the November 2015 elections, will result in a Supreme Court less sympathetic to physician concerns.

If there is a trial, the defendants will be free to present experts who define the standard of care more narrowly, confining it to what we would normally characterize as medical care and treatment and excluding child abuse reporting. Separately, the defendants can provide testimony from experts who support the physician's explanations of why they did not call the Hotline; it is often the case that hindsight and real time show different pictures. The discussion in this article is not intended to lead to the conclusion that any physician involved in K.H.'s care acted improperly.

There are two takeaways from the decision. First, when a serious thought of child abuse crosses your mind, dial the phone and let the state officials sort it out. Of course, do not act without a fair basis to do so; the report itself, even if ultimately proven to be unfounded, will affect the child and family. Second, recognize that physician's duties may not be as limited to medical care and treatment *per se* as you may have thought. How much more broadly those duties may go remains to be seen.

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MBA school after their medical career begins. Fewer would need to go all in that way if we all had the basics of business training in our medical curriculum. The business of health care is controlled by businessmen. If more doctors had these skills, we could have a more collective influence in decisions.

Leadership training is another skill missing in medical school.

I love science, and science is powerful when it leads you to a solution to a big problem. Medicine has been really good in this area—at least since the Carnegie Foundation funded the Flexner Report in 1910. Today, science alone is no longer supreme. It is businessmen and nursing managers who run health care. I do not want to make enemies, but while their curriculums have minimal scientific training, they get lots of leadership training. How about we take the reins with health care leadership classes in medical school?

Structure of effective organizations, entrepreneurial management, organizational strategy courses, and effective business communication strategies are all skills that, supplemented by our rigorous understanding of the sciences, could make us more capable to lead than the current business and nursing leaders at the helm now.

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"Death Panels" Redux

When what is now known as Obamacare was working its way through the legislature, a certain former vice-presidential candidate led a chorus of voices in decrying, in the strongest terms, that the proposed legislation authorized "death panels" that would ration out medical care. The upshot was that these bureaucrats would deny care to the elderly and disabled. As most serious "truth raters" said at the time, the allegation was ridiculous, based on a complete misreading of a provision that would have allowed physicians to be compensated for spending time with patients discussing end of life decision-making. The proposed provision was removed. Until recently, the fear mongers prevailed.

With much less controversy, the Centers for Medicare and Medicaid Studies (CMS) announced this past fall that effective January, 2016, it will recognize, and compensate physicians for providing care under, two new codes relating to "advance care planning." Replete with Medicare lingo, CPT code 99497 is to be used when advance care planning "includes the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes, face-to face with the patient, family member(s) and/or surrogate." CPT code 99498 will cover each additional 30 minutes of time (think about it as base units.)

Medicare, possibly still aware of the prior controversy, is quick to say that these services, like medical services generally, are entirely dependent on the patient wanting them and agreeing to them. "For Medicare beneficiaries who choose to pursue it, advance care planning is a service that includes early conversations between patients and their practitioners, both before an illness progresses and during the course of treatment, to decide on the type of care that is right for them." The "bureaucrats" who will be having these discussions with patients are, of course, physicians.

Many attorneys counsel their clients on advance care planning issues, providing advanced health care directives, health care powers of attorney, POLST forms, and the like. Appropriately, they get paid for doing so. Many standard versions of these forms are available online. Physicians don't draft the forms, but they are much better informed than lawyers at the medicine side of end-of-life care. Minimally, physicians will now be compensated for having the talk. Hopefully, that fact will incentivize physicians to encourage patients to better address these uncomfortable but important issues. It is not rationing care, let alone denying it, to facilitate patients being able to control the care they want and do not want in the future.

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So it is that physicians, at least according to Superior Court, have a special duty to protect children from harm, not just disease. CMS has recognized that physicians have a special role in helping their elderly adult patients face the challenges ahead of them, and deserve to be compensated for the time spent doing so. It is all part of the ever evolving role of physicians in society.

Anesthesia PQRS Compliance Reporting is Hard: 3 Tips to Help

by Jeff R. Zavaleta, M.D., Chief Medical Officer Graphium Health www.GraphiumHealth.com

The public has made it very clear: they want quality health care. As a result, we have the "Physician Quality Reporting System" (PQRS). Simply described, PQRS offers a set of penalties and rewards for providers who are able to report quality measures. While such an effort sounds good in theory, the implementation of such a measurement framework, especially for today's anesthesia practice, can be very complicated, expensive, and if executed poorly, will have little impact on the actual patient experience. Here are three tips to consider when implementing a PQRS compliance solution for today's anesthesia practice.

1. Use Intelligent Software

The Anesthesia Quality Institute has published a 70+ page document defining 27 quality measures specific to the practice of anesthesia. This document describes in great detail each measure, listing both denominator and numerator inclusion and exclusion criteria. Suffice it to say, it gets complicated very quickly, and it's impractical for providers to be tasked with coding their own quality outcomes by circling codes on a sheet of paper. Providers cannot realistically keep track of all the details within a 70+ page reference document.

Not only is it impractical, but it could be fraudulent. If a patient's medical documentation does not support each quality component of a Cat II CPT code or ASA Outcome code, then the provider who "attests" quality compliance could be at risk for failing a CMS audit. And ignorance is no defense. On the bright side, as

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non-compliance penalties for PQRS arrive to the market place, so do new, innovative vendor solutions. With today's mobility options and ever-increasing connectivity availability, reporting can be really easy — and valid — right at the point of care.

2. Use Existing Workflows

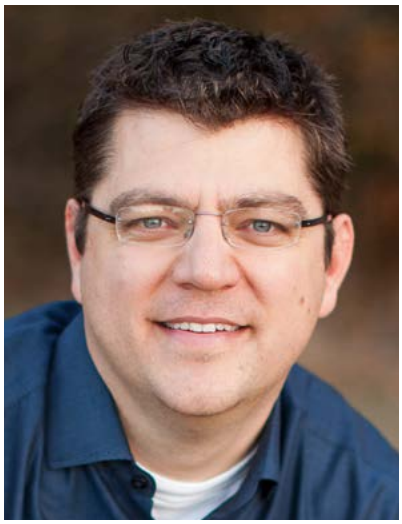
Too common in a provider's existing paper-based workflow, the reporting solution of choice includes adding another form. Consider the forms we currently need: pre-op record, pre-op order sets, intra-op anesthesia record, PACU order sets, post-op notes, complications, billing form, and now a new "PQRS Compliance" form. The list continues to grow, and our profession becomes more about documentation than actually improving quality or caring for patients. It doesn't need to be this way.

For example, intelligent anesthesia software can be "baked in" to your existing charting efforts, removing the need for "additional forms". By intelligently monitoring the discrete fields on the EMR, you can remain confident you're recording all of the quality data needed to support every reported quality code — without additional documentation effort. The best software will code your clinical work the correct way, every time, and then there's no need for your providers to know the difference between 4048F-1P and 4047-8P.

3. Take Advantage of Innovation

Undoubtedly, remaining compliant in a world of ever-increasing regulatory confusion and burden requires adoption of new software. Use this opportunity to adopt solutions that not only improve quality compliance, but also offer other value-added benefits. For example, implement solutions that offer real-time analytics so you can actually implement change and improve the patient experience. Choose solutions that include operational insight into efficiency, productivity, and location utilization, while also offering efficiency gains in your existing charge capture and billing work flows.

Just like every other industry, mobility and software are disrupting the market place. This is certainly true for anesthesia practices. Evaluate new options and recognize they don't have to break the bank nor do they require a team of experts to implement. Can we actually become more efficient with increased reporting requirements? We think so. It can be easy, it can make you more profitable, and just maybe, it can improve outcomes!



Author Bio

Dr. Zavaleta is Fellowship trained in Bioinformatics, a Diplomate of the American Board of Anesthesiologists, and Board Certified in Clinical Informatics. As a private-practice pediatric anesthesiologist, he understands the need for vigilant patient focus, consistent speed, and unfailing focus on patient safety. His driving passion is to make the limited resource of healthcare available to more people by lowering costs and improving efficiency.

PSA Resident Update

by Bradford L. Cardonell, M.D., President, PSA Resident Component, Geisinger Health System

Anesthesiology residents from around the Commonwealth recently traveled to San Diego, CA for the 2015 American Society of Anesthesiologists Annual Meeting. Many residents presented their scholarly work during the scientific portion of the meeting, and nine residents represented Pennsylvania at the ASA Resident Component House of Delegates.

PSA Resident Component

Our annual meeting of the PSA Resident Component also took place during this meeting. Topics of discussion primarily included how PSA could help advance the education of anesthesiology residents in Pennsylvania. This year, we plan to explore webinar and teleconference-based discussions and lectures that will be available to anesthesiology residents from all programs in our Commonwealth. We are also increasing the availability of CME material and lectures for anesthesiologists at all levels on the PSA website. This is available, free as a member benefit, within the members section of the website and is an excellent source to review high-yield topics with a summary of the most current literature. Any PSA member, including resident members, may contribute to this peer-reviewed resource. If you have a topic you wish to write, reach out to Kristin Ondecko-Ligda, M.D., chair of the PSA Resident Activities Committee.

PSA Annual Meeting and Luncheon

While in San Diego, more than 20 residents attended the PSA Annual Meeting and luncheon. Dr. Robert Campbell, now immediate past president of PSA, recapped the challenges and accomplishments of our organization during the past year. Dr. Andrew Herlich, newly-elected PSA president, discussed the importance of continuing to mentor residents to further our education and advocacy. If there are residents seeking a mentor with a particular interest, PSA leadership will be certain to facilitate pairing a mentor to those residents.

Resident Advocacy

At the meetings, we also discussed how important it is to continue our ongoing efforts in advocacy. Four of our residency programs were recognized for 100% resident participation in ASAPAC. Congratulations to Thomas Jefferson University, University of Pittsburgh Medical Center, Geisinger Health System, and Penn State Hershey Medical Center. An additional congratulations to Geisinger Health System for achieving 100% resident participation in every year of its existence. Throughout the year we will collaborate and share ideas on how to increase participation across all residency programs in Pennsylvania. On behalf of the residents in Pennsylvania we appreciate the support PSA has provided to us and we look forward to another productive year as we advance the medical specialty of anesthesiology.

Deliberations of the 2015 ASA House of Delegates and ASA Advocacy Update

by Erin A. Sullivan, M.D., ASA District Director

The 68th meeting of the American Society of Anesthesiologists House of Delegates (HOD) convened in San Diego in October. As in previous years, there was a spirited discussion about practice guidelines, policy statements and professional standards that impact our specialty.

Four documents were approved by the HOD and are available for review on the ASA website (www.asahq.org): *Practice Guidelines for Obstetric Anesthesia: an Updated Report; Practice Guidelines for the Prevention, Detection and Management of Respiratory Depression Associated with Neuraxial Opioid Administration: An Updated Report; and Statement on Nonobstetric Surgery During Pregnancy; Statement on Pain Relief During Labor.*

Committee on Performance and Outcome Measurement: Annual Report

Testimony was presented before the Reference Committee on Professional Affairs indicating concern regarding the quality measure generation process. Broader discussion affirmed that the current process is effective but under continuing improvement. Testimony also indicated that the House of Delegates and ASA members have had, and will continue to have, the opportunity for input in the performance measure development process. The Committee on Performance Outcomes Measurement utilizes committee expertise and draws upon the expertise of other committees, Anesthesia Quality Institute and methodologists.

Election of ASA Officers

The Mid-Atlantic Caucus, of which the Pennsylvania Society of Anesthesiologists is a member, is very pleased to be represented on the ASA Administrative Council by John F. Dombrowski, M.D., who serves in the office of ASA Assistant Secretary.

The ASA officers for this year are:

President
Daniel J. Cole, M.D.
President Elect
Jeffrey Plagenhoef, M.D.
First Vice President
James D. Grant, M.D.
Immediate Past President
John P. Abenstein, M.D.
Vice President for Scientific Affairs
Beverly K. Philip, M.D.
Vice President for Professional Affairs
Stanley W. Stead, M.D.
Secretary
Linda J. Mason, M.D.
Assistant Secretary
John F. Dombrowski, M.D.
Treasurer
Mary Dale Peterson, M.D.
Assistant Treasurer
Michael Champeau, M.D.
Speaker of the House of Delegates
Steven L. Sween, M.D.
Vice Speaker of the House of Delegates
Ronald L. Harter, M.D.

Protect Safe VA Care

The primary advocacy issue focused on the proposed Department of Veterans Affairs Office of Nursing Services "VHA Nursing Handbook". If this handbook is adopted, all advance-practice registered nurses, including nurse anesthetists, would be required to practice independently, effectively abandoning the VA's proven model of physician-led, team-based anesthesia care. Without physician involvement, VA would be lowering the standard of care for our veterans and putting their lives at risk. ASA strongly opposes the inclusion of the surgical/anesthesia setting and nurse anesthetists in the "VHA Nursing Handbook" and is working to have this portion "carved-out".

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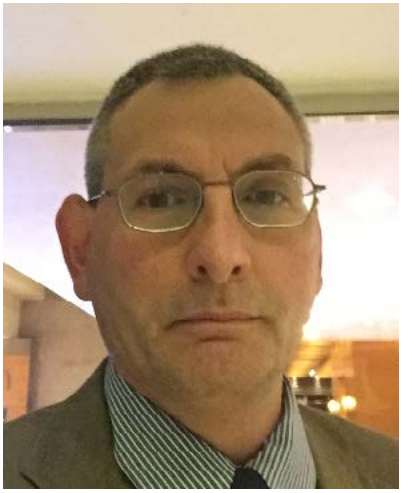
Enhanced Recovery 2: Education, Coordination, Implementation, Reevaluation, Reimplementation, and Then…Do It Again

by Joseph F. Answine, M.D.



What is a protocol? It is a noun. It is commonly defined as the customs and regulations dealing with diplomatic formality, precedence, and etiquette. However, in the medical world, it is a plan for carrying out a scientific study or a patient's treatment regimen. Protocols are considered when there is an "assumed" level of variability in care, likely leading to a "perceived" decline in quality of care based on a comparison of institutional outcomes versus those of systems deemed quality leaders, or versus regional or national benchmarks.

How these benchmarks are established is another question for another time. But, suffice to say that the impetus is that something is felt to be substandard or broken within the system. Possibly, some evaluating organization which has a significant amount of "hits" on its website puts you at or below a certain percentile for a particular quality of care benchmark such as mortality, length of stay or patient satisfaction. Administration realizes that a billboard is being raised somewhere touting that a competitor has achieved a "center of excellence" status, which leads to a midlevel administrator within your institution getting a new job and title, "coordinator of the enhanced recovery initiative".

In all honesty, I believe there is a level of validity in the premise of enhanced peri-operative care pathways. First, most of what we do intra-operatively is how we were taught many years ago. Some are based on very old studies and some are just based on habit. Analyzing the available data or collecting current data to strengthen or refute many common beliefs are greatly needed. Second, I feel that we as physician providers are being short-sighted and underutilizing our wealth of knowledge when we concentrate our skills and efforts on intra-operative care. We can provide the patient with much more benefits if we apply our skills from the very early pre-operative period when the case is scheduled to the point when the patient is home and back to their normal daily activities. It turns out that stress relief, pain control and maintenance of body and mind homeostasis, which are the directives of an anesthesiologist, can occur throughout the whole peri-operative course.

But, starting the process of implementing such a "package" of peri-operative initiatives especially with the amount of "change in thinking" required is not easy and not without a significant amount of work. It all starts with education. Few are likely to remember it, as wonderful as I am sure it was. You need to analyze your current peri-operative pathways and find out if and where true deficiencies exist. Anesthesiologists need to determine determine the accuracy of data, whether it be mortality, infection rates, readmission rates, etcetera. Make sure that you are comparing apples to apples. Understand what an enhanced recovery protocol is from its individual goals to the package as a whole. Determine the resources available within your institution to begin the process, such as appropriate rehabilitation services, a centralized patient processing center or a way to adequately and accurately collect data along the way. If not, begin by gathering such resources. Now you need to educate the rest of the key players (once you identify them).

Coordination and cooperation hold it all together.

As stated above, the coordinator has just gotten a new full-time job. Since the process has started, it is assumed that the administrators are on board. But, are they on board to the point of spending money and manpower to make it work? For example, are they ready to open a centralized enhanced recovery clinic, well-staffed with providers in many fields and ready to

accept all patients scheduled for surgery? Seek out the "champions", those individuals with the desire and the influence to make it happen. An individual or two from each department or those individuals who already demonstrate leadership within the system, such as surgeons and anesthesiologists, would be ideal choices. These individuals have to truly buy into the process or it will fail before too long. Now, build the team. Representatives from surgery, anesthesia, primary care, nursing (pre/intra/post), pharmacy, rehabilitation, the "stoma" team or other specialized care teams based on the procedure(s) performed, and quality control/ data collection individuals are a start. Have "kick off" meetings—one for the "champions" followed by others for the team members. Break them up to tackle different components, such as 1) pre-operative/ prehabilitation 2) intraoperative and 3) postoperative. Stress "cooperation" and the need for a unified agreement as to the benefits of this undertaking. Set a reasonable timeline to implementation date, which can easily be up to a year. It may seem like a long time, but an initial failure may set the process back years to never. Begin to distribute information by scheduling seminars (morning/ full day/weekend) especially aimed at individuals usually separated from the peri-operative process, such as primary care physicians and their office teams. Have more meetings. Distribute minutes from the meetings to those individuals tasked with other portions of the protocol to continue the coordination of ideas. The team members can also begin to disseminate the information to their departments. Even though you can and may start with a subset of individuals, whole department buy-in, whether surgery, anesthesia, etc. increases the chance for success.

Now it is time to see the fruits of your labor.

Patients have been through the system, talked with enhanced recovery team members, prehabilitated, drank the carbohydrate drinks, taken the medications for preemptive analgesia, and now will be the beneficiaries of all the hard work. Remember, big or small, many or few providers, all or a subset of cases, all or most of the goals, start somewhere. Collect data immediately and have frequent QA meetings to praise the successes and correct the deficiencies. Accept deficiencies and setbacks as inevitable and expected. Continuous early communication between providers is a necessity. If nothing else, it will show those individuals that may not have prepared themselves for the delivery of the enhanced recovery package the successes of those that have. No one likes not being the best.

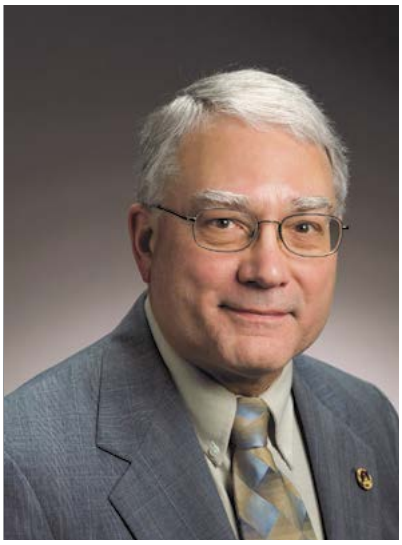
Now, reevaluate.

No first idea or process turns out to be the best. Edison learned many times how not to make a light bulb before he learned how to make one. Alter, tweak, add and delete until the protocol is yours and then alter again it to change with changes in technology and individual skills. If you don't, the system will eventually be no better than the one you left behind due to old data or outdated beliefs. Repair deficiencies and obtain previously unidentified but needed resources. Keep the teams intact and have honest and friendly discussions. Reeducate, restructure and then do it all over again.

Listening to those individuals and groups that have gone through the start-up and have implemented successful enhanced recovery protocols, as well as seeing the early stages within my institution; it is a rewarding but painful learning process no different than medical school and residency. This all leads to the inevitable—there will eventually be a standardized test involved.

Pennsylvania Medical Society Specialty Leadership Cabinet

by Donald E. Martin M.D.



PAMED's advocacy efforts and the work of the Specialty Leadership Cabinet over the past several months include current health policy issues with an impact on our specialty. The ongoing efforts of nurses to expand their scope of practice most recently focused on CRNPs. On Oct. 22, the House Professional Licensure Committee held a hearing on House Bill 765, which would remove the collaborative agreement between physicians and nurse practitioners and instead allow independent nurse practitioners to practice without physician participation and direction. The specialty of anesthesiology and PSA were represented at this hearing by Craig Muetterties, M.D., Mukul Parikh, M.D., Kevin Harley from Quantum Communications, as well as myself.

Physicians in our medical specialty work closely with both nurse practitioners and nurse anesthetists. Therefore, this bill and this hearing were important to us as a medical specialty. A long-term member of the Professional Licensure Committee remarked following the hearing that the basis for this debate has actually not changed much over the last 20 years, whether it involves CRNP's and primary care physicians, nurse anesthetists and anesthesiologists, optometrists and ophthalmologists, or midwives and obstetricians. It was clear from the hearing that disagreements between the physicians and mid-level practitioners in each of these groups center on:

1. The importance of the differences in training and qualifications of nurses and physicians;
2. The current shortage of primary care physicians;
3. Access to care;
4. Cost of care;
5. The bureaucracy associated with "supervising", "medical direction", or "collaboration"; and
6. The ability to recruit and retain physicians and nurses in Pennsylvania.

The bottom line for the Oct. 22 hearing, as in most of these discussions, was summarized by Karen Rizzo, M.D., Pennsylvania Medical Society president, "We will only succeed with increased collaboration and physician-led teamwork, and not with an increase in fragmentation of care."

PAMED House of Delegates

Oct. 24 and 25, the House of Delegates of the Pennsylvania Medical Society made several important policy decisions.

The single issue which likely received the most attention from both delegates and the general public was Pennsylvania Senate Bill 3, sponsored by Senator Mike Folmer, which legalizes the medical use of marijuana. After considerable debate, the House of Delegates resolved to continue its opposition to the broad-based legalization of cannabis for medical use in Pennsylvania, and instead supported five principles which would strengthen the medical research associated with cannabis use, and reclassify cannabis as an FDA schedule II controlled substance, so that research and compassionate clinical use would be possible — especially for children with seizure disorders.

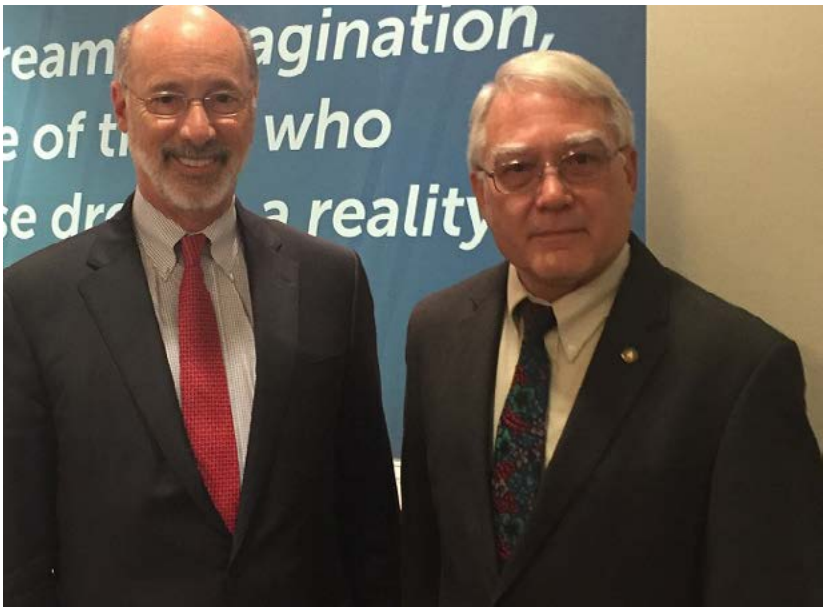
Second, the House of Delegates dealt with the issue of maintenance of certification in all medical specialties. Recently there has been some support in Pennsylvania for the National Board of Physicians and Surgeons, an organization which grants recertification at regular intervals to physicians who are already certified by an American Board of Medical Specialties' primary certifying board, such as the American Board of Anesthesiology, if they obtain current CME credits. However, the PAMED House of Delegates did not support this new board as an alternative to primary board recertification. Instead, the House of Delegates advocated

a statement of 20 principles for improvement of the maintenance of certification process, and working within the ABMS process as the PAMED has done so effectively for the past several years.

Many anesthesiology practices have exclusive contracts with hospitals or ambulatory surgery facilities. Though it did not involve an anesthesiology practice, a resolution was brought to the PAMED House of Delegates which called for elimination of exclusive contracts that would restrict the use of hospital facilities by independent physicians. The House of Delegates, however, did not support this resolution and rather reaffirmed existing PAMED policy which supports the access of independent physicians to health care networks and healthcare facilities.

Finally, on the current issue of CMS expansion of the program for the "meaningful" use of the electronic health records, significant discussion of the House of Delegates strongly supported reforming the electronic health record so that it would support rather than impede patient care in clinical practice.

PSA Members Taking Action in Advocacy



Caption: Governor Tom Wolf and Donald E. Martin, M.D., PSA Delegate, Pennsylvania Medical Society House and Specialty Leadership Cabinet, discussed the role of physicians in Pennsylvania's health care at a Democratic Governors Association meeting in Washington, D.C.

Welcome New PSA Members

Effective August 12, 2015 to November 4, 2015

ACTIVE

Olubukola O. Olla, M.D.

Andrew J. Riester, M.D.

Yu Shi, M.D.

AFFILIATE

Matthew D. Muller, PhD.

RESIDENT

Marshall Patrick Bahr, M.D.

Scott Michael Clarke

Renee L. Coleman, M.D.

Christopher Ashley Collins, M.D.

Molly Fay Deacutis, M.D.

Rory Francis Jake Detar, M.D.

Seth Marshall Eisenberg , M.D.

Evan Marshall Fuller, M.D.

Tyler Cameron Gillmen, D.O.

Nathan Steve Hoaglund , M.D.

Hayden Edwards Hundley, M.D.

Andrea J. Ibarra, M.D.

Jordan Elizabeth Ireton, M.D.

Brandy Nicole Johnson, M.D.

Patrick James Kennedy, M.D.

Christian I. Lauver, M.D.

Evan Edward Lebovitz, M.D.

Kevin McVeigh, M.D.

Kevin James Nolt, M.D.

Kofi Osei Owusu, M.D.

Agnes Kim Pace, M.D.

Jae Hyung Park, M.D.

Matthew Milind Patil, M.D.

Brandon Patrick Staub, M.D.

Chelsey Lynn Woodrum, M.D.

Insider View: My Experiences with the Pennsylvania Medical Society Year-Round Leadership Academy

by Kristin Ondecko Ligda, M.D.

Three members of the Pennsylvania Society of Anesthesiologists are participating in the Pennsylvania Medical Society's (PAMED) Year-Round Leadership Academy (YRA). Joining me in the 2015-2016 cohort are Christan Caramia, M.D. and PSA Past President Richard O'Flynn, M.D.

The PAMED YRA is a year-round program for physicians who desire comprehensive leadership training, opportunities and experiences in a diverse array of online and interactive courses. In addition to the leadership training, networking with other physician leaders from across the Commonwealth creates opportunities to discuss practice challenges amongst the different specialties and to better understand and attempt to resolve challenges within their practice settings and institutions.

The 2015-2016 YRA started in September and over the next ten months, our cohort will participate in eight online courses and three day-long live sessions held at the Pennsylvania Medical Society. Facilitators for the program are faculty members with the American Association for Physician Leadership, with online discussions guided by PAMED staff.

For the first time this year, PAMED offered scholarships to early career physicians to attend the YRA. Dr. Caramia and I were fortunate to have been selected as Early Career Physician Leader scholarship recipients.

The topic for our first session in September was Physician in Management: Communication. Prior to our online session, we each took a DiSC assessment—a tool that allowed us to evaluate our personal communication and teamwork styles. By understanding our own DiSC profile, we were able to have a common basis for discovering how each profile responds to problems, motivations, stresses and response to conflict and stress. We learned how to optimize interaction with each profile group as each style has their own set of dispositions and priorities. By recognizing our own profile characteristics, we may work to identify, respond and strive to improve our interactions and behaviors with others.

In October, our group met for our first live session at the Pennsylvania Medical Society Building where our topic focused on conflict resolution with Transforming Conflict, Restoring Productivity. We started the day with introductions from all of the members of this year's YRA, since this was our initial face-to-face encounter with our group. We completed a conflict mode instrument that evaluated our behavior in conflict situations and provided us with information on our conflict-handling styles and responses. With this information, we were empowered to understand the differences between the styles and how each style interacts with each other, to develop a foundation for improved listening, and to practice skills for carrying out difficult conversations. We also focused on our ability to give meaningful feedback and learned skills for improvement in the quality of feedback that physician leaders often must give. Our last focus of the day was how to improve our management of stress and conflict utilizing our experiences from this and the previous session.

Establishing the foundations of communication and conflict resolution allowed a smooth transition into our next topic of Meta Leadership which focuses on building cross connectivity between differing personnel within a department, specialty or other organizational group. With our meta-leadership module, we learn to connect the work of many people with differing areas of expertise and differing sets of resources. Understanding how to create a multi-dimensional solution to a program through the skills of meta leadership provides a basis for the delivery of quality patient care in a health care system and functions as a key component of leadership development.

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Additional topics this year include Effective Physician Leadership, Finance, Quality, Negotiation, Strategic Thinking, Decision Making, Strategic Planning and Building and Leading Effective Teams.

This year's program provides the opportunity for up to 60.5 CME credits and credits toward the Certified Physician Executive (CPE) certification. Information on the PAMED's YRA can be found on their website http://www.pamedsoc.org/yra

For more information on my personal experiences with YRA, please email me at kristin.ondecko@gmail.com

DELIBERATIONS OF THE 2015 ASA HOUSE OF DELEGATES AND ASA ADVOCACY UPDATE

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The leading experts on surgical anesthesia care in the VA, the chiefs of anesthesiology, have informed VA leadership that the new policy "would directly compromise patient safety and limit our ability to provide quality care to veterans." The VA leadership has ignored their concerns. Leading national medical associations, prominent Veterans Service Organizations (VSOs), and bipartisan members of congress have also challenged the VA on this change.

During Anesthesiology 2015 in San Diego, the "Safe VA Care" initiative was launched. There were several kiosks and canvassers strategically located throughout the San Diego Convention Center that allowed and encouraged ASA members to submit their comments for the Federal Register at www.SafeVACare.org. ASA is storing these comments and will submit them on your behalf when the "VHA Nursing Handbook" is published in the Federal Register. This highly successful launch had thousands of participants, but we need each and every member to participate and to also encourage their family members, neighbors, friends and colleagues to take action and submit comments.

On Nov. 11, 2015, I hosted a webinar in my role as chair of the ASA Committee on Governmental Affairs. "Take Early Action to Protect Safe VA Care" provided valuable information on how ASA members can take action to protect our veterans and maintain physician anesthesiologist-led care and the anesthesia care-team model in the VA. ASA members can login to access a recording of the webinar as well as advocacy materials on the ASA website (www.asahq.org) under the 'Advocacy' tab, 'Federal Activities'.

Taking action is simple. Go to www.SafeVACare.org and there you will see some sample, pre-drafted comments. You are also encouraged to personalize the comments or add a personal story. The best stories you can contribute are your personal stories. Some things to consider when writing your comments are: your education and training, a time when your experience made a difference in patient outcome or any involvement with the military, veterans or the VA. Remember, the VA is looking not only at the number of submissions, but also the quality and personalization. After writing your comments, fill in your contact information and submit. It's that easy!

Thank you for your advocacy and involvement on this patient's rights issue. Our veterans have sacrificed to protect our freedom. Now it's our turn to protect them when seconds count!

PENNSYLVANIA
society of
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P.O. Box 8820
Harrisburg, PA 17105-8820

Follow PSA on Facebook

To sign up for a new account, enter your name, birthday, gender and email address into the form at https://www.facebook.com. Then pick a password.

After you complete the sign up form, Facebook will send an email to the address you provided. Just click the confirmation link to complete the sign up process.

How do I follow PSA on Facebook?

First, sign in to your Facebook account. At the top of the screen, in the "Search for people, places, and things" box, type "**PA Society of Anesthesiologists**" and press "Enter." This will take you to the PSA Facebook page.

On the PSA Facebook page, click "Like" under the cover photo. Doing this will add you to the list of PSA followers, so to speak, and through your Facebook account, you will be alerted about any activity or updates made to the PSA Facebook page.

Follow PSA on Twitter

Visit https://twitter.com/signup to create a Twitter account.

Twitter will send a confirmation email to the address you entered on sign up. Click the link in that email to confirm your email address and account.

How do I follow PSA on Twitter?

First, sign in to your Twitter account. At the top of the screen, in the "Search" tab, type "**@PSAnesth**" and press "Enter." This will take you to the PSA Twitter page.

On the PSA Twitter page, click "Follow" under the cover photo. Doing this will add you to the list of PSA followers, so to speak, and through your Twitter account, you will see all of the new items posted by PSA.