Grassroots advocacy refers to a movement that grows naturally and spontaneously, without encouragement from outside sources, much like the roots of stubborn grass. It is a form of advocacy that originates among concerned individuals rather than being orchestrated by organizations.

In today’s rapidly changing health care environment, anesthesiologists must respond to public as well as governmental concerns through the establishment of open and ongoing communication. The ASA Grassroots Network provides members with a voice in the specialty’s advocacy efforts in order to influence legislation or regulatory issues at both the federal and state levels. Grassroots advocacy is achieved through many venues ranging from writing letters and e-mails to political leaders, to organizing educational activities for our colleagues and patients. So one might ask, “Why should I become involved in the ASA Grassroots Network?” The answer is simple: The future of our specialty demands it. In recent months and years, there has been a growing assault on physicians. From a desire to cut Medicare payments to efforts to expand scope of practice for less qualified providers, the attacks come in many forms. Each of these attacks will not only harm our specialty but also our patients. To continue to be able to provide high-quality care to our patients, we must now engage the political process.

The recent ASA Legislative Conference held in Washington, D.C. focused on four key issues that directly impact our practices and patients:
1. Ensure Fair Payment
2. Empower Patients
3. Expand Access
4. Ease Drug Shortages.

Ensure Fair Payment: The complex issues that relate to the national deficit and spending priorities have propagated demands for statutory provisions seeking to drive government payment for medical services to even lower rates than those that currently exist. Anesthesiologists, the leaders in patient safety, are already unfairly paid under Medicare at only 33 percent of private rates, the lowest rate among health professionals. Yet the application of the Medicare sustainable growth formula (SGR) continues to target anesthesia with the same percentage cuts as all other eligible Part B professionals, despite the fact that our specialty’s services are not contributing to the growth of the program spending. In fact, recent data from the Congressional Budget Office demonstrate that Medicare anesthesia cumulative spending is decreasing and below the neutral line. The non-elected Independent Payment Advisory Board (IPAB) created by PPACA that takes effect in 2014 has the full authority to mandate across-the-board reductions in Part B payments on top of SGR cuts.
If our federal legislators do not address these problems, safe access to anesthesia care for millions of Americans could be endangered. The newly conceived perioperative surgical home concept with anesthesiologists as the natural team leaders of this approach may hold some promise in containing hospital costs and coordinating and improving quality care related to surgery. There are pieces of legislation in both the House of Representatives (H.R. 452, Medicare Decisions Accountability Act of 2011) and the Senate (S. 668, Health Care Bureaucrats Elimination Act) that would essentially repeal IPAB.

**Empower Patients:** As the debate on health care reform continues, we should ensure that our patients are provided with adequate information in order to make wise and cost-conscious health care choices and decisions. In simple terms, patients should know the qualifications of the individuals involved in their health care. With the increasing ambiguity of health care provider advertisements, marketing and degree titles, patient autonomy and decision-making has been compromised. H.R. 451, the “Healthcare Truth and Transparency Act” introduced by Representatives John Sullivan (R-OK) and David Scott (D-GA), would improve transparency in the identification of health care providers and in health care provider-related advertisements and marketing. The requirement for transparency would empower patients with an improved understanding of the health care delivery system and allow them to make informed choices.

**Expand Access:** Anesthesia providers are customarily paid under the Medicare Part B fee schedule. Historically, these low Part B payments combined with low patient volume have made it difficult for rural hospitals to retain anesthesia providers. In the 1980s, Congress addressed this issue by approving a rural provider incentive that would allow certain rural hospitals to use the more lucrative Medicare Part A “pass-through” arrangement to contract the services of non-physician anesthesia providers, but not anesthesiologists. Because of the “rural pass-through” arrangement, patients seeking care in rural hospitals may not have access to care from an anesthesiologist. H.R. 1044, the “Medicare Access to Rural Anesthesiology Act” sponsored by Representatives Lynn Jenkins (R-KS), Henry Cuellar (D-TX) and Todd Akin (R-MO), would broaden the current policy to allow the use of already available funding for rural hospitals to employ or contract all types of anesthesia providers, including anesthesiologists. In 2002 and 2010, ASA formally requested that the Centers for Medicare & Medicaid Services (CMS) permit the rural hospitals to use the rural pass-through arrangements for anesthesiologists; however, CMS responded that this would require a change in the current law by Congress.

**Ease Drug Shortages:** Drug shortages continue to occur at alarming levels. Since 2006, the number of identified new drug shortages has increased from 70 to more than 211 in the year 2010. Many of these drugs in critically short supply are used for the administration of anesthesia, most notably propofol and succinylcholine. Others, such as epinephrine, are the mainstay for the support of hemodynamic function and as a rescue drug. As a result, these shortages have caused significant disruptions in patient care, including delay of medical procedures, cancellation of elective surgeries, less than optimal outcomes and, in some cases, death. These drug shortages have multifactorial causes and will require a multifaceted approach. Senator Richard Blumenthal (D-CT), who spoke at the 2011 Legislative Conference, has formally contacted the Government Accountability Office (GAO) requesting an investigation into the causes of drug shortages. Senator Amy Klobuchar (D-MN) has introduced S. 296, the “Preserving Access to Life-Saving Medications Act,” legislation that would increase the Food and Drug Administration’s authority to require manufacturers to notify the FDA of a drug’s anticipated withdrawal from the market.

At first glance, these issues may seem overwhelming, and one might ask, “How can I possibly make a difference to affect the future of the practice of anesthesiology?” It is much easier than you think! The Committee on Governmental Affairs, led by Chair Jane C.K. Fitch, M.D., has created a wide range of advocacy tools you can use to influence elected officials. The first step is joining the ASA Grassroots Network http://grassroots.asahq.org/. The ASA Grassroots Network will contact you when major advocacy efforts are needed. In addition, the Grassroots Network will provide you with contact information for your elected officials as well as some sample language you can use when contacting them. The next step is to look at the Advocacy Guide and determine what actions you can take to advance the interests of our specialty. Finally, you can complete the 2011 “Advocacy Involvement Challenge.” For more information, please visit http://www.asahq.org/For-Members/Advocacy/Advocacy-Resources.aspx.
States Issues Featured at ASA Legislative Conference

In keeping with the theme of this year’s Legislative Conference, “All Politics is Local,” the record number of attendees not only had a chance to lobby their federal lawmakers but to also hear from individuals who provided updates on state legislative and regulatory issues. On May 2, the State Issues Forum featured an update on a number of issues at the state level from our state leaders. The State Affairs Panel, held on May 3, featured Richard Rosenquist, M.D., Chair of ASA’s Committee on Pain Medicine, and Thomas Hill, M.D., a member of the North Carolina Society of Anesthesiologists who is currently serving on the North Carolina Medical Board. Dr. Rosenquist gave a national perspective on interventional pain management issues, and Dr. Hill emphasized the importance of serving on a medical board and how medical boards can impact the specialty.

The following is a summary of state issues that ASA is tracking as of June 2011. It is not a comprehensive list of issues being tracked.

Opt-Outs

Sixteen states have opted out of the federal requirement that a physician supervise the administration of anesthesia by a nurse anesthetist. The list includes Alaska, California, Colorado, Idaho, Iowa, Kansas, Minnesota, Montana, Nebraska, New Hampshire, New Mexico, North Dakota, Oregon, South Dakota, Washington and Wisconsin.

California – In February 2010, the California Society of Anesthesiologists (CSA) and California Medical Association (CMA) sought two forms of relief from the court. Petitioners sought a motion for summary judgment and writ of mandate to direct the Governor to withdraw the opt-out. The judge in the California opt-out lawsuit issued a written order denying the petitioners motion for summary judgment and writ of mandate. The judge granted Respondent Governor Arnold Schwarzenegger’s motion for summary judgment, and the California Hospital Association’s application to file an amicus brief. CSA and CMA agreed to appeal the decision, and in April, CSA and CMA filed their opening brief in their appeal challenging Governor Schwarzenegger’s opt-out decision.

Colorado – Immediately upon learning of the opt-out, the Colorado Society of Anesthesiologists and Colorado Medical Society filed a lawsuit against the governor challenging the legality of the opt-out. In April, the Denver District Court ruled on pretrial motions and dismissed the lawsuit. The court found that the delivery of anesthesia by CRNAs is not contrary to Colorado law. The court found that “a CRNA performing what she or he has been specially trained and licensed to perform, i.e., the administration of anesthesia, is performing an independent nursing function and not a delegated medical function.” ASA is supportive of an appeal of this decision.

Nurse Anesthetist Scope of Practice

Florida – H.B. 4103 would have deleted supervision requirements for ARNPs who provide services at medical offices other than the physician’s primary office location. The Federal Trade Commission (FTC) wrote a letter of support for the bill, citing that “restrictions on the supervisory relationships between physicians and ARNPs impose costs on Florida health-care consumers.” Despite FTC’s letter, this bill died upon adjournment.

Mississippi – H.B. 605/S.B. 2860 would have removed the requirement of a collaborative relationship between nurse practitioners and physicians. Died in committee.

New Jersey – In February 2011, the Department of Health and Senior Services (DHSS) adopted regulations that provided that APNs can only administer anesthesia in accordance with a joint protocol that addresses that an anesthesiologist is: 1) available for a consultation on-site, on call, or by electronic means; and 2) is present during induction, emergence and critical change in status.

North Dakota – Enacted into law, S.B. 2148 eliminates the statutory requirement that prescriptive practices for APRNs include evidence of a collaborative agreement with a licensed physician. The bill also eliminates the requirement that the Board of Nursing consult with the medical profession in the establishment of prescriptive practice standards for APRNs.

Oklahoma – Several bills were introduced relating to scope of practice for nurse anesthetists. H.B. 1351 and S.B. 544 would have removed the requirement that nurse anesthetists be supervised by a physician. Died in committee.

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Vermont – H.B. 358 would have created an expanded scope of practice for advanced practice registered nurses. The bill would have allowed APRNs in clinically integrated settings to perform medical acts independently under practice guidelines approved by the Board of Medicine. APRNs practicing outside of a clinically integrated setting would have been able to perform medical acts independently within a collaborative practice with a licensed physician under written practice guidelines that are mutually agreed upon between the APRN and the collaborating physician. The bill would have also required the Board of Nursing to perform two studies: 1) a comparison of the curriculum and education requirements for medical and osteopathic physicians and advance practice registered nurses and; 2) a study on the collection of baseline numbers of APRNs who are participating and advance practice registered nurses and; a study on the collection of baseline numbers of APRNs who are participating in solo practice in Vermont or in group practices consisting only of APRNs by location and specialty, and track changes of these through time. Died upon adjournment.

**Pain**

Alabama – The Alabama State Board of Medical Examiners issued a proposal that would define interventional chronic pain management as the practice of medicine, including the use of fluoroscopy and other imaging modalities when used to assess the cause of a patient’s chronic pain or to identify anatomic landmarks during interventional techniques. Further, interventional treatment of pain would only be performed by a qualified, licensed physician and it would prohibit such physician from delegating to a nonphysician the authority to utilize such procedures to diagnose, manage, or treat chronic pain patients. The Federal Trade Commission (FTC) wrote to the Alabama State Board of Medical Examiners, urging the medical board to “avoid adopting provisions that would limit the role of CRNAs in pain management more strictly than patient protection requires” and states that “absent evidence that the proposed restrictions are necessary to protect the public, there appears to be no reason to sacrifice the benefits of CRNA pain management services ....” The Alabama State Board of Medical Examiners delayed action on the proposed rule. In January 2011, ASA wrote to the FTC, educating them on the invaluable role of anesthesiologists in treating chronic pain.

Florida – Governor Rick Scott (R) proposed in his budget package to repeal the prescription drug monitoring database. The database was approved in 2009 but has not been implemented. In April, Governor Scott reversed his stance on the database and will move forward with the implementation of the database.

Georgia – Signed by the Governor, S.B. 36 establishes an electronic database of all controlled substances dispensed in Georgia pharmacies over a one-year period.

Illinois – S.B. 140 prohibits any person other than a physician from practicing interventional techniques for pain medicine. The bill defines interventional pain medicine as “the diagnosis and treatment of pain-related medical conditions primarily with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain.”

Iowa – In November 2010, Polk County District Court entered a “stay” order regarding regulations adopted by the Iowa Board of Nursing (IBN) and Iowa Department of Public Health (IDPH) that authorizes ARNPs to directly supervise the use of fluoroscopy for diagnostic or therapeutic purposes. The court concluded that “there exists a high likelihood that IDPH and IBN acted beyond their statutorily delegated authority in enacting these rules.” The stay returns the law to its position prior to IDPH and IBN’s enactment of the rules. The matter will be fully litigated during a one or two day trial expected to commence in fall 2011.

Maryland – Enacted into law, S.B. 883 establishes the prescription drug monitoring program in the Department of Health and Mental Hygiene. This bill was one of Governor Martin O’Malley’s (D) priorities.

Tennessee – H.B. 1896/S.B. 1935. The bills limit the performance of interventional pain management procedures by an APN or physician assistant (PA) in unlicensed settings. Specifically, an APN or PA may only perform invasive procedures involving any portion of the spine, spinal cord, sympathetic nerves or block of major peripheral nerves under the direct supervision of a Tennessee physician who is actively practicing spinal injections and has current privileges to do so at a licensed facility. Direct supervision is defined as being physically present in the same building as the APN at the time the invasive procedure is performed. The bill also provides that a physician may only practice interventional pain management if the licensee is either: 1) Board certified through the American Board of Medical Specialties (ABMS) in one of the following specialties: anesthesiology; neurological surgery; orthopedic surgery; physical medicine and rehabilitation; or any other board certified physician who has completed an ABMS subspecialty board in pain medicine or completed an ACGME-accredited pain fellowship; 2) a recent graduate in a medical specialty listed in 1) not yet eligible to apply for ABMS board certification; provided, there is a practice relationship with a physician or an osteopathic physician who meets certain requirements; or 3) a licensee who is not board certified in one of the specialties listed in 1) but is board certified in a different ABMS specialty and has completed a post-graduate training program in interventional pain.