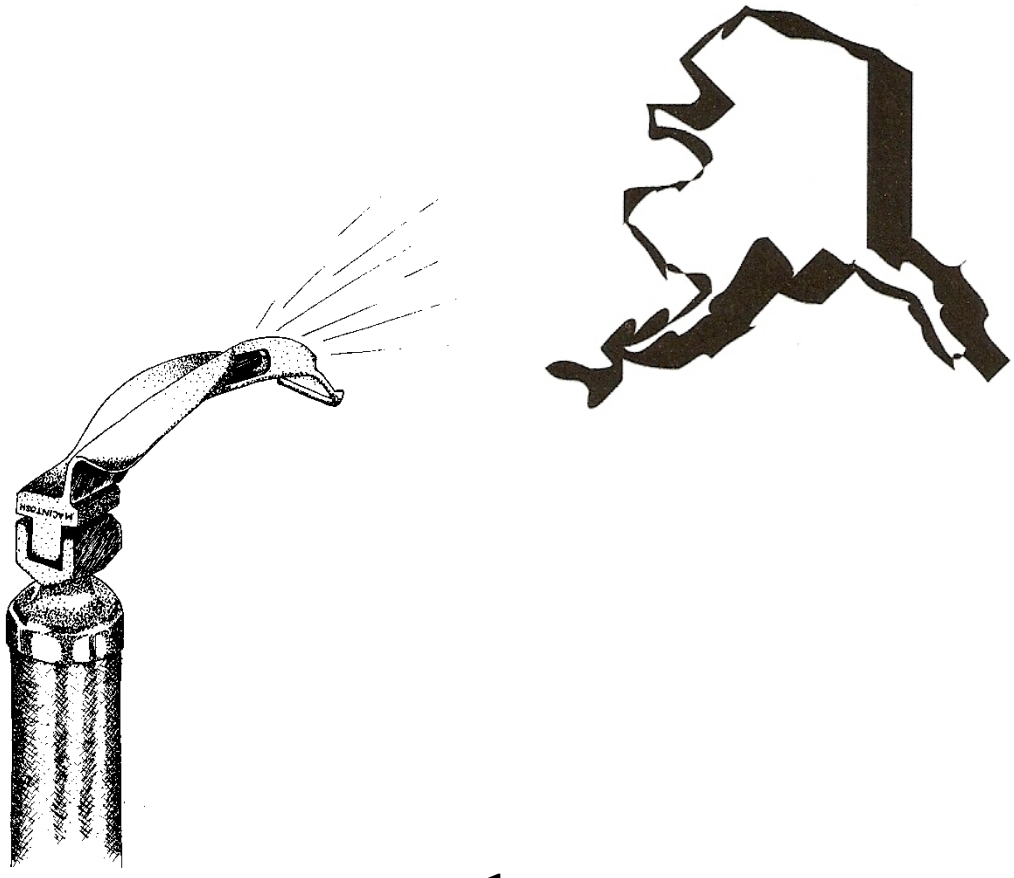
AKANA

ALASKA ASSOCIATION OF NURSE ANESTHETISTS

C/O ALASKA NURSES ASSOCIATION - 3701 E. TUDOR RD., SUITE 208 - ANCHORAGE, AK 99507



Newsletter

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Alaska Association of Nurse Anesthetists
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Editorial

The best laid plans~~

Adam Dalgleish, CRNA, took over as editor of the newsletter this spring and put out a fine newsletter in June~then promptly moved with his family down to the Seattle area.

Ah, well, these things happen, so I'm back to editing the newsletter again for the time being. It's something I enjoy doing, and have a bit more time to do it now that I'm cutting back on my work hours.

I'm still looking for a replacement, though, so if you have any interest contact me or any Board member.

Over the years I've witnessed the Alaska Association go from a sleepy little group of folks into a very dynamic and dedicated assemblage of CRNAs who, through their vigilance and hard work, protect our right to practice in Alaska and nationally.

There are potentially momentous changes on the horizon coming from the AK Board of Nursing, the MBCRNA, Medicare~ The articles in this newsletter, written by the AKANA leadership, will give you some insight as to what's coming down the road.

Wally Upham, CRNA
Editor

PUBLISHING INFORMATION

This newsletter is the official newsletter of the Alaska Association of Nurse Anesthetists and is published twice a year.

This newsletter is meant as a source of information for members of AKANA, students and other interested parties. Articles from readers are encouraged and will be accepted for publication if they have a specific value to AKANA and/or the anesthesia profession.

Letters to the Editor are also welcomed and will be printed on a space available basis. All correspondence sent to the Editor must be typed or e-mailed. Contents may be edited without submitter's approval. While being responsive to the readership of the AKANA newsletter, the Editor reserves the right of refusal of letters and articles.

Editorials and letters from readers do not represent the official view or stance of the Alaska Association of Nurse Anesthetists.

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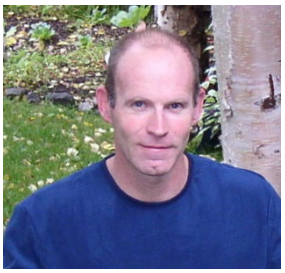
Presidents Update

Jeff Worrell, Ltc, USAF (retired), CRNA, MSN
President Alaska Association of Nurse Anesthetists



The new board for the Alaska Association of Nurse Anesthetist began their work on 1 September 2014. Wendy Monrad is the President Elect and Federal Political Director. Mary Holman is the Treasurer. Jennifer Lent is the Secretary. Nicole Bonfoey and Andrew Hansen are your directors. Sheila Jensen has volunteered to stay on as the State Reimbursement Specialist (SRS). Kelly Rygh and Julie Christensen are your Education Committee representatives. Chris Logan, past president, has volunteered to continue to be the Advanced Practice Registered Nurse (APRN) liaison .

Wendy Monrad, Sheila Jensen, Jen Lent and myself are scheduled to attend the AANA leadership conference in Chicago the second weekend in November. We continue to keep close tabs on the AANA/NBCRNA controversy.

We will be having a board meeting sometime in December to finalize plans for the State of Alaska Association of Nurse Anesthetists annual spring meeting. We will publically post the time for the December meeting.

Chris Logan instituted the use of the "Go to Meeting" software. This has allowed us to have individuals "meet" from various locations using their laptop, home PC, or tablet. We plan to continue to use this technology to reach members from around the state.

R-U-Distracted??

You have reviewed the preoperative history and physical on a 30 year old female coming to the operating room for an elective laparoscopic cholecystectomy. Her history is unremarkable except that she is slightly overweight with a body mass index (BMI) of 30. Her preoperative lab work is normal including liver function tests. She has a normal airway (MP1). You begin her anesthetic regime with an anxiolytic medication midazolam before moving to the operating room.

Once you have her comfortably positioned on the operating room table, you place standard intraoperative monitors including an EKG, non-invasive blood pressure cuff, and pulse oximeter. All of her pre-induction

vital signs are within normal limits. You have taken the time to preoxygenate her before induction. You administer a weight appropriate dose of the induction drug Propofol. You know that Propofol has been proposed to have several mechanisms of action, both through potentiation of GABA receptor activity, thereby slowing the channel-closing time, and also acting as a sodium channel blocker. Recent research has also suggested that the endocannabinoid system may contribute significantly to propofol's anesthetic action and to its unique properties.

In addition to Propofol, you select the drug fentanyl, a synthetic narcotic, in a dose appropriate for her weight. You know that fentanyl is approximately 80 to 100 times more potent than morphine, is a potent, synthetic opioid analgesic with a rapid onset and short duration of action. It is a strong agonist at the μ-opioid receptors. Fentanyl will help blunt the physiologic response to intubation and provide necessary analgesia.

After proving that you can ventilate this patient you elect to administer a nondepolarizing muscle relaxant Rocuronium. You know that rocuronium (ZEMURON) is a nondepolarizing neuromuscular blocking agent with a rapid to intermediate onset depending on dose and intermediate duration. It acts by competing for cholinergic receptors at the motor end-plate. Within about 90 seconds, you expect conditions to be adequate so you are able to intubate this patient. You notice excellent intubating conditions: her jaw is relaxed, vocal cords apart and immobile, no diaphragmatic movement. You place a 7.0 endotracheal tube on one attempt with a #2 miller blade. You tape the tube to her lip at 20cm and note bilateral breath sounds and a normal end tidal carbon dioxide (ET CO2) reading. You place an oral gastric tube at the request of the surgeon. You also place an esophageal stethoscope that contains a temperature probe. Her initial vital signs post -induction are within normal limits. You dial in 1 MAC of an inhaled agent.

The patient is prepped for surgery, drapes are applied and the surgeon begins the case.

You now take time to begin reading your last text message. You respond politely. In the mean time you start searching the web on your hand held device for the latest details of today's events. The initial heart rate was 75bpm, now 95bpm but the patient now has a pneumoperitoneum established and has had trocars placed. You are not concerned about this increase in heart rate and continue to manage your hand held device. The ET CO2, which was 38mmHG has climbed to 48mmHG. You did not notice?

Over the next five minutes, the ET CO2 continues to climb despite changes in the ventilator settings. The heart rate is now 110bpm. The temp probe records a reading of 37.8F, the baseline temp was 35.8. Are you concerned? Were you paying attention?

Every one of us is a well trained certified registered nurse anesthetist. I wrote the few paragraphs above to demonstrate that you have detailed knowledge of pharmacology, physiology, anesthesia equipment and sophisticated monitoring equipment. We do our jobs extremely well. Complication rates

are low. “Routine cases” may seem mundane at times.

Late recognition of signs and symptoms of critical events often leads to a cascade of disaster. It is more and more common to see electronic aids (I-phone, I-pad, tablet, laptops, cell phones) being brought into the operating room. These electronic devices have the potential for distraction. Look at the strength of many state laws that pertain to cell phone use while driving.

My youngest son is a medical defense attorney—he represents medical professionals. We talk often in general about anesthesia mishaps. In one very recent case, the anesthesia practitioner accused of inattention during a critical period of an anesthetic mishap was asked directly if there were any distractions that would have caused them to take their attention away from the patient. During testimony, the practitioner indicated that there were none.

The attorneys then presented a detailed log of the practitioners electronic hand held device. It was clear that at the time of the critical incident the practitioner was distracted by the device. The device log included date, time (to the second) and web information. The inference was this inattention contributed to the detrimental outcome of the case. The practitioner changed their testimony once the log was produced. Everything pertaining to an adverse outcome during a case is “discoverable”.

Our electronic devices can add value in the form of a ready reference. Cellular phones can be used for an immediate call for help.

I am asking you to recommit yourself to the vigilance in anesthesia care that every patient expects from us. You may choose to never bring an electronic device into the operating room. You may be a person that brings a device into the operating room daily. I believe we have plenty to think about during a “routine case”. There are many sources of distraction. We often do not have the ability to control the actions of others. We do have the option to choose wisely using adjuncts that promote the well being of our patients.

Being VIGILANT is carefully noticing problems or signs of danger. R-U-distracted?

“Jeff”

Treasurer's Report

Mary Holman, CRNA
AKANA Treasurer

In starting my fourth year as AKANA Treasurer I have been reflecting on how we have grown as an organization. The budget has been well thought out and reflects our evolving framework. It has been approved in its entirety by the board at the September meeting.

We have been working on expanding our website and newsletter to better share information with members, and will be going electronic with voting to make it more accessible and convenient for everyone. With members all over this large state we are always looking for ways to improve communication.

Meetings, both in state and outside, are important to us. We have funds for members to participate in national AANA meetings to bring information and resources back to the state association. Another funded resource to get us involved in state affairs is the annual Juneau Fly In. There we get to talk to state leaders about out professional concerns and get our message heard.

And as always we will be working hard to bring you a quality state meeting this next year. It is important for our state to send the appropriate amount of people to these meetings. We strive to send four representatives to the Fall Leadership Academy in November and four to the Mid Year Assembly in April. The Nurse Anesthesia Annual Congress has two funded positions and will be held in Salt Lake City.

If you are interested in going to any of these meetings please let the board know. We again have budgeted scholarship monies to members to help with the expenses of attending these meetings. If you are interested in a scholarship please let me know.

Besides making budget decisions and taking care of expenses, I am looking into ways to manage our reserve funds more effectively. As interest rates decrease reflecting our present economy I will be looking into investment strategies that would better manage our funds.

According to our bylaws I should have at least 2 finance committee members beside myself to meet and work on such tasks. If anyone has knowledge of finance or a degree that could be helpful please let me know.

This will be my last year as treasurer and I am looking for interested persons to fill my position. If you are interested in finance and would like to see what the position entails, a spot on the finance committee would be a great way to investigate it.

We, as a board, are here for you and as treasurer I try to be as transparent as I can. Please let me know if you have any questions or concerns, otherwise I will see you at the state meeting.

Mary Holman, CRNA#

Report from the

AKANA State Reimbursement Specialist

Shelia Jensen, CRNA

Most of you have heard of the SRS position but may not be aware of the role we play in our professional organization, so I would like to start with a brief overview.

Two years ago the AANA created a position within each state organization for an individual that would be responsible for keeping abreast of issues affecting the practice of nurse anesthesia and how these issues impact our re-imbursement and scope of practice.

The conduit to this information lies in relationships developed with healthcare decision makers at the local, state & national level. As the AKANA SRS I am responsible for establishing and maintaining relationships with these individuals.

In the past year I have met with Bret Kolb, State of Alaska Insurance Director, Margaret Brodie, Director of Alaska Medicaid, the BCBS director for the northwest region and have attended several political fundraisers.

At each of these meeting I have supplied a nicely laid out folder provided by the AANA explaining the role of nurse anesthesia in providing access to safe, quality and affordable healthcare in both urban and rural Alaska. I have also been working the Dental Examiners Board in revising some language in their rules and regulation that prohibits CRNA's from practicing to the full extent of our license in the state of Alaska in an office based setting.

The Fall Leadership Academy had a track geared specifically for the SRS. The information presented and the individuals presenting were all outstanding. Our day began with an inspirational & informative message from our hard working lobbyist, Frank Purcell. Frank works tirelessly on the hill advocating the practice and necessity of nurse anesthesia in our changing health care environment.

CRNA Value and Fundamentals Reimbursement were presented by our national president-elect, Juan Quintana. He presented an overview of Medicare, focusing on statutes, regulations and policies relevant to CRNA reimbursement. .

Medicare Part A covers inpatient hospital fees, skilled nursing and hospice and is paid by Social Security. Part B covers doctor fees, out-patient, supplies not covered under part A and is paid by premiums of enrollees and general funds from the US Treasury.

Under Medicare part A CRNA's must be supervised unless the state is an opt-out state. Under Medicare part B there is no requirement for CRNA supervision. Our anesthesia services are billed under

Medicare part B typically with a QZ modifier. This QZ modifier indicates that the CRNA is not medically directed. In the recent past the QX modifier was attached to our service which indicated we were "medically directed".

Even though many of us practice in a 'team model' which includes an anesthesiologist, the QZ modifier removes the seven requirements of TERFA (tax Equity and Fiscal Responsibility Act) from the anesthesiologist while assuring no change in their reimbursement for our services. So why would there be any reluctance by the MDA's to change from a QX to QZ modifier? What this modifier does impact is the demographic percent of anesthetics recorded as administered by nurse anesthesia.

Crystal Kuntz, VP of Policy & Regulator Affairs at America Health Insurance Plans, analyzed opportunities of CRNAs with private health plans within the context of health plan mission and motivations and discussed future trends in health plan reimbursement that may impact CRNAs. The most interesting item discussed during her presentation as the "Any Willing Provider" law which has been enacted in 34 states. This law prevents insurance providers from refusing negotiation with a healthcare provider interested in being included in their network.

Shuchita Madan, State Affairs Manager for Medicaid Health Plans of America, summarized the role of the State Medicaid director and their relationship with Medicaid plans in the states. Frank Purcell attended this meeting and used it as an opportunity to encourage Ms. Madan to examine more closely the vital role nurse anesthesia plays in providing safe, quality and available healthcare in all demographic areas.

In closing, I apologize for the longwinded article. There is so much more for us to be aware of in the business of anesthesia to remain informed and competitive in this changing healthcare market. I look forward to seeing you all at the Annual Meeting in March. President-elect Quintana will be speaking. It promises to be an informative and inspiring weekend!

Shelia Jensen, CRNA

Nominations Committee Update

Brian McCorison CRNA
Chair, Nominations Committee
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There is not a lot to report from the nominations committee this time. We have decided upon utilizing Simplyvote.com as our web based election server. We have done an election trial and found that it was simple to use and maintained the privacy an election requires. The AKANA treasurer Mary Holman, and the board approved the cost for the election services. It should be no more than 250.00. The SRNA students from ANMC will input all of the nominations information for the 2015 elections.

So far, we do not have any candidates for the positions available. I personally feel, the more involved in our association we are, the stronger we will be. Please feel free to nominate yourself or someone else (who has agreed) to be a part!

Brian McCorison CRNA
bmccoris@hotmail.com

Holly Chelmo, CRNA
hollychelmo@gmail.com

Ansley Carter, CRNA
akc1552@aol.com

Available positions for 2015 Election

President-elect (2 year term)

Treasurer (2 year term)

Director (2 positions) (2 year term)

Here are the job descriptions for the President elect and President. President- elect spends one year as pres-elect, then one year as president, for a total of two years. The time commitment involved for Pres-elect includes 2 hour board meetings 4 times a year, plus 4 days at one out of state conference, (expenses paid), and around 1 hour per week on association and regulatory business via email or phone.

1) The President-elect's term shall begin on September 1 following the annual meeting and shall conclude upon her/his ascendance on September 1, one year hence, to the office of President. The President-elect shall:
    a) Assume the duties of President in the event the President is unable to serve.
    b) Represent this Association at the AANA Annual Congress or appoint a representative from the Board of Directors.
    c) Approve selections of program chairpersons for the annual meeting of the year of his/her Presidency
    d) Assist the President with monitoring and responding to issues that affect nurse anesthesia.

The Presidents time commitment involves 4-2 hour quarterly board meetings, plus 4 days at one out of state conference (expenses paid), 2 days at the annual nurse fly-in at Juneau, and around 2 hours per week on association and regulatory business via email or phone, usually daily email correspondence with the AANA or regulatory agencies. Also attends/testifies at quarterly board of nursing meetings, and attends advanced practice legislative meetings as the CRNA representative.

The President shall automatically become such at the end of his/her term as President-elect. The President shall serve one year. The President shall:

a) Schedule and preside at meetings of this Association and of the Board of Directors.
b) Appoint standing committees and special committees, subject to the approval of the Board of Directors, except the Nominating and Consultants committees which shall be elected as provided below.
c) Be a member ex-officio of all committees, except Nominating Committee
d) Prepare and read at each Annual meeting a report on the work carried out since the previous meeting.
e) Prepare and read at each Annual meeting a report on the work of the year.
f) Keep the President-elect informed of Association affairs.
g) Appoint a new Continuing Education Director for each term of three years when it falls in his/her term of office.
h) Maintain ongoing communication with the AANA, and regional representative.
i) Maintain oversight and communication with state, local, regulatory, agency, and community groups with regard to issues that affect nurse anesthesia practice regulation and billing issues.
j) Appoint or serve as a liaison to the Alaska Board of Nursing.

Treasurer- time commitment includes attending 2 hour board meetings 4 times a year. Preparation for board meetings and annual meeting budget report requires 2-3 hours, but has been greatly simplified with our new budget software programs. Can attend out of state meetings as an association representative if desired. Most tasks are computer based.

2) The Treasurer shall serve for a term of two consecutive years. The Treasurer shall be eligible for re-election but shall not serve more than two consecutive terms. The Treasurer shall:
    a) Present a written finance report at each board meeting, at the annual meeting, and upon request to the Board of Directors.
    b) Receive, deposit and disburse funds of this Association as directed by the Board of Directors and record or provide for the recording of all transactions using an accounting system approved by the Finance Committee.
    c) Research options for investing fund balances and make investments at the direction of the Board of Directors.
    d) Works with accountant to complete corporate non-profit tax returns each year.
    e) Serve as an advisor on the Finance Committee for at least one year after leaving office.

Directors –there isn't a formal job description, but directors are a vital part of the board. Time commitment: attend 2 hour board meetings 4 times a year, give input, vote on association matters, can represent the association at out of state conferences if desired. Can serve on committees that have vacancies as interested.

Education Committee Report

Kelly Rygh, CRNA. MS
Julie Christensen, CRNA, MSN

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The Education Committee is currently working on the 2015 Annual Meeting. The date(s) will be ***March* 21 *& 22,2015.*** The meeting will be held at the Hilton in downtown Anchorage. We are continuing work on the speakers and topics. Kate Jansky, CRNA will be returning to provide our AANA update as well as a lecture on Multimodal Analgesia and Outpatient Surgery Centers.

We have been contacted by the NBCRNA and they may be sending a representative to the meeting to provide an update on our upcoming CPC and credentialing requirements. We will be sending out the brochures after the first of the year as a reminder to the members about the meeting.

We will be offering online registration and payment on the website for the meeting again this year. We hope to have another record setting attendance at our state meeting. We look forward to seeing the members and providing in state educational opportunities to our members. Thank you all for your support and membership of our State Association.

Please feel free to contact us if you have any questions. Kelly Rygh at kellyrygh@netscape.net and Julie Christensen at juleschristensen@msn.com

Sincerely,
The Education Committee

Kelly Rygh, CRNA. MS
Julie Christensen, CRNA, MSN

SAVE THIS DATE!

The Alaska Association of Nurse Anesthetists Annual Meeting

will be held on

March 21st and 22nd

At the

Hilton Hotel in Anchorage

Report from the AANA Annual Congress September 13-16, 2014

Chris Logan, CRNA
AKANA Past-President

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AANA Business Meeting, Bylaws and Resolutions-

I attended the AANA business meeting at 8am on a Sunday morning, expecting to sit in the back and sip my coffee and surf my Ipad for the next four hours. What I witnessed was more than enough to keep my attention, and also to hope that the doors were locked and there weren't any ASA spies in the room. (Which there probably were.)

The long suffering AANA Board of Directors were uber professional in their suits, sitting under the hot lights for a total of 5 hours without a single break. A majority of the audience had clearly been organizing together in anticipation of the bylaws and resolutions vote.

The primary target was the Resolution of the vote of no confidence in the NBCRNA, the CRNAs sole credentialing body. If you have ever been to a board meeting, you might be familiar with Roberts Rules of Order, of which whose use was very clearly demonstrated, to keep the testimony from spiraling out of control. Which it did anyway. The business meeting ran an hour over time, and it was disappointing that some essential business did not get conducted, due to what can only be described as infighting.

The basic argument against the NBCRNA is that they have been creating the new mandatory certification standard, which includes the four modules and a big test and blah, blah, blah and there is no grandfathering, and the AANA has no input or control over the new standard. (Which, by the way, is supposed to be implemented starting January 2015, oh wait, is that 6 weeks from now?)

The NBCRNA made some back door deal with the National Board of Certifications to declare that user groups cannot have undue influence over the certification process. The NBCRNA decided that this meant they didn't have to listen to anything the AANA said, much less negotiate with them about the credentialing process.

There is also the issue of who will be allowed to offer the education units, which potentially puts all those Danemiller©, Current Reviews©, cruise on the French Rivera while you earn 20 CMEs, out of business. Not a small amount of money at stake in the credentialing business. And by the way, if your state meeting can no longer offer CMEs under the new rules, would anyone bother going to the meetings, and then the state associations would be unable to conduct business and potentially collapse.
Every other health care profession has to recertify with a test every 10 years,

CRNAs are just about the only ones who don't. The flip side of that argument is that CRNAs cannot practice unless they are board certified, unlike some other groups who fail their boards, for whom it is just embarrassing.

So, some (not historically insignificant) CRNAs introduced a resolution to the AANA BOD calling for a vote of no confidence in the NBCRNA and demanding an end to the negotiations with them. After much wrangling and attempt to pass amendments to said resolution and arguing and tears and yelling and high fives, the unamended resolution passed with a majority vote.

Now, the resolution itself has no teeth, the AANA BOD does not have to take any action based on its passage. However, a group (432 CRNAs) representing all 40,000 members of the AANA, just declared that we have no confidence in our certifying body, and therefore our certification. Which we are required to have in order to practice. Hmm.

It was interesting to watch the students in the room, who were not allowed to vote, witnessing this entire scene. Many of them expressed concern over whether they would become certified to practice once they graduated. I thought it was also a very good lesson in what happens if you don't show up, pay attention, or participate in the process.

What will happen now is unknown. The options are; the AANA will disavow the NBCRNA and create a new credentialing body; the NBCRNA BOD will resign and new leadership will come to the table and work in peace and harmony with the needs of the AANA and it's members; implementation of the new credentialing program will be delayed while the current players continue negotiating in good faith, despite the resolution of no confidence, and get everything worked out.

If you would like more information on this ongoing situation, please visit the AANA website, and read some of the emails that the AANA sends you from time to time.

Federal Issues

APRN scope of practice in the Veterans Administration. The AANA is requesting letters of support from individuals and state associations. The VA only accepts comments via USPS. Personal stories involving your own military experience, or experience taking care of a veteran, are the types of correspondence that gets read by the decisionmakers.

Each VA facility is mandated to hold a live town hall. Jeff Worell attended the Anchorage meeting in September and was not able to comment, but listened to the lively discussion. Kate Fry at the AANA-DC wants to know if CRNAs are having any issues, such as backlash from MDs or perceived limits on their scope of practice while working at the VA.

Mark Begich got $10,000, CRNA PAC max donation. He has been very helpful to CRNA issues during his tenure. This article will be published after the Nov 4 election, so may the best man win! (If Dan Sullivan won, we will need to start again creating a relationship with his office on behalf of CRNA, APRN and nursing issues.)

The CRNA PAC is doing well, with donations coming from about 20% of members. The CRNA-PAC has $3 million to the ASAs $9 million (one of the largest health care PACs). If every AANA member gave $100, we would have an additional $4 million more. As most Alaskans are aware following the November 4 elections, money talks, and most of comes from outside sources.

Regional Issues

AA's- Many states are facing AA fights including Colorado and Nevada in the AANA's Region 5. MD's are bringing them in under physician delegation rules, so they do not even have to be licensed in order to sit in the anesthesia chair. In apparent retaliation for CRNAS in Colorado recent win of the opt-out in court, Colorado MDs opened an Anesthesia Assistant school. Reported by the Colorado representative at the AANA conference, the AA students are not required to have medical backgrounds, and most have never touched a patient. They are having difficulties passing anatomy and physiology. The MDs don't want to teach them, so the program is flopping. CRNAs are being tasked with AA clinical supervision. A sticky issue, which creates conflict of interest in the workplace, and makes working CRNAs responsible for training their potential replacements.

Alaska needs to make sure our net is in place to watch for AA regulations being brought up by the medical board. Our lobbyists have been educated on AAs, and are watching for any issues. Please report any AA activity or discussions immediately to the AKANA board.

Insurance/Reimbursement

Blue Cross Blue Shield- in their latest Dear Provider letter, buried deep on the third attachment back is a statement that says they are cutting CRNA reimbursement to 65%. This has happened in California and Idaho. California fixed it by talking repeatedly to the people in charge. State association boards are having to fight line by line with the insurance companies to maintain reimbursement. If your facility is having any issues involving reimbursement, please be sure to report them right away so we can stay on top of this in Alaska.

State regulations

The APRN Consensus model was recently passed by Idaho and Montana. Washington and Alaska are working on it. There is a new APRN state Compact for licensure, but state adoption of the APRN consensus model must include full practice for all four specialties or they cannot participate.

This is a big deal for tele-health, where practitioners can video or telephone conference with patients and write prescriptions without a physical exam. This is a nightmare of regulation, and the tele-health bill for Alaska was voted down last year due to many of these issues. Right now, APRNs who work across state lines must have license in every state where the patients are. APRN compact would presumably make this easier. This should have minimal affect on CRNAs in Alaska, because patient care is not crossing state lines.
The APRN Alliance is working on revising the nursing statutes to come in line with the APRN Consensus Model.

All four specialties are included and work on statute language is ongoing. We expect to introduce legislation in the next Alaska session.

We will be advocating for our bill during the Juneau nurses fly in, February 17-19, 2015. Any CRNA who would like to participate in the fly in, or with the Alliance, please contact Chris Logan. Reasonable expenses will be reimbursed by the AKANA.

Chris Logan, CRNA
Past President, AKANA
Co-Chair, APRN Alliance

Report from the

Fall Leadership Conference

Nov. 7-9, Chicago

Jeff Worrell, Ltc, USAF (retired)
CRNA, MSN
President Alaska Association of Nurse Anesthetists

Hello from Chicago,

This message is for you from Jeff, Sheila Jensen, Jen Lent, and Wendy Monrad.

Summary day 1:

1. AANA is 48,000 members strong and represents 91% of CRNA's in practice.
2. You have received the most up-to-date information on negotiations with NBCRNA regarding certification/recertification –from the AANA board of directors. Please refer to their message. Feel free to email the AANA BOD or me with questions.
3. The AANA President is working on technology for video chat with her. More to follow.
4. Please take time to explore the AANA website and the new PR campaign. The site is loaded with pertinent information for you. Here is the link:
    a. http://www.future-of-anesthesia-care-today.com/
    b. Look at the "share your story" portion of the website and feel free to contribute positively.
5. The key note speaker, Dr. Marty Makary, spoke volumes about his book "Unaccountable". He spoke for hours about methods to be more transparent in health care from costs, to personal performance. The book is a quick read and a contemporary resource for improvements in health care.
6. Closed claims stats released: 81% of claims ASA I & II. 70% of claims are hospital based.
7. I am very interested in updating our state demographics for our upcoming meeting this spring with our state and federal legislators. Please prepare to respond in a separate email some basics of your practice. Information is power.
8. "treat each other – and your health care team members--with dignity, respect and accountability" – lesson from Sheila and speakers

Here is a brief summary from day 2 of the AANA Fall leadership Conference.

1. Jen, Sheila, Wendy and I spread out to attend as many lectures in different tracts as possible.
    a. Workplace Leadership (Jen), Federal Political Director (Wendy), State Reimbursement Specialist(Sheila), President Elect (Wendy) and a track for our lobbyist(s)
    b. Both our lobbyists from Juneau were invited, neither could attend.
2. RN sedation using propofol incorporating the sedasys system is occurring in various states in the country. Here is a link to the sedasys system: http://www.sedasys.com/
    a. In places where this has been implemented "anesthesia" has been involved in guiding safe practice an implementation.
3. Integration of emergency checklists for critical incidence, for example anaphylaxis, are being integrated into hospital operating rooms and ambulatory surgery centers around the country. Jen will be providing a link for you for "free" access to these valuable resources. Implementation using these products gives a practical, readily available, team approach to handling a variety of emergency conditions much like ACLS protocols.
4. Mounting evidence recommends specially formulated high carbohydrate drinks for patient use as a clear liquid 2-hours before surgery. More literature is supporting use of these products. NPO guidelines continue to be amended.
5. Intraoperative guidelines for intravenous fluid administration continue to change as well. Maintaining a euvolemic state is becoming increasingly important. Trying to eliminate over hydration.
6. Implementation of the affordable care act "Obama Care" continues to be a challenge for insurance companies. There will continue to be changes as carriers adjust to the population base of insured.
7. Medical Staff offices are being asked to perform better assessments of your competency. If you do not currently keep a log of your cases, I highly recommend you do so. Other competency measures will include peer review, records review, professional development activities, and patient satisfaction surveys. Ongoing Professional Practice Evaluation (OPPE) is being driven nationally from the Centers for Medicaid/Medicare (CMS)
8. AANA now sends your board an updated list of your contact information monthly—the difference is that the database now contains information about legislators, down to state district levels. It makes is easy for the board to help you contact the legislator closest to you. This has been a huge undertaking by AANA. We are hopeful this will allow us to identify key contacts (you), when necessary to facilitate disseminating issues to legislators when necessary.
9. All of us attending this meeting we very impressed with the AANA boards diligence in maintaining our scope of practice. Challenges to your practice are ongoing and multifaceted. The AANA IS WORKING FOR YOU EVERYDAY.

Jeff Worrell, Ltc, USAF (retired), CRNA, MSN

President Alaska Association of Nurse Anesthetists

Photos from the

Fall Leadership Conference

AANA President Sharon Pearce

AKANA Pres. Jeff Worrell and keynote speaker Dr. Marty Makary

Wendy Monrad, Sharon Pearce, Jeff Worrell

Jeff Worrell, Sharon Pearce, AANA VP Juan Quintana

Shelia Jensen, Juan Quintana, Sharon Pearce

Jennifer Lent

Points of Interest from

Fall Leadership Assembly 2014

Jennifer Lent, CRNA
Secretary, AKANA

Of the many speakers at the 2014 FLA, there was one whose message resounded quite clearly with me. Robert J. Gauvin, CRNA, MS, spoke on the topic of influencing key decision makers and working with [hospital] management.

His take home message, for me at least, was "…unchain yourself from the anesthesia machine!" What did he mean by that? Well, how many times have we not attended the medical staff meeting because we were too tired post call? Or just couldn't possibly make the monthly OR/Pharmacy meeting or M&M or grand rounds because it was too early or too late or too inconvenient? Did you attend the hospital Holiday Party?

Mr. Gauvin reminded all of us in attendance of how important it is to forge interpersonal relationships with those in other departments of the hospital. How can these others be expected to understand what we do when they don't even know who we are? As a group, we need to unchain ourselves from the anesthesia machine and get involved!

There is a trend of increasing use of cognitive aids, simulators, and target films to improve management of crisis situations. Recent studies have shown that integration of emergency manuals results in better management during operating room critical events.

Stanford Anesthesia Group has produced a compact and accessible emergency manual that is available to download for FREE. This emergency manual contains 25 critical events and management points helpful pre-, during, and post- crisis in the operating room, outside anesthetizing locations, and peri-operative acute care areas. For more information about this topic, or to download a copy of the manual, go to: emergencymanual.standford.edu

Jennifer Lent, CRNA

Notes from the

Fall Leadership Conference

Nov. 7-9, Chicago

Wendy Monrad, CRNA
President-elect and
Federal Political Director, AKANA

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1. Keynote speaker – Martin Makary, MD (surgeon at Johns Hopkins, published widely on patient safety). ***"Leadership & Change in an Era of Transparency in Healthcare"***
    a. Refreshing perspective on the state of our healthcare culture - many things "wrong" with few answers - meanwhile innovators are beginning to light the way.
        i. Culture of "speaking up" – Mayo clinic doing briefings with OR team before cases (huddle)
        ii. Patient Centered Outcome Institute - competition becoming based on outcomes an price
        iii. Gatorade CHO loads preoperatively to temper patient stress responses to surgery
        iv. Oscar Insurance Company – new radical approach to health insurance (apps to promote early care and preventative, 24/7 phone access to physicians of all specialties (has already saved millions in unnecessary ED visits)
        v. Transparency leads to accountability
            1. Cleveland Clinic posted provider patient satisfaction scores – each year satisfaction scores increased (healthy competition)
            2. University of Utah – after 2 years of reporting 25% of their physicians were in the top 1% of US
        vi. Surgical Trigger Tools – preventative approach to mishaps rather than reactive. Identify dangers before they happen in real time, quicker intervention
        vii. Maximizing QI – metrics must be indorsed by clinicians, sound measurements, risk-adjustments, and data feedback = meaningful data.
        viii. Physician Engagement Project – peer to peer program to address variation in healthcare. Works to identify outliers and communicate to create awareness, mentoring and notification of employers/boards if necessary.
2. OR Checklists (12 critical events with checklists) & trigger films – used to be better prepared for critical events in the OR. (https://vimeo.com) By Sass Elisha & Jeremy Heiner from Kaiser Permanente.
3. New public education campaign kicked off Sept 2014: *CRNAs – The Future of Anesthesia Care Today*

a. Microsite (**future-of-anesthesia-care-today.com**) – awesome information. Also recommend you check out the ASAs campaign launched in 2013 – **whensecondscount.com**
b. National CRNA week Jan 25-31

4. Federal Political Director Track
    a. Midyear Assembly (April 18-22) – projected issues
        i. Encourage/Educate congress on VA nursing handbook ruling (final ruling expected soon followed by 90 day comment period – ASA expected to object and try to get congress to block enacting of the ruling)
        ii. Sustainable Medicare funding – up again in April for SGR cuts (21%)
        iii. Seeking funding for workforce reimbursement
        iv. Antidiscrimination for reimbursement
    b. Promote CRNA PAC
    c. Mobilize others to take action with issues like the VA nursing handbook
    d. Grassroots efforts – getting out in our work (CRNA week) and in our state (Juneau fly in)
    e. Encourage members in attending fundraising and other events to build relationships with our representatives
5. Critical/Sentinel Events – web site to help patients, families, and providers through an adverse event – www.mitss.org (Medically Induced Trauma Support Services)
6. Organizational Health Allocation (OHA) funding: funding available to smaller states (defined as states with due reserves of less than $62k – currently 16 states). Processed by the State Organizational Development Committee (SODC) and then approved by AANA board of directors. Designed to optimize the small state budgets to afford for same opportunities as larger states. Requirements include AANA meeting attendance, lobbyist, operating reserves as second line of defense, publishings/mailings, equipment, and legal counsel. Application process starts 1 March. AK has been receiving this additional funding annually for many years. Jeff and I will be working on it in March.
7. Strategic Reserve Fund (SRF): also processed by SODC and approved by AANA board of directors – available to states for challenging issues (legal battles).
8. Impact of recent elections on state issues:
    a. State concerns
        i. Access to Care – (Affordable Care Act & Medicaid expansion) CRNA services answer many of the barriers to this.
        ii. Medicaid expansion – even between parties, big issue for governors
        iii. Opt Out Support – signed to support OR remove support by governors (IA recently had a governor remove support for the Opt Out) – always an issue
        iv. Appointed positions
        v. Task forces
        vi. Prescriptive Authority – not required by most CRNAs but is very important to other APRNs and may play a role for CRNAs practicing independently in rural locations. Reinforces our independence with state BONs.

vii. APRN Consensus models – trend across the states to clarify language regarding independence – happening now in AK
viii. Action Coalitions – nurses of all backgrounds coming together on issues – great strength and strong voice.

b. Recent state concerns
   i. IA – governor reversed support for Opt Out
   ii. OR – recently passed office based & Rx authority in favor of CRNAs
   iii. PN – recently defeated a proposed supervision bill
   iv. NY – passed title protection bill in the houses for not signed by governor
   v. MN – recently passed APRN consensus model

c. Expected ASA issues affecting our states – keep the radar up for…
   i. Continue fight regarding CRNA pain management
   ii. Continue pushing supervision legislation
   iii. Continue to introduce Anesthesia Assistants legislation

9. <u>Effects of recent elections on federal issues</u>:
   a. VHA – Department of Veterans Affairs have put forward proposed changes to their Nursing Handbook to authorize Full Practice Authority (FPA) that would recognize 700 CRNAs and other APRNs to practice to their full scope and be recognized as Full Practice Providers (FPP). This designation follows the recommendation of the Institute of Medicine that APRNs be permitted to practice to the full scope of their skill and training, ensuring patient access to quality care and a more effective workforce. 27 states presented written support and 2000 AANA members also sent letters of support. The ASA has aggressively opposed the changes with statements that have no support or validity. Once the VA hands down a ruling on the issue, there will be a 90 day comment period that AANA members will be asked to actively participate in. The AANA expects a hard road with possible setbacks and challenges, knowing the outcome will be well worth the effort.
   b. Medicare Reimbursement Cuts – Sustained Growth Rate (SGR) cuts are once again looming. Last year's congressional vote to delay expected cuts is due to expire on 1 April. These cuts would be 20-21% (1/5) of our current reimbursement rates for anesthesia services. AANA is working hard to promote a final fix to looming cuts and every year nonsense voting to delay – however, unlikely.
   c. Affordable Care Act – dynamic relationships between federal and state governments will likely present great opportunities and challenges. AANA continues its aggressive advocacy as the voice of CRNAs in the negotiations of implementation, promoting the non-discrimination and value of CRNA services.
      i. Republicans campaigns all over the nation promised to enter repeal legislation, however, they will not have the necessary votes in congress despite the majority nor would such a bill be signed by President Obama.

They are likely to seek amendments, however these too will be difficult to achieve.

ii. Medicare language was entered this year preventing Anesthesia Assistants from billing QZ (non-medically directed)

iii. Medicare also approved coverage of anesthesia care for GI screening without a patient co-pay (colonoscopies have been no co-pay for a while but now patients have a choice for anesthesia as well). Due to go into effect 15 Jan.