

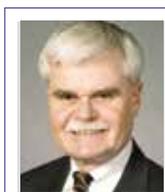


ANESTHESIA RECORD

NEWSLETTER OF THE MASSACHUSETTS SOCIETY OF ANESTHESIOLOGISTS

Volume 43 • 2016 Year In Review

Report of Counsel



Edward Brennan Jr., Esq.

The Massachusetts Legislature ended its formal session on July 31, 2016. While it continues to meet in informal sessions for the remainder of the year, only matters that receive unani-

mous consent (no representative or senator objects) can advance. The new Legislative session begins in January.

I. Nurse Anesthetist Independent Practice

The nurse sponsored bills, H.1996 and S.1207, failed to advance out of the House and Senate Ways and Means committees by July 31 and are effectively dead for the current session. The bills would eliminate the statutory provision requiring CRNAs and NPs to practice under the supervision or oversight of a physician, and remove the Board of Registration in Medicine from its current role in jointly regulating with the Board of Registration of Nursing the scope of practice of CRNAs and NPs. The scope of practice of these nurses would be left solely with the Nursing Board. Moreover, the bill would expand their scope of practice by allowing CRNAs and NPs to interpret tests.

A hearing on the bills was held in November 2015 before the Legislature's Public Health Committee. MSA leadership, Drs. Sheila Barnett, Shubjeet Kaur, Spiro Spanakis, and anesthesiologist resident Amanda Morris, testified in

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FEATURED HOSPITAL

Milford Regional Medical Center

By Donna Boynton, PR/Community Education Coordinator, Milford Regional Medical Center

Milford Regional Medical Center is a 145-bed, nonprofit, acute-care facility serving a region of 20-plus towns. The medical staff, with more than 300 physicians, are skilled in the most advanced procedures and technology, and provide personalized patient care in a warm and caring environment. Many hold teaching appointments at New England's finest medical school.

Founded in 1903, the hospital has become a highly recognized health care system locally, regionally, and nationally, and is dedicated to providing exceptional health care services with dignity, compassion, and respect. Milford Regional's honors have included being named Best Regional Hospital by *U.S. News & World*

Report and a 100 Top Hospitals™ National Benchmark for Success.

The department of anesthesia is staffed by Milford Anesthesia Associates, a private practice group founded by Paul Darcy, MD, in 2002. At that time, seven anesthesiologists and eight CRNAs were recruited to provide 24/7 in-house coverage for the medical center's growing surgical and obstetrical services.

The last 15 years have been marked by growth and expansion for both the hospital and the anesthesia department, all with the intent to provide the most progressive health care to the region in a state-of-the-art facility.



Paul Darcy, MD

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MSA COMMITTEES AND APPOINTMENTS 2016–2017

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 Shubjeet Kaur, MD
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 David Feinstein, MD
 Nicholas Kiefer, MD
 Kay Leissner, MD
 Roman Schumann, MD
 Maitriyi Shah, MD
 Sulpicio Soriano, MD
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District II Vacant
District III Charles Ho, MD; Nicholas Kiefer, MD
District IV Vacant
District V Ruben Azocar, MD; Ariel Nason, MD
District VI Charles Plant, MD

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District V Jeffrey Jackel, MD; Peter M. Ting, MD
District VI Vladamir Kazakin, MD; Richard Shockley, MD
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 Adjuncts: Fred Cobey, MD; Kay Leissner, MD

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COMMITTEE ON NOMINATIONS

Sheila Barnett, MD; Michael England, MD; Spiro Spanakis, DO

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 Adjuncts: Kulkumar Desai, MD; Stephen Heard, MD; Rafael Ortega, MD; Lee Perrin, MD; Glynne Stanley, MD
Website Subcommittee: D. Feinstein, MD (Chair); Stephen Heard, MD; Bhavani Kodali, MD; Rafael Ortega, MD; Lee Perrin, MD; Glynne Stanley, MD

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Mary Ann Vann, MD (Representative); Fred Shapiro, DO (Alt. Representative)

SPECIALTY DELEGATE TO THE HOUSE OF DELEGATES OF THE MMS

Fred Shapiro, DO

Report of Counsel

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opposition to the bills. In March 2016 the Public Health Committee, facing a reporting deadline, discharged the bills without any recommendation to the Committee on Health Care Financing. That committee reported the bills out to the House Ways and Means Committee (H.1996) and Senate Ways and Means Committee (S.1207) where they remain.

The nurses (NPs and CRNAs) worked hard to push their legislation. The MSA, the Massachusetts Medical Society, and other medical specialty societies marshalled their forces to oppose the legislation. With the assistance of our grass roots campaign, MSA members stepped up to the plate and contacted legislators advocating for patient safety and the team approach to the administration of anesthesia. **Your voices were heard!**

We expect the nurses to refile their legislation for the 2017 session. MSA urges you to continue your advocacy. Please be on the lookout for email messages from MSA calling members to action. We will provide you with talking points and guidance on contacting legislators. Your society's ability to advocate for you is dependent on your involvement and willingness to contact your state representative and senator and explain to them why nurse anesthetist independent practice is bad for patient care and safety. Please continue to stand up for your patients.

II. Opioid Legislation: Chapter 52 of the Acts of 2016: An Act Relative to Substance Abuse Treatment, Education and Prevention

A priority of Governor Baker and the Legislature this year was to enact a sweeping law to address the opioid scourge in Massachusetts. The law passed in March and is now in effect. Highlights of the law are as follows:

PRESCRIBING OF OPIOIDS

- Imposes a seven-day limit on prescribing opioids to a patient for the first time. Minors every time, with parental

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Report of Counsel

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- notification. Outpatient only. Exceptions for acute medical conditions, chronic pain, cancer, and palliative care.
- Prescribers must check the Prescription Monitoring Program (PMP) every time for Schedule II and III narcotics as well as a benzodiazepine. Only for prescriptions to be filled by the patient's pharmacy.
- Allows patients the option of partially filling an opioid prescription. The pharmacist must notify the prescriber within seven days. Prescribers must discuss with the patient the quantity of the prescription and the option to partially fill it. The remainder of the prescription becomes void.
- All prescribers must complete appropriate training in pain management and addiction, to be determined by boards of registration.
- Prescriptions for extended-release long-acting opioids require the prescriber and patient to enter into a written pain management treatment agreement.
- Requires the DPH to establish a voluntary non-opiate directive form, indicating to all practitioners that an

individual does not want to be administered or offered a prescription or medication order for an opioid. That directive may be revoked at any time — in writing or verbally — and be recorded in patient's medical records. Exemptions for emergencies. Liability protections for prescribers and pharmacists. Effective December 1, 2016.

- Establishes a “benchmarking” mechanism for prescribers. DPH determines mean and median quantity and volume of prescriptions for opiates, within categories of similar specialty or practice types. Prescribers who exceed mean or median will be sent notice. Rankings are confidential, are not admissible as evidence in a civil or criminal proceeding and are not to be used as the sole basis for an investigation by the board. Effective March 1, 2017.

III. Out of Network Billing

The Health Policy Commission (HPC), a state agency created as part of the Healthcare Finance Reform law of 2012, reviews health care spending and delivery in Massachusetts.

In its 2015 Cost Trends Report, the HPC recommended that the state “take action to implement safeguards for consumers and improve market function

related to out-of-network billing practices.” To that end, an HPC committee has been reviewing the issue with a particular interest in so-called “surprise billing” or balance billing where a patient is treated in a network hospital and some of the hospital-based physicians [emergency, radiology, anesthesia, pathology (ERAPs)] may not be in the patient's insurance network and bill the patient or his/her insurer the physician's charges rather than the “in network” fees (the physician does not have a contract with the insurer). Of particular concern to the HPC is that the patient may not know that some of the ERAPs are out of network.

The HPC conducted listening sessions this past spring to explore the issue with the expectation that some form of legislation could be recommended, including a ban on balance billing the patient and possibly the establishment by law of a maximum reasonable price for out of network providers. The MSA, represented by Dr. Alex Hannenberg, met with HPC staff to discuss the issue and MSA concerns over any recommendation to unreasonably limit or ban out of network billing.

As of this writing, no recommendations have been made by HPC.

MSA PAST PRESIDENTS

2015–2016 Sheila R. Barnett, MD
 2014–2015 Spiro Spanakis, DO
 2013–2014 Michael R. England, MD
 2012–2013 Selina A. Long, MD
 2011–2012 Ruben J. Azocar, MD
 2010–2011 Fred E. Shapiro, DO
 2009–2010 David L. Hepner, MD
 2008–2009 Beverly K. Philip, MD
 2007–2008 Donald G. Ganim, II, MD
 2006–2007 Mark D. Hershey, MD
 2005–2006 Glynne D. Stanley, M.B.
 2004–2005 Stephen O. Heard, MD
 2003–2004 Rosemarie Maddi, MD*
 2002–2003 Prasad R. Kilaru, MD
 2001–2002 Michael H. Entrup, MD
 2000–2001 Alan M. Harvey, MD
 1999–2000 Daniel F. Dedrick, MD
 1998–1999 Bernard H. Hand, MD*
 1997–1998 Jeffrey B. Brand, MD
 1996–1997 Robert H. Bode, Jr., MD
 1995–1996 Alexander Hannenberg, MD
 1994–1995 James S. Gessner, MD
 1993–1994 Lee S. Perrin, MD

1992–1993 Gerald L. Zeitlin, MD
 1991–1992 Stephen V. Hall, MD
 1990–1991 Fred G. Davis, MD
 1989–1990 Leonard S. Bushnell, MD*
 1988–1989 Marcelle Willock, MD
 1987–1988 D. Sean Restall, MD*
 1986–1987 Joseph R. Beauregard, MD
 1985–1986 Dorothy M. Crawford, MD
 1984–1985 John V. Donlon, MD
 1983–1984 Kenneth W. Travis, MD
 1982–1983 Bebe K. Wunderlich, MD
 1981–1982 Raymond J. Anton, MD
 1980–1981 Lawrence A. Simons, MD
 1979–1980 Herbert L. Everett, MD*
 1978–1979 George E. Battit, MD
 1977–1978 Richard A. Kemp, MD
 1976–1977 Joseph L. Murphy, MD*
 1975–1976 Franco R. Dinale, MD*
 1974–1975 Russell J. Rowell, MD
 1973–1974 John Hedley–Whyte, MD
 1972–1973 C. Thomas O'Connell, MD
 1971–1972 Frederick McAlpine, MD
 1970–1971 Jess B. Weiss, MD*

1969–1970 Donald P. Todd, MD*
 1968–1969 Robert D. Ouellette, MD
 1967–1968 Donald L. Mahler, MD*
 1966–1967 Henrick H. Bendixen, MD
 1965–1966 Robert N. Reynolds, MD
 1964–1965 Joseph G. Murphy, MD
 1963–1964 Leroy D. Vandam, MD*
 1962–1963 Peter G. Lehdorff, MD*
 1961–1962 Carroll Bryant, MD
 1960–1961 Francis J. Audin, MD*
 1959–1960 Phillip S. Marcus, MD*
 1958–1959 James H. Buskirk, MD*
 1957–1958 Benjamin Etsten, MD*
 1956–1957 John Bunker, MD*
 1955–1956 Robert M. Smith, MD*
 1954–1955 Dexter R. Branch, MD*
 1953–1954 Julia G. Arrowood, MD*
 1952–1953 Leo V. Hand, MD*
 1951–1952 William J. Martin, MD*
 1950–1951 Morris J. Nicholson, MD*
 1949–1950 Jacob H. Fine, MD*
 1948–1949 Urban H. Eversole, MD*

*Deceased

EDITOR'S WELCOME

“We cannot solve our problems with the same thinking we used when we created them” — *Albert Einstein*



Nikhil
Thakkar, MD

Welcome to the 43rd edition of the MSA newsletter. This past year was a year of changes for Massachusetts Society of Anesthesiologists in many ways. I would like to thank our new

communication point person, Nathan Strunk, and our new design team for giving a new look to this newsletter. We also have a new website and new team to make this communication better than ever. Keeping you informed on the state and national level in the world of anesthesia is our primary goal.

Changes are everywhere: the way we practice, the way we think about our specialty, the way we will get paid. In this edition, we present a feature article by Dr. Bailin with many thought provoking ideas in regards to changes. We are also fortunate to have Dr. Hannenberg, an expert at the national level in the area of MACRA, presenting a very informative article to guide us. I hope MSA members will find this very useful for our practice and helpful in providing better patient care.

We would like to welcome Dr. Mary Ann Vann as our new president as well as the new executive committee and officers. Dr. Mary Ann Vann shares her vision of leading this new team for the

upcoming year in her message. We will also get an opportunity to learn about our president-elect (2017–2018), Dr. Richard Urman. The MSA continues to work hard for the Massachusetts anesthesia community at multiple levels. The MSA along with the ASA has always been and continues to be at the forefront of dealing with the political aspects which affect our Anesthesia community. Government affairs at the state and national level are very well documented in reports by Dr. Hepner, Dr. Long, and MSA legal councilman Ed Brennan. New MSA bylaw changes are reported by Dr. Perrin. We would like to thank our past MSA president, Dr. Sheila Barnett, for her extraordinary leadership. Dr. Barnett describes the past year's activities in his report.

It was a pleasure to host Dr. Jeff Plagenhoff, ASA president-elect, as a guest speaker during our MSA annual meeting in May 2016. He visited many institutions during his visit and shared his thoughts and his vision for the future of the ASA.

It has been a tradition to cast light on a hospital and affiliated anesthesia group that provides care to our valuable patients in different areas of Massachusetts. Our featured hospital for this edition, Milford Regional Medical Center, along with Milford Anesthesia Associ-

ates provides excellent clinical care to their patients.

The MSA provides educational tools via CME courses, as mentioned in the report by the program committee. Take note of the courses and the dates offered for the upcoming events. MSA also continues to enhance capabilities of resident anesthesiologists to prepare them to become strong future leaders in the field. CORFA leaders, Drs. Bartels and Belani, summarize involvement of youth at state and national levels in their article (see page 18).

I hope that this edition will highlight ample opportunities to inspire you to participate and get involved with activities at the MSA and ASA. We also would like your active participation and contribution to MSA PAC and ASA PAC. Finally, please mark your calendars so that you can participate in many upcoming events including CME courses, MSA annual meeting, ASA legislative conference, and our MSA executive committee meetings.

I hope you enjoy reading this edition of the MSA *Anesthesia Record*. A copy of our newsletter will also be on our website, mass-anesthesiologists.org. If you have any questions or comments or are interested in contributing an article, please contact me at nikhil.thakkar@baystatehealth.org.



Milford Regional Medical Center

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In 2004, the hospital completed a patient care addition, featuring eight spacious, integrated OR's with advanced anesthesia technology, consolidated perioperative services (including admitting and pre-admission testing) and a medical/surgical floor with private rooms, many with patient monitoring capabilities. The maternity center offers home-like LDRP (labor, delivery, recovery, postpartum) rooms, three of which include whirlpool labor tubs and private postpartum rooms.

In 2008, Milford Regional expanded its campus to include a 54,000 square foot cancer center that provides comprehensive cancer services (including radiation therapy) from the world-renowned Dana-Farber/Brigham and Women's Cancer Center.

The hospital finished the largest expansion project in its history in October 2015 with the opening of a new 78,000 square-foot building, which houses a new emergency department, intensive care unit, and private patient rooms.

As the hospital has expanded surgical and obstetrical services, the anesthesia department has played a key role in providing the expertise and capacity to facilitate the development of these programs. Growth in Orthopedics (total joints, sports medicine, spine and hand surgery), minimally invasive General Surgery, Thoracic Surgery (Brigham and Women's-affiliated), Breast Surgery (Dana Farber-affiliated), ENT, GYN, and new programs in Bariatrics (UMass-affiliated) and Robotic Surgery transformed the scope of surgical services at MRMC. The scope of anesthesia services has also expanded to include areas outside the operating rooms. The Endoscopy Suite and Cardiac Cath Lab routinely utilize the sedation services offered by the department.

To keep pace with these increasing clinical demands, the anesthesia department has expanded to include 12 anesthesiologists, 12 CRNAs, 3 anesthesia technicians, an anesthesia PAT nurse and several per diem staff members. Milford Regional's anesthesiologists



Milford Regional Medical Center, located in Milford, MA.

have been trained in residencies such as Beth Israel-Deaconess, Tufts-New England Medical Center, University of Virginia, New York Medical Center, St. Elizabeth's, and University of Massachusetts Medical Center, offering diverse expertise and backgrounds.

"A collaborative anesthesia care team approach in a supportive workplace environment has been the department's trademark since its inception," says Dr. Darcy, chief of anesthesia and medical director of perioperative services at Milford Regional.

The department is committed to providing safe, high quality and cost effective anesthesia care, utilizing new technology and techniques in a community hospital setting. A highly successful ultrasound guided regional anesthesia program combined with the latest methods of multi-modal pain relief highlights this focus. Checklists, crisis management manuals, and standardized handoffs are an integral part of the Department's practice. Outside the operating room, Department members serve on multiple committees including the Board of Trustees, as well as provide lectures and presentations for nursing CEU programs and medical staff. The Department's commitment to excellence is demonstrated by its leadership role in promoting patient safety initiatives, teamwork, and culture of safety training (i.e., TeamSTEPPS) and performance improvement projects throughout the organization.

"One of the best decisions Milford Regional made was to enhance our anesthesia coverage in 2002 by bringing in Dr. Paul Darcy and his outstanding anesthesia group," says Edward J. Kelly, president and CEO of Milford Regional Medical Center. "Their expertise and continuous efforts to provide patients with the very latest advancements in anesthesia care have solidified their stellar reputation both in- and outside our health care system. We are very fortunate to have Milford Anesthesiology Associates as part of our team."

Milford Regional Medical Center continues to expand the surgical and medical programs it offers to the communities it serves. Likewise, the Milford Anesthesia Department continues to evolve its role by providing to its patients the many value-added services being developed by leaders in the field. In the coming years, ventures, such as the Patient-Centered Perioperative Surgical Home, Early Recovery After Surgery (ERAS), and comprehensive multi-disciplinary pain management, will be exciting opportunities for the department. Together, the MRMC and the MAA will meet the challenges of delivering safe, compassionate, and cost-effective health care in an integrated community hospital system.

President's Report



Mary Ann Vann, MD

The last six months have delivered unprecedented activity for the MSA. I took over as president in May 2016 and hit the ground running as the Safe VA Care

comment period began. It has been a whirlwind since then and the reason for the delay in publication of this report.

We were fortunate to have Chair of the ASA's Safe VA Care campaign and ASA President Elect Jeff Plagenhoef, MD, visiting here in Massachusetts when the comment period opened. He visited many departments, and with his tremendous drive and determination motivated anesthesiologists from Worcester to Boston. I want to thank MSA membership for their strong response with comments in the Federal Register on the VA Advanced Practice Nursing proposed rule. As you know CRNAs were carved out of the final rule and will not be practicing independently at the VA. However, as you heard in early January, this issue is not settled. The second comment period, which began in December after publication of the final rule, sought information on delays in OR care at the VA hospitals. However, it was used instead by CRNAs to protest the final rule and the Safe VA Care website was reopened for comments. Also, after the original comment period was closed I met with Congressman Seth Moulton of Marblehead, who is a veteran himself, with two of his constituents. Rep. Moulton is supportive of physician anesthesiologist led anesthesia care and we urged him to work with his contacts in the VA administration to ensure that CRNAs were carved out of the final rule. The VA issue was near and dear to my heart. I am the wife of a veteran. My mother was a WWII veteran, and a CRNA. I knew how strongly she supported the anesthesia care team. From a young age, she encouraged me to go to medical school, and was extremely proud that I chose anesthesia and got a residency position at MGH.

At the same time this summer, the two-year state legislature session was winding down and finished on July 31, 2016. The independent practice bills for nurse practitioners and CRNAs fortunately remained in committee at the completion of the session, but anything could have happened right up to the stroke of midnight. We can expect similar independent practice bills to be introduced soon in the new legislative session. We will be asking for your participation to contact your state senators and representatives early in the process to discourage them from signing onto any of the bills as sponsors. We want to remind them that there is opposition to independent practice by CRNAs. Massachusetts needs to maintain the highest standards of anesthesia care which attracts patients from all over the country and world. Please watch out for my emails alerting you when action is needed or legislation is introduced.

Also this summer, the MSA transitioned from a private office to professional management by the Massachusetts Medical Society (MMS). Chapter Administrator Nathan Strunk and the MMS team provide valuable resources, professionalism, and better access for members. It was a great step forward for the MSA.

One crisis we faced this summer was a hacking of our now defunct website. No MSA members were affected, but our site was used for "excessive care testing" of stolen credit card numbers. We responded by creating a new website with a new web designer and enhanced security. We have a new domain

name as well: mass-anesthesiologists.org. Please tell us what you think!

Other priorities I plan to undertake in the last five months of my presidency will focus on the MSA finances. I will continue to increase transparency and examine the finances closely with some actual budgeting which was begun last year for the first time. Since our costs to combat the independent practice bills are high, we need to keep our expenditures under control. Last year we were awarded a \$15,000 grant from the ASA to assist our efforts; we cannot expect that again.

Finally I want to encourage all MSA members to become actively involved in the society leadership. We need fresh faces and ideas. It was great to interact with many of you as the independent practice bills moved through the legislature. I hope you all remain engaged and consider increasing your involvement with the MSA. We are especially in need of district representatives, who will be our contacts with the Congressional leaders. There are many benefits to becoming more involved in addition to helping the anesthesiologists in our state.

I especially encourage you all to attend the MSA Annual meeting on Wednesday, May 31, 2017, which for the second year will be held at the Westin Hotel in Waltham. The location and the food are excellent, and ASA President Elect James Grant, MD, will be speaking. It is a great time for us all to get to know each other.

If you have questions or comments, don't hesitate to email MAAnesthesiologists@mms.org or call (781) 434-7329.



From left to right: Former MSA President Jeffrey Brand, MD, and Justin Stiles, MD, who are both constituents of Representative Seth Moulton, and MSA President Mary Ann Vann, MD.

President-Elect Profile —Richard D. Urman, MD



Richard D. Urman, MD

Richard D. Urman, MD, MBA, became president-elect of the MSA in May 2016. He is currently an associate professor of Anaesthesia at the Brigham and Women's Hospital. He received both his MD and his MBA from Harvard University, and he completed his anesthesiology training at Beth Israel Deaconess Medical Center. He

has been a member of MSA since 2003, and is currently a member of the MSA Executive Committee and chairs the MSA Programs and Education Committee. He is an MSA delegate to the ASA House of Delegates.

Dr. Urman's research interests include perioperative outcomes, shared decision-making, patient safety, and informatics. He is a member of several ASA committees, including the committees on Performance and Outcomes Measurement, Surgical and Perioperative

Anesthesia, Patient Safety and Education, and Ambulatory Surgical Care. He also serves as an alternate representative to the Joint Commission on behalf of the Society of Ambulatory Anesthesia, and is on the executive committees of the Society of Perioperative Assessment and Quality Improvement, the Society of Non-OR Interventionalists and Anesthesiologists (SONORIA), and the Society of Enhanced Recovery After Surgery (ERAS) USA.

back in subsequent years and reporting requirements will become more stringent and the size of the negative and positive payment adjustments will grow over the first four years. These are compelling reasons to prepare your practice for participation in the new MACRA payment pathways by finding APM opportunities or by building infrastructure for reporting on the MIPS metrics. Bear in mind also that while prior CMS reporting programs (PQRS, et al.) have been pay-for-reporting programs, the reincarnated versions are actually pay-for-performance programs in which your reported data will be compared with national norms and a performance threshold established from which eligibility for payment adjustments will be determined. This means that both an infrastructure for reporting and a program to insure excellent performance will be needed.

There are many resources available to help you understand how MACRA affects your practice. ASA has established a MACRA page on its website: www.asahq.org/quality-and-practice-management/macra with tools specifically designed for anesthesia practice. CMS maintains an extensive collection of MACRA educational materials at <https://qpp.cms.gov>.

FEATURE ARTICLE

Get Ready for MACRA in 2017

By Alexander A. Hannenberg, MD
Chair, MSA Committee on Economics
Chair, ASA Payment Reform Steering Committee



Alexander A. Hannenberg, MD

The MACRA payment reform legislation enacted in 2015 creates two pathways for physician payment effective January 1, 2017. From the first payment year under MACRA, don't

expect any significant routine annual updates to Medicare's payment rates, meaning that inflation will eat away at your Medicare practice revenue. The annual payment adjusts of the past will be replaced under MACRA's fee-for-service pathway (MIPS, or the Merit-Based Incentive System) with negative or positive payment adjustments based on performance in four categories: Quality, Cost, Practice Improvement, and Advancing Care Information. If you are already reporting quality measures under PQRS or for the Value Based Modifier program, you are well situated to transition to MIPS. Going forward, enrollment in a Qualified Clinical Data Registry or Qualified Registry will be increasingly important.

The other pathway involves Alternative Payment Models (APM) including

a number of existing Medicare-recognized accountable care organizations and similar groups. If you practice in a system that supports a recognized APM, there are many advantages of becoming a participating provider, including more generous fee schedule updates, payment bonuses, and potential for shared savings. Many of the care coordination and redesign activities developed through the Perioperative Surgical Home can be important contributions to the success of an APM.

Recognizing the complexity of transition to the new system, CMS introduced the "Pick Your Pace" approach to MIPS and established 2017 as a "transition year." The reporting requirements in 2017 necessary to avoid a negative payment adjustment to allowables in 2019 are minimal. The entire cost measurement category is suspended for the first year. Reporting the barest minimum data in any of the three remaining MIPS categories will protect against the (-)4% payment adjustment. Because it will be so easy to avoid negative adjustments and the MIPS adjustments are budget neutral, the likelihood of significant (+) adjustments in 2019 from 2017 reporting is small.

The relief that "Pick Your Pace" has provided for 2017 is certain to be rolled

back in subsequent years and reporting requirements will become more stringent and the size of the negative and positive payment adjustments will grow over the first four years. These are compelling reasons to prepare your practice for participation in the new MACRA payment pathways by finding APM opportunities or by building infrastructure for reporting on the MIPS metrics. Bear in mind also that while prior CMS reporting programs (PQRS, et al.) have been pay-for-reporting programs, the reincarnated versions are actually pay-for-performance programs in which your reported data will be compared with national norms and a performance threshold established from which eligibility for payment adjustments will be determined. This means that both an infrastructure for reporting and a program to insure excellent performance will be needed.

There are many resources available to help you understand how MACRA affects your practice. ASA has established a MACRA page on its website: www.asahq.org/quality-and-practice-management/macra with tools specifically designed for anesthesia practice. CMS maintains an extensive collection of MACRA educational materials at <https://qpp.cms.gov>.

FEATURE ARTICLE

Outcomes That Matter to Patients Must Matter to Us: A Call to Action

By Michael T. Bailin, MD
Chairman, Department of Anesthesiology,
Baystate Medical Center



Michael
Bailin, MD

In this issue of the Massachusetts Society of Anesthesiology Newsletter, Dr. Hannenberg reviews MACRA, a bipartisan piece of legislation sustained by over 90 percent of the U.S. Congress in 2015. It fundamentally affects how physicians are paid. Payment or penalty will be tied to results and value. Today, individual physicians are compensated regardless of quality or outcome. Every day, another news story relates fee-for-service payments are being replaced. Rewards are given for avoiding unnecessary variation in care and producing consistently good results. Physicians are learning their costs and figuring ways to cut expenses. In the new age, successful practices will spend less yet deliver superior care. Decreasing pharmacy spends or overtime costs or permitting 100 additional cases in an operating room in a year will be incentivized. An ordinary equation illustrating value in health care is shown in the box. This article focuses on the quality outcome numerator.

Shared Accountability

Measuring how well we adhere to a process of care, like using a PACU checklist after surgery is easier to quantify and less controversial than assessing outcomes. Is our goal to check “process measure” boxes or to provide what is important to patients and insurers? Value-based outcomes accrue when we reliably produce better results and fewer complications across a population. “We’re surviving” is a common reply when you ask contemporaries how their practice or department is performing. Individuals who answer contrarily, “We’re thriving” are likely working in a continuously learning health system (defined by the Institute of Medicine; see footnote). These systems look at the

continuum of care delivery as an opportunity for unceasing performance improvement. They innovate to drive more efficient health care. They optimize surgery start times, minimize cancellations, and demonstrate better patient outcomes and provider experiences by sharing data, perceptions, and wisdom across departments and superficial boundaries.

Improvement cycles are easier to implement in a system that is structured to receive and apply feedback. In order to do this, we need to form collaborative alliances among anesthesiologists, surgeons, nurses, administrators, insur-

$$\text{Value} = \frac{\text{Quality (or Outcome)}}{\text{Cost}}$$

*Outcome is related to safety,
patient experience, and effectiveness*

ers, patients, families and the health care organization. Interdisciplinary workgroups aligned to achieve reliable, safe and value-based outcomes will be the new normal. An anesthesiologist should sit at the table when investigating a postoperative fall, delirium, or a neurological deficit after surgery. Historically, anesthesiologists resisted sharing accountability for outcomes and cost with surgeons and facilities. We own postoperative respiratory insufficiency secondary to inadequate reversal of neuromuscular blockade, but what about a surgical site infection?

Value-based incentives and penalties for anesthesia providers now exist. At the hospital level, CMS financially punishes for readmissions, hospital acquired conditions, and negative outcomes. Physician profiling (cost, effectiveness, outcomes, complications, patient relationships) is already in play, and it is in our collective best interests if we are the ones gathering outcome data and determining how best to use it. Failure to act or procrastination will only get us further behind. As anesthesiologists, we will maximize our value

and impact by bearing more responsibility in the entire care process.

It will not be simple to agree on what to examine and get on with it. After listening to Dr. Michael Porter from Harvard Business School give the October 2016 ASA keynote, I feel motivated to grab onto “outcomes that matter.” Health care costs are out of control, and defects in quality continue to cause harm. Can we redirect wasted effort and money spent measuring unimportant things and focus on patient experience, particular outcomes and care innovation? As leaders of medical businesses we have a duty to find the path forward. Participating in clinical bundles and alternative payment models are crucial rungs to climb on the MACRA reform ladder.

Patient voice and outcome

A Chinese proverb states, “When the wind of change blows, some build walls while others build windmills.” This squall should stimulate us to choose a few clinical performance goals perhaps in conjunction with a patient family advisory council. Hospital process improvement committees often listen to patient voices. From outside the hospital, they recount frustrating experiences and complications. Patients easily comment on hard endpoints. Was the surgical and anesthetic encounter what they expected? Did mother experience complications during her hip replacement hospitalization? How is her functional outcome? Did we ease her pain and anxiety? Before my family and friends visit a restaurant, they have searched on Yelp or TripAdvisor. Crowd-sourced reviews describe both mediocrity and excellence. We can start slowly and share the anesthetic experiences of patients in our system among ourselves. I have to imagine a patient’s perception is as valid to them as your view is to you. At Baystate Health, we publically upload verbatim patient comments about physician-specific encounters and their outpatient medical experiences, and we

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Outcomes

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are listening and making improvements. We recognize the value of transparency and have evidence from other health systems this will translate into meaningful improvement in patient satisfaction and physician performance.

No provider wants to cause a corneal injury or fail to convey information during a handoff in care. Yet without learning from our failures and feeding that information back, it will be very difficult to advance. Anesthesiologists have always led patient safety initiatives, and now is our time to lead in value-based outcome measurement science. Although national data may be imperfect, inconsistent, or incomplete, comparisons with appropriate cohorts and specific benchmarks is an important early step. We need regular and open-minded discussion of results. Working in interdisciplinary teams

may reduce complications like postoperative delirium or postop falls in geriatric surgical patients. Anesthesia providers are champions of acute pain services and chronic pain management, and we offer addiction consultative expertise. These specialized proficiencies bring real value to patients and health systems. Many ask why we should have a stake in financial risk and measurement of outcomes that are only partially in our scope of influence. Because united interest in our patients will inspire innovations and produce better results.

Consumer Reports, U.S. News & World Report, Hospital-Compare.gov, Yelp, Leapfrog Group, and Healthgrades, among others are outside looking in. For us inside looking out, the importance of participating in clinical registries such as the AQI National Anesthesia Clinical Outcomes Registry (NACOR) is central. Through NACOR we can compare outcomes to national

benchmarks. There is always a danger of incorrectly classifying performance or using invalid measurements, so we must get involved in the development and testing of metrics to trust. With increasing financial responsibility for optimizing patient outcomes, we can no longer defend the status quo, but rather create truly integrated patient care teams. We will ensure our mutual patient achieves the first-rate outcomes we strive to provide. Investing in outcomes that matter will undoubtedly produce dramatic advantages for our entire society. These are complicated subjects, and that is why anesthesiologists need to become involved.

Footnote

Institute of Medicine. The Learning Healthcare System: Workshop Summary. Olsen L, Aisner D, McGinnis JM, eds. Washington, DC: National Academies Press; 2007. Available at www.nationalacademies.org/hmd/reports/2007/the-learning-healthcare-system-workshop-summary.aspx. Accessed December 29, 2016.

CME COURSE — ENHANCED RECOVERY AFTER SURGERY

The purpose of this course is to introduce practitioners to evidence-based best practices for Enhanced Recovery After Surgery (ERAS). The course is intended for the entire health care team and will address preoperative patient

preparation, intraoperative management, postoperative care, and data collection. The course will include a workshop to provide practical tips to the participants on how to design and implement ERAS programs at their

home institutions using an interdisciplinary team approach.

Come Join Us! Register today at mass-anesthesiologists.org.

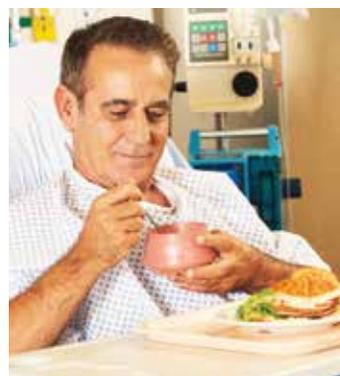


Massachusetts Society of Anesthesiologists, Inc.
mass-anesthesiologists.org



Endorsed by the ERAS® Society and ERAS®-USA Society

Enhanced Recovery After Surgery (ERAS): A Multidisciplinary Approach to Patient Care



Saturday–Sunday, March 25–26, 2017

Waltham Woods Conference Center
Waltham, MA

Richard Urman, MD, MBA, Course Director

MSA Annual Reports



Sheila Ryan Barnett, MD

It is hard to believe that it is May — and my year as president is already wrapping up. The past 12 months have passed quickly in a whirlwind of legislation, advocacy, and out-

reach. The dominant issue has been the independent practice bills in Massachusetts and physician supervision nationally within the VA system. However, our society has also been involved in important issues such as the opioid crises facing our state, multidisciplinary questions regarding cataract safety, continued inquiries into MACRA and the ACA, and most recently “surprise billing” or out of network payments. These are just a few examples of areas where I have been able to draw upon experts within our state to provide opinion and guide strategy. We are fortunate that our state is home to so many experts in academia, economics, and clinical care!

I have included a brief recap of the year; although by no means comprehensive it will hopefully provide a sense of our state society’s activities this past year.

Advocacy

With advocacy and the scope of practice legislation in our minds, we kicked off the year with a professional poll of 800 voters in the summer of 2015. This re-affirmed our belief that the public wants physician anesthesiologists involved in their anesthetic care in Massachusetts. Some key results: 87 percent of voters polled wanted a physician to administer their anesthesia when undergoing surgery or responding to an emergency during surgery; while only nine percent said a nurse. Overall, voters ranked quality over cost as the most important factor when considering health care in the Commonwealth. The complete results of this poll were very valuable — especially when talking

Outgoing President’s Report

with legislators. We shared a detailed analysis with the Massachusetts Public Health Committee Members and other key lawmakers. *Complete poll results are available on demand through the MSA.*

Our most significant efforts within advocacy have been dedicated to defeating the scope of practice legislation, bills formally known as H.1996 and S.1207: “An Act to remove the restrictions on the licenses of nurse practitioners and certified registered nurse anesthetists”. In addition to numerous letters to legislation from our grassroots networks and MSA members, and meetings with individual senate and house members, a panel of MSA leaders provided testimony at the State House in November 2015. “The formal session of the legislature ended on July 31, 2016, without the House or Senate taking up the bills. The bills are effectively dead for the 2016 session.”

We continue to work closely with our PR firm Rasky and Baerlin. This partnership has been invaluable for reaching out to our grassroots network and contacting legislators. The MSA was very fortunate to have Massachusetts be one of the few states to receive a grant for the ASA to help cover the cost of using a PR firm. Over the past year I have also had the opportunity to work closely with our lobbyist, Edward Brennan, Esq. — and I want to extend a special thanks from myself and on behalf of our society. He has provided excellent guidance over the past year and frequently alerted us to important issues at the statehouse. We are fortunate to have such a connected and experienced lobbyist!

Fast Facts: When You Only Have a Few Minutes...

As we started to reach out to members early in the year it became apparent that our members needed more from the MSA leadership in terms of information. In November I started MSA Fast Facts — which provides monthly email updates for membership. This has

been helpful to organize our efforts and keep our members up to date. These will be archived on the website.

Scholarship and Education

Education and growing the next generation of leaders in Anesthesiology is an important aspect of the MSA’s mission. The MSA hosted several popular CME courses under the guidance of the program committee chair, Dr. Richard Urman. In addition we were thrilled to receive funding assistance from FAER for prizes for the recently held NEARC conference at St Elizabeth’s Hospital. The MSA also has a tradition of funding a Massachusetts Medical Student to attend the ASA each year to participate in resident and medical school ASA initiatives as well as the House of Delegates. It was encouraging to receive several excellent applications from across the state’s medical schools. Ms. Elizabeth Walsh, from Harvard Medical School was the successful applicant and it was gratifying to see her interacting with other ASA delegates from multiple states as well as our CORA members. She provided an excellent report and continues as a leader and an advocate for Anesthesiology at Harvard Medical School. On the resident side, the Alexander Hannenberg Scholarship is awarded annually to a resident and provides funding to attend the ASA Legislative Conference in Washington, DC. Again we received several great applications, and this year’s recipient was Dr Brandon Minzer, a CA1 at MGH.

CORA

This year the bylaws of our society received a through overhaul led by Dr. Lee Perrin, to place them in line with the ASA bylaws, and this provided us with the opportunity to recommend going ahead with two co-chairs for CORA as opposed to a single Chair — as well as the usual delegates. The combined leadership provides better continuity as residents enter busy periods in

Outgoing President's Report

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their training. Another significant change is that going forward CORA is now *CORFA* — formally acknowledging the importance of fellows in the organization — both for leadership and continuity. In Massachusetts this is a boon to the group because of the high density of active members pursuing fellowships. (*see the website for a full listing of CORA and now CORFA members*) This year our CORA residents again impressed us with their energy and enthusiasm — especially during *Physician Anesthesiology Week*. Led by Dr Maggie Tilquist and Amanda Morris, the Brigham residents led the way — arranging several social and speaker events during the week. Baystate, under leadership of Dr. Michael Bailin and Nikhil Thakker, also celebrated and I was honored to give a talk and share in a breakfast as well as spend time with Baystate residents.

Cataract Surgery Practice

Last year several adverse events occurred during cataract surgery in Massachusetts, a few involving anesthesia. In response, the Betsy Lehman Center for Patient Safety and Medical Error Reduction put together a task force to examine cataract surgery practice. Dr. Spiro Spanakis represented the MSA on the panel. The full report is now available (soon to be posted to MSA website) and provides a comprehensive history and recommended approach to safe anesthesia and surgery for cataracts.

Opioids

The “Opioid crisis” is huge on both a national and local level. Governor Baker has been one of the biggest proponents of reform — and several MSA leaders participated in both Governor-appointed committees as well as MMS events. The MSA also formed a pain task force to provide a resource for immediate responses on any important pain issues. This continues to be an important issue and an area that our society can and should lead. The MSA pain

task force includes experts from both academic and private practice, including Dr. Daniel Carr, Carol Warfield, Cristin McMurray, and Christine Peeters-Asdourian.

DSA

Dr. Alex Hannenberg, past ASA (and MSA) President — was recognized by the ASA for his tremendous contributions to our profession and awarded the Distinguished Service Award of the ASA. In Massachusetts, we are fortunate to have Alex available — to draw upon his expertise in multiple issues regarding the impact of changes to legislation, billing and an in depth understanding of ACA (which is truly hard to decipher!). His willingness to participate is especially helpful when speaking with legislators and responding to the state on various health care queries from multiple state agencies. In addition he led sessions for residents on the ASA and its structure. I was glad to note that the residents again raised money for Alex's true passion — *Life Box* — during one of their post board celebrations.

Safe VA Care

On a federal level I am happy to report that we had a productive trip to Washington, DC, this year where I believe we were able to educate several lawmakers regarding the risk facing our veterans if the nursing handbook was to pass as it stands. Our participation in Safe VA Care; the ASA led initiative that is collecting letters started dismally low at 20 percent but I am now proud to say we are now approaching 60 percent participation. Please keep going and spread the word — this is so important for our veterans and our profession. You can visit www.safevacare.org for more information.

Administration Changes

On the administrative side, last year we moved to unified billing which combines the dues collection of the MSA with the ASA. Within our own Society we will be making significant changes to our management style in the upcoming

year. After an extensive review of the finances and reserves within the MSA, the executive committee agreed that our members would be better served using the professional society management services offered by the Massachusetts Medical Society. Nationally using professional management societies has become increasingly common amongst the state societies and the MMS is already handling our CME endeavors and familiar to many members. There will be a transition period over the summer, but by October we anticipate being fully managed by the medical society. This is a significant change but we believe it will be advantageous for our members in the long run. Unfortunately change often brings pain too and this does mean that Ms. Beth Arnold will be leaving our society at the end of September, I am happy to report that she has graciously agreed to stay with us and work with the MMS during the transition period. Beth has been with our society for 30 years and we are deeply indebted to her for her years of loyal and dedicated service.

Thank You

So finally I just wanted to say thank you to the members of the Massachusetts Society of Anesthesiology, and especially the executive committee for the support over the last year. I cannot possibly mention everyone here — but I have appreciated the responsiveness and enthusiasm of all the members I have encountered. It has been an interesting and challenging year — but an experience I would recommend as something well worth doing and I look forward to serving as an active member for many years to come!



Sheila Barnett, MD, with James Gessner, MD, president of Massachusetts Medical Society.

MSA Annual Reports

Secretary's Report



Bronwyn
Cooper, MD

The active membership of the Massachusetts Society of Anesthesiologists has surpassed the 1,000 mark, with the present count at 1,030 active members. This entitles the MSA to

11 ASA Delegates at the ASA House of Delegates, October 22–26, 2016, Chicago, IL.

The MSA has worked hard this past year to keep the database up to date. As of January, the MSA joined the ASA Unified Billing program. Billing of your MSA dues statement is in conjunction with ASA dues statement. All payments will go through the ASA and transferred to MSA monthly. Coming soon is the ability for members to log in to a password protected area on the website to view bylaws, meeting minutes, and current legislative activities. MSA

balloting was done this year via survey monkey.

MEMBERSHIP TOTALS AS OF MAY 26, 2016

Active	1,030
Affiliate	30
Resident.....	525
Retired.....	200

For a current list of committee members and appointments for 2016–2017, please see page 2.

ASA Director's Report



David L.
Hepner, MD

Leaders from the Massachusetts Society of Anesthesiologists, representatives from the majority of the districts and resident representatives (CORA designees and Alex Hannen-

berg's award recipient) participated in the annual ASA Legislative Conference in Washington, DC on May 16–18. The 2016 Legislative Conference was well attended with over 500 physician anesthesiologists from around the country. We heard from members of Congress about the latest health policy issues and learned about current regulatory and payment issues. For the third year in a row, the Veterans Health Administration (VHA) nursing handbook was the major focus of discussion during our congressional visits on Capitol Hill. Fourteen MSA members and residents attended the Conference and made visits to Capitol Hill. We visited every Congressperson's and Senator's offices from Massachusetts.

As you may recall, the Department of Veterans Affairs' (VA) Office of Nursing Services has proposed a new policy that seeks to change how care is being delivered in Veteran Health Administration health care facilities and

abandon the VA's proven model of physician-led team-based anesthesia care. The Department of Veteran Affairs uses handbooks to prescribe mandatory department- or administration-wide procedures or operational requirements implementing policies. This proposed handbook would replace the team approach to anesthesia care delivery within the VA and support APRNs practice as independent providers without regard to state practice acts. This proposed policy would contradict the current policy from the VHA Anesthesia Services Handbook, which calls for team to fashion care taking into account the education, training, and licensure of all practitioners. The proposed policy authorizes APRNs to function as independent practitioners regardless of the scope of practice defined by their licensure. Since we learned about this proposal three years ago around the time of the legislative conference, we have lobbied members of Congress and VA leaders about the importance of physician-led anesthesia care and have made significant progress in preventing independent nursing practice at VA hospitals. Even though it is good news that this proposal has not been finalized, unfortunately it is still a pending matter. Hence, the fight is not quite over. The VHA Nursing

Handbook has moved one step closer to a formal release date in the Federal Register and a public comment period. The Nursing Handbook proposed regulations have cleared the U.S. Department of Veterans Affairs and are currently under review at the Office of Management and Budget (OMB), Office of Information and Regulatory Affairs, which is part of the usual rulemaking process. Once the OMB completes its review, the proposed regulation will be issued in the Federal Register with a public comment period.

Although ASA has not been provided information regarding the content of the proposed regulation or when the OMB's review will be completed, it appears likely that the proposed rule will be issued with the nurse anesthetists included as part of the "full practice authority" initiative. The VA leadership will be looking for information specific to the question of whether nurse anesthetists should be granted "full practice authority." ASA plans a robust response to that question, including the full engagement of our members and other key stakeholders.

ASA continues to encourage its members to go to the *Protect Safe VA Care* initiative to collect comments on the VHA Nursing Handbook. As of

ASA Director*continued from page 12*

May 19, Massachusetts has recorded 809 comments thus far, which represents 54.47 percent of our state's membership. Out of 50 states, the District of Columbia, and Puerto Rico, our state ranks 46 in comments as a percentage of membership and 13 in total comments. With publication even more imminent, ASA is asking every member to be prepared. ASA has compiled social media posts, graphics, and sample email language. If you and your colleagues have not done so already, go to www.SafeVACare.org and submit your comments. More specifically, please participate in ASAs 1+5 campaign. Once you have submitted your comments, engage five other individuals — including your colleagues, friends and family — to also make their voices heard. Every single comment will count in this effort. ASA will provide you more information about the proposed regulation, the Federal Register posting and our response in coming days. Stay tuned.

During our visits to Capitol Hill, we emphasized that this is a dangerous policy because the health status of our Veterans is poorer when compared to the overall surgical population. Many Veterans are older with multiple comorbidities that put them at greater risk for complications during and after surgery. Furthermore, there are independent peer-reviewed studies demonstrating better outcomes with anesthesiologists. Other studies finding that no harm was found when nurse anesthetists work without supervision by physicians did not include VA facilities and were funded by the American Association of Nurse Anesthetists. We also emphasized the fact that this is a discriminatory policy because if an APRN prefers not to attain independent status, they would not be able to practice in the VHA. We also relayed the message that Veteran Service Organizations, such as American Veterans and the Association of the United States Navy, and the National Association of

Veteran Affairs Physicians and Dentists, have raised patient safety concerns. We also emphasized the fact that although there is a shortage of primary care providers, there is no such shortage of anesthesiologists. We acknowledged that APRNs may fill the PCP void and hence would like to carve out the CRNAs from this policy.

Our visits were very successful and we were able to meet Senator Elizabeth Warren in person. Senator Warren wasn't very happy when she heard that substandard care would be provided to our nation's Veterans. She agreed with us that Veterans deserve to receive the same state of the art medical care that civilians receive and was interested to hear about the possible carve out. We also emphasized this point in our discussion with the legislative aides of Senator Markey and of the nine Massachusetts members of the House of Representatives.

In addition to discussing the VHA handbook, we also discussed the Medicare Access and CHIP Reauthorization Act (MACRA) that repealed the flawed Sustainable Growth Rate (SGR) formula and created a new Medicare physician payment system for two pathways for participation: Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). We emphasized during our visits to the Hill that we need appropriate timeline for implementation, recognition of the role of physician anesthesiologists and access to resources to develop important quality measures.

Our own, Dr. Alex Hannenberg, is the chair of the Ad Hoc Committee on Payment Reform. This committee is exploring the potential opportunity to collaborate with the American Academy of Orthopedic Surgeons and other specialties relative to an Alternative Payment Model. Dr. Hannenberg gave a presentation at the Legislative Conference on the state of MACRA. In addition to MACRA, there was a call for members of Congress to take action to address the prescription opioid abuse epidemic by implementing strategies to reduce the misuse, abuse, and diversion

of prescription opioid medications. Some of these strategies include increase patient access to and physician education on multimodal and multidisciplinary pain management and make naloxone more accessible to those who might witness an opioid overdose; reauthorize the National All Schedules Prescription Electronic Reporting Act (H.R.1725); revise pain management questions in the Hospital Consumer Assessment of Healthcare Providers and Systems Survey; and permit partially filled prescriptions for controlled substances.

ASA and the Anesthesia Quality Institute (AQI) were informed by Centers for Medicare and Medicaid Services (CMS) that only 7 of 22 Qualified Clinical Data Registry (QCDR) measures submitted for inclusion in the 2016 QCDR were accepted. This will allow members to choose from 26 Physician Quality Reporting System (PQRS) measures and seven non-PQRS QCDR measures to meet PQRS reporting requirements. ASA leaders appealed to CMS and will convene a meeting of the QCDR roundtable. Leaders of the ASA and AQI met via conference call with members of the CMS QCDR Measure review team on four measures that were initially rejected in the QCDR. During the call, CMS approved the four measures for inclusion in the 2016 QCDR.

ASA First Vice President James D. Grant, MD, and Sherif Zaafran, MD, chair of ASA's Ad Hoc Committee on Out-of-Network Payment, represented ASA at a meeting with leadership of the U.S. Department of Health and Human Services (HHS) in Washington, DC, in late April concerning the rising problems with out-of-network payment (i.e., surprise bills or balance billing). The meeting was arranged by HHS and served as a forum for HHS leadership to elicit feedback from provider stakeholders about initiatives needed to address the topic. Dr. Sherif Zaafran gave a presentation at the Legislative Conference on the current state of Out-of-Network Payment.

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MSA Annual Reports



Richard D. Urman,
MD, MBA, CPE

I took over as the chair of the Program Committee during the spring of 2014, and I have had a great year working with all of the members to ensure that our programs are well re-

ceived and continue to meet the requirements of our accreditation through the Massachusetts Medical Society. We have tried a few different types of committee meetings this year — in a restaurant, at the medical society, and through conference calls. In 2015, we met in April, August, and October; this year, we met in March and July.

Committee on Programs

Since the last MSA annual meeting, we have held two CME programs: the Eighth Annual Update in Sedation and Analgesia on April 9, 2016, and a two-day course, the Abdel Mehio Ultrasound-Guided Regional Anesthesia Course and Workshop, on May 21–22, 2016. Both courses were hosted at Waltham Woods Conference Center at the Massachusetts Medical Society. The programs were both well attended and well received. Both courses were financially viable.

The MSA provided continuing medical education (CME) credits for the New England Society of Anesthesiologists Annual Meeting and Fall Conference through joint providership. The NESAC conference was held at the Ocean

Edge Resort and Golf Club last September and at the Westin Portland Harborview Hotel this past September.

Looking ahead, the Program Committee anticipates another excellent year in 2016–2017. We are currently preparing courses for next spring, including a course in Colombia in cooperation with the Colombian Society of Anesthesiologists, the Second International Perioperative Medicine Symposium on February 2–4, 2017, and a course on March 25–26 in cooperation with the ERAS Society, *Enhanced Recovery After Surgery (ERAS): A Multidisciplinary Approach to Patient Care*.



Directors, Speakers, and Workshop Leaders from the Ultrasound-Guided Regional Anesthesia Course. From left to right: Ian Richmond, MD (Associate Course Director); Issam Khayata, MD (Course Director); Hyun Kee Chung, MD; Gaurav Rajpal, MD; Alvaro Andres Macias, MD; Jose Luis Zeballos, MD; Sonia Kapoor, MD.

ASA Director

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I hope that from this update of ASA activities, you recognize the significant value that you get from your ASA membership. I am sure that Dr. Plagenhoef will expand on many of these issues tonight. Please remember that since every single anesthesiologist benefits from ASA's efforts, all anesthesiologists should be ASA members. I urge all of you to support ASAs legislative/political efforts by contributing to the ASAPAC. MSA member contributions

continue to be poor when compared to other component societies. With over 1,500 members (including residents), so far we only have 59 donors for fiscal year 2016. This is a dismal number of contributors, less than 4 percent of our members! I challenge you to not only contribute to the ASAPAC, but also to recruit friends and colleagues from the anesthesia community to contribute. In addition, if you know of any member in your department who is not a member of the MSA or ASA, please let the MSA

office know and urge them to become members and get more involved.

It has been my distinct honor and privilege to serve as your Director to the ASA. I am thankful for the continued help and support that I get from the Executive Committee and other MSA members. I also appreciate the confidence that you have in me to represent you to the ASA.

I look forward to continue serving as your director to the ASA and thank you for your vote of confidence.

Committee on Bylaws and Rules



Lee
Perrin, MD

Last October (2015), the ASA House of Delegates made a number of changes to their Bylaws concerning the Delegates and Membership categories. The following is a brief summary

of changes that we may wish to make to our Bylaws for consistency.

In addition, there is a new proposal from the Committee on Resident Affairs to give them the flexibility to have co-chairs and several other housekeeping recommendations.

The following amendments to the Bylaws were approved by the Executive Committee at its meeting on March 10, 2016. A two-thirds affirmative vote is required for their adoption.

The ASA has defined the term of office for Delegates and Alternate Delegates differently than our current Bylaws.

5.2.3 DELEGATES

Three years, commencing at the beginning of the next Annual Meeting of the ASA House of Delegates and end at the beginning of the fourth Annual Meeting of the ASA House of Delegates following their election.

2. The ASA redefined the category of Affiliate member. To make this change, bylaw 3.3.2.3 would be deleted because these physicians can choose to belong to the armed Services Component and pay half dues or be active members of the MSA.

3.3.2 AFFILIATE MEMBERS

3.3.2.1 A physician not in the clinical practice of anesthesiology.

3.3.2.2 A scientist, who, while not engaged in administering clinical anesthesia to humans, is nevertheless interested in anesthesiology.

3.3.2.3 A physician who resides outside the United States and is

not a member of any other component society and who has previously been a member of this Society.

3.3.2.4 Application for affiliate membership in this Society shall be endorsed by two members of this Society who are personally acquainted with the applicant.

3. Retired Members: Each component has its own rules on retired members. As the ASA level a Retired member pays dues of \$50 (or may receive a dues waiver if they forego receiving a printed copy of the Monitor) and does not count toward a component's delegate count. ASA also requires Retired members to have been ASA Active or Affiliate members for 20 or more years AND be retired from practice. Bylaw 3.3.4.1, as written currently, is inconsistent with the ASA Bylaws.

3.3.4 RETIRED

3.3.4.1 An individual who has been an Active and/or Affiliate member of this or another component society for 20 or more years and has retired from clinical practice.

3.3.4.2 An individual who has been an Active and/or Affiliate member of this or another component society for 20 or more years and has reached the age of 70 years.

3.3.4.3 Active members of this society who do not meet the requirements in 3.3.4.1 or 3.3.4.2 and are permanently disabled and unable to engage in the clinical practice of their profession shall, at their request, be placed in retired membership status.

3.3.4.4 A written request to change to Retired member status shall be submitted to the Secretary of this Society who will review and may approve the change of membership status request.

ASA has a category of Life Member that consists of Past Presidents of the ASA. The Committee on Bylaws proposes adding this category.

3.3.7 LIFE MEMBERS

3.3.7.1 Each Past President of the ASA who would otherwise be an Active or Retired member of this Society shall be a Life member of this Society if they choose this Society as their component society.

3.3.7.2 Life members shall pay no dues.

5. ASA now officially includes Fellows along with the Residents in their component. In addition, the ASA now allows residents to maintain their resident/fellow status until the end of the year of graduation. The following changes are proposed:

3.3.5 RESIDENT/FELLOW MEMBERS

3.3.5.1 A resident/fellow member shall be a physician in full-time training in anesthesiology in Massachusetts, in a program accredited by the Accreditation Council for Graduate Medical Education. The eligibility for resident/fellow membership ceases on December 31 of the year of graduation or upon discontinuance of such training for a reason other than graduation.

3.3.5.2 Application for resident/fellow membership in this Society shall be endorsed by a member of this Society who is the program director of the training program of the applicant.

In addition, there are a number of places where the term "resident" is used. Without listing all of them, the Committee on Bylaws recommends changing "resident" to "resident/fellow" wherever the term occurs.

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Bylaws

continued from page 15

7. Consistent with adding the new category of Life member is to update Bylaw 3.7 to give Life member privilege.

3.7.1 FULL PRIVILEGES

Active members, life members, honorary members and, retired members who have previously been active members, shall be entitled to all rights and privileges of this Society.

3.7.2 LIMITED PRIVILEGES

Affiliate members, life members, resident/fellow members, medical student members, honorary members and, retired members who have not previously been active members, are entitled to participate in the functions and activities of this Society, including membership on Standing and Special Committees, but are not eligible for election to office and have no right to vote except at meetings of committees on which they serve.

We have been using conference calls for meetings for some time. State law does allow this. We should formally add this to our Bylaws. The Committee on Bylaws recommends adding this new section:

11.5 ATTENDANCE BY CONFERENCE TELEPHONE OR SIMILAR EQUIPMENT

Any one or more members of the Executive Committee or of any MSA committee, may participate in a meeting of such committee, by means of a conference telephone or similar equipment which allows all persons participating in the meeting to speak and hear each other at the same time. Participation by such means shall constitute presence in person at such a meeting. Votes may be taken in either the same manner as an in-person meeting or using electronic voting and shall be considered proper as long as appropriate notice was provided and a quorum is present.

In section 8.2.11, the term “ad hoc” appears instead of “adjunct”. We propose the substitution of the proper term in section 8.2.11.1.

Section 11.2 requires bylaws amendments to be “mailed”. The Committee on Bylaws proposes that we allow emailing as well as using the postal service.

11.2.1.2 Such amendment shall have been recommended by the Executive Committee and mailed or electronically mailed to each voting member at least (30) days prior to the annual session using the address on file with the Society.

The Committee on Resident Affairs (CORA) this year has had “co-Chairs” instead of a Chair and Chair-elect. This is not consistent with our Bylaws. CORA has requested a change in the Bylaws to permit this. The submitted Bylaws substitute the Chair/Chair-elect with two co-Chairs.

In addition, CORA is requesting that MSA support two resident/fellows going to the House of Delegates and the Legislative Conference and has proposed a mechanism to do this. Consistent with adding “Fellow” where “Resident” is in the Bylaws, the name of the Committee would change to the Committee on Resident and Fellow Affairs (CORFA).

8.2.11 COMMITTEE ON RESIDENT AND FELLOW AFFAIRS (CORFA)

8.2.11.1 Composition

The Committee shall consist of one member of the resident and fellow membership from each of the anesthesiology residency programs within the Commonwealth of Massachusetts accredited by the Accreditation Council for Graduate Medical Education. At the suggestion of the Chairman of the Committee the President of the Society may appoint additional residents and fellows as ad hoc members of the Committee. The co-Chairpersons shall be entitled to only one vote on the Executive Committee of the MSA.

8.2.11.2 Terms

Two individuals serving as co-Chairpersons plus a Secretary and a Treasurer shall be appointed from resident or fellow members who have completed at least six months of training in an approved Anesthesiology program within Massachusetts. At least one member shall be appointed who was a member of the Committee during the previous year. Each year the outgoing Chairperson(s) of the Committee shall make recommendations to the President-Elect of the Society candidates for appointment as members/officers of the committee. The term of membership shall be for one year.

8.2.11.3 Duties

The Resident/Fellow representatives shall:

8.2.11.3.1 Council with the members of his/her program on matters pertaining to residency/fellowship training;

8.2.11.3.2 Report to the members of his/her program the action at the meetings of the Executive Committee of the Society.

8.2.11.4 ASA Resident/Fellow Delegates, ASA Legislative Conference

Delegates to the ASA Resident/Fellow Component House of Delegates at the ASA Annual Meeting will be elected by the committee from the committee members. The 2 CORFA co-Chairpersons are invited to attend the Annual ASA Legislative Conference each year. If they are unable to attend, their positions may be filled by other CORFA members at the discretion of the MSA President. If no CORFA member is able to go, their positions may be offered by application, consisting of CV and letter of intent submitted to the MSA President. Applications will be judged by the co-Chairpersons of CORFA and by the President and President-Elect of the Society.

Committee on Publications



Nikhil
Thakkar, MD

Publications Committee has a very important role in communicating vital information to our valued members. Our MSA Record (newsletter) published last summer (2015 issue),

was a great success. Our publication continues to provide an abundance of information to our current and potential members which is why many teaching institutions used it as a resource tool during Resident Interviews. I am very honored to continue to serve as a chair of the Publication committee.

Our goal is to improve every year and provide valuable information to MSA members.

In the last couple of years American Society of Anesthesiologists has promoted the concept of celebration Physician Anesthesiologists. To bring this concept to a state level, during

2015–2016, MSA Publication Committee joined Committee on Public Education (Chaired by Dr. Shapiro) to successfully celebrate Physician Anesthesiologists week in our state. We were successful in enhancing residents' efforts to celebrate our specialty during this week throughout Massachusetts by displaying posters, organizing various activities at many hospitals, and raising awareness through social media. We were also able to raise awareness among our colleagues from other specialty by publishing an article written by Dr. Schoor (Anesthesia resident) on Massachusetts Medical Society Facebook page.

The goal of the publication committee is to continue the tradition of publishing a newsletter (MSA Anesthesia Record) yearly following the Annual meeting. This newsletter is viewed as a very effective communicating tool and a wonderful opportunity to educate our colleagues and peers regarding many

aspects of our professional lives. I encourage all MSA members to take advantage of this tool and share their stories, whether it's about a political movement or changes in clinical practice affecting our profession.

Our website is also a great resource for the anesthesiology community in Massachusetts. I am thankful to our subcommittee on website, Dr. Feinstein, Dr. Spanakis, Dr. Quartraro, for their leadership and support to enhance our website. Along with the help of Beth Arnold and others, we continually update the website to provide updated and current information to our members.

I would like to thank Dr Barnett, MSA president, for her support and assistance to make my work successful along with my committee members. I encourage any feedback to help us grow.

Committee on Economics



Alexander
Hannenberg, MD

Two issues were the priorities of the MSA Committee on Economics in the past year.

Time reporting for labor epidural analgesia. In the past several

years, Tufts Health Plan and Neighborhood Health Plan have interpreted the definition of anesthesia start and end time as implying that only "face to face" time can be reported for labor analgesia. They also illogically superimposed time unit ceilings on this policy. In both instances, we have met with plan leadership and persuaded them that the local standard approach has been to recognize time units from insertion through delivery (or related ancillary procedure) subject to a time unit limit.

Most recently, it has become evident that Fallon's anesthesia policy is ambiguous in this respect and we have had a series of exchanges with Fallon about updating their anesthesia policy to clarify that time units are accounted for differently with surgical anesthesia or labor analgesia.

We recommend that MSA members review the anesthesia policies of the carriers with whom they do business and confirm that language explicitly addressing "insertion through delivery" time appear so that disputes based on confusion between the two methodologies can be averted.

"Out-of-Network" or "Surprise"

Billing. Patient complaints and regulator concerns are focusing across the nation on the phenomenon of a patient receiving services in a facility that is part of a provider network and also

receiving care from physicians or others who are not under contract to that provider's network. This is most often a phenomenon seen with ambulance companies and hospital-based specialists, including anesthesiologists. The Massachusetts Health Policy Commission has begun hearings on this subject and regulators and legislators across the country have focused on it in recent months. The ASA has appointed an ad hoc committee to address the issue. The threat of a statutory requirement for non-participating physicians to accept health plan payment without billing rights is a major concern. Providers raise questions about the adequacy of the health plan provider networks and suggest a requirement that they demonstrate adequacy. MSA is following the Health Policy Commission activity closely.

Committee on Resident and Fellow Affairs Update



David
Bartels, MD



Kiran
Belani, MD

Since last year's annual meeting, the MSA Committee on Resident Affairs (CORFA) continues to work towards its mission to:

Ensure proper representation at MSA and ASA meetings

Ensure medical student exposure to the specialty

Work on behalf of Massachusetts residents regarding state and national issues affecting future anesthesiologists

The following summarizes CORFA activities and contributions since annual meeting 2016.

- Expansion of the Committee on Resident Affairs (CORA) to the Committee on Resident and Fellow Affairs (CORFA) so as to include fellows training in Massachusetts. Two members of CORFA are currently completing fellowships at MA programs: David Arcella, Pain Medicine at BWH, and Frankie Joyce, Critical Care at MGH. This change has allowed us to expand our outreach and involve trainees at all levels.
- ASA Annual Meeting: Eight members of CORFA representing 6 out of 7

Massachusetts residency programs served as ASA resident delegates; Mayur Patel (Tufts Medical School) served as elected medical student delegate. The MSA CORFA delegation was involved in Resident House of Delegates debate on a range of issues. David Bartels served on the Resident Scientific Affairs Committee. Jamie Sparling served on Professional Affairs. Michael Schoor served on Administrative Affairs. CORFA delegates also participated in NE Caucus events.

- ASA Legislative Conference: Alex Hannenberg Scholar Brandon Minzer (MGH) and CORA reps Margaret Tillquist and David Arcella attended the annual Conference in May 2016. We look forward to selecting the 2017 attendees and will be distributing application materials in January.
- Education Session on ASA Governance Pathway: After its success last year, CORFA will be organizing a repeat educational session for residents with Dr. Alexander Hannenberg, former ASA President and 2015 Distinguished Service Award Recipient, about the ASA governance pathway. This is planned for January 2017.

In conclusion, similarly to last year, CORFA representatives have attended state and national meetings, including a medical student delegate, ensuring representation and disseminating information from these sessions for fellow residents. Our medical student delegate from last year, Elisa Walsh (Harvard

Medical School) is currently applying for anesthesiology residency programs. Mayur Patel, our medical school delegate from this year, continues in the tradition of spreading the word about MSA and anesthesiology in general at the medical school level. We look forward to increasing our visibility among medical students, continuing the tradition of strong involvement in professional meetings, and hope to increase our involvement with global-health related projects.

Thanks for allowing us to serve,

Kiran Belani, Co-Chair
Beth Israel Deaconess Medical Center

David Bartels, Co-Chair
Massachusetts General Hospital

David Arcella, Treasurer
Brigham & Women's Hospital

Michael Schoor, Secretary
UMass Memorial Medical Center

Amita Jain, Social Chair
Tufts Medical Center

Brandon Napstad, Social Chair
Brigham & Women's Hospital

Huan Wang, Social Chair
Brigham & Women's Hospital

Maggie Tillquist, Program Liaison
Brigham & Women's Hospital

Chris Hansen, Program Liaison
Boston Medical Center

Jamie Sparling, Program Liaison
Massachusetts General Hospital

Frankie Joyce, Fellow Liaison
Massachusetts General Hospital

Mayur Patel, Medical Student Delegate
Tufts Medical Center



Nikhil Thakkar, MD (fifth from left), and Sheila Barnett, MD (fifth from right), meet with residents from Baystate Medical Center during Physician Anesthesiologists Week celebration.

Committee on Public Education



Fred
Shapiro, DO

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.

In October 2015, Dr. Sheila R. Barnett and Dr. Fred E. Shapiro participated in the Annual Medical Student Mentoring Night at the Massachusetts Medical Society (MMS) Headquarters in Waltham, Massachusetts. It proved to be an excellent turnout generating lots of enthusiasm and interest in anesthesiology profession.

Dr. Nikhil Thakkar and Dr. Shapiro joined the Public Education and Publications Committees to bring the American Society of Anesthesiologists (ASA)

Physician Anesthesiologists week to a state level. They were very successful in getting residents' efforts to celebrate our specialty during the week throughout the state by displaying posters, organizing various activities at many of the hospitals, and raising awareness through social media. An article written by Dr. Michael Schoor was posted on the MMS Facebook page to raise awareness among other specialties.

Dr. Shapiro has been a member of the Executive Board and chairman of the Public Education Committee since 2001, past president of the Massachusetts Society of Anesthesiologists, president of the MMS's Suffolk District, vice chair of the MMS Interspecialty Committee, and chair of the ASA Committee on Patient Safety and Education.

Committee on Governmental Affairs



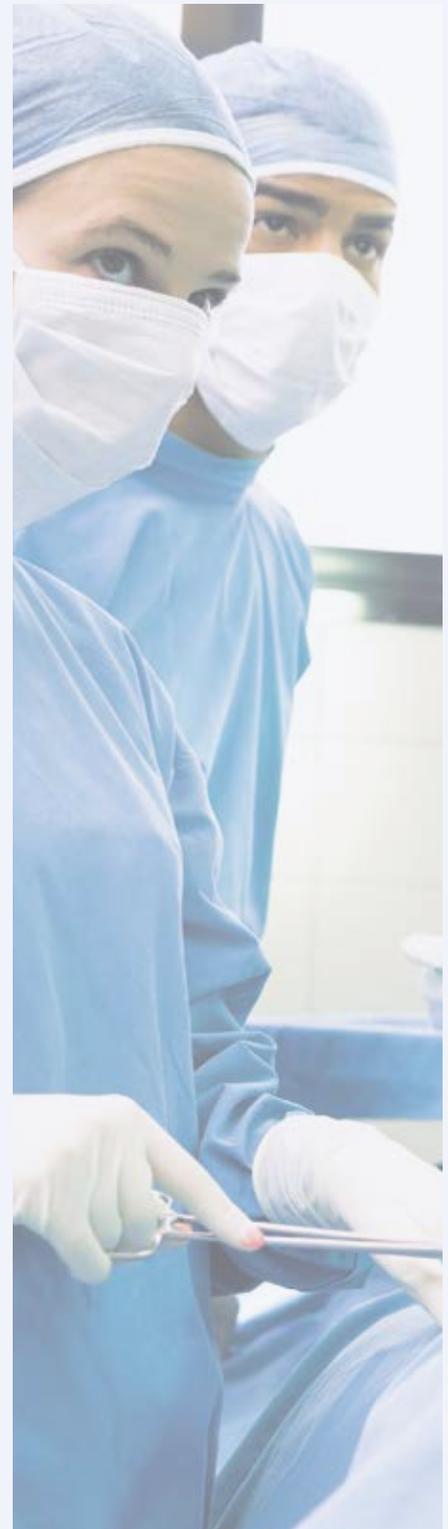
Selina A.
Long, MD

With the coming of the new legislative cycle, new advanced practice nursing bills were filed in January of 2015 (H.1996 and S.1207). We have re-filled and received ASA financial sup-

port (thanks to me Dr. Mary Ann Vann), renewed our contractual relationship with Rasky Baerlein for grassroots advocacy, and Mr. Brennan is closely monitoring the movement of these bills at the State House and leading our lobbying efforts there. A hearing was held last fall before the Legislature's Public Health Committee at which MSA officers, Drs. Barnett, Spanakis, Kaur, and Dr. Amanda Morris, a resident, testified. The bill was discharged to the Health Care

Financing Committee in March with no recommendation. That committee has until June 22 to act on the bills. With the formal session of the Legislature ending July 31, 2016, the next two months will prove critical in defeating these bills, so we really do need all hands on deck for this last "push"! Jason Hansen, Esq., of the ASA's State's Affairs Office, has also been of invaluable assistance in this effort.

On the federal level, the threatened re-working of the VA "nursing" handbook continues to challenge the safety of our nation's veterans, and while the ASA is leading that campaign to maintain the team approach to anesthesia care in the VA system, we remain committed to supporting the ASA campaign with Dr. Kay Leissner, dept. chief of the West Roxbury VA!



**Check out our new
website**

mass-anesthesiologist.org

MSA Annual Reports

MSA Annual Meeting 2016



From left to right: MSA President Mary Ann Vann, MD; ASA President Jeffrey Plagenhoef, MD; Outgoing President Sheila Barnett, MD; ASA Director David Hepner, MD



Alexander Hannenberg, MD, with the president of the American Society of Anesthesiologists, Jeffrey Plagenhoef, MD



From left to right: Elisa Walsh, MD; Huan Wang, MD; Mariah Tanious, MD; and Alexander Hannenberg, MD



Christin McMurray, MD, delegate; and Lisa Kunze, MD



From left to right: President of the MMS, James Gessner, MD; Konstantin Balonov, MD; and Kay Leissner, MD



Outgoing President Sheila Barnett with former administrator, Beth Arnold

MSA Annual Meeting 2016



Beverly Philip, MD, with MMS President James Gessner, MD



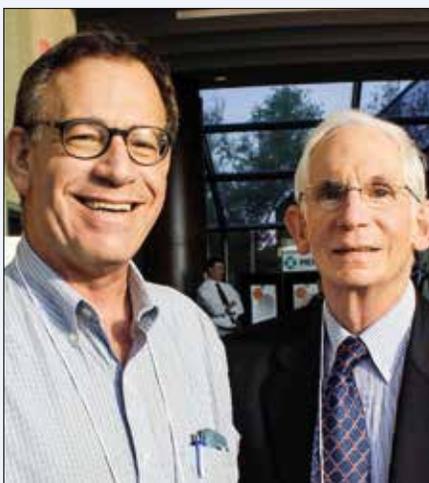
MSA Vice President Nikhil Thakkar, MD; ASA President Jeffrey Plagenhoef, MD; MSA President-Elect Richard Urman, MD, MBA



Tessa Hedley-Whyte, MD, MBBS; John Hedley-Whyte, MD



From left to right: Huan Wang, MD; President-Elect Richard Urman, MD; Alice Vijjeswarapu, MD; David Hepner, MD; Scott Kelley, MD; Dennis McNicholl, MD; Maitriyi Shah, MD; Amanda Morris, MD; Mariah Tanious, MD



Mark Lempert, MD, and Jeffrey Brand, MD



From left to right: Elisa Walsh, MD; Mariah Tanious, MD; Huan Wang, MD; Amanda Morris, MD; Sheila Barnett, MD; Alice Vijjeswarapu, MD

ASA Annual Meeting 2016



From left to right: (front row) Mary Ann Vann, MD; Alexander Hannenberg, MD; Selina Long, MD; Shubjeet K. Kaur, MD; Sprio G. Spanakis, MD; (back row) Sheila Barnett, MD; Daniel Hepner, MD; Fred Shapiro, MD; ASA Speaker Steve Sween, MD; Nikhil Thakkar, MD



Former ASA President Daniel Cole, MD, presenting Alexander Hannenberg, MD, with the ASA Distinguished Service Award.



ASA Delegates from left to right: Michael England, MD; Nikhil Thakkar, MD; Richard Urman, MD; Selina Long, MD; Mary Ann Vann, MD; Sheila Barnett, MD

A Student's Perspective



Mayur Patel

Brilliantly overwhelming — these are the two words that perfectly describe my experience at Anesthesiology 2016. There were so many interesting topics to choose from

that I nearly froze in deciding what to attend next. From witnessing the multitude of lectures, workshops, presentations, exhibits, and networking events, one thing is clear: the field is dedicated

to pushing the limits of excellence in patient care.

At the meeting, I had the chance to meet and attend a thought-provoking talk by Dr. Paul Barash on whether there is a role for cognitive testing in aging anesthesiologists. I also took advantage of lectures to refresh on basic concepts such as acid-base balance. It was great to connect with other medical students and re-connect with mentors. Sitting in on the caucuses and house of delegates meetings opened my eyes on the important work that takes place

behind-the-scenes. Even though everyone may not always be in agreement, the ultimate goal to protect patients by protecting anesthesiologists is crucial.

This was my first time attending an ASA national conference, and I was pleasantly taken aback by the whole experience. Anesthesiology is an incredibly stimulating field, and the meeting reaffirmed my decision to pursue a residency in it next year. Thank you to the Massachusetts Society of Anesthesiologists for this wonderful opportunity!

2017 Programs and Events

**Jan 29
to
Feb 4**



**Physician Anesthesiologists
Week**

Located in institutions throughout
Massachusetts.

**Second International Perioperative
Medicine Symposium**

Intercontinental Hotel, Medellin,
Colombia



**Feb 2
to
Feb 4**

**Mar
18**



**11th Annual New England
Anesthesia Resident Conference
Intercontinental**

University of Massachusetts Memorial
Medical Center

**Enhanced Recovery After Surgery
(ERAS): A Multidisciplinary
Approach to Patient Care**

Massachusetts Medical Society



**Mar 25
to
Mar 26**

**May
31**



**Massachusetts Society of
Anesthesiologists Annual
Meeting**

The Westin Waltham, MA

**American Society of
Anesthesiologists Annual
Meeting**

Boston, Massachusetts



**Oct 21
to
Oct 25**

ANESTHESIA RECORD

Massachusetts Society of Anesthesiologists
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MSA's New Chapter Administrator

On behalf of the Specialty Society Services department of the Massachusetts Medical Society, I would like to extend a warm welcome to the membership of the Massachusetts Society of Anesthesiologists. I have had the pleasure of working as MSA's CME Event coordinator since the beginning of 2016, and as we begin a new year I look forward to working for MSA and its membership as its chapter administrator. I am currently updating our database. Please help me support and serve you better by confirming your name, email address, and telephone number by sending them to:



Nathan Strunk
nstrunk@mms.org

Check Out Our Updated Website

We are proud to announce the launching of our new website at mass-anesthesiologists.org. Please visit us often for the latest updates in anesthesiology, both nationally and regionally, for upcoming events, and for opportunities for you to connect with your friends and colleagues.

