By Jeffrey A. Green, MD, FASA

Although he likely wasn’t the first to speak these words, Ronald Reagan is credited with having said, “If not us, who? If not now, when?” which he used to talk about tax cuts in the 80s.

However, it could not be more appropriate to apply these words to VSA advocacy at this very moment. We ARE advocating to advance the profession and secure the future for our specialty. Your VSA has been working very hard to promote your interests both in Richmond and in Washington, DC this year. I would like to share with you a summary of some of our activities.

At the Virginia General Assembly, we fought and lobbied hard on behalf of all physicians to support surprise medical bills/balance billing legislation and very nearly succeeded in protecting our patients from the gaps in their narrow insurance networks of which they are unaware. We continue to have a seat at the table with the working

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The VSA delegation attending the ASA Legislative Conference took time out of a busy schedule to enjoy dinner at the Charlie Palmer Restaurant. From left to right: Ronald Bank, MD, FASA; Marie Sankaran-Raval, MD; Casey Dowling, DO, FASA; Martha Kelly, Practice Administrator; J. Mark Hylton, Jr, MD; and Jeffrey Green, MD, FASA, VSA President.

ASA Legislative Conference: A First-Timer’s Perspective

By Catherine Dowling, DO, FASA

This year I had the pleasure of attending the ASA Legislative Conference for the first time. It was an amazing experience and a real testament to grassroots advocacy.

The ASA prepped us well. The talking points were concise, and the printed materials were appealing. Five points is enough but not too much, and most had real bipartisan appeal. I have to say though, I couldn’t have done it without my mentors, Dr. Marie Sankaran and Ms. Martha Kelley.

While I have been in DC as a tourist, I had never been there as an advocate. I honestly didn’t even know where to go! They guided me to the locations as well as through the presentation process. I cannot thank them enough.

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The VSA Update newsletter is the publication of the Virginia Society of Anesthesiologists, Inc. It is published quarterly. In January, a special annual legislative issue is published. Editorial comment in italics may, on occasion, accompany articles. Letters to the editor and comments are welcome and should be directed to:

Paul Rein, DO • 409 Moody’s Run, Williamsburg, VA 23185  
Phone (757) 880-6115 • earein@aol.com

The VSA encourages physicians to submit announcements of changes in professional status including name changes, mergers, retirements, and additions to their groups, as well as notices of illness or death. Anecdotes of experiences with carriers, hospital administration, patient complaints, or risk management issues may be useful to share with your colleagues.

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Of course, we were not alone on the Hill. The lobbyists were everywhere. Elected officials have meetings all day, every day, with constituents, industry experts and other organizations.

You must wonder - how can we possibly make a difference here? But if you think about it, how else are politicians going to be able to make educated decisions with all this noise unless they get a consistent and continual stream of true information from us. This is our opportunity to educate.

I very much look forward to attending the ASA Legislative Conference next year. I also encourage my fellow physician anesthesiologists to develop relationships with their elected officials. See that they get a consistent and continual stream of facts.

Let’s seize the opportunity to educate.

Update Your Member Profile

New email? Institution/practice update? Last name changed? New address? These minor changes make a big impact. Please take a moment to log in to your online profile at vsahq.org to be certain it is up to date.

To update your profile, follow these simple steps:
• Log in to vsahq.org and click on the membership tab at the top of the page.
• Under the “Already A Member” section, select ‘Update Profile’.
• Enter your username and password. If you need help with your log in information, please click the “Retrieve Login” link.
• Scroll through your profile to make sure everything is up to date. If anything needs to be changed, click on “Update Profile” at the bottom of the page.
• Make any necessary chances and click save.

The most important areas to check for errors are the following:
• First Name
• Last Name
• Title
• Address
• Email
• Hospital / Institution / Practice

We don’t want you to miss out on any meeting or membership information with the Virginia Society of Anesthesiologists. If you have any questions, please contact Julie Hitt, Membership Coordinator, at julie@societyhq.com.
“If You Aren’t at the Table, You Are on the Menu”
A Resident’s Reflection on the 2019 ASA Legislative Conference

By J. Mark Hylton, Jr., MD
Chief Resident, VCU Health

What a great 2019 ASA Legislative Conference! Some people say when they come to this conference, they get the “spark.” I would agree. It definitely added fuel to my fire.

On the train back to Richmond, Virginia, the title of this article came to mind every time as I thought about advocacy. As most of us know, we must be advocates for our specialty and patients. If not, someone else will and we will not like the outcome/solution. This year, there was a record number of anesthesiologists that descended on Washington, DC for three days. With over 600 anesthesiologists in attendance, of which 10% were residents, I believe we made our mark.

A major key in advocacy involves education and being knowledgeable about various topics. Having the opportunity to hear from legislators during the conference and getting to meet them or their staff members was amazing.

However, legislators and physicians can be on two separate pages when it comes to some of these issues. This is where education and advocacy play a huge role in medicine.

You also may not know that we as physicians have representation in both the House of Representatives and Senate from both political parties. During the conference, we were fortunate to hear from Congressman Andy Harris, MD, an anesthesiologist

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Twenty-two VSA Members Have the FASA Designation – You Could Be Next!

Stand out from the crowd and be recognized for your work and contributions to the anesthesia specialty - join the ranks of nearly 800 of your peers nationally and 22 of your peers in the state of Virginia and apply to become a Fellow of the ASA!

“FASA members have dedicated their careers to serving the specialty and protecting their patients,” said ASA President Linda J. Mason, MD, FASA. “I’m extremely proud of the group of individuals who have risen to the occasion and been recognized for their achievements and look forward to welcoming new members to this esteemed group.”

ASA members who have demonstrated the highest levels of dedication and leadership in anesthesiology may apply for designation as a Fellow of the American Society of Anesthesiologists (FASA®). The FASA designation is ASA’s highest acknowledgment that recognizes years of dedication to exceptional education, leadership and commitment to the specialty and to ASA. Applications and all supporting documentation are reviewed and approved by the ASA Committee on Membership Sub-Committee on FASA Approval.

FASA applicants must meet specific eligibility criteria, all occurring within the past 5 years of application submission, including:

- Five years continuous ASA Active membership
- Five years continuous ASA Active component society membership
- Unrestricted medical license(s)
- Board certified by the American Board of Anesthesiology or American Osteopathic Board of Anesthesiology
- Must meet six total qualifications in the areas of professionalism, leadership, advocacy, education and scholarly activities

To apply, applicants must submit documentation, including:

- Two letters of endorsement from ASA Active members in good standing
- CV and optional bibliography
- Application fee $350

Apply at www.asahq.org/fasa
It was the evening of October 11, 2018, in the midst of Tropical Storm Michael. Hanover Fire & EMS Lt. Brad Clark, with Firefighters Carter Lewis, David Johnson and Christopher Elish, were responding to a motor vehicle crash on I-295.

Shortly after arriving, a truck driver lost control of his vehicle, striking their firetruck, killing Lt. Clark and severely injuring Firefighters Lewis and Johnson.

Transported to VCU Health Trauma Center, Lewis and Johnson underwent emergency surgery, and then spent months recovering from their injuries.

Dr. Jay Napoleon, anesthesiologist and pain physician at VCU Health provided anesthetic management perioperatively, as well as pain management during their hospital stay.

On May 18, 2019, Dr. Napoleon was among many emergency medicine first responders, physicians, nurses and other healthcare personnel who were recognized at The 11th Annual Shining Knight Gala. The VCU Health Trauma Center Shining Knight Gala is a fundraising event that highlights a trauma patient’s story of triumph, and honors the caregivers who worked to save that patient’s life.

When asked how it made him feel to be recognized, Dr. Napoleon responded, “Most go into anesthesiology not seeking the spotlight, or even any recognition. But this case involving severe casualties of medical providers in the line of duty was so dramatic and so emotional, that I could not help but feel privileged and honored to be a part of the ceremony honoring Carter, David and Lt. Clark’s widow.”

Congratulations to VSA member and VCU anesthesiologist and pain physician, Dr. Jay Napoleon, on a job well done.
Political Correctness and Confronting Common Problems

According to the Encyclopedia Britannica, the term political correctness first appeared in Marxist-Leninist vocabulary following the Russian Revolution of 1917. It was used to describe adherence to the policies and principles of the Communist Party.

In today’s world, it refers to language that gives the least amount of offense to someone. I start out this editorial this way because I’m about to head into waters that some might consider politically incorrect. As one who matured in the 60’s, I happen to be a believer in sharing ideas without the intent of personally attacking anyone.

I have been a bit amazed by the “I’m all in” approach the ASA has taken to fixing the opioid crisis that exists in the United States today. No one can argue that we have a substance abuse problem in the USA. It’s been estimated that in 2017, 30.5 million Americans age 12 and older are illicit drug users. How many of those are marijuana only is hard to find out, but no doubt that number is huge. Over 70,000 people died in this country last year as a result of a drug overdose. That represents a 100% increase since 2010. Some of these are from prescription drugs and some are from obtaining street drugs.

Regardless, it is a big problem. The question I ask you: Is it really something that we as anesthesiologists can do to fix or to lower the rate?

In my opinion, other than pain management practitioners being cautious with what they prescribe, the answer is a resounding NO.

We can certainly provide pain relief to our surgery patients with multi-modal therapy, thus using judicious amounts of narcotics. As a professional society, we should be supportive, but truthfully that’s about as far as it goes.

I believe what we should be more involved in are the common medical problems that we deal with in the operating room and in preoperative screening.

The two biggest problems we experience every day are obesity (BMI >30) and cigarette smoking.

Since 1990, the obesity rate in Virginia has virtually tripled from around 11% to just over 30% in 2017. Think about the health problems created by obesity. Some, but not all, include increased risk of colon cancer and prostate cancer, CAD, DM type 2, stroke, gallstones, OSA, arthritis, and early mortality. Then think about counting Americans that are overweight (BMI>25) and we have close to 70% of the population. That is a health problem we can and should take a more active role in fixing.

An overlooked fact is that the average obese person spends almost $1,500 more per year in health costs than a non-obese individual. That amounts to close to $150 billion in healthcare costs per year.

Bariatric surgery has shown a 50% increase in the number performed from 2011 to 2017. In 2017 there were 228,000 bariatric surgeries performed in the USA. These are expensive procedures with significant side effects. One more procedure to consider is a TKR. I wonder how many are performed on obese patients, and how much they cost.

We listen to so many people talk about health, yet why is there no organized movement to at least raise the tax on cigarettes to $15/pack and give that money to provide healthcare for the poor?

We as healthcare providers take care of these people and all their medical problems because the politicians have been bought off by the tobacco industry. This is probably the most frustrating thing of all.

The money generated by tobacco is more important than health to our government. The simple question is why does our government allow this?

The second issue I mentioned is cigarette smoking. Everyone, I repeat everyone, including smokers, know that it is bad. Yet our government (who knows cigarette smoking is a health hazard), to whom many want to entrust healthcare, still allows tobacco to be commercially produced and sold.

We know the highest rate of smoking is in the lowest socioeconomic groups. It is a serious public health problem. In this country there are more cigarette smokers than illegal substance abusers. The simple question is why does our government allow this?

We as healthcare providers take care of these people and all their medical problems because the politicians have been bought off by the tobacco industry. This is probably the most frustrating thing of all.

The money generated by tobacco is more important than health to our government. Think about that. Think about that when we are told what a good job the federal government will do providing healthcare to all.

I believe what we should be more involved in are the common medical problems that we deal with in the operating room and in preoperative screening...

I believe what we should be more involved in are the common medical problems that we deal with in the operating room and in preoperative screening...
Opioid Prevention Initiative: Outreach on Invisible Dangers

By Dr. Denise Lester
Hunter Holmes McGuire Veterans Affairs Medical Center, Richmond, VA

“Silent No More.” This is the theme for a new opioid prevention initiative in Virginia founded by Olivia Emerson, Assistant United States Attorney and Kimberly Ulmet, Victim/Witness Specialist with the Eastern District of Virginia US Attorney’s Office.

Their mission is to reduce the incidence of opioid overdoses and death through community outreach and education. They have partnered with two anesthesiologists: Dr. Denise Lester, an anesthesiologist board certified in Pain Management with more than 20 years of experience, and Dr. Robert Trainer, an anesthesiologist board certified in Pain Management and Addiction Medicine.

In collaboration with Michael Barbuti, Assistant Special Agent in Charge at the Drug Enforcement Agency (DEA) and two mothers who lost sons to opioids, the seven professionals come together to create an entertaining, memorable, but very raw and emotional program for middle and high school students and their parents.

The aim of their program is to educate students and parents on the many invisible dangers of opioids and the relentless effect these drugs have on their bodies.


In that program, the presenters grab students’ attention with shocking and highly emotional real life stories of friends, sons and daughters, who became addicted one way or another to an opioid, and died by unintentional overdoses.

A mom tells her heartbreaking story of her normal, healthy, happy son who first became addicted to prescription drugs after an injury several years before, eventually moving onto heroin, and later overdosing while in Boston. Pictures flashing across the screen depict life pre-addiction: times he played sports, graduated high school, ate dinner together with family, and traveled on family vacations. She tears up, along with the rest of the room, as she tells how she suspected something was wrong, but never asked directly and never spoke up.

Now, the “Silent No More” request becomes real as moms explain that their sons had many friends or family who were “silent” even as they watched or knew their sons were struggling. Only after their children’s deaths, did friends come forward. Too late. Too silent.

Assistant US Attorney talks about federal cases she prosecuted involving overdose deaths due to illegal distribution of opioids...friends giving friends opioid pills and then the friend dies. The DEA agent plays a short film developed by the FBI and DEA called “Chasing the Dragon” which shows the unimaginable measures taken to obtain, inject, and maintain heroin addiction. Dr. Lester uses drama and interactive skits to make analogies between opioid use disorders and dopamine brain chemistry.

She runs in the room screaming “Who wants to win a free t-shirt?” As the kids jump up and down excitedly, she explains, “The feeling you have right now, that’s dopamine, the behavior is jumping, and all of it is an action taken to get the reward.” This is a similar behavior and feeling people with opioid use disorder exhibit when they seek their “reward.”

Dr. Trainer ends the program with a lecture to the parents on the neurobiology of addiction. A Q&A session follows and students, parents, and schools are so appreciative of the time and effort provided to educate opioid prevention.

The “Silent No More” program combines a series of impactful serious short stories with thought-provoking video clips, and integrative, sometimes humorous, deeply engaging skits, aimed to relate the opioid epidemic as closely as possible to the students and parents being educated. The intent is to get them to understand that this problem is in their backyard.

This epidemic kills, and with the right set of circumstances, it could affect any one of us.
Anesthesiology Fellowship Training: To Pursue or Not Pursue…This is the Question

By Brooke Trainer, MD
Associate Editor

The decision to further your education and training by pursuing a fellowship should be weighed between benefits and sacrifices. Do not pursue a fellowship if the only reason is fear of not finding a job right out of residency. Instead, work on making yourself more marketable. Fellowships are very competitive as well as demanding. It should be viewed as a tool to further one’s expertise in a specialty and aid accomplishing ultimate career goals.

If you truly have no interest in cardiac, pediatric, chronic pain, or working in an ICU, and simply want to practice doing general anesthesia cases, then focus on seeking employment rather than fellowship after residency.

Rest assured knowing that 96% of anesthesia residents who decided to work right after training successfully found employment.

Some employers will hire without full board certification, usually at a lower income bracket, as long as you are in the examination process. Once ABA certified, the income bracket increases.

To become more marketable, join your local medical society or specialty society, attend meetings, and network with those who will one day be able to refer you to other employers.

If you can’t decide now, the option for fellowship training is always available later in your career.

Perhaps you decide to explore a different career pathway or want to broaden your scope in a certain area. Though pursuing a fellowship later in your career is more atypical, it is not impossible. In fact, it may end up being more beneficial with fewer sacrifices.

Take myself for example: I had really wanted to pursue a critical care fellowship right out of residency, but my commitment to the military after graduating prevented this desire. Instead, I was stationed overseas in Germany where I practiced general anesthesia at a Level 1 (at the time) trauma center outside of the US.

While there, I expressed interest again in working in the intensive care unit. Because of my interest, the Air Force decided to send me to train in Critical Care Air Transport, where I eventually served four years flying wounded veterans from Europe and the Middle East, back home to the US, in a plane equipped as an ICU.

This opportunity became one of the most rewarding experiences of my career. After separating from the military, I came to work in Richmond Virginia at a Level 1A Veterans Hospital, where I was recruited to help cover the surgical ICU at night.

Now, after working in a critical care environment for nearly seven years, I have decided to finally embark upon formal critical care training to expand my knowledge base and become board certified in critical care medicine. Fortunately, my institution is supportive of this decision and has secured a position for me upon my return, thus making the transition a smoother one.

Whatever your ultimate career goal may be, pursue a specialty you will be happy doing every day for the rest of your life.

With the increasing need for anesthesiologists and overall high demand for practicing physicians, you can rest assured employment will be awaiting you after graduation from anesthesia residency, with or without a fellowship.

Basic Facts About Each Possible Fellowship Track Within Anesthesiology (FREIDA)

• As of 2017, 1587 completed a residency in anesthesiology, 59.3% went on to complete more training. This is a 28% increase from 10 years ago.
• Only 30% decided to go directly into practicing anesthesia or other areas of interest.
• 85.5% of residents graduating decided to practice anesthesia.
• 55.9% entered group practice.
• Only 1.1% decided to serve in underserved areas. Of note, some states have a loan forgiveness program for those physicians desiring to work in underserved areas after residency as an option. Up to $2000/year.
• 9.1% went into academics – this is down nearly 43% from 10 years ago.
• 37.3% of residents remain in the same state they trained in.
• 96.1% of residents who went into practice right after residency went to work full time.
• Only 0.3% went into military anesthesia.
Putting Perspective on What We Do: Anesthesia in Rwanda

By Kamilla Esfahani, MD
and Brittany Aeschlimann, MD,
University of Virginia

“Amakuru!” (How are you?) I say as we enter the classroom in the simulation center at the University Teaching Hospital of Kigali in Rwanda.

It’s Monday - which is the designated lecture day for the anesthesia residents. The simulation center is the room next door, equipped with three mannequins, an old anesthesia machine, and cupboards filled with supplies. Brittany, the UVA CA-2 resident, and I are sweaty and probably smell of DEET spray that we doused ourselves in moments earlier; well, 40 minutes earlier, before we climbed the many hills to get to the hospital from our apartment. Rwanda is known after all as the Land of a Thousand Hills.

The residents replied, “Maramutse!” (Good morning!), shaking hands and hugging. After two weeks, Brittany had already acclimated to the new environment and was greeted by her usual resident friends, Emmanuel and Angelique, exchanging their weekend happenings.

We sat down, thankful for the shade and cool breeze from the fan in the corner. It was time for lectures. Two years ago, when I first came, I was teaching the lectures. Today, they were teaching each other.

After the infamous genocide in 1994 that killed roughly a million Rwandans, the country had only one anesthesiologist. The teaching program began in 2006, as organized by the University of Rwanda with help from the Canadian Anesthesiologists’ Society International Education Foundation (CASIEF) and the American Society of Anesthesiologists Global Humanitarian Outreach (ASAGHO). All involved realized that one of the biggest limiting factors to improving surgery and anesthesia is a lack of human resources.

The mission was simple: to build a sustainable training program to expand the number of physician anesthesiologists. The country now boasts 40 active anesthesia residents and 19 attendings, many of whom are graduates from this very program.

My mentor, Dr. Marcel Durieux, first introduced me to the program in 2017. He had gone himself at least three times prior with other residents and had been the teacher of many of the current anesthesia attendings there, who fondly remember him.

The teaching trips are each one month long and follow a well-organized lecture schedule that recycles every two years. Teams from various American and Canadian residency programs come to help supplement the teaching curriculum each month.

It was Brittany’s first time engaging with the program, so she couldn’t see what I saw when I went for my third time this past April. My friends were now senior residents, impressively running the ORs at the level of attendings. They were guiding new interns in the OR and mentoring them during Monday’s teaching sessions.

As CASIEF volunteers, these had pri-
Our roles, especially when my Rwandan friends were still junior residents. Our role evolved to guiding discussion, and continuing interesting teaching in the operating rooms. This Monday, the discussion was on anesthesia complications.

The next day, it seemed our lecture presented itself in the operating room. Our 65-year-old patient had presented emergently with a perforated stomach ulcer. Prior to induction, he had been severely hypoxic.

Intraoperatively, we were glad when his oxygen saturation held at a steady 80%. At this point, we recommended ICU care postoperatively. But the ICU was full. The next best option given our resources was to optimize his pulmonary status, extubate if tolerable, and keep him in the recovery unit until a bed opened up.

But then he didn’t wake up...

The OR was darkly lit and quiet. Only Brittany, the senior anesthesia resident, and I were present. The three of us began working through the differential diagnosis for delayed emergence. There were no signs of spontaneous ventilation or consciousness. The halothane had long been off.

Eventually, we obtained some lab results and found the patient was in renal failure. I was worried the morphine we had given, as well as the paralytic, were unable to be cleared by his poorly functioning kidneys. But we had no naloxone and no neostigmine, which had been on drug-shortage for the past two years. Succinylcholine is also not widely available, so the rapid sequence induction had been performed with vecuronium. We had no twitch monitor - a rare commodity.

Needless to say, we were all frustrated. The frustration turned into confusion and surprise when a nurse suddenly appeared with a twitch-monitor. With great haste, I checked twitches, only to realize that the patient was still paralyzed.

The junior resident at this point came in to learn how to use a twitch-monitor. More concerning was the potential that this patient could be awake. Vital signs, however, were stable. Perhaps the morphine took care of...
group who will guide the legislation for the next GA session to protect patients, ensure fair payment for services, and not allow the insurance companies to monopolize the payment system, forcing anesthesiologists to accept below-market in-network rates.

We also continue to seek answers on the issues of Medicaid payment reform and workers’ compensation fee schedule issues. On these topics we are looking for answers about how anesthesiologists’ payments can be improved in these programs.

Primary care physicians and emergency physicians received a modest positive adjustment to their Medicaid rate in the final budget this year, but anesthesiologists did not.

We are actively engaged with the appropriate stakeholders to make sure Virginia anesthesiologists are reasonably compensated for our services - caring for some of the most complex and difficult patients in the Commonwealth.

Earlier in May in Washington, DC, a delegation of Virginia anesthesiologists, residents, certified anesthesiologist assistants, and even a practice administrator met with our elected representatives on Capitol Hill to educate them on issues important to our specialty.

We discussed balance billing, Medicare-for-all proposals, a new Medicare payment study to be undertaken by the GAO, rural pass through legislation, resident student loan interest deferment, and the role of CAAs on the anesthesia care team.

We had a full day and a half of meetings with legislators and their healthcare advisors and staff, including just about every house district in Virginia. We also met with both Senator Warner and Senator Kaine’s health care legislative teams.

We hope to follow up with our legislators when they are back at home in their districts and highly encourage you to meet with your representative to become a key contact on medical issues of interest to anesthesia.

If you would like to learn more about these issues of importance that were the focus of the ASA Legislative Conference, please contact me, any VSA officer, or one of your VSA regional directors.

In Richmond at the MSV Legislative Summit and Specialty Advisory Council, I served as the VSA representative among our medical and surgical colleagues to help shape the advocacy agenda for MSV in the coming year.

There were 14 proposals for MSV to discuss, with wide ranging topics of interest to Virginia physicians. We also discussed long-term advocacy goals for the Society.

I’m pleased to report that one of the most important issues for MSV is Medicaid payment reform. Hopefully, this will be a central topic to the 2020 legislative agenda. It will be great to work cooperatively with MSV on this critical issue for our practices and for the additional new patients being added to the Medicaid system in Virginia who need access to care but may be unable to get care without fair physician payment for services.

I know all of you cannot take time away from your practices and families to help in our advocacy efforts. However, the way you can get involved is to contribute to the ASA and VSA PACs.

Since this coming year is an election year in Virginia, we critically need your support. Please consider making a modest contribution to both PACs so that VSA will continue to have a voice in our government. If everyone gave a small contribution, even as small as 0.1% of your income, we would be able to maintain a strong degree of influence in local and national politics.

Please reach out to me at any time at jeffrey.green@vcuhealth.org or at 804-337-3256 if VSA or I can do more to help you or your practice.

Ask yourself, if not us, who? If not now, when?

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**Anesthesia in Rwanda, from page 9**

that. The senior resident and I rushed to think of the next steps - do we put the patient back to sleep with halothane and propofol? Do we give him an amnesic drug?

Then all of a sudden, another surprise. In her hands, the nurse now held the most valuable drug - neostigmine. Our paralytic reversal agent, our gold, our panacea. With no time to wonder where in the world this suddenly came from, or why it showed up at this time, we quickly gave the medicine to the patient.

Within minutes, he woke up.

Brittany and I walked home that evening relieved, tired, and happy - we didn’t realize neostigmine could ever mean so much to us. The air was cooler, the walk was a little less uphill, but we also had a good, and interesting, teaching day behind us.

My Rwandan colleagues and I still face various challenges when it comes to practicing anesthesia there, from drug and equipment shortages to insufficient staffing. However, no matter what environment we work in, we adapt - the one beautiful constant being the practice and knowledge of medicine.
Legislative Update for June 2019

By Mark Schmitt

Conclusion of 2019 Legislative Session
The 2019 General Assembly Session officially wrapped up on April 3, after the legislature met for the “reconvene session.” This is where they vote to accept or reject the Governor’s actions on the budget and other bills.

We had a major victory concerning harmful budget language creating a balance billing workgroup. The original language was troublesome: the workgroup was non-inclusive and the scope was extremely limited. The physician community opposed this language and asked the Governor to amend it. We were thrilled that the Governor did as we requested and amended the language to something we support.

We are happy to report that it worked! Despite a last-minute effort by the health plans to thwart our efforts, both the Senate and House of Delegates voted to accept the Governor’s amendment.

Next Steps on Balance Billing
As required by the final budget, the office of the Secretary of Health and Human Resources will convene a workgroup this summer to discuss the issue and contemplate potential solutions. We will be participating in this process and closely following it. Stay tuned for updates.

Workers Compensation
VSA continues to monitor the newly implemented fee schedule for the unique workers’ compensation patient population.

The schedule is supposed to control cost inflation but also maintain fair, fast payment to providers. There are many concerns amongst VSA members on the rates set for anesthesiology.

As a result, we set up a survey to collect more information and analyze the results. Following this survey, VSA sent a letter to the Workers’ Compensation Commission with questions we would like the Commission and Oliver Wyman (the actuary that set the rates) to explore.

We are currently awaiting their response and have been told they are reviewing it internally. The Commission will likely present our concerns to the Regulatory Advisory Panel Committee to review and make any recommendations.

MSV Update
MSV hosted its annual advocacy summit on April 26th, where they heard advocacy proposals submitted by members.

MSV’s specialty advisory council then met on May 29th to give feedback on these proposals and MSV’s long-term advocacy agenda. Dr. Jeff Green represented VSA at both meetings.

The meeting began with a discussion of the long-term advocacy plan, which includes insurance reforms, advancing the profession, innovation in medicine, and population health and wellness. MSV staff solicited other major issues of concern from the specialties.

Responses included Maintenance of Certification (MOC), physician workforce shortages in various areas and specialties, physician burnout, loss of physician autonomy, reimbursement and payment models, outpatient diagnostics, health plan regulation, insurance and PBM reform, transparency in physician training and certification, and a process for addressing social issues. In addition, balance billing and out-of-network coverage continues to be a top priority for MSV and the physician community.

The specialty council then reviewed and discussed the 14 advocacy proposals. The proposals with the most support at the time were:
- Annual inflation increase for physician Medicaid reimbursements (VSA has already signed on in support of this)
- Reforming the Certificate of Need Program
- Monitoring the enforcement of legislation

The next step is for the MSV Board to review the proposals. The MSV Annual Meeting will be held in October 17-20 at the Omni Homestead.

2019 Elections
The upcoming November elections will be pivotal for Virginia. It is not an overstatement to say that it may be one of the most critical elections for the Commonwealth in a generation. All 140 seats in the General Assembly – 100 in the House of Delegates and 40 in the Senate – will be on the ballot. Both chambers are under narrow Republican control, 51-49 in the House of Delegates and 21-19 in the Senate of Virginia.

In 2017, control of the House of Delegates was nearly flipped from Republican to Democrat after a “blue wave” reduced the long-time Republican majority from 67 seats to a slim 51-49 edge.

Recent federal court decisions have resulted in a House of Delegates redistricting map imposed by the courts that will likely result in more Democratic seats. Retirements, expected vacancies, and up-ticket and primary challengers will further shuffle the political deck.

We fully expect control of both chambers to be at stake this election. Your VSA legislative team has a keen eye and finger on the pulse of the political trends, competitive races and key legislators that we should follow and target this year. If either or both chambers flip, we can expect a noticeable shift in policy. If current partisan control is maintained, incumbents will be calculating whether and how to adjust policy goals and positions.

VaSAPAC
Our PAC is a critical tool in our advocacy program. It allows us to support legislators who are friendly to our profession and issues in the General Assembly.

As you know, every year the legislature considers bills that could potentially impact our profession and patients. A strong PAC provides us the opportunity for our voice to be heard by elected officials in the legislature and executive branch. Our PAC enables us to support legislators who support our profession.

Please support the VaSAPAC and make your contribution today! https://www2.vsahq.org/forms/VaSAPAC.iphtml
SAVE THE DATE!

Annual VSA Luncheon and Meeting

SATURDAY, OCTOBER 19, 2019 • ORLANDO, FLORIDA