## Advocacy at Work: For Our Patients and Our Profession

# Victories in NY Show That Our Advocacy Works!

Rose Berkun, MD, FASA

Ever since the 2018 New York State budget came out with language that proposed to lift physician supervision of nurse anesthetists and allow them to practice chronic pain management independently, the New York State Society of Anesthesiologists (NYSSA) has been holding its collective breath each January when new bills are introduced. The 2021 budget's proposed expansions of scope of practice included pharmacists and nurse practitioners, but not nurse anesthetists.

Unfortunately, despite the fact that the CRNA independent practice was not included, Governor Cuomo's fiscal year 2022 budget bill included proposals that, if passed, would be detrimental not only to anesthesiologists but to all New York physicians.

One such proposal was a 50% physician cost sharing of excess medical liability insurance. This program was created in the mid-1980s by New York State and allowed an additional layer of $1 million of coverage to be provided to physicians with hospital privileges who maintain primary coverage at the $1.3 million/$3.9 million level.

New York has the highest cumulative medical liability payouts of any state in the country – 68% more than the state with the second highest amount, Pennsylvania. It also has the highest per capita liability payment – 10% more than the second highest state, Massachusetts. New York state has failed to enact meaningful liability reform to ameliorate this risk. The size of medical liability awards in New York State continues to rise significantly, and physician liability premiums remain far out of proportion compared with the rest of the country.

The Excess Medical Liability Insurance Program has been sponsored by New York State for several decades. This year, the state budget proposed a $51 million cut in program funding and imposed a 50% physician cost share requirement, which would have resulted in the imposition of thousands to tens of thousands of dollars of new costs on 17,000 enrolled physicians.

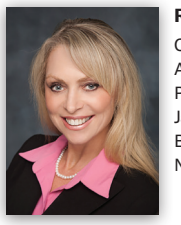
Another proposal in the budget bill, with no monetary gains for the state, included provisions that would allow the New York State Department of Health to disregard essential due process protections for physicians when a complaint is filed against a physician with the Office of Professional Medical Conduct (OPMC) and permit the commissioner to make information public about a physician under a disciplinary investigation.

In New York State, most complaints to OPMC of alleged misconduct do not become actual findings of misconduct. Most complaints to OPMC do not even get so far as advancing to a formal investigation committee review. According to the 2018 New York OPMC annual report, while over 9,000 complaints were received by OPMC and 8,782 complaints closed, only 210 cases resulted in the filing of actual charges. That is 2% of filed complaints ending in actual charges. This proposal would abandon longstanding due process protections and could unfairly destroy professional reputations and the patient-physician relationship so essential for providing high-quality care.

Throughout the budget negotiations, NYSSA physicians, together with the Medical Society of the State of New York (MSSNY), responded to these and other proposals by direct communication with their legislators via Zoom, call to action campaigns, and radio ads. NYSSA members participated in MSSNY Lobby Day with NYSSA President Chris Campese, MD, taking center stage and addressing over 1,300 physicians.

As a result of strong advocacy by physicians of New York State, the passage of a $212 billion fiscal year 2022 budget produced important victories for physicians and patients, namely:

- Excess Medical Liability Insurance Program extended
- Physician due process protected
- Pharmacy scope changes – including proposals to greatly expand the physician-pharmacy Collaborative Drug Therapy Management program – permitted pharmacist self-ordering of lab tests and significantly expanded the number of immunizations that can be performed by pharmacists, rejected.
- Proposed 1% across-the-board cut to Medicaid health care provider payments, rejected
- Collaborative practice by nurse practitioners with physicians extended.



**Rose Berkun, MD, FASA**
Committee on Governmental Affairs, and Clinical Associate Professor of Anesthesiology, Jacobs School of Medicine and Biomedical Sciences, Buffalo, New York.

This is advocacy at work! The process of advocating for physicians and patients is not easy. It requires dedication and perseverance, relationship building, and legislative outreach and acceptance of both accomplishments and disappointments. However, without advocacy, none of the wins in New York or on the federal level would have happened. I encourage everyone to join the ASA Grassroots Network and become a member of ASA Team 535. Visit **asahq.org/grassroots** for more information. ■

# Health Literacy in Anesthesia: Moving the Needle in Health Equity

Crystal C. Wright, MD, FASA Tripti Kataria, MD, MPH, FASA Lisa P. Solomon, DO, FASA Amy Lu, MD, MPH

The COVID pandemic has underscored the importance of addressing health disparities and health literacy. Although physicians have come a long way in understanding how to communicate with patients, not all communication effectively provides the information patients can understand or utilize to advocate independently for their care. Patients need to have medical information presented in several formats to best absorb and understand the education we are providing them and to help improve health outcomes.

Recently, a colleague of mine (CCW) recalled the events of a preoperative visit. While my colleague is well-versed in what should happen, she was caught off guard to discover she would not be under the direct care of a physician but solely under the supervision of a nurse anesthetist. Alarmed, she reached out to me, and I instructed her to ask a series of questions that began my curiosity about how patients not as educated in this realm would manage to ask the critical questions. Fortunately, she was astute enough to make well-informed decisions, but what if this had been someone from another country who did not understand the English language?

## Defining health care disparities and health literacy

According to the Agency for Healthcare Research and Quality, health care disparities are differences in access to or availability of medical facilities and services and variation in rates of disease occurrence and disabilities between population groups defined by socioeconomic characteristics such as age, ethnicity, economic resources, or gender and populations identified geographically (asamonitor.pub/352p69A).

In August 2020, the U.S. government's Healthy People 2030 defined health literacy with the categories of personal and organizational health literacy (asamonitor.pub/3g3jEte). "Personal health literacy is the degree to which individuals have the ability to find, understand, and use information and services to make informed health-related decisions and actions for themselves and others. Organizational health literacy is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions

*Continued on next page*