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THE LEADING SOURCE FOR PERIOPERATIVE HEALTH CARE NEWS

Each One, Reach One on the Drive for 35

Kraig S. de Lanzac, MD, MBA, FASA

Welcome to my first article as ASA Secretary, after five terms as assistant secretary. Once again, I will attest that ASA is a robust, member-driven organization. We are 58,000 members strong, bolstered by a continuing trend of increased resident, fellow, and medical student membership. That is not an accident. While we continue to deliver great value for our members across their careers, we have improved offerings to early-career members. We are also working to enrich the membership of retired anesthesiologists. You should be proud of our work that increases membership and enhances our relationships with current members. Membership in any organization can be transactional, but we want to make ASA membership a relationship – and more specifically, a positive relationship. It begins by working with our future colleagues as they start their journey through medical school, residency in anesthesiology, and throughout their careers. In this article, however, I want to focus on a particular group: our active members.

The ASA active member category consists of our practicing anesthesiologists – from those who have completed their formal training and up until retirement. We have one subset of our active membership, for our newest active members in their first three years of practice, that is participating in the Early-Career Membership Program (ECMP). The ECMP provides our early-career members with a low financial entry point into active membership, combined with a bundle of activities and services curated for their specific career stage. Consider this our three-year courtship with these members, as we hope to engage them in career-long and lifelong ASA membership. Our overall active membership last year, including early-career members, was approximately 32,000, which is terrific. Thank you for being in that group. But our active membership has plateaued over the past several years. Regardless of the factors, we want to address this plateau and grow. And with your help, we can accomplish that goal.

Nationwide, based on ASA analyses, only 62% of anesthesiologists are members of ASA. How can that be? I suspect that each one has their reason. Sometimes, nonmembership is a passive process where a potential member does not have ASA in mind or is waiting to be invited to join. For others, nonmembership may be an active process when someone is disappointed at something they perceive ASA did or did

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Three Featured Speakers ... and Countless Reasons to Join ASA in Philly

Eugene R. Viscusi, MD, FASA, Chair, Committee on Annual Meeting Oversight

The City of Brotherly Love will be a locus of expertise, energy, and education on October 18-22, 2024, when thousands of anesthesiologists gather to boost their knowledge of current practices and standards. Attendees will discover new ways to improve clinical practices and patient care, exchange ideas with industry thought leaders, and soak up the learning at anesthesiology's most impactful and interesting event, hosted in one of the country's most dynamic, family-friendly cities. The weekend will be loaded with opportunities to reconnect with peers and make new connections. The information on tap for this year's meeting is

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Ensuring Access to Pain Care

Muhammad A. Farooq Anwar, MD, MBA
Lisa V. Doan, MD Kristen Noon, MD

The IOM report "Relieving Pain in America" indicates that racial and socioeconomic disparities in pain treatment are common. There is a paucity of data regarding disparities in innovative pain procedures. Two existing studies discuss profound racial differences in patients receiving advanced pain procedures like neuromodulation (*Neuromodulation* 2021; 24:434-40; *Pain Pract* 2021;21:75-82). Patients with private insurance have the highest odds of undergoing these therapies, followed by Medicare and Medicaid patients (*Pain Pract* 2021;21:75-82).

In 2021, the U.S. Census Bureau published a brief titled "Health Insurance Coverage by Race and Hispanic Origin: 2021" using 2021 American Community Survey one-year estimates. The brief examined differences in health insurance coverage for the civilian noninstitutionalized population by race and Hispanic origin. The American Community Survey broadly classifies health insurance coverage

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SPECIAL SECTION

Updates in Medical Education 13-27

Guest Editors: Shobana Rajan, MD, FASA, and Lalitha Sundararaman, MBBS, MD, FASA

PERIODICALS

ACE Anesthesiology Continuing Education

ACE Question

Which of the following is MOST likely to be associated with an increased risk for postoperative urinary retention (POUR)?

(A) Decreased intraoperative fluids
(B) Male sex
(C) Gynecologic surgery

POUR is a common postsurgical complication. Depending on multiple interacting factors, the incidence ranges from 5%-70% (Table). Interdependence between risk factors (e.g., lower limb arthroplasty and conduction anesthesia, or male sex and benign prostatic hypertrophy) results in the wide variation in the incidence and risk of POUR.

Gynecologic surgery appears to be associated with a low risk for POUR, presumably because the bladder is routinely emptied during the surgical procedure. Excessive administration of intravenous fluids, rather than decreased intraoperative fluids, leads to overdistention of the bladder and impaired detrusor activity. ■

Category	Reported risk factors	Possible mechanism
Patient	Age	Age-related bladder dysfunction
	Benign prostatic hypertrophy	Obstruction
	Male sex	Benign prostatic hypertrophy
Anesthetic	General anesthesia	Pontine micturition center inhibition
	Spinal anesthesia	Blocks detrusor contraction
	Epidural anesthesia	Blocks efferent and afferent nerves
	Excessive intravenous fluid administration	Overdistension of the bladder
	Anticholinergics	Block detrusor activity
Surgical	Anorectal surgical procedures	Damage to pelvic nerves
	Lower limb arthroplasty	Conduction anesthesia
	Long duration of surgery	Fluid administration

Table: Some of the factors reported to increase the risk of postoperative urinary retention (POUR).

References:

1. Kowalik U, Plante MK. Urinary retention in surgical patients. *Surg Clin North Am.* 2016; 96(3):453-67. doi:10.1016/j.suc.2016.02.004
2. Baldini G, Bagry H, Aprikian A, Carli F. Postoperative urinary retention: anesthetic and perioperative considerations. *Anesthesiology.* 2009;110(5):1139-57. doi:10.1097/ALN.0b013e31819f7aea
3. Gropper MA, Cohen NH, Eriksson LI, Fleisher LA, Leslie K, Wiener-Kronish JP, eds. *Miller's Anesthesia.* 9th ed. Elsevier; 2020:1953.

Answer: B

Committee News: Access to Pain Care

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as private insurance plans provided through an employer or a union, coverage purchased directly by an individual from an insurance company or through an exchange (such as healthcare.gov), or coverage through TRICARE. Public insurance coverage includes federal programs such as Medicare, Medicaid, and CHIP, individual state health plans, and the Civilian Health and Medical Program of the Department of Veterans Affairs, as well as care provided by the VA. In people aged 19-64, 80% of Whites, 48% of American Indians and Alaska Natives, 63% of Blacks, and 57% Hispanics or Latinos had private insurance coverage. Racial differences existed even among people having the same employment status or income-to-poverty ratio. The employed White and Asian non-Hispanic adults under 65 years old had 20% higher rates of private coverage compared to employed Hispanic, American Indian, and Alaska Native adults (asamonitor.pub/3v0JwQH). In all, Whites are more likely to have access to better reimbursing private insurance plans than their non-White counterparts regardless of employment status.

Lack of insurance coverage for interventional pain procedures and multimodal pharmacologic options, along with unwarranted prior authorization requirements and frequent denials, has plagued the practice of medicine. In some cases, insurance providers continue to reduce coverage for treatment options that have a proven track record of safety and efficacy by simply inappropriately labeling them as "experimental" or "not medically necessary." This resulted in a lack of access to quality care, which helped precipitate the opioid overdose crisis. It also unnecessarily burdens emergency and inpatient services as pain patients desperately seek relief that has been denied on an outpatient basis by their insurance providers.

Health insurance plans require patients to fail on their preferred medications before a superior prescribed therapy is covered, which delays pain relief and adds to suffering. On the other hand, both Medicare and private insurance groups frequently and unexpectedly change their drug policies, denying patients medication that was previously covered.

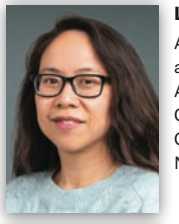
In addition to shrinking the scope of coverage, health insurance plans continue to expand the list of pharmacologic and procedural interventions that require prior authorizations – a process that is flawed, excessive, and time-consuming. It adds just another insurance-related barrier to delay quality and effective pain treatment. Internal guidelines for prior authorization are not based on scientific evidence, and rates of denial have skyrocketed in recent years. The appeal process is cumbersome, forcing physicians to spend an enormous amount of time documenting and communicating with insurance personnel. Most doctors hired by insurance companies for peer-to-peer calls do not specialize in pain management. There have been instances where insurance company employees are incentivized to deny cases without an adequate review (asamonitor.pub/4c2Khtl). These practices not only reduce access to pain care and increase health care costs, but also strain the physician-patient relationship and add a significant administrative burden. Not all pain practices have the extensive resources and staffing to deal with these excessive prior authorization requirements. As a result, some clinics have seen dramatic turnover in support staff due to the excessive work burden, which indirectly delays patient care and damages the clinics' reputations.

Access to insurance-covered, effective, evidence-based pain care is paramount. Person-centered nonpharmacologic, pharmacologic, and targeted interventional treatments provided by multidisciplinary teams in concert with a trained pain medicine specialist are best practices. They should be implemented promptly to reduce disability and patient suffering. Access to adequate insurance coverage for nonopioid medications and nonpharmacologic therapies is important. For acute pain, nonopioid medications can be as effective as opioids. Nonopioid therapies are recommended for the treatment of subacute and chronic pain (*MMWR Recomm Rep* 2022;71:1-95). Unfortunately, there are often coverage limitations for nonopioid therapies, such as off-label use of medications for specific pain conditions or pain interventions. Lately, health plans have been denying coverage for newer opioids with less abuse potential. Out-of-pocket costs for uncovered or denied treatments may leave them out of reach for many patients.

ASA opposes the misappropriation of the term "experimental" in coverage policies and encourages health plans to follow evidence-based guidelines supported by specialty societies to prioritize pain relief over profits (asamonitor.pub/3vZcz7P). CMS recently published a rule to streamline the prior authorization process for Medicare Advantage, Medicaid, and other government-sponsored health plans and to improve the timeliness and transparency of the denial process (asamonitor.pub/3V52YX5). For pain practices that have experienced the burdens of the prior authorizations process, these steps might be too little, too late.

ASA supports the scaling of telehealth services for pain, which could allow patients and clinical teams access to physician-led pain care across state lines (asamonitor.pub/3vZcz7P). The use of telehealth services increased in response to the COVID-19 pandemic. However, at present, states have varied legal requirements for prescribing and licensure across state lines (asamonitor.pub/3vZcz7P). Patients may have socioeconomic barriers to telemedicine visits, such as limited access to the internet or devices.

ASA is committed to ensuring patient access to high-quality, physician-led, comprehensive nonopioid pain treatments while minimizing the burden on clinicians working to provide for this complex and challenging care. ■



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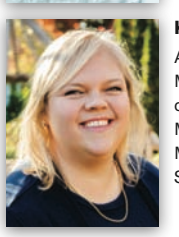

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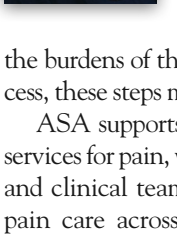

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