Crossing the payment bridge

Long-awaited post-SGR payment is here

Opening Ceremony keynote:
Mae Jemison, MD, former astronaut, engineer, physician, and educator

Practice profile:
Polaris Medical Group-ENT

American College of Surgeons on responsible surgery

FOR PATIENTS
What is laryngopharyngeal reflux (LPR)?
No longer will you need to tape eyeglasses to the forehead of your patients following surgery.

NoseComfort is the ideal solution for patients who must wear their eyeglasses following a Rhinoplasty, Septoplasty, or other nasal surgeries.

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- The adjustable headband allows NoseComfort to be worn with most hairstyles without any difficulty.
- NoseComfort can fit any head size with the adjustable elastic headband.
- A hypoallergenic foam pad rests against your patients forehead, ensuring a comfortable fit.

A single NoseComfort® can be purchased for $24.95 which includes shipping and handling. Medical professionals can also purchase in bulk, a carton of ten (10) NoseComforts® for $149.95 including shipping and handling. Please contact us at info@nosecomfort.com for bulk pricing of 100 NoseComforts in case quantity. This pricing makes it cost-effective for you to include NoseComfort in your Post-Rhinoplasty Recovery Kits, or to resell at a competitive price.

Please visit NoseComfort.com for more information.
Crossing the payment bridge
Long-awaited post-SGR payment is here.

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Become a Member
Membership in the ARS places you in a highly respected professional organization that has a significant and far-reaching impact on the subspecialty of rhinology.
Online registration and membership forms available at: http://www.american-rhinologic.org/membership_application

JOIN US

5th Annual ARS Summer Sinus Symposium
July 14-16, 2016 | Westin Michigan Avenue Hotel, Chicago, IL

Meeting Registration is FREE with paid ARS membership!

Keynote Speaker: David Kersey, MD: Frontal Sinus Surgery: Today: What's Changed and What's the Same?
- Pearls and Pitfalls: Safe and Successful Sinus Surgery
- Cases: Medical or Surgical Management
- Frontal Sinus: Tips, Tricks, and Tools
- Doc, I Still Got Sinus
- Uh Oh! What Do I Do Now? Managing Complications

Preoperative Steps to Facilitate Sinonasal Surgery
Postoperative Steps to Improve Sinonasal Outcomes
Medical Malpractice: Steps to Avoid Being Sued
Coding Update 2016: ICD-10, E&M and CPT
Extending FESS Technique Beyond the Usual Bounds
Innovations for Your Rhinology Practice

Topical Therapies in Recalcitrant CRS
Rhinoplasty for the Rhinologic Surgeon
Immunotherapy Update 2016
Allergy Testing and Safety Monitoring
Medical Advances in the Management of AR/CRS/Asthma
CF, Immunodeficiency & AERD: What You Need to Know & How to Treat
Sinus Headaches: Medical or Surgical Management
Debate: GERD Causes CRS
Expanding Your Armamentarium: In-office Procedures
Cadaver Dissection
Meet the Protessors - All Past Presidents at the Conference
Women in Rhinology Luncheon

ANCILLARY NON-CME & Social Events - The following instructional ancillary events will take place during the ARS 5th Annual Summer Sinus Symposium. Food and beverage will be provided for all symposia. Please note that these events are non-CME and are neither sponsored, nor endorsed by, the ARS.

THURSDAY, JULY 14, 2016
2:00 pm – 4:00 pm (Session 1), 5:00 pm – 7:00 pm (Session 2): Hands-on Cadaver Workshop
"Advances in Frontal Sinus Surgery": Lecture, Demo Dissection, & Hands-on Cadaver lab
Guest Faculties: Roy Casalino, MD; Amber Luong, MD; Jeremiah Al MD
Sponsored by Medtronic

2:30 pm – 4:30 pm (Session 1), 5:00 pm – 7:00 pm (Session 2): Hands-on Cadaver Workshop
"Advanced Sinus techniques utilizing innovative technologies: Balloons, Navigation, Multi-Debrider and RF energy...a cadaveric, hands-on opportunity to explore." Sponsored by Acclarent, Part of the Johnson & Johnson Family of Companies/Olympus America, Inc.

7:30 pm – 9:00 pm: Evening Symposium & Reception
"Office Based Sinus Procedures Utilizing Image Guidance" Sponsored by Medtronic

FRIDAY, JULY 15, 2016
7:30 am – 8:20 am: Breakfast Symposium
"Breakthrough Evidence in Frontal Sinus Surgery"
Guest Faculties: Amber Luong, MD; Amreet Singh, MD; Pablo Solontzky, MD; Troy Woodard, MD
Sponsored by Intersect ENT

12:30 pm - 1:30 pm: Lunch Symposium
"Biologic Tissue Grfts in Modern Rhinology"
Guest Faculties: James Palmer, MD; Bradford Woodworth, MD; Jeff Suh, MD; Michael Hiles, MD
Sponsored by Cook Medical

5:00 pm – 6:00 pm: Evening Symposium & Reception
"A New Treatment Paradigm in Endoscopic Surgery"
Sponsored by Acclarent, Part of the Johnson & Johnson Family of Companies

SATURDAY, JULY 16, 2016
7:30 am – 8:20 am: Breakfast Symposium
"Innovations in Sinus Surgery"
Sponsored by Olympus America, Inc.

10:00 am – 10:30 am: Mid-Morning Symposium
"Topics in Practice: Considerations in Management of Allergic Rhinitis for Appropriate Patients"
Guest Faculties: Neil Lobry, MD
Sponsored by Medtronic

12:30 pm – 1:30 pm: Lunch Symposium
"The Office in 2020: How Innovations in Technology, Shifting Economics and Patient Activism are Reshaping ENT Practice"
Sponsored by Entellus Medical

Details at http://www.american-rhinologic.org/sss

Contact Wendi Perez, Executive Administrator, ARS, PO Box 495, Warwick, NY 10990
Tel: 845-988-1631 | Fax: 845-986-1527 | wendi@amrhso.com

Accreditation Statement: The American Rhinologic Society (ARS) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. Credit Designation Statement: ARS designates this live activity for a maximum of 15.25 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

www.american-rhinologic.org
A new year, academically speaking

June marks the end of another academic year and the completion of various aspects of training—medical school, residency, and fellowship. About 20.4 percent of Academy Members are in full-time academic practice, and another, more fluid group of practitioners are either in part-time or voluntary academic otolaryngology. Nearly 15 percent of our Members are residents or fellows-in-training. As such, many of us will be attending end-of-year and graduation parties and ceremonies as another batch of chief residents and fellows goes out into the world and other residents advance to the next year of training.

The residency experience is like no other. You become intimately involved with people you didn’t choose, but who become your family for several years and, indeed, your lifetime. You get to know each other’s partners, children, taste in music. You learn how to negotiate: “I’ll cover your call this weekend if you’ll take my next weekend,” for example. You learn how to learn and teach on the run. The senior resident figures out how to guide the junior resident for part of the case, while the attending supervises both. Residents pair up to make presentations and posters better, and get to travel to nice locations to present them, such as San Diego for this year’s Annual Meeting. One resident starts a really good research project, and breathes longevity into it by engaging the next one and so on, so that that residency program becomes really outstanding at that topic. Another resident applies for a Leadership Forum & Board of Governors Spring Meeting travel grant, comes home enthused, and the next year three residents from that program attend. And they all see that they can make a difference.

If you are involved in any teaching, June provides a time to reflect on how you’ve done over the year. I have the great fortune to interact with residents from four of the five New York City programs on a regular basis. I see residents start with one level of knowledge and understanding, and end having leapt forward to an advanced status. It is said that a teacher is one who makes her- or himself progressively unnecessary; I agree with this wholeheartedly.

I have been thinking about the joy of watching a student advance, and the pride in having had even just a little to do with it. A young medical student came to me when I was full-time faculty at Rutgers New Jersey Medical School, interested in otolaryngology. He was smart and hardworking and self-motivated, and fantastic both clinically on his rotations and in my lab. By the time he was ready to apply to residency, I had moved across the river and was teaching in New York City. I was so happy that he matched from the medical school where I had previously taught into the residency program where I was currently teaching. He excelled in his residency and went to Florida to do a prestigious fellowship. He came back to NJMS and in six short years had become full professor and vice chair of the department! And then, as the rapper Big Sean says, “It’s evolution, man. Eventually the student becomes the teacher.”

Jean Anderson Eloy, MD, that young man I had mentored so many years before, became my mentor in thinking and writing about, of all things, gender issues in otolaryngology. There is something overwhelmingly gratifying about reflecting on the students and residents I have trained, where they started, and how they have succeeded.

When the Academy says it’s your partner from residency to retirement, it means it. Just as your co-residents and co-fellows are your buddies for life, and your professors are always there to offer advice and introductions, every Academy initiative is designed for otolaryngologists in all stages of their careers.

This issue of the Bulletin details many of the Health Policy programs at the Academy. As you read the particulars, you will see how you benefit from the work that is being done, no matter your type or location of practice. How can you help? Please participate in Academy surveys when you get them; please fill out the RUC surveys so that our Health Policy team can ensure that we are reimbursed properly for services that we render. As you transition from year to year in residency or practice, engage your juniors to do the same.

Have a great new year!
and not a summer lost... even with ventilation tubes

Please consider **DOC'S PROPLUGS** for all your patient's swimming and bathing needs

- pink, non-vented*
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New payment models

This month’s Bulletin highlights many facets of the activities of our Health Policy team and the rapidly escalating demands that they face in the shifting healthcare environment. The death of the SGR and subsequent onboarding of the healthcare community into the replacement Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM)-structured system has exposed the uncertainty involved in the implementation of this radically different payment model. In fact, it has taken more than one year since the passage of the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) for the Centers for Medicare & Medicaid Services (CMS) to publish the initial set of rules guiding this implementation. During the process of formulating the rules, CMS regularly requested input from affected stakeholders. Your Academy Health Policy staff submitted thoughtfully prepared responses to CMS on your behalf highlighting the necessity for the ability for the majority of otolaryngologists to meaningfully participate in both the MIPS and APM arms of the new quality-based paradigm. A recent meeting with Patrick Conway, MD, Deputy Administrator for Innovation and Quality & CMS Chief Medical Officer, was helpful in our understanding of the upcoming process that will be used by CMS.

A number of groups are exploring APM options for surgeons and specialists. The American College of Surgeons is leading a project with Brandeis University with input from surgical specialty societies to identify opportunities for surgeons to participate in APMs. After discussions with several Congressional committees, it is clear that most practitioners will not be able to participate in APMs in 2018.

The trend to regulate activities in physicians’ offices continues as the United States Pharmacopeia (USP) is recommending changes to the process used to prepare immunotherapy vials that would markedly change requirements for office preparation and alter the way subcutaneous immunotherapy is delivered. We are working with the American Academy of Otolaryngic Allergy (AAOA) and the American Academy of Allergy, Asthma & Immunology (AAAAI) to mitigate these proposed changes. Additionally, concerns involving standards of sterilization and reuse of “single use” devices have surfaced and clarity is needed regarding their safe and ethical use and the way that the payment system handles such practices.

Regent<sup>SM</sup> pilot testing

The pilot phase of Regent<sup>SM</sup>, our Qualified Clinical Data Registry, is well under way and we are grateful to the academic and private practices who are participating in the original pilot process that will set the stage for the launch of the registry to our full membership. Significant progress has been made in working with physicians utilizing both Epic and Cerner EHR systems. Other EHR products have already proved to be compatible with the FIGmd data collection system. The pilot phase will be completed in time for the launch for the general membership around the Annual Meeting in September.

Over the next few months, we will be accepting applications and completing contracts for groups who wish to take advantage of being in the first 1,000 participants who will have the registration fee and first year participation fee waived. Many Members have already placed their names on the “founders list” and will be contacted first. We have no limitations as to the number that the registry can accommodate so if you have not signed up please contact us at regent@entnet.org, and we will send the pertinent information to you. I would like to furthermore thank all of the specialty societies that are participating with our Clinical Advisory Committees to ensure that we are prioritizing and measuring the most pertinent areas of practice initially. I would also like to thank the American Board of Otolaryngology for its willingness to work with the Foundation both related to Regent<sup>SM</sup> and other educational activities that will benefit the diplomates and members of each group.

‘Concurrent and overlapping’ surgery

The Boston Globe called into question the practice of “concurrent and overlapping” surgery in a series of articles. The American College of Surgeons convened a Task Force to address the issue, and, with input from specialty societies including the AAO-HNS, has produced a document (see page 28) that defines the applicable situations and outlines principles to ethically handle them and protect the public. We would appreciate your responding to the recently sent AAO-HNSF survey on this topic.

Leadership in 2017

Finally, I would like to recognize the outstanding young leaders being developed among our ranks. The Academy will actively cultivate and promote these young leaders through our emerging Leadership Development Program, which we hope to have in place by early 2017.
Quality reporting for 2016

Now is the time to prepare for Physician Quality Reporting System (PQRS) reporting for calendar year 2016. There are many changes to requirements this year and the fines associated with failing to report are significant. Highlighted below are important considerations and information on reporting via RegentSM, a Qualified Clinical Data Registry (QCDR.)

For practitioners who still maintain paper charts, or who want to take advantage of the simplicity of reporting measures groups, RegentSM offers a solution. Make sure to read the July Bulletin for information on all of Regent’s measures and measures groups that will be available to you in 2016. Also, make sure to visit www.entnet.org/Regent as we will be updating this page frequently with RegentSM PQRS reporting resources.

Using RegentSM for PQRS 2016

RegentSM does all of the work for you if you are reporting as an individual or as a group, and depending on whether you choose to report individual measures or measures groups.

1. Know the penalties

<table>
<thead>
<tr>
<th>PRACTICE TYPE</th>
<th>PQRS AND VALUE MODIFIER PENALTIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo practitioners and practices with 2-9 providers</td>
<td>-2% PQRS and -2% Value Modifier = -4%</td>
</tr>
<tr>
<td>Practices with 10 or more providers</td>
<td>-2% PQRS and -4% Value Modifier = -6%</td>
</tr>
</tbody>
</table>

2. Decide how to report

You may report either as an individual or as a group. Individuals may report individual measures or measures groups, while practice groups may report individual performance measures only.

If you decide to report as a group, first, understand your practice size as there are different CMS requirements depending upon how many Eligible Professionals (EPs) are in your group. Next, make sure to register with CMS if you plan to report as a group. For more information on group reporting and to self-nominate with CMS before the June 30, 2016 deadline, visit https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html.

3. Learn about Regent’s measures and measures groups

Visit www.entnet.org/Regent and sign up to learn more. Then, make sure all the physicians in your practice are AAO-HNS Members and up-to-date on dues payment with the AAO-HNS even if they choose not to participate in RegentSM. Nurses, physician assistants, audiologists, speech pathologists, and non-physician providers do not have to become AAO-HNS Members to participate.

Dues payment for 2017 starts in October 2016. All Member dues must be paid by January 15, 2017, for participation in RegentSM. Stay tuned to your AAO-HNSF emails and watch for our full launch date, which is anticipated to be late summer 2016. Visit www.entnet.org/Regent.

PQRS reporting needs already addressed?

PQRS reporting is just the first phase of RegentSM. RegentSM is the first Otolaryngology Clinical Data Registry and will be growing to include measures covering the depth and breadth of the specialty. In the future and as measures are added, Members will be able to engage with RegentSM data for research, quality improvement, and meeting Maintenance of Certification and licensure needs. If your practice or institution cares about defining quality in practice and documenting the value of the care you provide, then you need to become part of RegentSM, even if you don’t need to report for PQRS.
Finding joy in what we do

Lawrence M. Simon, MD, Vice-chair, BOG Socioeconomic & Grassroots Committee

This month, the Bulletin addresses health policy and the budget—two subjects that always bring a smile to physicians’ faces. No doubt, the ever-present consternation over coding, reimbursement, HIPAA, regulatory changes, and the myriad other obstacles that we face on a daily basis can sometimes make us wonder why we ever chose to do this for a living. Well, if you feel this way, you are not alone, as multiple articles on physician burnout now populate blogs, traditional media, and even medical journals.

In December 2015, the Mayo Clinic published an update to its 2011 study on physician burnout. The results are staggering: 54.4 percent of physicians report burnout; 44.5 percent report work/life imbalance; 39 percent feel symptoms of depression; and 7.2 percent report suicidal ideation. Clearly, a lot of us are struggling. Many physicians attribute this struggle to the increasing regulatory burden, and there is truth to this. For while it is unclear if we are working longer hours than our predecessors, we are clearly spending fewer hours caring for patients and more hours dealing with administrative tasks that do not bring any satisfaction.

Unfortunately, these regulations are likely not going anywhere soon. Therefore, we must reflect on how we can still find joy both in our practices and in our lives in general. This can be surprisingly easy. First, we ought to remember how wonderfully joyful it is to be a physician. Our occupation provides an intellectually stimulating environment with opportunities for lifelong learning. Additionally, even with changes in reimbursement, we remain among the highest paid professionals in the country.

Lastly, almost everyone that we come across on a daily basis will be better off for having interacted with us. Think about that—almost everyone we see every day will be better because they saw us! How many other people can say that about their jobs?

After finding joy in our practices, it is then time to find joy outside of our practices. To accomplish this, we must each learn what is important to us, and then work to involve ourselves in such endeavors. We all need something outside of our practice to bring us additional fulfillment—to remind us that we are part of something bigger. It could be anything from coaching the soccer team, to playing golf, to volunteering in a soup kitchen. For me, these things have been volunteering for the Academy and helping my wife run our Animal Rescue Foundation. The point is for each of us to learn what makes us happy—what brings us joy—and do it for ourselves.

In conclusion, increasing regulatory burdens provoke frustrations that run deeply in all of us. However, they can also unify us, and while reading this issue of the Bulletin, I hope that we can all remember two things. First, our profession remains pretty great. Second, there is life to be lived outside of our medical practices. If we can remember these two things, regardless what comes our way, we will continue to find joy.

Almost everyone that we come across on a daily basis will be better off for having interacted with us. Think about that—almost everyone we see every day will be better because they saw us! How many other people can say that about their jobs?

Lawrence M. Simon, MD
Vice-chair, BOG Socioeconomic & Grassroots Committee
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AAO-HNSF
ANNUAL MEETING & OTO EXPO™
SEPTEMBER 18-21, 2016
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Register now at www.entnet.org/annual_meeting
Proposed fiscal year 2017 combined budget

The Executive Committees (ECs) were presented with the Finance and Investment Subcommittee (FISC) proposed budget for the next fiscal year, July 1, 2016–June 30, 2017 (FY17), and endorsed it for approval by the BODs. During their April meeting, the BODs reviewed and conditionally approved the FY17 budget that is presented here for our membership.

Budgeting for FY17 represents the collaborative work of both the staff leadership and the Members of the FISC to develop a balanced combined AAO-HNS/F budget. The debt covenants of AAO-HNS/F require a balanced budget whereby total revenue is sufficient to meet all operating expenses plus the next year’s debt service principal payment. The proposed FY17 budget is structured to meet these compliance requirements, the strategic plan goals of the AAO-HNS/F, and continue to provide member services in the most effective and efficient way possible.

In early spring, the FISC reviewed financial results for the first six months of the FY16 budget year showing that a favorable variance, as compared to budget, is projected for the year.

**FY17 budget highlights**

The FY17 balanced budget is proposed at $19.15M and prioritizes the direction of the BODs. Development of RegentSM, the ENT clinical data registry, continues to be a strategic priority and significant area of budget resources. The BODs previously approved up to $3M of reserves for RegentSM start-up costs of which $2M was budgeted for use in FY16 and $553K is budgeted for use in FY17.

Starting in FY17, dividend and interest income will be credited directly to reserves. This change supports the AAO-HNS/F strategic goal of ensuring long-term sustainability by focusing our investment portfolio on long-term growth rather than generating cash flow for operations.

The decrease in the amount of reserves used for the registry, plus the change in accounting for dividend and interest income, accounts for the majority of the difference between the FY16 and FY17 revenue budgets. No change in membership dues is proposed. Annual Meeting revenue is budgeted to be consistent with the prior year budget and continue the change made in 2015 to provide Instruction Courses at no additional cost.

The expenses for the AAO-HNS/F are separated below into two areas.

Direct Operating Expenses include costs directly related to carrying out the priorities of the strategic plan and ongoing mission-related programs. Two areas with notable changes in resource use for FY17 are Meetings and Education. Costs to hold the 2016 Annual Meeting & OTO EXPO in San Diego will be significantly more than the costs of the prior year’s Dallas meeting. City selection is made years in advance and, in addition to cost, takes a number of factors into consideration. Also, education printing and production costs are budgeted to decrease as the Home Study Course moves to include an online format option.

The direct costs of RegentSM are funded by reserves and budgeted to be significantly less than the prior year. With the registry project now underway, we are able to better estimate actual costs to be incurred on an annual basis. Research grants awarded by AAO-HNS/F remain approximately equal to the prior year budget. However, a $130K grant previously funding data collection is not budgeted for FY17 as this need will be met through use of RegentSM.

Allocated Costs relate to staffing and benefits as well as the operating costs that are incurred for the good of the whole organization, such as occupancy and building-related expenses, and organization-wide HR, Financial, and IT costs. In total, these costs are budgeted to be less than the prior year, due to elimination of certain staff positions and operational efficiencies incorporated over the past several years.

The complete budget is available to any Academy Member who requests it in writing. Email requests to Carrie Hanlon, CPA, Senior Director, Financial Operations to chanlon@entnet.org.

### AAO-HNS/F Combined Budgets

<table>
<thead>
<tr>
<th>Revenue</th>
<th>Approved Budget FY16</th>
<th>Proposed Budget FY17</th>
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</thead>
<tbody>
<tr>
<td>Membership Dues</td>
<td>$6,855,000</td>
<td>$6,850,000</td>
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<tr>
<td>Meetings</td>
<td>6,901,000</td>
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<tr>
<td>Products &amp; Program Sales</td>
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<td>1,693,000</td>
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<td>Royalties</td>
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<td>Corporate &amp; Individual Support</td>
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<td>825,000</td>
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<td>Dividends and Interest</td>
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<td>0</td>
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<tr>
<td>Miscellaneous</td>
<td>140,500</td>
<td>128,000</td>
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<tr>
<td>Funds Released from Restrictions</td>
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<td>581,500</td>
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<tr>
<td>Funds Designated for Data Registry</td>
<td>2,000,000</td>
<td>553,500</td>
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<tr>
<td><strong>Total Revenue</strong></td>
<td><strong>$20,861,800</strong></td>
<td><strong>$19,151,000</strong></td>
</tr>
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<table>
<thead>
<tr>
<th>Direct Operating Expenses</th>
<th>Approved Budget FY16</th>
<th>Proposed Budget FY17</th>
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</thead>
<tbody>
<tr>
<td>Meetings</td>
<td>$1,603,000</td>
<td>$2,104,000</td>
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<tr>
<td>Printing &amp; Production</td>
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<td>485,000</td>
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<td>Travel</td>
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<td>Connectivity &amp; Software</td>
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<td>381,600</td>
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<td>Office Expenses</td>
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<td>336,000</td>
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<tr>
<td>Grants</td>
<td>664,300</td>
<td>503,500</td>
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<tr>
<td>Consultants &amp; Professional Fees</td>
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<td>2,706,900</td>
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<tr>
<td>Data Registry Support</td>
<td>2,000,000</td>
<td>553,500</td>
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<tr>
<td><strong>Total Direct Operating Expenses</strong></td>
<td><strong>$8,871,000</strong></td>
<td><strong>$7,587,300</strong></td>
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<table>
<thead>
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<th>Allocated Costs</th>
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<tbody>
<tr>
<td>Salaries &amp; Benefits</td>
<td>8,939,400</td>
<td>8,612,600</td>
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<tr>
<td>Occupancy</td>
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<td>1,555,000</td>
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<tr>
<td>Shared Support</td>
<td>1,468,400</td>
<td>1,396,100</td>
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<tr>
<td><strong>Total Allocated Costs</strong></td>
<td><strong>$11,990,800</strong></td>
<td><strong>$11,563,700</strong></td>
</tr>
</tbody>
</table>

| Total Expenses            | **$20,861,800**       | **$19,151,000**      |
How to write a business plan

Brian J. McKinnon, MD, MBA; Selena Heman-Ackah, MD, PhD, MBA; Ken Kazahaya, MD, MBA; and C. Anthony Hughes, MD, MBA, MPH

Many years ago, one of the authors came across the book, *Handbook of Law Firm Mismanagement*, a tongue-firmly-in-cheek exposé on the business of a learned profession. The real lesson of the book is the need for the professional to know and understand the applicable business principles to ensure that services provided can be self-sustaining and economically viable. As otolaryngologists, we are keenly aware of institutions that have provided great service to our profession that, however, have struggled or failed economically despite their great success in research and clinical care. Their stories are a reminder that the elements for achieving clinical excellence do not end at the exam room door.

One key business activity is the preparation of a business plan. Writing a business plan provides a process to assess the viability of a potential new service or product, or expansion of a current service. A well-written business plan may also help guide a company after its launch, especially if the direction becomes unclear. During the AAO-HNS/F 2016 Leadership Forum & BOG Spring Meeting, we introduced the audience to the process of developing a business plan, using their formal business education and personal experiences in the public and private sector.

The groundwork for a business plan includes an in-depth evaluation of an opportunity or concern the project is to address—identifying stakeholders, assessing the impact of the opportunity or concern on each stakeholder, and the manifestations of the opportunity or concern. Any previous attempts at addressing the opportunity or challenge should be reviewed for lessons learned. Evaluation of organizational resources will reveal what is available internally, and what may be needed externally to address the opportunity or concern.

Assessment of the organization’s strengths and weaknesses in regard to its ability to be effective or take advantage of a particular opportunity is of central importance. This is often referred to as a SWOT analysis, an acronym referring to its four components: strengths, weakness, opportunity, and threats. While seeming simplistic, this analysis requires objective, often brutal honesty. When done well it will markedly improve the quality of the business plan, and the likelihood of success.

Elements of a business plan typically include: the Executive Summary, company description, organizational structure, product details, market analysis, marketing/sales strategy, and financials/funding. The Executive Summary, written last, should include a mission statement, experience/background of the key individuals, summaries of market analysis, target market, and future plans. The company description and organizational structure provides a clear picture of the company’s abilities and weakness, helps organize information, and provides an accurate assessment of the company’s ability to take advantage of an opportunity and/or effectively counter a threat. Product details and market/sales analysis and strategy provide the background for the need or desire for a product or service, and the likelihood that an action will succeed in achieving the desired results. Growth strategy and funding/financials provide for planning the monetary needs that will be demanded to achieve the proposed plan.

Presenting and executing the plan is the culmination of the research and writing of the plan. The “elevator pitch” is the succinct telling of the business plan’s key elements, why it is important, and how the listener can contribute. The written plan should be professional, typed, and edited. A cover letter should be included, giving readers a very concise picture of the proposal and why they should support your plan. The goal is to interest and inspire, with the hope of gaining the opportunity of a more detailed presentation. Executing the plan is a cyclical process, requiring the stakeholder to engage in a constant and active process of re-evaluation to incorporate lessons learned and ensure that the goals of the business plan remain achievable and rewarding.

The writing of the business plan does take time and patience to learn; learning to do so effectively will go a long way toward improving our care and our profession.
My mini-MBA

Peter M. Vila, MD, MSPH, Vice-chair, Section for Residents and Fellows-in-Training (SRF), Washington University School of Medicine, St. Louis, MO

As vice-chair to the Section for Residents and Fellows-in-Training (SRF), I was very lucky to be able to attend the 2016 AAO-HNS/F Leadership Forum & BOG Spring Meeting in Alexandria, VA, and benefit from the wonderful mentorship and wisdom being passed along to all the residents and fellows in attendance.

The overall focus of the meeting was on developing leadership in otolaryngology, or as Board of Governors (BOG) Chair David R. Edelstein, MD, put it, a “mini-MBA.” The day began with a panel on developing a long-term career plan, followed by an informative and energizing speed-mentoring session. Admiral Christine S. Hunter, MD, then delivered a keynote speech, “Leadership in Large Organizations,” focusing on her experience in the U.S. Navy and the federal government. She shared some key lessons that she picked up along the way, making sure to impart on the audience that ambition and a willingness to speak up are helpful in securing leadership roles. Through her past stories of being “outspoken,” she described how those experiences later led to her being awarded leadership roles where she was able to carry out her vision, while adapting to the environment around her. The rest of the day featured panels on marketing with social media, managing online reviews, crafting a business plan, and the nuts and bolts of the Board of Governors, culminating with a panel of Academy leaders on how to navigate leadership challenges in medicine.

To me, the meeting overall conveyed the sense that perhaps otolaryngologists should be more involved in leadership roles, and that there are specific tools available to us that might help us attain those goals. Pursuing an MBA might be helpful, but certainly not necessary. There are elements from the MBA curriculum that we can teach ourselves, such as developing a business plan, understanding one’s leadership style, and adapting to different group environments and cultures. I left Alexandria feeling energized and hopeful that the future of otolaryngology is bright, and hope that we as a specialty can take charge of our careers by pursuing more leadership roles in the future.

Pursuing an MBA might be helpful, but certainly not necessary. There are elements from the MBA curriculum that we can teach ourselves.
Hosakere K. Chandrasekhar, MD

Hosakere K. Chandrasekhar, MD, is a clinician-academic, thoroughly dedicated to patient care and resident education, who has overcome the barriers of being foreign-trained and brown-skinned with his encyclopedic knowledge of otolaryngology, his generosity with that knowledge, and his respectful care of patients. This citation is given to him in honor of his many contributions to otolaryngology and his unfailing support of others.

How do I thank my father, who was also my professor in residency, who was also my temporal bone dissection partner, and who is also my scientific collaborator, for always believing in me and always believing that I could do anything I set my mind to? Dr. Hosakere K. Chandrasekhar is a brilliant otolaryngologist, outstanding temporal bone histopathologist, patient and thorough teacher, and wonderful mentor. He is also a major leader in the Indian-American community, serving as the New York City Mayor and State Governor’s Ethnic Liaison for Indian-American affairs, spearheading the erection of the iconic statue of Mahatma Gandhi in New York City’s Union Square Park, leading both our native language society and the Federation of Indian Associations, as well as the Hindu Temple Society of North America. He was honored with India’s Hind Rattan Award, the highest honor that India gives to its expatriates, and with our Academy’s Jerome C. Goldstein, MD Public Service Award. He and my mother, Dr. Sree Devi Chandrasekhar, are patrons of the arts, hosting the highest caliber of musicians, poets, and playwrights in our home for chamber performances, and bringing Kannada drama to life in the United States.

I was born when my parents were doing their house-surgeries in otolaryngology and pediatrics, respectively, in England. They were brave enough to send me to India with an air hostess when I was three months old, and didn’t see me again until I was two. Three years later, our little family of four moved to the U.S. on my mother’s coattails, as she had secured a fellowship in adolescent medicine at what is now Children’s National Medical Center. A year later, we moved to New York City where my parents had to redo their residencies and establish their practices while raising three rambunctious little girls. Education, arts, and community service were always the priorities in our house. I did my residency at NYU, where my father is a professor, and did my research rotation in his temporal bone histopathology lab. It was the most wonderful experience I can imagine, even though he knew every time I did something wrong, which was, unfortunately, not that rare! One of his most important legacies is to be found in the halls of our Annual Meeting convention center, where we always encounter his former students, all of whom adore him. Another is the fantastic relationships he has with each of his 10 grandchildren.

I attended my first AAO-HNSF meeting tagging along as a resident with my father, in San Diego. This many years later, it is an indescribable feeling to be able to honor this man who has so shaped who I am, what I believe in, and how I live my life, with this Presidential Citation.
Karen Jo Doyle Enright, MD, PhD

Karen Jo Doyle Enright, MD, PhD, embodies the complete person that we all aspire to be. Karen Jo is not only a leader in otolaryngology, but has actively encouraged others up into their leadership positions. This citation is given to Karen Jo Doyle Enright, MD, PhD, in recognition of her selfless work to advance our specialty and her generous and enduring friendship.

Karen and I overlapped as fellows. Initially a wonderful PhD audiologist, she went on to medical school and became a star resident and otology and neurotology fellow at the House Ear Clinic. She had been an audiologist there prior to going to medical school, so she knew the lay of the land. She found me at the Boards before I got to the clinic, and befriended me immediately. Once I had been there for a month or so, she saw I was looking lost—LA is most definitely not New York—and she organized an evening out for us along with two other House women, a senior statistician and audiologist. I was transported to off-off Broadway and my homesickness was quashed.

The House Ear group had never had two female fellows simultaneously before us. Somehow the “nice” Japanese-Irish woman and the “nice” Indian woman showed them who we really were—and the Institute stayed standing! Her academic career in the University of California system spanned decades of meaningful research on childhood hearing loss, mentoring medical students and residents, and leadership in national otology. That continues now in Michigan where another group of patients and residents benefit.

Lauren S. Zaretsky, MD

A busy private practice otolaryngologist, physician practice manager, wife and mother of three, and strong leader in the AAO-HNS, Lauren S. Zaretsky, MD, makes “having it all” look effortless. This citation is given in honor of her exacting and tireless work on behalf of Academy Members worldwide, and her frank and honest nature.

Lauren is the ultimate in private practice otolaryngology. She and her husband, Lee M. Shangold, MD, have been in practice together since completing their training. They have three wonderful, creative, funny children. Lauren claims that she was in part-time practice, but I could always find her at the office or in the hospital making rounds on weekends. She not only does the breadth of otolaryngology, but she ran the business end of their five-person practice for years. When Members ask me how they can possibly participate at the Academy when they are in private practice, I just show them a picture of Lauren. She served on the Board of Directors for years, and came to every meeting thoroughly prepared, having read all of the materials and using her sharp memory to keep the Academy and Foundation on the right path. She was chair of the Ethics Committee when our Code of Ethics was rewritten, a prodigious feat that serves all of us very well. Her contributions on the Nominating Committee as Ethics Chair have made our Academy stronger for years to come. Lauren was part of the active conversion of the Women in Otolaryngology Committee to a section, and has remained in a very important advisory role there. She unfailingly attends local and regional scientific programs, every AAO-HNSF Annual Meeting, and is a leader in the Long Island Society of Otolaryngology. She currently works with ENT and Allergy Associates there.

An aspect of Lauren that you might not glean from her CV is that she is an outstanding consigliere. I heard once that when you speak your dreams, they become goals. A few years ago, I whispered to Lauren and to the late Linda Brodsky that I thought I’d like to become Academy President. Boom! They turned that right into a goal. Their advice and encouragement, both when I was feeling confident and especially when I was hesitant, allowed me to lay out my rationale and my plan. With friends like Lauren, it’s hard to go wrong. I am delighted to be able to present my friend and a true otolaryngology leader, Dr. Lauren Zaretsky, with this Presidential Citation.
The Presidental Citations are given to individuals who have had a profound influence on the AAO-HNS/F president’s life and otolaryngology. President Sujana S. Chandrasekhar, MD, has selected the following individuals for their outstanding contributions and dedication to the Academy and Foundation.

John W. House, MD, on behalf of the Associates of the House Ear Institute and House Clinic

The House Ear Institute and House Clinic (HEI/HEC) are synonymous with the best in otology and neurotology clinical excellence, research, and education. The motto, “so that all may hear” translates to a generosity of spirit in sharing not just knowledge but reasoning, in order to spread outstanding ear care around the world. This citation is given to the Associates of the HEI/HEC to acknowledge their myriad contributions to advancement of otology and neurotology worldwide, and as a personal form of great gratitude from me to them for sharing their wisdom with me and for always supporting me in my career.

I met the HEI/HEC associates first when I interviewed there for a fellowship position. They were gracious and generous to a visiting resident, and once I got in, I was made to feel like a part of the team. The expectations were high, as were the rewards. The laughs were plentiful, even in such a serious place. John W. House, MD, joked with me about my facial reaction after meeting his beautiful, elegant wife, Barbara. He said, “You didn’t think I could get someone like her, did you?” He introduced me to the best French dip sandwich at the train station; I introduced him to my “New Yawk” accent. Howard P. House, MD, told wonderful stories of what it really means to be a physician: being compassionate, taking care of the whole patient and his or her family, and maintaining a healthy sense of humor.

Ralph A. Nelson, MD, was the cool guy who came and went on a motorcycle or in a sports car. He had that je ne sais quoi of an ex-Navy man who shrugged off the fact that he had penned the world authority lab manual on temporal bone dissection.

Back then, Donald E. Brackmann, MD, was nearly double my age and had four times the energy, every single day. He could do four acoustic neuroma operations, throw in some chronic ears, tell some really funny jokes, and be ready to go home by 7 pm.

James L. Sheehy, MD, (Jim) played his big band music so loudly in the operating room that I could barely hear myself think, and had to shout around the microscope to the scrub nurse for instruments. He’d say, “Chandrasekhar, let me know if the music is too loud … and I’ll turn it up!” At the end of a busy day, we’d go up to his office where he’d have a beer, I’d have a soda, and he would go over every single patient we saw that day in detail, no matter how late it was. William E. Hitselberger, MD, (Bill) cursed constantly—but only at himself—and took wonderful care of the patients and the fellows, letting us do as much neurosurgery as we were capable of. Antonio A. De La Cruz, MD, took me under his wing. He and his patients from all over the world put up with my New York Spanish, and he allowed me to accompany the team on a surgical trip to Costa Rica that I will never forget. He always had a horde of visitors in the OR—so he would explain every step of every surgery in English, Spanish, French, Portuguese, and Italian. Thus I got to hear each explanation five times! I miss those three men so very much.

M. Jennifer Derebery, MD, embodied then, and embodies now, the idea that we can have it all. She is a brilliant physician, a to-the-point leader, a wonderful wife and mother, and effortlessly elegant. I remember how proud I felt when she broke the gender barrier as the first female president of the AAO-HNS/F.

The House Ear Associates adopted me as one of their own. I have never felt as comfortable and homey in any other professional setting. Each one is generous with their knowledge. I never had to memorize anything, as every step and thought had reasoning behind it, which they shared openly. They believed in me, and still do, and I am eternally grateful to them for their friendship, their tutelage, and their guidance. It is an honor for me to be able to recognize them with this Presidential Citation.
Mae Jemison, MD, will launch Annual Meeting

Mae Jemison, MD, will inspire attendees at the Opening Ceremony of the AAO-HNSF 2016 Annual Meeting & OTO EXPO™ with stories of her adventures in space and achievements in medicine and science. Dr. Jemison, a former NASA astronaut and the first woman of color in the world to go into space, is an engineer, physician, and educator.

During her six years at NASA, Dr. Jemison flew aboard the Space Shuttle Endeavour, STS-47, a cooperative mission between the United States and Japan, and served as NASA’s first Science Mission Specialist performing experiments in material science, life science, and human adaptation to weightlessness.

“I am delighted to introduce Dr. Jemison as our keynote speaker. Her dynamic background in space travel and medicine will energize all who hear her story,” said Sujana S. Chandrasekhar, MD. “As healthcare professionals, we can all appreciate her message of determination and scientific advancement.”

Prior to working at NASA, Dr. Jemison earned her medical degree from Cornell University, completed her residency at the University of Southern California, and practiced general medicine in Los Angeles. She served as an Area Peace Corps Medical Officer for Sierra Leone and Liberia, and oversaw the healthcare system for the Peace Corps and the State Department in Sierra Leone.

She is currently leading 100 Year Starship (100YSS), an initiative seed funded by DOD’s Defense Advanced Research Project Agency (DARPA) to assure the capability for human interstellar space travel to another star is possible within the next 100 years. She also is the founder and president of two medical technology companies and the Dorothy Jemison Foundation for Excellence.

Dr. Jemison is a member of the National Academy of Sciences’ Institute of Medicine, and serves on several boards of directors, including the Texas Medical Center. She is an inductee of the National Women’s Hall of Fame, the National Medical Association Hall of Fame, and the Texas Science Hall of Fame. She has received the National Organization for Women’s Intrepid Award, the Kilby Science Award, and in 1999 was selected as one of the top seven women leaders in a presidential ballot national straw poll.

The Opening Ceremony will take place Sunday morning during the AAO-HNSF Annual Meeting & OTO EXPO™, September 18-21, in San Diego, CA. This is an Opening Ceremony that no one will want to miss.

“If September 1992, while I was biting off the last of my nails before my Boards exams, Dr. Jemison was conducting microgravity investigations in materials and life sciences on the Space Shuttle Endeavour. She is truly a remarkable person, and I hope you all attend the meeting and feel inspired by her experiences and character,” Dr. Chandrasekhar said.
Polaris Medical Group-ENT, LLC, in Atlanta, GA, is owned by Academy Member Lisa C. Perry-Gilkes, MD. As a solo private practitioner, Dr. Perry-Gilkes (above, third from left) employs four full-time staff members and one part-time.

“I saw three kids with nosebleeds yesterday, and then three older people with tinnitus. I am a general ENT. I treat neonates to my oldest patient who is 103—whatever walks through the door,” Dr. Perry-Gilkes says cheerfully.

Her positivity radiated through the phone in an interview with Bulletin staff.

“I like being a specialty of small dark holes. I like the technical part—the amazing changes you can make in someone’s health and life through little tiny holes, no huge incisions. I like that we still have nonsurgical parts of our practices, and I love seeing a wide range of patients. Maybe it’s because I just like people,” she chuckles, “I’m kind of chatty myself. I think of my office as my house. I welcome you—the patient—into my home. I want you to be comfortable. You’re an invited guest. I want you to have a good time, and the ultimate goal is for me to make you feel better.”

Dr. Perry-Gilkes grew up in the Midwest, and says she sometimes feels like she is in a Tennessee Williams play or Truman Capote novel living in the South. She insists, “Some of my patients are absolutely, positively wonderful. One patient can make you forget all about the trials and tribulations—one grateful patient can just make your whole day or even your whole week.”

What are some of the challenges she faces as a private practitioner?

“Oh baby, I could write you a book!” Dr. Perry-Gilkes said. “The investment, of course. The cost of doing business. My lease is ridiculous. And finding competent employees is a challenge.” One of her best employees was in her 60s, but recently resigned. Another top employee that she tells us about is in her 70s. “She is amazing. Do you remember “The Golden Girls”? I have Blanche Devereaux in my office, in charge of collections. She used to be a patient of mine and she could make me do just about anything, so one day I thought to myself, how about getting her to call these people? She’s as sweet as pie, but she can get blood from a stone.”

With her office located 10 minutes from the Hartsfield-Jackson Atlanta International Airport, Dr. Perry-Gilkes doesn’t peak marketplace. She is in a middleclass
Yes, it’s an investment but the dues pay for themselves if you take advantage of what the Academy offers. For example with PQRS [Physician Quality Reporting System], they either earned you $2,000 or saved you a huge fine. That pays for your dues right there.

Lisa C. Perry-Gilkes, MD

Local, national collaboration benefits Members

Dr. Perry-Gilkes appropriately highlights the essential nature of collaboration among all levels of organized medicine. Optimal results are most likely obtained when organizations synergize their resources and take advantage of their respective areas of expertise and influence to solve complex problems. The Academy participates in a number of coalitions both national and local that deal with legislative and regulatory issues, public health initiatives, patient care issues, and humanitarian opportunities.

The Academy works closely with national organizations such as the American College of Surgeons, the American Medical Association, national specialty societies within otolaryngology, and consumer advocacy groups, as well as state and local medical societies to represent the interests of our Members and their patients.

A key ingredient to the success of this system is the knowledge that there is some matter that is affecting our Members’ ability to practice the type of medicine that benefits their patients most. The Board of Governors, particularly those participating in PROJECT 535 and the AAO-HNS State Tracker programs, is an essential pipeline of information that alerts us when action is needed. The earlier that the Academy knows of a problem, the more likely we will be able to intervene in a meaningful fashion.

Some recent examples of collaborative efforts include successful modification of the policy regarding providers of allergy service for Texas Medicaid patients, advocacy on the USP 797 proposal that would alter the way immunotherapy vials are prepared, and recent comments on a Federation of State Medical Boards (FSMB) resolution that would affect compounding of medicines in physician offices.

Activities such as these are critical for the day-to-day practice of medicine for our Members and will continue to be emphasized in the future.
Crossing the payment bridge

Long-awaited post-SGR payment is here

On April 27, 2016, the Centers for Medicare & Medicaid Services (CMS) released the long-awaited replacement for the Sustainable Growth Rate (SGR) as the payment system for physicians participating in Medicare: the Merit-based Incentive Payment System...
Crossing the payment bridge (MIPS) and Alternative Payment Model (APM) programs. Although the rule will not be finalized until later this year, it is important for physicians to become familiar with many of the concepts and new terminology that accompany the new payment models.

**Merit-based Incentive Payment System**

Under the new MIPS program, starting January 1, 2017, physicians will report on four categories that add up to a composite score, which CMS will use to determine whether or not Eligible Clinicians (ECs), including most otolaryngologist-head and neck surgeons, receive a bonus payment or are subject to a payment reduction for 2019 payments. The graphic at right, courtesy of CMS, provides a broad explanation of the four categories ECs will begin reporting in 2017.

**Alternative Payment Models**

ECs may be exempted from the MIPS program if they participate in a CMS-defined Advanced APM. An Advanced APM requires participants to use certified EHR technology; provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of MIPS; and be either an expanded Medical Home Model or bear more than a nominal amount of risk for monetary losses. The Academy expects otolaryngologist-head and neck surgeon participation in Advanced APMs to be low due to the strict eligibility criteria.

Some ECs may participate in a MIPS APM to receive bonus points and alternative scoring criteria for the MIPS program. MIPS APMs are participants of CMS-defined APMs, such as a Track 1 Accountable Care Organization, that do not meet Advanced APM criteria.

For a more detailed outline and further explanation of the reporting criteria for the MIPS and APM programs, please see the Academy’s summary on page 22. Members can also access more detailed information on the MIPS and APM programs at www.entnet.org/content/physician-payment-reform.

**Categories for Reporting**

- **COST**
  - 10 percent of total score in year 1; replaces the cost component of the Value Modifier Program, also known as Resource Use
  - The score would be based on Medicare claims, meaning no reporting requirements for clinicians. This category would use more than 40 episode-specific measures to account for differences among specialties.

- **QUALITY**
  - 50 percent of total score in year 1; replaces the Physician Quality Reporting System and the quality component of the Value Modifier Program
  - Clinicians would choose to report six measures versus the nine measures currently required under the Physician Quality Reporting System. This category gives clinicians reporting options to choose from to accommodate differences in specialty and practice.

- **CLINICAL PRACTICE IMPROVEMENT ACTIVITIES**
  - 15 percent of total score in year 1
  - Clinicians would be rewarded for clinical practice improvement activities focused on care coordination, beneficiary engagement, and patient safety. Clinicians may select activities to match their practice goals from a list of more than 90 options. In addition, clinicians would receive credit in this category for participating in Alternative Payment Models and in Patient-Centered Medical Homes.

- **ADVANCING CARE INFORMATION**
  - 25 percent of total score in year 1; replaces the Medicare EHR Incentive Program for physicians, previously known as “Meaningful Use”
  - Clinicians would choose to report customizable measures that reflect how they use electronic health record (EHR) technology in their day-to-day practice, with a particular emphasis on interoperability and information exchange. Unlike the existing Meaningful Use program, this category would not require all-or-nothing EHR measurement or quality reporting.
Academy updates CPT for ENT articles

As part of a process to continue to provide the most up-to-date resources for our membership, Academy CPT experts have begun to reevaluate and update the Academy’s list of CPT for ENT articles.

CPT for ENT articles are a collaborative effort among the Academy’s team of CPT Advisors, Members of the Physician Payment Policy (3P) Workgroup, and health policy staff. Articles are developed to address common coding questions received by this health policy team as well as to clarify coding changes and correct coding principles for frequently reported ENT procedures. These updated articles help the Academy to provide Members with the latest coding resources.

These are the recently updated CPT for ENT articles: Transtympanic Therapeutic Injections and Laryngoscopy.

All updated CPT for ENT articles can be found at www.entnet.org/content/cpt-ents as part of the Academy’s Coding Corner.

In addition to CPT for ENT articles, the Academy’s Coding Corner offers access to AMA CPT Assistant articles, annual code change summaries, an updated annual list of the top 100 ENT billed services, template appeal letters, ICD-10 coding resources, and information on Centers for Medicare & Medicaid Services quality initiatives and reporting programs.

All of these resources can be found at the Academy’s Coding Corner (www.entnet.org/content/coding-corner).

Meaningful Use hardship exception application due July 1

The Centers for Medicare & Medicaid Services (CMS) extended the application deadline in February 2016 for the Medicare EHR Incentive Program hardship exception process. The deadline for Eligible Professionals, Eligible Hospitals, and Critical Access Hospitals is Friday, July 1, 2016, by 11:59 pm ET.

If a provider cannot attest for a 2015 reporting period or believes her or his attestation may be unsuccessful, the provider may apply for a hardship exception to avoid the payment adjustment in 2017. For more information on which sub-category to file under, see CMS FAQ 12845 (www.entnet.org/CMS/FAQ-12845).

CMS does not require a provider or group of providers to submit documentation for this or any other hardship category selected and CMS will not be reviewing documentation supporting the application on a case-by-case basis. CMS will review the application to record the category selected and use the identifying information to approve the hardship exception for each provider listed on the application.

You can send the application via email to ehrhardship@provider-resources.com or fax in an application to (814) 456-7132. The application and instructions can be found at www.entnet.org/content/electronic-health-records-ehr-and-meaningful-use.

Academy develops ICD-10 FAQs

ICD-10 has been in effect as of October 1, 2015. The Academy is dedicated to helping our Members through the ongoing transition from ICD-9 to ICD-10. Based on Member inquiries the Health Policy Team received, the following two ICD-10 FAQs were developed in conjunction with the AAPC.

• General ICD-10 FAQ: questions on resources for the ICD-10 transition
• ICD-10 Private Payer FAQ: questions on how private payers are handling the ICD-10 transition

These FAQs were presented at the Spring Leadership Forum this past March, and are also available online on the Academy’s website at www.entnet.org/icd-10-coding-resources.
EDUCATION ELEMENTS THAT MEET YOUR LEARNING STYLE

AmW Annual Meeting Webcasts
In summer 2016, full audio recordings of the 2014 and 2015 Annual Meeting & OTO EXPO™ Education Program will be found in AcademyU®. This gives members and non-members an easy way to view recordings of the many great sessions and speakers who have presented. The 2016 Annual Meeting recordings will be available for Continuing Education credit.

AmX Annual Meeting Expert Series: Interview
New this year, the online Expert Series includes nineteen complete video recordings of select Annual Meeting sessions presented by key leaders in the field. They are chosen based on the critical and timely topics of great relevance to AAO-HNS Members. In addition to the video recordings, nine of the recordings include a special Expert Interview with the presenter conducted by Foundation Education leaders.

aQ AcademyQ™ CME
Enhance your knowledge of otolaryngology-head and neck surgery with 800 study questions to test your recall, interpretation, and problem-solving skills. Users are provided with instantaneous detailed feedback and they can highlight, take notes, and mark questions for future review.

PAC ENT for the PA-C Conference
Held annually, this conference is organized to provide advanced practice providers with an excellent and practical education opportunity. The program includes hands-on workshops to maximize learning as well as basic and advanced tracks on a variety of otolaryngology topics.

Pmp Patient Management Perspectives
Patient Management Perspectives allows the learner to manage a patient from presentation to discharge and follow-up. With an interactive question-and-answer self-assessment format. Each topic includes clinical cases study, detailed patient management summaries, references for further study, and a self-assessment.

Co COOL™
Written and peer-reviewed by otolaryngology experts, COOL™ cases are interactive patient scenarios that prepare the learner for a variety of common otolaryngologic situations. COOL™ is an engaging learning experience for PCPs, APPs, medical students, and any healthcare professional who encounters otolaryngologic cases.

PWS Pediatric OTO Webinar Series
Pediatric Otolaryngology Webinars, co-produced by the American Society of Pediatric Otolaryngology (ASPO) and AAO-HNSF, offer talks presented by expert faculty on pertinent pediatric otolaryngology topics relevant to the practicing pediatric and general otolaryngologist.

COOL™
Clinical Fundamentals Satisfy the American Board of Otolaryngology’s Clinical Fundamentals requirement for Part III of Maintenance of Certification (MOC) by viewing the online recordings of Clinical Fundamentals sessions held at the Annual Meeting on subjects common to all otolaryngologists regardless of their practice focus. Residents and medical students may also find these useful.

eB eBooks
The Foundation offers a number of eBooks as education resources for otolaryngologists, residents, medical students, and other healthcare professionals.

eL Online Courses
Online courses are self-paced learning activities developed through the Foundation education committees. These peer-reviewed courses provide in-depth study of critical otolaryngology-head and neck surgery topics.

The Online Lecture Series (OLS) offers quick and concise versions of top Annual Meeting sessions in an online format. The format includes the speaker’s presentation audio and slides, reference lists, and links to additional resources.

Hsc Home Study Course
One of the Foundation’s most popular education products, each section of the Home Study Course (HSC) brings you a compendium of select scientific articles, reference bibliography, self-assessment exam, and faculty symposia covering each of the eight otolaryngology specialty areas.

Xs ENT Exam Video Series™
This four-part video series is a great tool for teaching residents and medical students. This series, available on YouTube, depicts how to perform a thorough ENT Exam. Presented in four short episodes, it provides instruction on exams of the ear, oral cavity, face, nose, neck, nasopharynx, and larynx. All videos include images of normal anatomy, normal variances, and common abnormalities to enhance the learning experience.
On April 27, 2016, the Centers for Medicare & Medicaid Services (CMS) released the proposal for the long-awaited replacement for the Sustainable Growth Rate (SGR) as the payment system for physicians participating in Medicare: the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) programs. These two programs are key components of the new Quality Payment Program (QPP), which was created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Under the MIPS, starting January 1, 2017, physicians will report on four categories that add up to a composite score that CMS will use to determine whether or not Eligible Clinicians (ECs), including most otolaryngologist-head and neck surgeons, receive a bonus payment or are subject to a payment reduction in 2019 and beyond. According to the Brookings Institution: “Under the new MIPS program, physicians report to the government payer directly (CMS) and receive a bonus or penalty based on performance on measures of quality, resource use, meaningful use of electronic health records [now known as Advancing Care Information (ACI)], and Clinical Practice Improvement Activities (CPIA). The bonus or payment reduction physicians may see starts at 4 percent of the fee schedule in 2019 (based on their performance two years prior—in this case 2017) and increases successively to 5 percent in 2020, 7 percent in 2021, and...
New CMS payment system provides two paths for quality reporting: the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM)

MIPS
Under the MIPS, physicians will report on four different categories. Each category will count toward a final composite score, which is used to determine whether or not an EC is subject to a bonus payment or payment reduction. These bonuses and payment reductions escalate over the first few years of the program. In addition to the 4 percent to 9 percent bonus payments, top performing ECs may be eligible for additional bonus payments. Like the Physician Quality Reporting System (PQRS) and Meaningful Use programs, MIPS will use data reported two years prior to determine payment adjustments. For example, CMS will use data reported by ECs in 2017 to determine payment for 2019. For a more detailed look at the MIPS performance categories, including links to CMS informational materials, visit the Academy’s MIPS webpage at www.entnet.org/content/merit-based-incentive-payment-system.

Resource Use: 10 percent of composite score
The Resource Use category will replace the Value-based Modifier (VM) program and account for 10 percent of an EC’s composite score for the first year. CMS will use Medicare Spending per Beneficiary, 41 existing condition- and episode-based measures, and total per capita costs to calculate a resource use score, which will be adjusted for geography, beneficiary risk, and by specialty. The Resource Use score is determined using claims and does not require any reporting by ECs.

Quality: 50 percent of composite score
The quality category will replace the PQRS program and account for 50 percent of an EC’s composite score for the first year. ECs will report a minimum of six measures with at least one cross-cutting measure and one outcome measure, if available. If an outcome measure is not available, ECs can report one other high priority measure. MIPS ECs will be able to use a qualified registry, a qualified clinical data registry (QCDR) such as RegentSM, or an electronic health record (EHR) to report quality measures.

CPIA: 15 percent of composite score
CPIA (Clinical Practice Improvement Activities) is a new category under MIPS and accounts for 15 percent of an EC’s composite score for the first year. CPIA allows physicians to select from a list of more than 90 activities to receive credit for this category. ECs can report CPIA through a qualified registry, an EHR system, a QCDR such as RegentSM, the CMS web interface, and attestation data submission.

ACI: 25 percent of composite score
The Advancing Care Information component will replace the EHR Meaningful Use program and account for 25 percent of an EC’s composite score for the first year. MIPS ECs will report measures to form a base score and performance score. Unlike the all-or-nothing scoring in the Meaningful Use program, ECs can receive partial credit for the ACI portion of the MIPS composite score. ECs can use a qualified registry, EHR system, QCDR such as RegentSM, attestation, and CMS web interface submission methods to report ACI measures.

APMs
A small number of physicians are exempted from the MIPS by participating in an Advanced APM. Advanced APMs defined as those that meet criteria for linking payments to quality measures, using EHRs, and bear more than a nominal financial risk. Participants who meet the strict Advanced APM criteria would be eligible for a 5 percent bonus payment from CMS on top of any incentives built into the Advanced APM model. Current APMs that meet Advanced APM criteria are Track 2 &
Due to the restrictive Advanced APM definition, the Academy does not expect that many otolaryngologist-head and neck surgeons will be able to participate in the Advanced APM program for the first few years.

3 Accountable Care Organizations (ACOs), Next Generation ACOs, Comprehensive Primary Care Plus, and some Comprehensive End State Renal Disease Care Organizations.

In addition to Advanced APMs, there are several other APMs available to ECs including MIPS APMs, which provide more favorable MIPS composite scoring, and Physician-Focused Payment Models, which are submitted to the Physician-Focused Payment Models Technical Advisory Committee (PTAC). Due to the restrictive Advanced APM definition, the Academy does not expect that many otolaryngologist-head and neck surgeons will be able to participate in the Advanced APM program for the first few years. However, the Academy is working with the American College of Surgeons in addition to other stakeholders to evaluate and hopefully develop APMs that will help otolaryngologist-head and neck surgeons participate in Physician-Focused Payment Models, MIPS APMs, and hopefully Advanced APMs in the future. Members can access more information on APMs and the Academy’s efforts by accessing www.entnet.org/content/alternative-payment-models.

Academy staff and physician leaders are currently reviewing the extensive proposal and will advocate for continued progress toward a less burdensome reporting system that truly incorporates quality of care for patients into payment while still allowing for necessary reporting flexibility. Although the Academy believes the MIPS and APM programs are a start in the right direction, CMS can continue to work with otolaryngologist-head and neck surgeons to allow for the widest range of innovative ideas to ensure the greatest numbers of physicians are able to not only participate, but succeed in these future payment models. The Academy met with CMS in May and plans on submitting comments. Once submitted, the Academy will make these comments available to all Members. Members should look out for the comment letter in the News, HP Update, and on the Academy’s website at www.entnet.org/content/physician-payment-reform.

Due to the restrictive Advanced APM definition, the Academy does not expect that many otolaryngologist-head and neck surgeons will be able to participate in the Advanced APM program for the first few years.
As mandated by the Department of Health and Human Services (HHS), the ninth revision of the International Statistical Classification of Diseases and related health problems (ICD-9) was updated to the 10th revision (ICD-10). The required deadline for the transition from ICD-9 to ICD-10 has been effective since October 1, 2015. The Centers for Medicare & Medicaid Services (CMS) provide official resources that can support your organization and systems with the continuing ICD-10 transition. The following resources can help analyze, track, and improve your ICD-10 progress.

- **Assessment & Maintenance Toolkit**: [www.entnet.org/CMS/Assessment-Maintenance-Toolkit](http://www.entnet.org/CMS/Assessment-Maintenance-Toolkit)
- **Frequently Asked Questions on Medicare Fee-for-Service (FFS)**: [www.entnet.org/CMS/FAQs-Medicare-FFS](http://www.entnet.org/CMS/FAQs-Medicare-FFS)

You can also sign up for CMS ICD-10 email updates by registering at [www.entnet.org/CMS/Email-Updates](http://www.entnet.org/CMS/Email-Updates). Visit the Academy’s website for the latest ICD-10 news and other ICD-10 resources at [www.entnet.org/icd-10-coding-resources](http://www.entnet.org/icd-10-coding-resources).
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As of June 1, 2016

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WHAT IS LARYNGOPHARYNGEAL REFLUX

During gastroesophageal reflux (GER), the contents of the stomach and upper digestive tract may flow back (reflux) all the way up the esophagus, beyond the upper esophageal sphincter (a ring of muscle at the top of the esophagus), and into the back of the throat and possibly the back of the nasal airway. This is known as laryngopharyngeal reflux (LPR), which can affect anyone.

WHAT ARE THE SYMPTOMS OF LPR?
In adults the symptoms of LPR include a bitter taste, a sensation of burning, or something “stuck” in the back of the throat. Some patients have hoarseness, difficulty swallowing, a need for throat clearing, and the sensation of drainage from the back of the nose (“postnasal drip”). Some may have difficulty breathing if the voice box is affected. Many patients with LPR do not experience the symptom of heartburn associated with gastroesophageal reflux disease (GERD).

In infants and children, LPR may cause breathing problems such as cough, hoarseness, stridor (noisy breathing), asthma, sleep-disordered breathing, feeding difficulty (spitting up), turning blue (cyanosis), aspiration, pauses in breathing (apnea), apparent life-threatening event (ALTE), and even a severe deficiency in growth. Proper treatment of LPR, especially in children, is critical.

While GERD and LPR may occur together, patients can also have GERD alone (without LPR) or LPR alone (without GERD). If you experience any symptoms on a regular basis (twice a week or more), then you may have GERD or LPR. For proper diagnosis and treatment, you should be evaluated by your primary care doctor or an otolaryngologist-head and neck surgeon (ENT doctor).

WHO GETS LPR?
Women, men, infants, and children can all have LPR. These disorders may result from physical causes or lifestyle factors. Physical causes can include a malfunctioning or abnormal lower esophageal sphincter muscle (LES), hiatal hernia, abnormal esophageal contractions, and slow emptying of the stomach. Lifestyle factors include diet (chocolate, citrus, fatty foods, spices), destructive habits (overeating, alcohol and tobacco abuse), and even pregnancy. Young children experience GERD and LPR due to the developmental immaturity of both the upper and lower esophageal sphincters. It should also be noted that some patients are just more susceptible to injury from reflux than others. A given amount of refluxed material in one patient may cause very different symptoms in other patients. Unfortunately, LPR and GERD are often overlooked in infants and children, leading to repeated vomiting, coughing in GERD, and respiratory problems in LPR, such as sore throat and ear infections. Most infants grow out of GERD or LPR by the end of their first year, but the problems that resulted from the GERD or LPR may persist.

WHAT ROLE DOES AN EAR, NOSE, AND THROAT SPECIALIST HAVE IN TREATING LPR?
Laryngopharyngeal reflux is primarily treated by an otolaryngologist or ear, nose, and throat specialist. Symptoms related to LPR, including throat discomfort, laryngitis, hoarse voice, and airway or swallowing problems, are all conditions commonly treated by otolaryngologists. These problems require an otolaryngologist-head and neck surgeon, or a specialist who has extensive experience with the tools that diagnose GERD and LPR. They treat many of the complications of GERD and LPR, including: sinus and ear infections, throat and laryngeal inflammation and lesions, as well as a change in the esophageal lining called Barrett’s esophagus, a serious condition that can lead to cancer. Your primary care physician or pediatrician will often refer a case of LPR to an otolaryngologist-head and neck surgeon for evaluation, diagnosis, and treatment.

HOW IS LPR DIAGNOSED AND TREATED?
LPR (and GERD) can be diagnosed or evaluated by a physical examination and the patient’s response to a trial of treatment with medication. Other tests that may be needed include an endoscopic examination (a long tube with a camera inserted into the nose, throat, windpipe, or esophagus), biopsy, x-ray, examination of the esophagus, 24-hour pH probe with or without impedance testing, esophageal motility testing (manometry), and emptying studies of the stomach. Endoscopic examination, biopsy, and x-ray may be performed as an outpatient or in a hospital setting. Endoscopic examinations can often be performed in your ENT’s office, or may require some form of sedation and occasionally anesthesia.

Most people with LPR respond favorably to a combination of lifestyle changes and medication. Medications that could be prescribed include antacids, histamine antagonists, proton pump inhibitors, pro-motility drugs, and foam barrier medications. Some of these products are now available over the counter and do not require a prescription. Children and adults who fail medical treatment or have anatomical abnormalities may require surgical intervention. Such treatment includes fundoplication, a procedure where a part of the stomach is wrapped around the lower esophagus to tighten the muscle (sphincter), and endoscopy, where hand stitches or a laser are used to make the lower esophageal sphincter tighter.

LIFESTYLE CHANGES TO PREVENT LPR

- Avoid eating and drinking within two to three hours before bedtime
- Do not drink alcohol
- Eat small meals and eat slowly
- Limit problem foods: caffeine, carbonated drinks, chocolate, peppermint, tomato, citrus fruits, and fatty and fried foods
- Lose weight
- Quit smoking
- Wear loose clothing

ABOUT THE AAO-HNS The American Academy of Otolaryngology—Head and Neck Surgery (www.entnet.org), one of the oldest medical associations in the nation, represents about 12,000 physicians and allied health professionals who specialize in the diagnosis and treatment of disorders of the ears, nose, throat, and related structures of the head and neck. The Academy serves its members by facilitating the advancement of the science and art of medicine related to otolaryngology and by representing the specialty in governmental and socioeconomic issues. The AAO-HNS Foundation works to advance the art, science, and ethical practice of otolaryngology-head and neck surgery through education, research, and lifelong learning. The organization’s vision: “Empowering otolaryngologist-head and neck surgeons to deliver the best patient care.”

AMERICAN ACADEMY OF OTOLARYNGOLOGY—HEAD AND NECK SURGERY
The American College of Surgeons defines the intraoperative responsibility of the primary surgeon.

The American College of Surgeons has released a Statement on Principles on the responsibility of the primary surgeon during surgery. Recent news reports have raised questions about the primary surgeon initiating a second surgery before the first surgery was fully completed. These reports led to a larger discussion of the reasons why surgeons may leave an operating room during the course of a surgery and the appropriate actions that need to be taken to inform the patient and ensure continued safe care.

**General statement**
The primary attending surgeon is personally responsible for the patient’s welfare throughout the operation. In general, the patient’s primary attending surgeon should be in the operating suite or be immediately available for the entire surgical procedure. There are instances consistent with good patient care that are valid exceptions. However, when the primary attending surgeon is not present or immediately available, another attending surgeon should be assigned as being immediately available.

The definitions at the end of this Statement provide essential clarification for terms used herein.

**Concurrent or simultaneous operations**
Concurrent or simultaneous surgeries on two different patients in two different rooms is not appropriate.

**Overlapping operations**
Overlapping of two distinct operations by the primary attending surgeon occur in two general circumstances.

The first and most common scenario is when the key or critical elements of the first operation have been completed and there is no reasonable expectation that there will be a need for the primary attending surgeon to return to that operation. In this circumstance a second operation is started in another operating room while a qualified practitioner performs non-critical components of the first operation allowing the primary surgeon to initiate the second operation, for example, during wound closure of the first operation. This requires that a qualified practitioner is physically present in the operating room of the first operation.

The second and less common scenario is when the key or critical elements of the first operation have been completed and the primary attending surgeon is performing key or critical portions of a second operation in another room. In this scenario, the primary attending surgeon must assign immediate availability in the first operating room to another attending surgeon.

The patient needs to be informed in either of these circumstances. The performance of overlapping procedures should not negatively impact the seamless and timely flow of either procedure.

**Multidisciplinary operations**
Contemporary surgical care may require multidisciplinary operations. During such operations, it is appropriate for surgeons to be present only during the part of the operation that requires their surgical expertise. However, an attending surgeon must be immediately available for the entire operation.

**Delegation to qualified practitioners**
The surgeon may delegate part of the operation to qualified practitioners including, but not limited to residents, fellows, anesthesiologists, nurses, physician’s assistants, nurse practitioners, surgical assistants or another attending under his or her personal direction. However, the primary attending surgeon’s personal responsibility cannot be delegated. The surgeon must be an active participant throughout the key or critical components of the operation. The overriding goal is the assurance of patient safety.

**Procedure-related tasks**
A primary attending surgeon may have to leave the operating room for a procedure-related task. Such procedure-related tasks could include review of pertinent pathology (“frozen section”) and diagnostic imaging; a discussion with the patient’s family; and breaks during long procedures. The surgeon must be immediately available for recall during such absences.

**Unanticipated circumstances**
Unanticipated circumstances may occur during procedures that require the surgeon to leave the operating room prior to completion of the critical portion of the operation. In this situation, a backup surgical attending must be identified and available to come to the operating room promptly.

Circumstances in this category might include sudden illness or injury to the surgeon, a life-threatening emergency elsewhere in the operating suite or contiguous hospital building, or an emergency in the surgeon’s family.

If more than one emergency occurs at the same time, the attending surgeon may over-
see more than one operation until additional attending surgeons are available.

**Surgeon-patient communication (Section II.A.)**
The surgical team involved in an operation is dependent on the type of facility at which the operation is performed and the complexity of the surgery. At a free standing outpatient surgical center, many procedures are performed solely by the primary attending surgeon with no assistant. In contrast, a complex procedure at an academic medical center may involve multiple qualified medical providers in addition to the primary attending surgeon. As part of the pre-operative discussion, patients should be informed of the different types of qualified medical providers that will participate in their surgery (assistant attending surgeon, fellows, resident and interns, physician assistants, nurse practitioners, etc.) and their respective role explained. If an urgent or emergent situation arises that require the surgeon to leave the operating room unexpectedly, the patient should be subsequently informed.

**Definitions**
In an effort to provide some standardization of nomenclature and terminology, the following definitions are provided:

**Back-up surgeon/surgical attending**
The qualified surgical attending who has been designated to provide immediately available coverage for an operation, during a period when the primary surgeon might be unable to fill this role.

**“Concurrent or simultaneous operations” (or surgeries)**
Surgical procedures when the critical or key components of the procedures for which the primary attending surgeon is responsible are occurring all or in part at the same time.

**“Critical” or “key” portions of an operation**
The “critical” or “key” portions of an operation are those segments of the operation when essential technical expertise and surgical judgment are required in order to achieve an optimal patient outcome. The critical or key portions of an operation are determined by the primary attending surgeon.

**Immediately available**
Reachable through a paging system or other electronic means, and able to return immediately to the operating room. This should be defined more completely by the local institution.

**Informed consent**
Described in ACS Statements on Principles II.A.

**Multidisciplinary operations**
One example of this would be a procedure where a surgeon of one specialty provides the exposure required by a second surgeon who performs the main surgical intervention (e.g., a general or thoracic surgeon providing exposure for a neurosurgeon or orthopaedist to operate on the spine). Another example would be an operation that requires the involvement of two or more surgeons with different specialty expertise (e.g., chest wall or head and neck resection followed by plastic surgical reconstruction; face or hand transplantation; repair of complex craniofacial defects).

**“Overlapping or sequenced” operations for surgeons**
The practice of the primary surgeon initiating and participating in another operation when he/she has completed the critical portions of the first procedure and is not essential for the final phase of the first operation. These are by definition surgical procedures where key or critical portions of the procedure are not occurring simultaneously.

**Physically present**
Located in the same room as the patient.

**Primary attending surgeon**
Considered the surgical attending of record or the principal surgeon involved in a specific operation. In addition to his/her technical and clinical responsibilities, the primary surgeon is responsible for the orchestration and progress of a procedure.

**Qualified practitioner**
Any licensed practitioner with sufficient training to conduct a delegated portion of a procedure without the need for more experienced supervision and who is approved by the hospital for these operative or patient care responsibilities.
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The American Board of Otolaryngology (ABOto) invites qualified individuals to apply for the position of full-time Executive Director to serve beginning January 1, 2018, following a six-month overlap period with the current Executive Director.

The Executive Director functions as the chief physician officer of the ABOto and works with the Board of Directors (BOD) and its officers to fulfill the ABOto’s mission. Primary responsibilities include, but are not limited to, oversight of office operations, finances, the certification process, Maintenance of Certification, and implementation of strategies and policies developed by the BOD.

A successful candidate must be an ABOto Diplomate in good standing with senior-level administrative experience including fiscal management, organizational administration, and graduate medical education. Candidates must possess leadership abilities, and excellent communication and interpersonal skills. An academic background and experience with the ABOto are preferable.

Interested candidates should send (1) a statement of intent briefly describing why you are interested in the position, and (2) a current CV, to the attention of Dr. Ron Cannon, ABOto President and Chair of the Search Committee, c/o the American Board of Otolaryngology, 5615 Kirby Drive, suite 600, Houston, TX 77005. Confidentiality will be maintained throughout the process.

The deadline for application receipt is August 15, 2016, and the interview and selection process will occur during the Fall and Winter of 2016-17.

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Head and Neck Surgical Oncologist Faculty Position

The Department of Otolaryngology at Harvard Medical School, the Division of Otolaryngology at Brigham and Women’s Hospital, and the Head and Neck Oncology Program at the Dana-Farber/Brigham and Women’s Cancer Center invites applications for a full-time academic head and neck surgical oncologist. Fellowship training or extensive experience in ablative surgery, reconstructive microsurgery and multidisciplinary management of head and neck cancer patients is required. This position will support the clinical and research goals of the Dana-Farber/Brigham and Women’s Cancer Center and the academic mission of the Harvard Department of Otolaryngology.

We are interested in a collegial physician who practices excellent, compassionate multidisciplinary clinical care. The candidate should be board certified or eligible in Otolaryngology and qualified to be appointed as a faculty member at Harvard Medical School at the Instructor, Assistant Professor or Associate Professor level. Academic rank will be commensurate with experience, training, and achievements.

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Stanley W. Ashley, MD at sashley@partners.org

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Head & Neck Surgery, PA
P.O. Box 5007, Greenville, NC 27835
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Dr. Dwight Jones, Professor and Chair
Department of Otolaryngology – Head & Neck Surgery
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All interested candidates should apply via the American Head and Neck Society Match.

www.ahns.info/residentfellow

Rhinology and Skull Base Surgery Fellowship

The Department of Otolaryngology-Head & Neck Surgery at the University of Kansas Medical Center has added a new Rhinology and Skull Base Surgery Fellowship and is currently accepting applications for the 2017-2018 academic year.

Under the mentorship of Drs. Alexander Chiu and David Beahm, this one-year fellowship will facilitate exposure to a large volume of sinus and skull base procedures. The fellow will also be afforded tremendous opportunities for clinical and/or translational research within the department’s research program. The fellow will learn medical management of sinonasal disease and otologic allergy practice via experience in outpatient clinics.

Eligible applicants must have successfully completed an ACGME-accredited Otolaryngology residency training program, are expected to be American Board certified/eligible and must be able to obtain a Kansas and Missouri medical license.

All interested candidates should apply via the SFMatch.

www.SFMatch.org
South Florida ENT Associates, a fifty-five physician group practice operating in Miami-Dade, Broward and Palm Beach Counties, has immediate openings for full-time ENT Physicians. South Florida ENT Associates is the second largest ENT group in the country and the largest in the state of Florida. We provide full service ENT including Audiology, Hearing Aid Sales, Allergy, Facial Plastics, Robotics and CT services.

We offer an excellent salary/bonus with partnership track, health insurance, paid vacation time, malpractice insurance and CME reimbursement, plus other benefits.

Candidate must have strong clinical knowledge, excellent communication skills, be highly motivated and hardworking.

This position will include both office and hospital settings.

Requirements:
- Board Certified or Eligible preferred
- MD/DO from approved medical/osteopathy school and graduation from accredited residency program in ENT
- Current Florida license
- Bilingual (English/Spanish) preferred
- Excellent communication and interpersonal skills
- F/T - M-F plus call

For more information about us, please visit www.sfenta.com.

Contact Information:
- Contact name: Stacey Citrin, CEO
- Phone: (305) 558-3724 • Cellular: (954) 803-9511
- E-mail: scitrin@southflordaent.com
The Division of Laryngeal Surgery is seeking applicants for clinical fellowship positions. The fellowship training covers all aspects of laryngeal surgery, voice disorders, and management of the professional voice. The curriculum will provide a wide range of experiences, including phonomicrosurgery (cold instruments and lasers), laryngeal framework surgery, novel operating-room and office-based laser (Pulsed-KTP, Thulium) treatment, complex laryngeal stenosis with aortic homograft transplantation, and the use of botulinum toxin injections for spasmodic dysphonia.

The fellow will participate in the management of voice disorders and clinical research as a member of a multidisciplinary team (voice scientists and speech pathologists) that has access to state-of-the-art voice clinic and surgical engineering laboratory facilities. The research fellowship provides numerous opportunities to focus on grant-funded (NIG and private foundations) clinical and basic science research projects in collaboration with interdisciplinary teams of scientists and clinicians at the Massachusetts Institute of Technology and the Wellman Laboratories of Photomedicine at the Massachusetts General Hospital. The option to collaborate with local music conservatories is also available.

Qualified minority and female candidates are encouraged to apply. Send curriculum vitae and three letters of recommendation. The Massachusetts General Hospital is a teaching affiliate of Harvard Medical School.

Direct inquiries to:
Steven M. Zeitels, MD, FACS
Eugene B. Casey Professor of Laryngeal Surgery, Harvard Medical School
Director: Center for Laryngeal Surgery & Voice Rehabilitation
Massachusetts General Hospital
One Bowdoin Square, 11th Floor
Boston, MA 02114
Telephone: (617) 726-0210  Fax: (617) 726-0222
zeitels.steven@mgh.harvard.edu
For more information please contact:
Chad Zender, MD, FACS
Associate Professor • Director of Head and Neck Fellowship • Vice Chair of Clinical Affairs and Translational Research
University Hospital-Case Medical Center • Department of Otolaryngology-Head and Neck Surgery
Chad.Zender@UHhospitals.org  •  216-844-5307

This one year fellowship offers advanced training in:
- Microvascular free tissue transfer
- Over 150 cases per year
- Endoscopic and open skull base surgery
- Minimally invasive head and neck surgery
- Transoral laser and transoral robotic surgery
- Sentinel node mapping for head and neck melanoma

Applicant requirements:
- Completion of an ACGME accredited Otolaryngology-Head and Neck surgery residency
- ABO board eligible or certified
- Ohio Medical license eligible

Fellowship requirements and opportunities include:
- Clinical duties
- Teaching residents and medical students
- 1-12 call
- Clinical or basic science research
- Participation in our resident microvascular course and skull base workshop
- Travel and presentation at national meetings
- Productivity bonus in line with a competitive fellowship salary

Please visit http://uhhospitals.org/ENT to view the position online and to submit CV for consideration.

For more information please contact:
Chad Zender, MD, FACS
Associate Professor • Director of Head and Neck Fellowship • Vice Chair of Clinical Affairs and Translational Research
University Hospital-Case Medical Center • Department of Otolaryngology-Head and Neck Surgery
Chad.Zender@UHhospitals.org  •  216-844-5307
Otolaryngologist Opportunity in Toledo, Ohio

ProMedica Physicians Ear, Nose and Throat is seeking highly motivated, personable BC/BE otolaryngologists to join their progressive and expanding practice. The practice consists of five ENT physicians and is the only ENT practice in Toledo with fellowship-trained otolaryngologists in head and neck surgical oncology and neurotology. We offer a full range of services including allergy testing and treatment, and complete audiology and vestibular services including ENG, rotary chair, posturography, and cochlear implantation and mapping.

We are seeking candidates who excel at general ENT or with advanced subspecialty interest and fellowship-trained in head and neck surgical oncology, laryngology, and neurotology.

- Full employment with ProMedica Physicians
- "Built in" referral base and high volume
- Call shared equally among all members (currently 1:5)
- Trauma call is optional and paid separately
- Opportunity for teaching residents and medical students
- All members participate in weekly board meetings
- Competitive compensation and generous benefits package
- Relocation paid up to $10K
- Perfect balance of work and lifestyle

Please visit www.promedica.org/doctors

Toledo, Ohio is home to an extensive Metropark system, Toledo Zoo, Toledo Museum of Art, and excellent institutions of higher education.

Contact: Denise Johnston, physician recruiter, at 419-824-7445, denise.johnston@promedica.org.

Chester County Otolaryngology & Allergy Associates

SCENIC PHILADELPHIA SUBURBS

- Flourishing four physician Otolaryngology practice seeking an additional BC/BE physician.
- Located in beautiful Chester County, Pennsylvania’s fastest growing county, with easy access to Philadelphia, New York City, Washington DC, mountains, and shoreline.
- Current services include audiology with hearing aid dispensing and balance testing, sinus surgery and allergy testing/immunotherapy, endocrine surgery, head and neck oncologic surgery, reconstruction of malignant cutaneous defects, and general pediatric and adult otolaryngology.
- Competitive salary, early partnership, health/dental insurance, 401k/Profit Sharing, paid CME and vacation.

Interested candidates please forward letter of interest and curriculum vitae to Alice via email at ccofps@comcast.net.
Assistant, Associate, or Full Professor in the Division of Laryngology
Stanford University School of Medicine
Department of Otolaryngology-Head and Neck Surgery

The Division of Laryngology in the Department of Otolaryngology-Head and Neck Surgery at Stanford University School of Medicine seeks a board-certified Otolaryngologist to join the department as an Assistant Professor, Associate Professor, or Full Professor in either the Medical Center Line or the Clinician Educator Line. Faculty rank will be determined by the qualifications and experience of the successful candidate.

The predominant criteria for appointment for faculty in the Medical Center Line shall be excellence in the overall mix of clinical care, clinical teaching, scholarly activity that advances clinical medicine, and institutional service appropriate to the programmatic need the individual is expected to fulfill. The major criteria for appointment for faculty in the Clinician Educator Line shall be excellence in clinical care, clinical teaching, and scholarly activity.

The successful applicant should be board eligible or board certified in Otolaryngology-Head and Neck Surgery. We expect the successful candidate to develop an active clinical practice in laryngology, be an active teacher of medical students and residents, and to develop a robust research program.

Stanford University is an equal opportunity employer and is committed to increasing the diversity of its faculty. It welcomes nominations of and applications from women, members of minority groups, protected veterans, and individuals with disabilities, as well as from others who would bring additional dimensions to the university’s research, teaching, and clinical missions.

Submissions will be reviewed beginning May 1, 2016, and accepted until position is filled.

Head and Neck Surgical Oncologist/ Microvascular Reconstructive Surgeon
FULL-TIME BE/BC FACULTY FELLOWSHIP TRAINED FACULTY

The Department of Otolaryngology at UTMB Health in Galveston, Texas is actively recruiting enthusiastic candidates for a full-time position. This job entails opportunities to participate in all aspects of clinical practice, as well as resident and medical student teaching. UTMB Health is undergoing rapid growth as exemplified by the building of two cutting-edge surgical hospitals and the acquisition of a third. With a light call schedule and generous benefits, this is an outstanding opportunity in one of the fastest growing geographic regions in the country. Clinical research is encouraged but not mandatory.

Please direct your Letter of Interest and CV to:
Vicente Resto, MD, PhD, FACS
Chair, Department of Otolaryngology, UTMB Health
301 University Boulevard, Galveston, TX 77555-0521
Email: varesto@utmb.edu Phone: 409-772-2701

UTMB is an equal opportunity, affirmative action institution which proudly values diversity.
Candidates of all backgrounds are encouraged to apply.
University of Wisconsin – Madison
Assistant/Associate/ Professor Laryngologist

The Division of Otolaryngology, Department of Surgery at the UW School of Medicine and Public Health, is seeking a full-time, board eligible or board certified laryngologist to join our excellent team of academic physicians in a state-of-the-art environment. Requirements include completion of a one-year laryngology fellowship training program and board certification in Otolaryngology. The incumbent will develop a clinical practice and establish and/or continue an extramurally funded research program in laryngology. Protected time will be assured for research. A strong commitment to teaching residents and medical students is required. Faculty appointment will commensurate the candidate's experience and academic credentials. The successful candidate will also participate in departmental, professional, public, and university service appropriate to the faculty rank.

A competitive salary and fringe benefit package will be provided. If interested, please submit a letter of interest and curriculum vitae to:

K. Craig Kent, MD
Chairman, Department of Surgery
University of Wisconsin-Madison
H4/710 Clinical Science Center
600 Highland Avenue
Madison WI  53792-7375
officeofthechair@surgery.wisc.edu

UW-Madison is an equal opportunity/affirmative action employer. Women and minorities are encouraged to apply. Unless confidentiality is requested in writing, information regarding applicants must be released upon request. Finalists cannot be guaranteed confidentiality. Wisconsin open records and caregiver laws apply. A background check will be conducted prior to offer of employment.
As a company founded by doctors for doctors, we believe that doctors deserve more than a little gratitude for an outstanding career. That’s why we created the Tribute® Plan—to reward our members for their loyalty and commitment to superior patient care with a significant financial award at retirement. How significant? The highest distribution to date is $138,599. This is just one example of our unwavering dedication to rewarding doctors.

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