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American Academy of Otolaryngology—Head and Neck Surgery

January 2013—Vol.32 No.01

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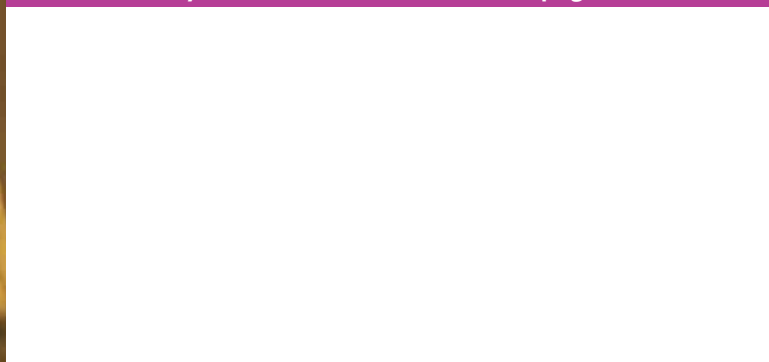
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American Academy of Otolaryngology—Head and Neck Surgery

January 2013—Vol.32 No.01

2012 Committee Highlights

At the 2012 Annual Meeting & OTO EXPOSM in Washington, DC, Academy and Foundation committees met and discussed achievements during the past year and planned for 2013. Read summaries of actions taken by committees in this issue of the *Bulletin*.

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AMERICAN ACADEMY OF
OTOLARYNGOLOGY—
HEAD AND NECK SURGERY

David R. Nielsen, MD
Executive Vice President, CEO, and Editor,
the *Bulletin*

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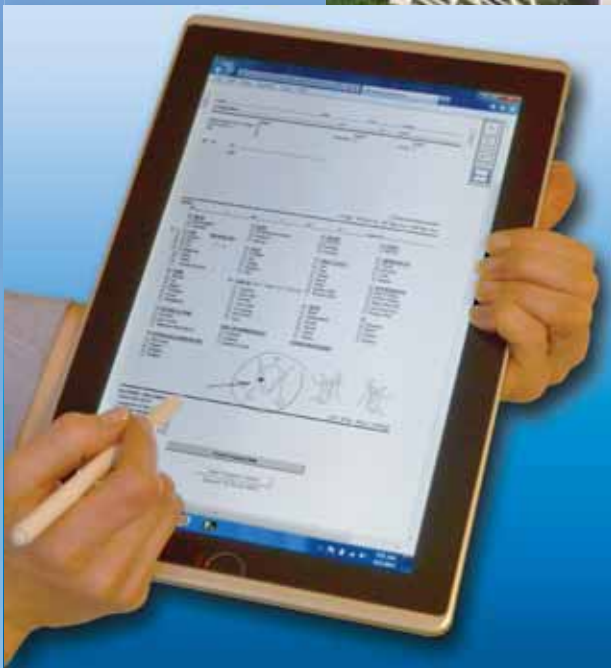
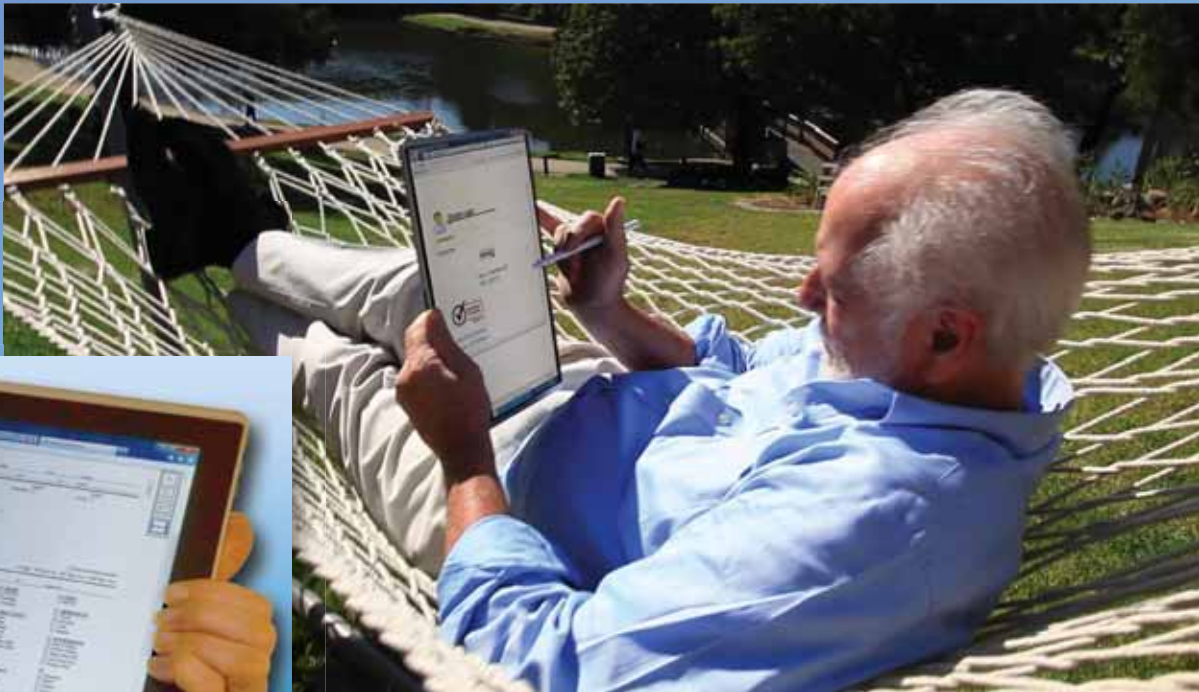
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Planning for Relevance

No matter what we call it, the beginning of a new year is a natural time to renew commitments and revise our goals. And, as discussed in this column previously, the AAO-HNS/F begins this year with new guidance from its leaders who gathered in December to revise and renew our strategic plan.

In preparation, we sent Board Members and other AAO-HNS/F leaders various materials for the strategic planning event, including the 2011 book, *Race for Relevance: 5 Radical Changes for Associations*. We based this year's strategic planning on a system described by the book's authors, Harrison Coerver and Mary Byers, CAE. The importance of being increasingly relevant to our Members had been brought to my attention as part of training for association presidents-elect and their CEOs. And, I believe this book to be a very useful and powerful assessment vehicle.

Both authors present impressive knowledge of association management. Harrison Coerver is president of Harrison Coerver & Associates, a management consulting firm that specializes in strategy and planning for trade associations, professional societies, and other tax-exempt membership organizations. In the last 25 years, he has consulted with more than 1,200 associations on strategy, planning, governance, and management.

His colleague, Mary Byers, is a former association executive, consultant, and professional speaker who specializes in facilitating strategic planning and organization-focused events. Together they have more than 40 years of experience working with associations.

In their work, the authors researched emerging changes in the association environment and presented convincing case studies. Their book targets what associations need to be aware of to continue to provide member value in the future.

Why Radical Change?

Harrison Coerver, who agreed to facilitate our strategic planning sessions, and his co-author, make a strong case for bold changes that will be needed to sustain our

organization now and in the future. In fact, the authors attest that while it was a given in the past for professionals to support their societies, renewing their membership yearly, volunteering within the society on boards, committees, and task forces, such loyalty has been severely constrained by changes in our world.

The authors outlined three areas of environmental shift so basic that they shook up our economy and changed our society. They further pointed out that most of these changes evolved from advances in technology. Specifically, the things that have changed in all of our lives involve "Time" available and the pace of change, the "Expectations for Value," the "Market Structure" in its consolidation and specialization, "Competition" from specialized sources, the "Generational Differences," and a sea change in the nature of competition.

What We Have Done Already and How We've Moved Forward

Governance and Value—efficient, flexible, and relevant

Fortunately, our Academy and Foundation have seen this shift coming and we have worked during the past several years to make some of the changes that will address the needs of our new age. These included assessing and reworking our governance systems and researching our value offerings with members.

However, radical change requires more from us.

And so we asked our leaders to read the book prior to our meeting. That book provided the foundation to make our strategic

As I write, our expert staff enthusiastically takes on the responsibility for moving the plan forward, transitioning our efforts to action plans and budgets.



James L. Netterville, M.D.

James L. Netterville, MD
AAO-HNS/F President

planning even more successful and our time more effective, efficient, and satisfying. We also asked them to complete and return a strategic planning matrix that addressed the "Related to Mission and Vision" and the "Competitive Advantage" areas. And they did.


When we came together in December, the AAO-HNS/F leaders rated 36 programs for:

- 1) their importance related to our mission and vision, and for
- 2) their relative competitive advantage.

It was not easy, especially when hard choices resulted in some assumptions not being realized, but with gratitude and respect for all of my colleagues' efforts, I can say we reached a consensus for moving forward.

The 2014 Plan

As I write, our expert staff enthusiastically takes on the responsibility for moving the plan forward, transitioning our efforts to action plans and budgets. Tactics are being assigned and measureables set. In March, our boards will receive a draft of the budget for the plan that will be finalized during their May meeting and offered to you as the FY 2014 Budget in the June *Bulletin*.

I hope you can see the determination and respect for each of you that your leaders bring to these activities. We act for you who care so deeply for our specialty and our patients' health. 



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Guideline for Guidelines

One of the most important advances the Academy has made to improve healthcare outcomes and fulfill its mission to empower physicians to provide the best healthcare has been the successful development and implementation of a process for creating relevant, valid, otolaryngology-specific evidence-based guidelines. Our published methodology, which has been cited by the Institute of Medicine (IOM) and the Council of Medical Specialty Societies (CMSS) in their work on guidelines, is just receiving its third revision and will be published this month as a supplement in our journal *Otolaryngology–Head and Neck Surgery*.

The Academy first published its guideline methodology in the journal in October 2006, followed by an advanced and updated version in June 2009. Since the first issue, the Academy has been successfully building guidelines, applying them to quality improvement through performance measurement, and providing members and other practitioners with better tools to improve patient care. As Academy members and staff have presented at multi-disciplinary meetings on quality improvement, evidence-based medicine, and performance measures throughout the years, we have frequently made copies of our methodology available to other specialties, international participants, and even allied health provider groups. Our approach was highly regarded and the number of copies was always insufficient to meet the demand. Over time, we have been complimented and cited for the principles contained therein that are essential to effective use of guidelines for improving care.

In 2008, the U. S. Congress passed the Medicare Improvements for Patients and Providers Act (MIPPA), which required the IOM to undertake a study of guideline development and to make recommendations for better application of medical knowledge to improve patient care. The IOM committee's work in

response to the MIPPA was published in March of 2011, outlining eight standards for creating rigorous, trustworthy clinical practice guidelines (CPGs). The report, "Clinical Practice Guidelines We Can Trust," called upon the Agency for Healthcare Research and Quality (AHRQ) to engage in demonstrations of the application of these standards to assess their validity and reliability. If you have not read it, at least a cursory review of these standards is important to understand the true value of guidelines—not as "cookbook medicine" or a prescriptive mandate for care; but as a useful tool for all physicians who daily face difficult decisions and uncertainty in their care of each patient. These standards can be found on the IOM's website at www.iom.edu/Reports/2011/Clinical-Practice-Guidelines-We-Can-Trust/Standards.aspx and a short summary of the development of the IOM report is at www.iom.edu/Reports/2011/Clinical-Practice-Guidelines-We-Can-Trust.aspx.


During the course of the committee's deliberations, its chair, Sheldon Greenfield, MD, expressed to Norman Kahn, MD, CEO of the Council of Medical Specialty Societies, his hope that the CMSS would engage its member societies (which represent nearly 750,000 specialist physicians in the United States) in creating their own statement of best practices for implementing these standards so that all guidelines developed could be relied upon to represent the best available care recommendations. CMSS took this charge seriously and assigned the CPG Component Group, which it convened to draft a white paper that would serve as a guide on which societies could model their methodology for CPG development. After nearly 18 months of collaboration and work this "guideline for guidelines" was presented in November 2012, and approved by the Council. The Academy's Board of Directors voted to support this document and recognized that it mirrors most of the carefully crafted elements



David R. Nielsen MD

David R. Nielsen, MD
AAO-HNS/F EVP/CEO

of our published methodology. It is well worth noting that both the IOM and the CMSS received input and testimony during their work from otolaryngologists and both entities cited the Academy's published methods in their reports.

As you read *Otolaryngology–Head and Neck Surgery* this month, I urge every Academy member to read the supplement on guideline methodology and become familiar with the motivation behind, and the purpose for, developing and implementing guidelines. Reference to the appropriate uses of guidelines and their limitations is made within the document. Key elements, such as including multiple specialties and perspectives in guideline development, transparency, avoiding and managing conflicts of interest, articulating strength of recommendations, and extensive external review are all critical to achieving the goal of effectively using guidelines to apply the best available evidence to patient care and achieving the best outcomes. I extend my personal thanks to the tireless volunteers on our Guidelines Development Task Force, reviewing committees, specialty societies, and staff who have built such a strong culture of quality improvement. 

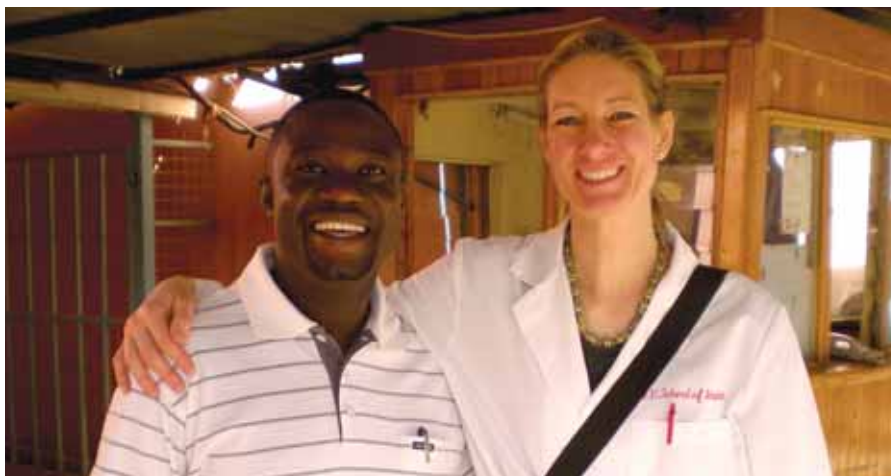
After All, We Are All Humanitarians

Susan R. Cordes, MD
Vice chair, BOG Legislative
Representatives Committee
and chair, WIO Section

It is human nature to be concerned about the welfare of others, and physicians seem to have a few exclamation points after the humanitarian gene. It sounds like a cliché when people say they want to be a doctor so they can help people, but it's so true. We went to medical school and made countless personal and financial sacrifices so we could help other people through a profession that is known for altruism and compassion. Ask physicians who go overseas on humanitarian trips why they do it and a common answer is because it reminds them of why they went into medicine in the first place. Stripped of the paperwork, rules, regulations, and bureaucracy that come with practicing medicine in the United States, it is the opportunity to practice medicine at the core of what it is all about—caring for patients.

Not every physician who wants to help is ready or able to jump on a plane to a far-away underdeveloped country, but there are many other ways to get involved in humanitarian efforts without ever leaving the office. For instance, the next time you trade in for new equipment, consider asking if the old equipment can be donated to an otolaryngology mission. Old, out-of-date equipment is often state-of-the-art and highly useful in a developing country. If you don't know someone personally to give the equipment to, the Academy's humanitarian efforts staff can facilitate getting the equipment to otolaryngologists traveling overseas.

Another opportunity to help is through the Millennium Society. Your gift can be designated to benefit humanitarian outreach. Such money is used for a multitude of valuable programs, including grants allowing residents to participate in a mission trip. The benefits gained from your donation are exponential when you fund young, impressionable residents who will likely then participate



Henry Nono, MD, International Visiting Scholar, and Susan Cordes, MD, at Moi Teaching and Referral Hospital, Eldoret, Kenya, February 2012.


in humanitarian efforts throughout their careers. Millennium Society gifts can also be used to fund a young otolaryngologist from a developing country to attend the AAO-HNSF Annual Meeting & OTO EXPOSM and gain experience in a U.S. otolaryngology program through the International Visiting Scholarship Program.

Additional opportunities exist through Academy involvement. Consider joining the Humanitarian Efforts Committee. In addition to sponsoring miniseminars, this committee reviews resident travel grants, is working on a searchable database, has created disease-specific focus groups to develop best practices in humanitarian otolaryngology, and is involved in a host of other worthwhile activities. See more about the AAO-HNS/F Humanitarian Grant Winners in the March issue.

By donating to the ENT PAC and/or attending the BOG Spring Meeting and the OTO Advocacy Summit May 5-7, 2013, we can advocate for the future of our specialty and preserve our ability to participate in humanitarian work. Increasing pressure from the government could threaten our financial ability to take time away from our practices in the United States so we can assist patients and otolaryngologists in less fortunate parts of the world. We must do all we can to preserve the reputation of our

profession as honest, compassionate, and ethical in spite of the mischaracterization that occasionally appears in the media or legislative debate.

Or, maybe it's time to take that plunge and go on a mission trip, but it is difficult to know where to begin. Again, the Academy is an excellent resource. The Humanitarian Efforts page of the Academy website includes practical information and opportunities. In every issue of the *Bulletin*, otolaryngologists recount their experiences and provide a glimpse into the range of opportunities available. Finally, there are numerous otolaryngologists who have been providing humanitarian care in the U.S. and abroad, and a simple email or phone call is sometimes all it takes to get the process underway. That first step can be a difficult one to take, but the results can be amazingly gratifying.

As physicians, we are fortunate to provide direct care to people in the course of our daily work; it is truly a gift to have the means, knowledge, and skill to be able to help people in our own communities and around the world. We should be proud of ourselves for using our gift wisely, but with talent comes responsibility. How we respond to that responsibility is what makes us unique individuals, but one thing we all have in common is that, at the end of the day, we are all humanitarians. 

Dates to Remember

At AAO-HNS/F

January 1

Bulletin feature: Committee Highlights; Summary of Guideline on Guidelines; read it online at www.entnet.org/bulletin.

January 21

Annual Meeting & OTO EXPOSM Call for Papers Deadlines for Scientific Oral & Poster: Jan. 21-Feb. 18 at www.entnet.org/annual_meeting.

January 30

Nomination forms for the 2013 Jerome C. Goldstein Public Service Award due. Email elaguna@entnet.org.

February 1

2013 Committee Application Opens on November 15 and closes on February 1. See www.entnet.org/committees.

February 1-2

Coding and Reimbursement Workshop, Dallas, TX at www.entnet.org/conferencesandevents.

In Otolaryngology

Details at www.entnet.org/conferencesandevents.

January 13-14

AACE Advances in Thyroid Cancer Diagnosis and Therapy

January 15-18

10th GCC Otorhinolaryngology HNS Conference

January 18-19

AACE Advances in Thyroid Cancer Diagnosis and Therapy

February 2-3

ACS Thyroid and Parathyroid Ultrasound Skills-Oriented Course

February 8-9

81st Midwinter Research Study Club of Los Angeles Recent Advances in Otolaryngology—Earn up to 16 CME Credits

February 14-17

2013 Advanced Techniques in Endoscopic Sinus Surgery

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19th Annual Advances in Diagnosis and Treatment of Sleep Apnea and Snoring

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February 17

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Third Edition of AAO-HNSF Guideline Development Manual Published

This month, the American Academy of Otolaryngology—Head and Neck Surgery Foundation (AAO-HNSF) publishes its newest guideline development manual “Clinical Practice Guideline Development, 3rd Edition: A Quality-Driven Approach for Translating Evidence into Action” in *Otolaryngology–Head and Neck Surgery*. The latest manual reflects our continued efforts to refine our guideline development processes so we remain at the forefront of the field. The new manual is authored by **Richard M. Rosenfeld, MD, MPH**, AAO-HNSF senior consultant for Quality and Guidelines; **Richard Shiffman, MD, MCIS**, associate director, Yale Center for Medical Informatics; and **Peter Robertson, MPA**, AAO-HNSF senior manager of Research and Quality Improvement.

Several areas within the manual are highlighted below, reflecting recent changes to the guideline development process.

Standards for Guideline Development

In March 2011, the Institute of Medicine (IOM) published “Clinical Practice Guidelines We Can Trust,” which revised the Institute’s definition of clinical practice guidelines and outlined a set of eight standards for trustworthy guidelines.¹ The Guidelines International Network also outlined standards for guideline development; both sets of standards are summarized in the table on the next page.² While there has not been

universal acceptance of the standards, they do represent an initial set of best practices for developers who have begun to assess the degree to which their processes comply.

“Clinical Practice Guidelines (CPGs) are statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.”¹

Action Statement Profiles

Action statement profiles, previously known as evidence statement profiles,³ support each of the guidelines’ key action statements and outline all key decisions made by the guideline development group. To promote the importance of the information conveyed in the action statement profile, the profiles now immediately follow each key action statement. Each profile outlines the aggregate evidence quality, level of confidence in the evidence, benefits, risks, harms and costs, benefit-harm assessment, value judgments, intentional vagueness, role of patient preferences, exemptions, policy level, and differences of opinion.

As recommended by the IOM, we added “level of confidence” and “differences in opinion” to our action statement profiles. The level of confidence relates to quantity, consistency, precision, and generality of the aggregate evidence, which is distinct from evidence level. It is possible to have “low” confidence in evidence from randomized trials if the trials are inconsistent, have design flaws,

and relate poorly to the guideline’s target population. Conversely, it is possible to have “high” confidence in observational studies if they are consistent, well-designed, and applicable to patients covered by the guideline.

Differences of opinion among guideline development group members can occur with any component of the action statement profile. Mechanisms for resolving disagreements should be specified early in the development process, such as a member vote with a specified threshold for approval (e.g., 50 percent, 70 percent). Any differences of opinion are rated as “minor” or “major” with an explanation of what occurred and how it was resolved.

Public Comment

Independent external review of a guideline is a critical aspect of development. To build off our previous external review process (the guideline was reviewed by 30 to 40 individual reviewers), each guideline is now made available for a two-week period of public comment. The public comment follows the external review, with the final guideline draft being posted to the AAO-HNSF website. The comment period is publicized via member communication, press releases, and direct solicitation to pertinent organizations, such as consumer advocacy groups. For more information about when guidelines are available for public comment, visit www.entnet.org/guidelines.

As with the external review, all comments are reviewed and addressed by the guideline development panel and the draft is further refined, where appropriate.

Updating Guidelines

Guidelines should be viewed as living documents, so that the guidelines’ recommendations will continue to be assessed for their relevancy and the document will be updated when appropriate. The third edition of the guideline

Clinical Practice Guidelines (CPGs) are statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.

Table 1. Standards for Trustworthy Clinical Practice Guidelines (CPG)

Standard	Institute of Medicine (IOM) ¹	Guidelines International Network ²
Methods and Scope	The processes by which a CPG is developed and funded should be detailed explicitly and be publicly accessible.	A guideline should specify its scope and objective, and clearly describe the methods used for development in detail.
Conflict of Interest (COI)	Prior to selection of the guideline development group (GDG), individuals should declare, in writing, all interests and activities potentially resulting in COI; management of COI includes divestment and exclusions.	A guideline should include disclosure of the financial and nonfinancial COIs for members of the GDG and should also describe how any identified conflicts were recorded and resolved.
Guideline Development Group (GDG) Composition	The GDG should be multidisciplinary and balanced, comprising methodological experts, clinicians, and populations expected to be affected by the CPG; patient and public involvement should be facilitated by including (at least at the time of clinical question formulation and CPG review) a current or former patient and a patient advocate or patient/consumer organization representative in the GDG.	A GDG should include diverse and relevant stakeholders, such as health professionals, methodologists, experts on a topic, and patients.
Evidence Reviews	CPG developers should use systematic reviews that meet standards set by the IOM.	Guideline developers should use systematic evidence review methods to identify and evaluate evidence.
Decision-making Process	Not specified.	A guideline should describe the process used to reach consensus among the panel members and, if applicable, the sponsoring organization; this process should be established a priori.
Recommendation Wording	Recommendations should be articulated in a standardized form detailing precisely what the recommended action is and under what circumstances it should be performed; strong recommendations should be worded so that compliance can be evaluated.	A guideline recommendation should be clearly stated and based on scientific evidence of benefits, harms, and, if possible, costs.
Recommendation Strength	Each recommendation should have a clear description of potential benefits and harms, a summary of relevant available evidence (quality, quantity, consistency), an explanation of the part played by other factors (values, opinion, theory, clinical experience), a rating of the level of confidence in (certainty regarding) the evidence, a description and explanation of any differences of opinion, and a rating of recommendation strength.	A guideline should use a rating system to communicate the quality and reliability of both the evidence and the strength of its recommendations.
External Review	External reviewers should comprise a full spectrum of relevant stakeholders; reviews should be kept confidential; the GDG should consider all reviewer comments and keep a written record of disposition; a draft of the CPG should be made available to the general public for comment.	Review by external stakeholders should be conducted before guideline publication.
Updating	The CPG publication date, date of evidence review, and proposed date for future CPG review should be documented in the CPG; literature should be monitored regularly and the CPG updated when new evidence suggests a need for modification.	A guideline should include an expiration date and/or describe the process that the GDG will use to update the recommendations.
Financial Support	Not stated.	A guideline should disclose financial support for the development of the evidence review and guideline recommendations.

development manual further outlines the AAO-HNSF guideline update process. At a minimum, AAO-HNSF guidelines will be updated five years after publication. An early update may take place if there are significant changes in the clinical evidence, there are changes in available interventions, there are changes in the importance or value of outcomes, there is a shift in the balance of benefits versus harms, or there are changes in the resources available for healthcare.

The update follows a similar process to guideline development: convening a guideline update group, reviewing the original guidelines recommendations, performing update literature searches, and determining the extent of the guideline update. The AAO-HNSF has identified three different levels of guideline update:

1. Reaffirmation, if no significant changes are required. The guideline update group prepares a brief statement for publication stating how the group reached its decision and the duration of the reaffirmation. *Note:*

guidelines may be reaffirmed only once.

2. Minor update, if revisions are required to the key action statements, but they do not substantially change the conclusions or recommendations.
3. Major update, if revisions that substantively change recommendations or the inclusion of new key action statements are required.

The AAO-HNSF's 2006 clinical practice guideline on acute otitis externa is the first to undergo an update. The guideline update is expected to be published in the summer of 2013.⁴


Learn More

The third edition of the guideline development manual is available to AAO-HNS members and the public as a supplement to the journal *Otolaryngology-Head and Neck Surgery*, visit <http://oto.sagepub.com>.

To find out more about the AAO-HNSF guideline development activities, including copies of previously published guidelines, products under development,

and how to participate in guideline public comment, visit <http://www.entnet.org/guidelines>.

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How a Medical Student's Cranial Nerve Numbering System Led to Widespread Inaccuracies in Modern Anatomical Illustrations

Eduardo C. Corrales, MD
for the Otolaryngology
Historical Society

In 1778, Thomas Soemmerring, a 23-year-old medical student in Goettingen, Germany, described in his dissertation the cranial nerve numbering (I–XII), which remains in common use today. His system was based on the rostro-caudal exit points of the nerve roots from the brain.

Limited by naked eye observation and poor preservation, errors were made in the rank order. The abducens nerve (VI)


actually exits in the groove between the pons and medulla just rostral to the glossopharyngeal nerve (IX) and well caudal to the facial (VII) and audiovestibular nerves (VIII). To further complicate things, modern microscopic observation shows the facial nerve actually exits the pons caudal to the audiovestibular nerve.

The weight of authority of this classical numbering system led generation after generation of textbook authors and their illustrators to distort human anatomy to fit with the traditional rank order. Depictions of the ventral surface of the brain and brainstem, with rare exceptions, show the exit order of abducens-facial-auditory-glossopharyngeal rather than the anatomically correct auditory-facial-abducens-glossopharyngeal. For more than 200 years, drawings have been distorted to make anatomy conform to the universally accepted numbering system.

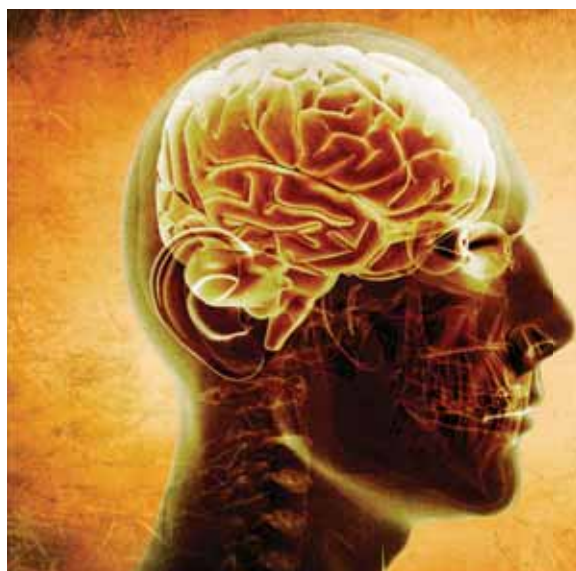
Early in medical school, physicians are taught that there is nothing left to be discovered in gross anatomy. The numbering system has been impressed upon beginning medical students, often



memorized with the aid of colorful mnemonics, and thus becomes deeply engrained.

In a culture that routinely questions the validity of scientific principles, physicians tend not to doubt the correctness of a well established truth such as the numbering of the cranial nerves. While it is always difficult to go against entrenched dogma, it is worth noting that legions of anatomists chose to alter reality rather than rise to this challenge. 

While it is always difficult to go against entrenched dogma, it is worth noting that legions of anatomists chose to alter reality rather than rise to this challenge.



This article is based on the paper, co-authored by Robert K. Jackler, MD, and Albert Mudry, MD, PhD, and presented by Dr. Corrales at the Otolaryngology Historical Society meeting, September 10, 2012. If you are interested in presenting at the next OHS meeting, Vancouver, BC, Canada, September 30, 2013, email museum@entnet.org.

To join the society or renew your membership, please check the box on your Academy dues invoice or email Catherine R. Lincoln, CAE, MA (Oxon) at clincoln@entnet.org or call 1-703-535-3738.

2012 Committee Highlights

Committees are the lifeblood of the AAO-HNS/F and a great way for members to contribute meaningfully to the organization and the specialty. At the 2012 Annual Meeting & OTO EXPOSM in Washington, DC, Academy and Foundation committees met and discussed achievements during the past year and planned for 2013. On the following pages are brief summaries of actions taken by the committees.

The October 2012 *Bulletin* included listings of all committee members and an article on how to join a committee. The deadline for applications for the 2013 committee appointment process is February 1, 2013.

Standing Committees

Audit Committee

Kenneth W. Altman, MD, PhD, Chair

- The committee reviewed the audit timeline for audit of the financial statements for the year ended June 30, 2012 (FY12). The timing of the audit is on schedule for completion in mid-October.
- The audit partner for the AAO-HNS/F independent audit, made a presentation about internal control systems and the audit committee's role therein.
- The committee will meet to review the audit with staff and the independent auditors in early November, 2012.

Ethics Committee

Lauren S. Zaretsky, MD, Chair

- Transitioned from an Academy committee to a standing committee of both the Academy and Foundation.
- Began the implementation of the AAO-HNS/F Code for Interactions with Companies.



- Submitted three miniseminars for the AAO-HNSF 2012 Annual Meeting & OTO EXPOSM.
- Performed an extensive review of the current “AAO-HNS/F Operational Handbook.”

Finance & Investment Subcommittee of the EC (FISC)
John W. House, MD, Secretary
Gavin Setzen, MD, Secretary-elect

- The subcommittee heard proposals from investment advisors under consideration for management of the AAO-HNS/F’s investment portfolios and made a recommendation to the Executive Committee. The FISC’s recommendation to engage The Sardana Group as AAO-HNS/F’s professional investment advisory firm was subsequently accepted.
- The FISC had earlier received and reviewed the Treasurer’s Report for the fiscal year ended June 30, 2012 (FY12), which showed a positive variance between actual FY12 results as compared to the FY12 budget.

- In November FISC reviewed the report of the Audit Committee on the FY12 audit completed in mid-October.

Science and Educational Committee
Sonya Malekzadeh, MD, Chair

- The Science & Educational Committee met in September, December, and May, regularly sharing information on initiatives and activities within the Foundation’s key strategic areas of education, scientific program, instruction courses, and international outreach. The coordinators and senior staff responsible for these areas identified opportunities for further integration to mutually support the Foundation’s advancement across the entire spectrum of scientific and educational support for members.

Academy Committees

Airway and Swallowing (A&S) Committee
Milan R. Amin, MD, Chair

- A representative of the A&S Committee (Stacy L. Halum,

MD) attended the ITQIC meeting in Scotland, which focused on Tracheotomy Care.

- A&S Committee members **Robert J. Stachler, MD**, **Albert L. Merati, MD**, and **Milan R. Amin, MD**, are producing a manuscript based on a miniseminar that was sponsored by the committee last year regarding treatment of Zenker’s Diverticulum.
- The A&S Committee has ongoing database projects focused on tracheotomy and TNE that continue to collect and provide data for analysis.

Allergy, Asthma, and Immunology Committee
Karen H. Calhoun, MD, Chair

- Presented five instruction courses at the AAO-HNSF 2012 Annual Meeting & OTO EXPOSM:
 - Eosinophilic Gastrointestinal Disorders for the ENT
 - Skin Testing for Inhalant and Food Allergies
 - Sublingual Immunotherapy: Why and How?
 - Pediatric Allergy Update 2012

- Unified Airway Disease: Fact or Myth? The Current Evidence
- Presented one miniseminar at the AAO-HNSF 2012 Annual Meeting & OTO EXPOSM:
- Food Allergy 2012: State of the Science

Certificate Program for Otolaryngology Personnel Committee

Peter A. Weisskopf, MD, Chair

- In June, the workshop portion of the CPOP program took place in Detroit, MI. Twenty-one individuals participated in this two-day hands-on training.

Credentials and Membership Committee

Pierre Lavertu, MD, Chair

- At this year's meeting, the committee discussed working closely with Academy staff with the creation and implementation of new alternatives for increasing Academy membership and reinstating non-members and help in our overall efforts to ensure we do not lose members who transition out of residency.

Complementary/Integrative Medicine Committee

Edmund A. Pribitkin, MD, Chair

- At the 2012 Annual Meeting & OTO EXPOSM in Washington, DC, the committee worked on its plans for 2013 including:
- The committee planned for its 2013 miniseminars including the topics of atypical facial pain, headaches, and migraines,
- It will do a *Bulletin* article on "How to Initiate a Discussion about CIM with Patients."
- It also discussed its current instruction course content with the intention of adding the topic of Comparison of Levels of Evidence into the "Common Ailments" topic.

CPT & Relative Value Committee

Jane T. Dillon, MD, Chair

- At the annual meeting in Washington, DC, the committee agreed to several goals for 2013 including:

- A multi-pronged approach to educating members and subspecialties about the importance, and process of, RUC surveys; working with ARS and other key subspecialties to survey the nasal/sinus endoscopy codes;
- Drafting a letter to the Centers for Medicare and Medicaid Services (CMS) urging them to assign a HCPCS J code to the new Propel, drug eluting stent; and
- Working with Zupko and Associates to draft a *Bulletin* article clarifying how to use unlisted codes to properly code for endoscopic skull-based procedures.
- A presentation was also made by a member of the Sleep Committee, **Eric Kezirian, MD**, to request consideration for a new sleep endoscopy CPT code. The committee declined the initial request, but agreed to re-review the proposal once further details on pre, intra, and post time for the new code were provided.

Diversity Committee

Duane J. Taylor, MD, Chair

- Began the process of selecting candidates for the endowment distribution.
- Program directors at universities are receptive to working with the committee to promote avenues for diverse residents to conduct rotations.
- The Diversity Committee members pledged to make some sort of donation to the Harry Barnes endowment to show 100 percent committee member support.
- Joseph S. Schwartz, MD, (3rd year resident in Canada) presented a report on the breakdown of U.S. otolaryngologists by racial background.

Endocrine Surgery Committee

Lisa A. Orloff, MD, Chair

- The committee, named a Model Committee for the second time, has provided volunteer faculty for another sold-out Ultrasound Workshop on the Saturday before the annual meeting.

- Committee members worked on the Voice Outcomes guidelines (soon to be published), and reviewed several American Thyroid Association (ATA) guidelines.
- The *Bulletin* carried articles by **Drs. Orloff and Gregory W. Randolph, MD**, about the ATA and Thyroid Cancer awareness.
- Several committee members have been on thyroid humanitarian missions led by **Merry E. Sebelik, MD**.

Equilibrium Committee

Allan M. Rubin, MD, Chair

- The committee reviewed and provided keywords for several webpages as part of the website content relevancy project.
- The committee provided input on several private payer issues including the use of intratympanic steroids and transtympanic micropressure as treatment options for Meniere's disease.
- The AAO-HNS policy statement on micropressure therapy was reviewed and updated by the committee.

Geriatric Otolaryngology Committee

David E. Eibling, MD, Chair

- The committee supported the idea of researching other organizations' documents and criteria for a policy on "the practicing of otolaryngology by the aging otolaryngologist."
- It also discussed a possible miniseminar with the Sleep Committee on geriatric sleep issues.
- It would like to make available the Geriatric educational resources document developed by **Kelly M. Malloy, MD**, and **Sarah H. Kagan, RN, PhD**.

Head and Neck Surgery & Oncology Committee

Daniel G. Deschler, MD, Chair

- The question that came up on the 2011 HNS Steering committee meeting last year was posed again here: "Is there a way to collaborate with other committees on the selection of miniseminar topics to prevent overlap and increase the chances of acceptance for presentation?"

- Miniseminar topic discussion included head and neck cancer in the HPV era and skin cancer management 2013.

Hearing Committee

Robert K. Jackler, MD

- Developed a minimal reporting standard for hearing results in clinical research.
- Provided feedback to the Aetna request regarding the "Intratympanic Administration of Corticosteroids for Meniere's Disease."

Imaging Committee

Gavin Setzen, MD, Chair

- This year, the Imaging Committee worked with the American Rhinologic Society (ARS) to develop a questionnaire to jointly survey members and residents, so that the committee will be able to analyze data to provide members and payers with data on imaging services. The survey was distributed to members in October 2012.
- Academy members were served by the committee through continued advocacy efforts against decreased payment and prior authorization for in-office imaging services throughout the year. The Academy assisted members with advocacy efforts resulting in overturning a restrictive policy on imaging series by Highmark West Virginia.
- Other major health policy activities included: providing members with information on the Centers for Medicare and Medicaid Services' (CMS) release of Comparative Billing Reports on Imaging Utilization. Reviewed and provided input on the American College of Radiology (ACR) Appropriateness Criteria.
- Clarified the role of education and provided members with options for CMEs to meet accreditation. Updates to CME available offerings by the Foundation were made to the Imaging Accreditation webpage.

Implantable Hearing Devices Committee

Jeffery J. Kuhn, MD, Chair

- Successful transition from a subcommittee to a committee following

AAO-HNS Board of Directors approval in December 2011.

- Review of BCBSA Medical Policy on Cochlear Implants and Auditory Brainstem Implants (WellPoint/Anthem).
- United Healthcare policy review on Implantable/non-implantable Hearing Devices and Bone Anchored Hearing Aids.

Infectious Disease Committee

Farrel J. Buchinsky, MD, MBChB, Chair

- The Infectious Disease Committee presented "Local Anti-Infectives and Anti-Inflammatory Therapy," a miniseminar moderated by **Alan Shikani, MD**, at the AAO-HNSF 2012 Annual Meeting & OTO EXPOSM in Washington, DC.
- The committee assisted the review of a 2005 *Bulletin* article, "Cleaning Equipment in Today's ENT Office." An updated article on instrument reprocessing, developed by the Patient Safety and Quality Improvement (PSQI) committee, was published in the September *Bulletin*.
- The committee provided feedback on a set of priority issues developed by the Association for the Advancement of Medical Instrumentation (AAMI) and Food and Drug Administration (FDA) summit on the reprocessing of reusable medical devices.

Media and Public Relations Committee

Wendy B. Stern, MD, Chair

- The Media and Public Relations Committee conducted a media training session for print and television reporters at the BOG Meeting, May 5-7, 2012, Washington, DC. The session covered several topics, including utilizing social media for your practice, pitching stories to print and television reporters, and using Academy media resources on the website.
- The committee continued to provide existing support of Academy PR Mini-campaigns for 2012 and Academy Health Observances: World Voice Day, Back to School ENT Health, Better Hearing and Speech Month, and Choking Hazards Campaign.

- Committee members reviewed and revised the content of AAO-HNSF literature and fact sheets for the Website Content Relevancy Project.

Medical Devices and Drugs Committee

Anand K. Devaiah, MD, Chair

- The Medical Devices and Drugs Committee (MDDC) reviewed multiple private payer policies at the request of the 3P Workgroup. The MDDC gave input on a policy from United Healthcare focusing on Transtympanic Micropressure Treatment for Meniere's Disease. In addition, the MDDC has provided input for Wellpoint's Policy on the use of the Propel device to maintain sinus ostial patency following functional endoscopic sinus surgery.
- Two miniseminars at the annual meeting in Washington, DC, were sponsored or co-sponsored by the MDDC: "Take It to Trial: Tips for Designing Your Research Study" and "Cochlear Implant Failures: Experiences and Recommendations."

Medical Informatics Committee

Edward B. Ermini, MD, Chair

- Dr. Ermini, Medical Informatics Committee Chair, was instrumental in providing the Health Policy business

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unit with comments on the quality measures included in the Meaningful Use EHR incentive program.

Microvascular Committee

Douglas B. Chepeha, MD

- The Microvascular Committee is actively engaged in a national retrospective review of reconstructive techniques after surgical salvage of patients who have failed chemoradiation treatment. At present 42 institutions have indicated interest and 14 have submitted data on 257 patients. The goal of this effort is to understand how different approaches to reconstruction affect fistula rates. The information is designed to guide future reconstructive approaches and help develop evidence for how surgeons should approach high risk reconstructive cases. This work has been supported in part by a grant from the AAO-HNS. An application for presentation of this data will be made in the form of a miniseminar in time for the next meeting in Vancouver.
- A miniseminar was presented on "The Difficult Wound," and was well attended with substantial audience participation. The committee has also taken on a bold effort to address redesign of the approach to the access to educational materials.

Patient Safety and Quality Improvement Committee

David W. Roberson, MD, Co-chair

Rahul K. Shah, MD, Co-chair

- The PSQI Committee reached out to SSAC and other relevant clinical committees for ideas for the Choosing Wisely™ campaign.
- Dr. Roberson represented AAO-HNSF members at a National Summit on Overuse conducted by the Joint Commission and the American Medical Association (AMA) Physician Consortium for Performance Improvement® (PCPI). Tympanostomy Tubes for Middle Ear Effusion of Brief Duration is one of the five advisory panels formed.
- The PSQI miniprogram sessions included Preliminary Survey Data on Adverse Events in Facial Cosmetic

Surgery; Avoiding Injuries in Sinus Surgery; Leadership View of PSQI; and Tonsillectomy Disasters. Planning for the 2013 PSQI miniprogram is underway.

- A patient safety web link will be launched at www.entnet.org in early 2013 to capture de-identified safety event information.
- Several committee members wrote an article on instrument reprocessing that was published in the Academy's September 2012 *Bulletin*.
- Data collection continued for the study on post-admission criteria for Obstructive Sleep Apnea and the study of patient hand-offs by residents.
- Ideas for this year's work plan for both database studies and survey topics included sustainability, costs, and burdens of public reporting; sterilization of office equipment; allergy; surgical competency; injuries associated with robotic surgery for treatment on peripheral nerve injury; and indication for PET scan where it may not be indicated in cancer.

Pediatric Otolaryngology Committee

David E. Tunkel, MD, Chair

- Miniseminars by the Pediatric Otolaryngology Committee included "Innovations in Pediatric Otolaryngology—Video Presentations," "Pediatric Lumps, Bumps, Cysts, and Pits: Current Concepts," and "Management Algorithms for the Noisy Infant."
- "Tympanostomy Tubes in Children" was submitted to the Guideline Development Task Force as a potential clinical practice guideline last year, and is now nearing completion by the committee assembled by GDTF.
- Committee members reviewed clinical practice guidelines on acute otitis media, acute pediatric sinusitis, and obstructive sleep apnea for the American Academy of Pediatrics.

Physician Resources Committee

David W. Kennedy, MD, Chair

- Continued with its focus on education and tools needed to prepare for workforce shortages and workforce

changes. The committee preliminarily estimates that there will be a significant workforce shortage within the specialty.

- The committee discussed the importance of another formal workforce study to address issues such as surgeons' readiness for practice, geographic trends associated with state malpractice legislation, and diversity.
- A formal workforce study developed with methodology expertise will define the ideology and characterization of the imminent shortfall and provide data to allow for members to have a more proactive understanding, through the Academy, of issues and trends, changing practice patterns, and specialty growth opportunities. Such data would provide the Academy with a major opportunity in terms of specialty planning and recommended changes to current training, particularly for residents and fellows.
- In the next year, the committee will work on reviewing baseline data of practicing otolaryngologists and using this information to move forward with a consensus document on the impending otolaryngologist shortages.

Plastic and Reconstructive Surgery Committee

Donna J. Millay, MD, Chair

- The Plastics and Reconstructive Surgery Committee has continued to be involved in Private Payer Coverage Policy reviews. To facilitate this process we will have a network set up within the committee to have members available for rapid reviews. The committee will also send in a proposal for a miniseminar involving coding in facial plastics.

Rhinology and Paranasal Sinus Committee

Scott P. Stringer, MD

- Review of three private payer policies at the request of the 3P Workgroup that included Wellpoint Chronic Headache, UHC Rhinoplasty, Septoplasty, and Repair of Vestibular Stenosis, and Wellpoint Sinus Ostial Patency.

- The committee also submitted three miniseminar abstracts for the 2012 annual meeting, one of which (Evidence-Based Post-Op Management of Chronic Rhinosinusitis) was approved.
- Its 2013 goals include the resubmission of all miniseminar topics not accepted for the 2012 meeting including: a co-sponsored session with infectious diseases on topical treatments; a co-sponsored session with infectious diseases on issues surrounding office based surgery (i.e., training, infection, safety).

Sleep Disorders Committee

Pell Ann Wardrop, MD

- Edward M. Weaver, MD, MPH represented the Academy at the Washington State Health Technology Assessment for "Diagnosis and Treatment of Obstructive Sleep Apnea."
- It offered an oral presentation "Safety of Outpatient Surgery for Obstructive Sleep Apnea" during the annual meeting.
- The committee completed Sleep Medicine: Basic and Translational mini-program, orals, posters, miniseminars, and instruction courses for the annual meeting.

Trauma Committee

Joseph A. Brennan, MD, COL, USAF, Chair

- With the first year under our belt, the Trauma Committee has a number of accomplishments. First, dedicated committee members, with the assistance of **G. Richard Holt, MD, MSE, MPH-BE**, and AAO-HNSF Director of Education Audrey Shively, created a comprehensive online handbook called, "Resident Manual of Trauma to the Face, Head, and Neck." Many committee members served as instruction courses presenters as well presenting the miniseminar "Trauma Update 2012: Answers to your AAO-HNS Survey." A May *Bulletin* article entitled, "Disaster and Mass Casualty Response for Physicians" was written by **Anna M. Pou, MD**, and **Mark E. Boston, MD**.

- The Trauma Committee is eager to submit a plan for approval for a Saturday workshop prior to the 2013 AAO-HNSF Annual Meeting & OTO EXPOSM.

Voice Committee

Clark A. Rosen, MD, Chair

- It was agreed that the committee should work to develop a paper on pre-op laryngoscopy, especially when there has been a history of thyroidectomy or other procedure involving the laryngeal nerve to be useful outside the specialty and for primary care.
- The committee responded to the request to review and integrate its Policy Statement on Voice Therapy in the Treatment of Dysphonia, its Hoarseness Guideline, and its consensus statement on the Use of Voice Therapy in the Treatment of Dysphonia. The American Thyroid Association requested Academy member review of its draft thyroid guideline and the committee responded to that request.

Young Physicians Committee

Monica Tadros, MD, Chair

- The committee co-sponsored two miniseminars at the 2012 annual meeting, "Finding Balance in a Surgical Career" and "Interviewing: What to Ask and How." The committee plans to submit several miniseminars again for the 2013 annual meeting in Vancouver, BC.
- During the 2012 meeting, the committee developed several task forces and will survey all young physicians in the specialty who are active members to identify their needs and determine the best way the YPC can fulfill its mission aligned with the Academy's guiding principles and strategic plan.
- The committee is also interested in working closely with **Sonya Malekzadeh, MD**, coordinator of education on product development for offering a pathway to leadership for young physicians who are transitioning into practice.

Foundation Committees

Development Committee

Nikhil J. Bhatt, MD, Chair

- The Development Committee conducted its first meeting during the annual meeting focusing the discussion on how to best meet its committee charge to lead fundraising efforts in support of achieving AAO-HNSF mission, goals, and programs. Proposed holding a financial planning miniseminar at the 2013 annual meeting to include information that assists members in considering non-cash options of major gift level charitable donations.
- To increase the engagement of young physicians and residents with the Academy, the committee will pursue securing four travel grants (two young physicians and two residents) to attend the 2013 annual meeting. Award selection will be based on submission of a 300-word essay describing why the member deserves the travel grant and how he or she plans to give back to the Academy. The next meeting of the committee was planned for mid-November.

Humanitarian Efforts Committee

Merry E. Sebelik, MD, Chair

- Congratulations to the Humanitarian Efforts Committee immediate past chair **James E. Saunders, MD**, for being selected as the next AAO-HNSF International Coordinator. The Humanitarian Efforts Committee expressed its sincere thanks to Dr. Saunders for his strong leadership during the past six years as chair.
- The committee decided to sunset the Research/Best Practices work group and to combine the Resident Travel Grants Panel with the Residency Advocacy work group. This year the committee will work on putting together better guidelines for each work group. The current work groups are: Resident Travel Grants Panel/Residency Advocacy; Gold Foundation; Emergency/Disaster Relief/Telemedicine; Head/Neck and Thyroid; Otolaryngology; Pediatric; Plastic Reconstructive

Surgery (PRS); and Senior Corps/Retirees.

- Awarded 25 residents and fellows-in-training with Humanitarian Travel Grants in 2012 to offer services in 16 less-developed countries.
- The Humanitarian Efforts Member Engagement Portal is up and running to help facilitate matching critical needs with medical specialty expertise.

History and Archives Committee

Lawrence R. Lustig, MD, Chair

- The Otolaryngology Historical Society's program at the Cosmos Club was well received and **Andrew G. Shuman, MD, Eduardo C. Corrales, MD, and Robert K. Jackler, MD**, will write their topics for the *Bulletin*. Two groups visited the History Factory, the professional archivists where the Academy collection is housed.

International Otolaryngology Committee

Nikhil J. Bhatt, MD, Chair

- Dr. Bhatt announced plans to expand the number of International Visiting Scholars, and invited national societies to publicize the call for applications. Five international travel grantees attended the annual meeting and the 2013 application forms will be distributed to U.S. and Canadian department chairs. Dr. Bhatt urged the committee to actively recruit new international members.

International Steering Committee

Gregory W. Randolph, MD, Chair

- Dr. Randolph has submitted an Academy panel for the IFOS World Congress, Seoul, Korea, June 2013, and **KJ Lee, MD**, plans a post-Congress tour of the Far East. Seven International Visiting Scholars from India, Africa, Latin America, and Southeast Asia attended the annual meeting followed by observerships. The committee will work closely with Dr. Netterville to welcome 2013 honored countries: Canada, Kenya, Nigeria, and Thailand.

Outcomes Research, and EBM Subcommittee

Scott E. Brietzke, MD, Chair

- Chair, **Scott E. Brietzke, MD, MPH**, wrote an article in the July issue of the *Bulletin* titled, "Evidence Gaps: Prioritizing Our Research 'To Do' List" emphasizing the importance of prioritizing and addressing gaps in research, which is the primary focus of this committee's efforts.
- **Melissa A. Pynnonen, MD, and Seth M. Cohen, MD**, each completed a systematic review with the assistance of several other committee members. One review has already been accepted in *Otolaryngology-Head and Neck Surgery*.
- **Lisa Ishii, MD, and Stephanie Misono, MD**, were awarded travel grants to attend the 2012 Cochrane Colloquium in Auckland, New Zealand, where they were to attend workshops and seminars for developing high quality systematic reviews.
- A survey-based study, led by **Eric J. Kezirian, MD, MPH**, that considers factors that may be relevant to the surgical treatment of obstructive sleep apnea, with a specific focus on procedures that treat hypopharyngeal or retrolingual obstruction was published in *Otolaryngology-Head and Neck Surgery*.
- A committee endorsed miniseminar titled, "Rapid Review: Guidelines in Pediatric Otolaryngology" was accepted for presentation at the 2012 AAO-HNS Annual Meeting & OTO EXPOSM.

Panamerican Committee

Juan Manuel Garcia, MD, Chair

- The 2012 Antonio de la Cruz, MD, scholar was **Gustavo Bravo, MD**, of Chile, and **Jaime Fandino, MD**, was the "goodwill ambassador" invited by **J. Pablo Stolovitzky, MD**, Latin American Regional Advisor to speak at the Global Health 2012 Symposium. The Salvadoran Society of ORL-HNS is affiliated as an International Corresponding Society and the Bolivian Society has requested affiliation.

Education Committees

Education Steering Committee

Sonya Malekzadeh, MD, Chair, Coordinator for Education

- The Education Steering Committee provided leadership to several new initiatives in 2012 including an update to the COCLIASM resident discussion portal, keyword indexing of all education activities as part of the Website Content Relevancy Project, and a relaunch of the AcademyU[®] platform. In addition, new education products released in 2012 include AcademyQ[™], the knowledge assessment mobile app for iPhone and iPad, the ENT Exam Video Series, available on YouTube, and the "Resident Manual of Trauma to the Face, Head, and Neck." Work continues on the "Maintenance Manual for Lifelong Learning" (MMLL) update with the new e-publication expected in fall 2013.

Core Otolaryngology and Practice Management Education Committee

Richard R. Waguespack, MD, Chair

- The committee continues to provide policy and content oversight to the Coding and Reimbursement workshops conducted regionally each year. Its members serve as experts in ever-changing coding and practice management issues. In addition, the committee produced a Home Study Course on "Clinical Competency Issues." **Brendan C. Stack Jr., MD**, has taken over as committee chair through 2014.

Facial Plastic and Reconstructive Surgery Education Committee

Fred G. Fedok, MD, Chair

- The committee produced a Home Study Course on "Plastic and Reconstructive Problems" and two PMP courses on "Adult with Tired Eyes" and "Adult with Saddle Nose Deformity." The committee welcomes **J. Randall Jordan, MD**, as the chair-elect for 2013.

General Otolaryngology Education Committee

Karen T. Pitman, MD, Chair

- The committee provided leadership to the second successful ENT for the PA-C conference conducted in conjunction with AAPA and SPAO. They also produced a Home Study Course on “Trauma and Critical Care Medicine” and an online course, “Grave’s Disease.” In addition, this committee served as reviewers for the ENT Exam Video Series. GOEC was designated as a Model Committee for 2012.

Head and Neck Surgery Education Committee

Dennis H. Kraus, MD, Chair

- The committee is currently developing three PMP courses on “Adult with Facial Pain,” “Adult with Cystic Neck Mass,” and “Nasal Reconstruction.” **Richard V. Smith, MD**, assumes the role of chair for this committee through 2014. HNSEC was designated as a Model Committee for 2012.

Laryngology and Bronchoesophagology Education Committee

Catherine R. Lintzenich, MD, Chair

- The committee produced a PMP course on “Adult with Chronic Cough” and is currently developing one on “Subglottic Stenosis.”

Otology and Neurotology Education Committee

Bradley W. Kesser, MD, Chair

- The committee produced a COOL course on “Dizziness in the Elderly” and a PMP course on “Adult with Progressive Hearing Loss.”

Pediatric Otolaryngology Education Committee

Sugki S. Choi, MD, Chair

- The committee produced a Home Study Course on Congenital and Pediatric Problems and three COOL courses on “Indications for Tonsillectomy,” “Aerodigestive Foreign Body,” and “Complications of Pediatric Sinusitis.” They also published a PMP on “Child with Sudden Onset of Drooling.” New committee

chair, **Kenny H. Chan, MD**, began his tenure in October 2012. POEC was designated as a model committee for 2012.

Rhinology and Allergy Education Committee

James A. Hadley, MD, Chair

- The committee just published a Home Study Course, “Rhinology and Allergic Disorders” and is developing a PMP course, “Epistaxis.” This committee welcomes **Brent A. Senior, MD**, as the new chair through 2014.

Board of Governors (BOG) Committees

Representatives from Board of Governors societies from across the country were well represented during the BOG meetings, conducted during the AAO-HNSF 2012 Annual Meeting & OTO EXPOSM. Highlights from the meetings included those outlined here.

BOG Development/Fundraising Task Force

Jay S. Youngerman, MD, Chair

- The BOG expressed its sincere thanks to Dr. Youngerman and the members of the Task Force for their successful fundraising efforts during the past several years. With the formation of the new Foundation Fundraising Committee, the Task Force sunsetted at the end of the 2012 annual meeting. Dr. Youngerman will continue his great work on the new Foundation committee.

BOG Legislative Representatives Committee

Paul M. Imber, DO, Chair

- The committee received updates on current federal and state legislative activities for 2012, including Medicare physician payment reform, repeal of the Independent Payment Advisory Board (IPAB), medical liability reform, cosmetic medical procedure taxes, and ongoing scope-of-practice battles. Committee members also received an update on the recent Supreme Court decision upholding the individual

mandate provisions of the Affordable Care Act. In addition, updates were provided on a new “look” for ENT PAC (the political action committee of the AAO-HNS), new “in-district” grassroots opportunities, and highlights of the 2012 OTO Advocacy Summit. The committee heard from guest speaker Ingrida Lusis with the American Speech-Language Hearing Association (ASHA) who spoke on their activities and collaborative efforts with the AAO-HNS.

BOG Rules and Regulations Committee

Joseph E. Hart, MD, Chair

- The committee conducted a strategy session for committee members to outline plans for auditing all current state/local BOG societies in the coming year.

BOG Socioeconomics and Grassroots Committee

Peter J. Abramson, MD, Chair

- Guest speaker **Richard W. Waguespack, MD**, updated attendees on the progress of the 3P Workgroup.
- Attendees reviewed and debated a proposal from the Georgia BOG Society, “Opposition to Subspecialty Certification in Pediatric Otolaryngology.” The proposal was forwarded to the BOG Executive Committee, slightly modified and then adopted by the BOG General Assembly attendees.
- A discussion of insurance challenges, including mandatory outpatient thyroidectomies and PET scan charge back and pay for appeals was presented.
- Dr. Abramson unveiled the Committee’s Regional Representation Plan to improve communications across BOG regions and to offer members a voice where viable BOG societies don’t exist.

BOG Executive Committee-sponsored Miniseminar—“Hot Topics in Otolaryngology: 2012”

Wendy R. Stern, MD, BOG Secretary

- Dr. Wendy Stern moderated a compelling panel presentation on current hot

topics in otolaryngology. They included the changing relationship between physicians and hospitals as a response to pressures to reduce healthcare costs and consolidate the healthcare system, specifically looking at integrated healthcare systems and Accountable Care Organizations and highlighting the advocacy work of our Academy.

BOG General Assembly

- BOG committee chairs provided updated reports on their committees' activities from the past year.
- The Connecticut Ear, Nose, and Throat Society (CENTS) received the 2012 BOG Model Society Award.
- BOG Chair **Sujana S. Chandrasekhar, MD**, presented Recognition Awards to **Michael D. Seidman, MD**, and **Susan R. Cordes, MD**, for their service on the BOG Executive Committee. Dr. Chandrasekhar also presented an award to **Jay Youngerman, MD**, for his strong leadership and dedication as the chair of the BOG Fundraising/Development Task Force.
- Dr. Chandrasekhar presented BOG Chair Awards to **Hosakere S. Chandrasekhar, MD**; **John W. House, MD**; and **Gavin Setzen, MD**.
- Governors (or their alternates) in attendance elected **Peter J. Abramson, MD**, to the position of BOG Chair-Elect and **Stacey L. Ishman, MD**, to the position of BOG Member-at-Large.

Sections

Section for Residents and Fellows-in-Training (SRF)

Jayme R. Dowdall, MD, Chair

- The Section for Residents and Fellows-in-Training (SRF) functions as an advisory board to the Board of Directors (BOD). During the annual meeting, Monday was officially recognized as Residents Day with several special events geared toward residents.

SRF General Assembly

The Section conducted a very well-attended General Assembly meeting. During the session, attendees elected the following new officers:

Nikhila M. Raol, MD, Chair
Nathan A. Deckard, MD, Vice Chair
John M. Carter, MD,
Member-at-Large
Meghan N. Wilson, MD,
Information Officer
Estelle S. Yoo, MD, BOG Governor
Kanwar S. Kelley, MD, JD, BOG
Legislative Representative
Brianne B. Roby, MD, BOG Public
Relations Representative

In addition, **Jayme R. Dowdall, MD**, transitioned to *Immediate Past Chair*.

SRF-sponsored/co-sponsored Miniseminars

- "Interviewing: What to Ask and How"
- "Finding Balance in a Surgical Career"

Women in Otolaryngology (WIO) Section

Shannon P. Pryor, MD, Chair

- The Women in Otolaryngology (WIO) Section seeks to support women otolaryngologists by identifying their needs, fostering their development, and promoting women as leaders in the specialty. The Section completed its transitional year and its committees are planning several activities in the coming year.

WIO Section Committees

Each of the six WIO committees conducted committee meetings to plan and coordinate their activities for the coming year. The committees and their current leaders are:

Valerie A. Flanary, MD, Chair,
Awards
Erika A. Woodson, MD, Chair,
Communications
Pell Ann Wardrop, MD, Chair,
Development/Endowment
Mona M. Abaza, MD, Chair,
Leadership Development and
Mentorship
Lauren S. Zaretsky, MD, Chair,
Program
Linda S. Brodsky, MD, Chair,
Research and Survey

WIO Luncheon/General Assembly

- Medical blogger physician, Kevin Pho, MD, AKA "KevinMD," kicked off the WIO luncheon with his talk, "Connect

and Be Heard: Make a Difference in Healthcare with Social Media."

- The Section honored **Sujana S. Chandrasekhar, MD**, as the recipient of the 2012 Helen F. Krause, MD Trailblazer Award. The WIO Governing Council also honored Dr. Pryor for her hard-work during the past year and welcomed incoming Chair, **Susan R. Cordes, MD**.
- General Assembly attendees had the opportunity to network with their colleagues and learn more about WIO Section committees by participating in breakout roundtable discussions.
- The WIO Endowment Fund has continued to be successful in their fundraising efforts and solicited "Requests for Proposals" that fulfill the Section's charge to support the career development of women otolaryngologist-head and neck surgeons.

WIO-sponsored/co-sponsored Miniseminars

- "Interviewing: What to Ask and How"
- "Role of Women in Humanitarian Outreach"

Advisory/ Other Committees

Centralized Otolaryngology Research Efforts (CORE) Study Section

Jay O. Boyle, MD, Head and Neck
Surgery Sub-Committee Chair
Christine G. Gourin, MD, Head and
Neck Surgery Sub-Committee Chair-elect
David R. Friedland, MD, PhD,
Otology Sub-Committee Chair
Rodney J. Schlosser, MD, General
Sub-Committee Chair

- One hundred reviewers participated in the 2012 Study Section (up 30 percent from 2011)
- Reviewed 189 research grant applications (up 24 percent from 2011) requesting \$3,517,630 in research funding.
- Made funding recommendations to the 11 partnering specialty societies.
- Provided written critiques back to all 189 research grant applicants.

- Ultimately, the partnering specialty societies and sponsors awarded 45 grants (up 18 percent since 2011) totaling \$737,471 (up 17 percent from 2011).

Instruction Course Advisory Committee

Sukgi S. Choi, MD, Instruction Course Coordinator

- The Instruction Course Advisory Committee reviewed and organized the instruction course program for the last annual meeting in Washington, DC. The committee:
 - Reviewed the course evaluation results completed by attendees at the 2011 annual meeting and based on the data along with attendance figures, auto-accepted 172 instruction courses to be presented at the 2012 Annual Meeting & OTO EXPOSM.
 - Reviewed an additional 326 applications to be considered for the 2012 program, ultimately presenting a total of 355 exceptional instruction courses.
 - Included two instruction courses specifically designed to fulfill the ABO's Clinical Fundamental requirements for Part III of Maintenance of Certification during the 2012 annual meeting:
 - Clinical Fundamentals: Treatment of Anaphylaxis
 - Clinical Fundamentals: Clinical Outcome Measures/Evidence Based Medicine

Physician Payment Policy (3P) Workgroup

Richard W. Waguespack, MD, and Michael Setzen, MD, Co-chairs

- Five comment letters to CMS, including comments on proposed and final EHR Meaningful Stage Two rules, proposed rules on the 2013 Medicare Physician Fee Schedule and Hospital Outpatient and Ambulatory Surgical Centers.
- Successfully advocated for coverage of sinus ostial balloon dilation by Humana with continued efforts to support members who are locally advocating for change, including the availability of a new template appeal

letter drafted for member's balloon sinus ostial dilation denials.

- Continued ongoing third party payer advocacy efforts in support of patient safety and opposing United Healthcare's (UHC's) direct-to-consumer hearing aid sales program including meetings with UHC executive leadership and a letter to the FDA.
- Eighteen responses were provided to Third Party Payers regarding their medical policies with input received from Academy Committees in comparison to five responses the previous year.
- CPT and RUC efforts were significantly increased with 20 codes RUC surveyed and presented to the AMA RUC and six Code Change Proposals (CCPs) submitted to AMA's CPT Editorial Panel.
- Nine Clinical Indicators were updated after detailed review by numerous Academy Committees and 3P, including "Endoscopic Sinus Surgery," "Nasal Endoscopy," "Canalith Repositioning," "Tonsillectomy, Adenoidectomy, and Adenotonsillectomy," "Septoplasty," "Adenoidectomy," "Laryngoscopy/Nasopharyngoscopy," "Endoscopic Sinus Surgery: Pediatric," and "Neck Dissection." Clinical Indicator page at <http://www.entnet.org/Practice/clinicalIndicators.cfm>.
- Three Health Policy Miniseminars for the 2012 annual meeting were hosted by 3P, including the 3P miniseminar on new strategies in Academy advocacy for physician payment; ICD10 transition miniseminar; and the Medicare Contractor Administrative Committee (CAC) miniseminar.

Program Advisory Committee ***Eben L. Rosenthal, MD, Scientific Program Coordinator***

- The Program Advisory Committee planned and conducted the scientific program for the 2012 Annual Meeting & OTO EXPOSM in Washington, DC. The committee:
 - Reviewed 985 oral and poster applications, ultimately accepting 274 orals and 442 clinical and basic translational posters.

- Reviewed 143 miniseminar applications, accepting 91 thought-provoking miniseminars presented by experts in the field.


Specialty Society Advisory Council ***Samuel H. Selesnick, MD, Chair***

- The SSAC discussed the value of producing an SSAC miniseminar for annual meeting. **Eben Rosenthal, MD**, AAO-HNSF coordinator for scientific program, gave the group an overview on the submission process.
- **Sonya Malekzadeh, MD**, AAO-HNSF coordinator for education, gave the group an update on the recent educational initiatives for the AAO-HNSF.
- **David R. Nielsen, MD, EVP/CEO**, gave the group an update on the Value Based Payment Modifier and PQRS.
- **Richard W. Waguespack, MD**, and **Michael Setzen, MD**, from 3P discussed with the group how to better communicate with the societies on providing input on payer/insurer payment policies

Surgical Simulation Task Force ***Ellen Deutsch, MD, Chair***

- The Task Force researched and reported to the Foundation Board on the state of surgical simulation in otolaryngology. Throughout the year members represented the AAO-HNSF on cross-specialty surgical simulation organizations, while continuing to gather data and information. Open surgical simulation meetings took place at both COSM and the annual meeting. A Simulation Fair took place in conjunction with several related miniseminars. The Task Force continues to work on a survey and plans for a surgical simulation summit in 2013.

Robotic Surgery Task Force ***Eric Genden, MD, Chair***

- The Robotic Surgery Task Force began work on best practices for training and credentialing in robotic surgery within otolaryngology-head and neck surgery. The Task Force represents the AAO-HNSF in national robotic surgery organizations and initiatives, such as the development of Foundations for Robotic Surgery. 

Patient Outreach: 10 Minutes That Could Save Your Life

Just because you can't feel it, doesn't mean it isn't there. Just ask the more than 50,000 Americans who were diagnosed with cancers of the head and neck last year. Unfortunately, many Americans do not recognize the symptoms of these life-threatening diseases, which include cancers of the oral cavity, larynx, and pharynx, and by the time they are diagnosed, for some, it's too late.

Oral, head, and neck cancers claim nearly 12,000 lives each year. However, there is hope. If diagnosed early, these cancers can be more easily treated without significant complications, and the chances of survival greatly increase.

Who Should Get Tested?

Every adult should get tested. Tobacco and alcohol users traditionally have been considered the populations at greatest risk for these cancers. However, oral cancer cases are on the rise in younger adults who do not smoke, and recent research indicates this development is due partly to the increase of the human papillomavirus (HPV) virus, a cancer-causing infection that can be transmitted by oral sex. HPV-related oral cancers are more difficult to detect because these cancers

If diagnosed early, these cancers can be more easily treated without significant complications, and the chances of survival greatly increase.

usually occur on the back of the tongue or on the tonsils, providing even more reason to get screened regularly.

What are the Potential Warning Signs of Oral Cancers?


The signs and symptoms of oral cancer often go unnoticed. However, there are a few visible signs associated with these cancers that require immediate attention, including:

- A sore in your mouth that doesn't heal or that increases in size
- Persistent pain in your mouth
- Lumps or white or red patches inside your mouth
- Difficulty chewing or swallowing or moving your tongue
- Soreness in your throat or feeling that something is caught in your throat

- Changes in your voice
- A lump in your neck

Why Should I Get Screened?

If the above stats weren't reason enough, know that the screening is quick, painless, and free, and it's right around the corner. Given the current state of the economy and rising healthcare costs, take advantage of the opportunity to benefit from this preventive health measure at no charge by taking 10 minutes to do something that could save your life. Early diagnosis and treatment improves outcomes and chances of survival, particularly for individuals with HPV-related oral cancers.

If you have any of the above warning signs, do not wait for the free screenings. Seek medical attention immediately. 

Take Part in Oral, Head, and Neck Cancer Awareness Week®

The 16th Annual Oral, Head, and Neck Cancer Awareness Week® (OHANCAW®) is scheduled for April 14-20, 2013. Sponsored by the Head and Neck Cancer Alliance, OHANCAW is a weeklong series of events promoting awareness of this life-threatening, but treatable (if caught early) disease, highlighted by a day of free oral cancer screenings at medical offices, centers, and institutions throughout the country. All members can participate by conducting a free screening at their medical practice, clinic, hospital, or university. The Alliance supports screening sites by providing free materials, including posters, T-shirts, and media kits, to help set up and promote the activity. For more details, and to register to organize a free screening in your area, visit www.OHANCAW.com.

SAVE the DATE

APRIL 14-20, 2013

Oral, Head and Neck Cancer Awareness Week®



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ALLIANCE

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Oral, Head, and Neck Cancer Facts	www.OHANCAW.com
What is OHANCAW?	Oral, Head, and Neck Cancer Awareness Week® (OHANCAW®) is a weeklong series of events that aims to educate the public about these potentially life-threatening, but eminently treatable cancers and to promote prevention, screening, and early detection. OHANCAW is highlighted by the free screenings and related activities at participating medical centers across the country. The screenings are quick, painless, and designed to advance early diagnosis, which can lead to better outcomes. OHANCAW is sponsored by the Head and Neck Cancer Alliance (HNCA).
When is OHANCAW?	The 16th annual Oral, Head and Neck Cancer Awareness Week is April 14-20, 2013. The primary focus of our media efforts will be directed toward awareness activities occurring during this week, but HNCA is encouraging all supporters to pick a week during the year that works best for their group to host a free screening event. For more information, go to www.headandneck.org , email info@ohancaw.com or call 866-792-4622.
Oral Cancer Facts	Oral cancer is cancer that arises in the head or neck region, including the nasal cavity, sinuses, lips, mouth, thyroid glands, salivary glands, throat, or larynx (voice box). According to the American Cancer Society, an estimated 52,610 new cases of cancer of the oral cavity and throat, and an estimated 11,500 deaths from these cancers were expected in 2012.
Signs and Symptoms	<p>Most oral cancers arise on the lips, tongue, or the floor of the mouth. They also may occur inside your cheeks, on your gums, or on the roof of your mouth. Other head and neck cancers arise from the voice box or throat.</p> <p>Some signs and symptoms include:</p> <ul style="list-style-type: none"> ■ A sore in your mouth that doesn't heal or that increases in size ■ Persistent pain in your mouth ■ Lumps or white or red patches inside your mouth ■ Difficulty chewing or swallowing or moving your tongue ■ Soreness in your throat or feeling that something is caught in your throat ■ Changes in your voice ■ A lump in your neck
Risk Factors	<p>Tobacco (including smokeless tobacco) and alcohol use are the most important risk factors for oral, head, and neck cancers, particularly those of the tongue, mouth, throat, and voice box. Eighty-five percent of head and neck cancers are linked to tobacco use. People who use both tobacco and alcohol are at greater risk for developing these cancers than people who use either tobacco or alcohol alone. (Source: National Cancer Institute).</p> <p>Anyone can develop thyroid cancers, although a family history or exposure to radiation is often a factor. Salivary gland cancers do not seem to be associated with any particular cause.</p>
Human Papillomavirus (HPV) and Oral Cancer	Researchers have attributed the increase of head and neck cancer incidence in young adults, a group traditionally at low risk, to the human-papillomavirus (HPV), a cancer-causing virus that can be transmitted through oral sex. Many studies support that oropharyngeal cancers—those affecting the tonsils, back of the mouth (throat), and base of the tongue—have been on the rise since the mid-1980s, and currently 50 percent to 70 percent of these cases are caused by HPV infection. Many studies show that patients with HPV-positive oropharyngeal cancers are more responsive to treatment and have better survival rates than HPV-negative patients.

Courtesy of the Head and Neck Cancer Alliance at www.ohancaw.com.

Opportunity Awaits: Attend the 2013 BOG Spring Meeting & OTO Advocacy Summit

Don't miss the opportunity to utilize a rewarding free AAO-HNS member benefit. Plan to attend the 2013 BOG Spring Meeting & OTO Advocacy Summit!


The BOG Spring Meeting, scheduled for Sunday, May 5, through Monday, May 6, is a great chance for members to be more involved with the Academy's Board of Governors and learn more about the BOG committee system by observing such meetings as the BOG Socioeconomic & Grassroots Committee, the BOG Legislative Representatives Committee, and the BOG General Assembly. In addition, BOG meeting attendees have the option to attend workshops on various topics helpful to otolaryngology—head and neck surgery practices, participate in leadership training sessions, hear from keynote speakers, and network with other AAO-HNS members.

Following the conclusion of BOG activities, the OTO Advocacy Summit

will immediately commence the afternoon of Monday, May 6, and conclude Tuesday, May 7, with pre-scheduled meetings on Capitol Hill. This advocacy-focused meeting provides members with an ideal opportunity to directly lobby the new 113th Congress on behalf of the specialty. Other advocacy activities include an in-depth briefing with insider knowledge on the Academy's priority legislative issues, including Medicare physician payment, truth in advertising, audiology direct access, GME funding, and comprehensive medical liability reform. AAO-HNS members also will have an opportunity to discuss key strategies to effectively communicate in their Capitol Hill meetings and be equipped with key talking points to fully brief members of Congress and/or Congressional staff on the legislative issues important to the specialty.

Finally, attendees will learn more about ENT PAC, the political action

committee of the AAO-HNS. ENT PAC is one of the main advocacy resources available to Academy members to help increase the visibility of the specialty with federal legislators and candidates. AAO-HNS members will be briefed on various ENT PAC initiatives that have carried over from 2012, including the Fundraising & State Membership Challenge and our exclusive Leadership Club levels. 2013 Leadership Club members are also invited to attend an exclusive ENT PAC event.

Mark your calendars today for the **2013 BOG Spring Meeting & OTO Advocacy Summit**—May 5-7, 2013, in Alexandria, VA, and Washington, DC. Online registration for both the BOG Spring Meeting and the OTO Advocacy Summit, a free AAO-HNS member benefit, will open in February 2013. A limited number of travel grants will be available for residents. For additional details, visit www.entnet.org/BOG&Summit. 

Stay Informed: Bookmark the AAO-HNS Legislative and Political Affairs Webpage

Do you want to be one of the first to know the status of healthcare bills moving through Congress or your state? Bookmark the Legislative and Political Affairs webpage today! By visiting the webpage, you can learn more about the issues affecting the specialty, including the flawed Sustainable Growth Rate (SGR) formula, medical liability reform, scope-of-practice battles, Graduate Medical Education (GME) funding, truth-in-advertising initiatives, and efforts to repeal the Independent Payment Advisory Board (IPAB). Visit www.entnet.org/advocacy.



ENT PAC

The Political Action Committee of
the American Academy of Otolaryngology—
Head and Neck Surgery, Inc.

ENT PAC, the political action committee of the AAO-HNS, financially supports federal congressional candidates and incumbents who advance the issues important to otolaryngology—head and neck surgery. ENT PAC is a non-partisan, issue-driven entity that serves as your collective voice on Capitol Hill and helps to increase the visibility of the specialty with key policymakers. To learn more about ENT PAC, visit www.entpac.org (log-in with your AAO-HNS ID and password).

A New Year, a New Congress

January is a month of new beginnings. As such, when the 113th Congress convenes this month it will face many of the same issues, but in a slightly altered environment. Read on to learn more about some of the AAO-HNS federal legislative priorities, and what we can expect in the coming year.

Healthcare Reform

Although the results of last year's elections failed to provide a clear outlook for what will be accomplished in the 113th Congress, they did finally confirm that the Affordable Care Act (ACA) is here to stay. It is unlikely that the Republican-controlled U.S. House of Representatives will continue efforts this year to pass legislation fully repealing the ACA. Instead, efforts will shift toward developing legislation designed to modify and/or improve the ACA. In particular, members of the U.S. House will likely renew efforts to repeal individual provisions from the ACA that have lacked popularity within the Chamber.

The most notable example is the Independent Payment Advisory Board (IPAB). The IPAB, a brainchild of U.S. Senator Jay Rockefeller (D-WV), which charges an "independent" board with developing recommendations to reduce costs within the Medicare program, has many critics in the House. In addition, the IPAB is widely opposed by various stakeholders, including the AAO-HNS and a vast majority of national physician organizations. In the 112th Congress, legislation (H.R. 452) to repeal the IPAB garnered broad bipartisan support, but closed-door politics prevented the bill from receiving a "stand-alone" floor vote. It is likely that IPAB repeal will remain a top priority in the U.S. House this year. However, while the President and many members of the Senate continue to herald the importance of the IPAB, the overall success of repeal efforts will remain difficult.



Scope of Practice

The AAO-HNS has long been at odds with the audiology community regarding physician referral requirements within the Medicare program. For years, the American Academy of Audiology (AAA) has sought passage of federal legislation that would provide audiologists with unlimited direct access to Medicare patients without a physician referral. Although the AAO-HNS has, at times, engaged AAA in an effort to negotiate our varying positions, our organizations remain in disagreement on this particular issue. In the 112th Congress, the AAO-HNS was successful in mitigating support for the direct access bill (H.R. 2140). However, strategic changes in the audiology community and developments in the latter part of 2012 have altered our course on this issue and increased the likelihood that direct access will reign as our top specialty-specific priority in the 113th Congress.

In November 2012, two direct access-related announcements were made. First,

AAA issued a statement publicizing a "study" that claimed providing direct access would result in \$240 million in savings to the Medicare system over 10 years. The result of the study, which was commissioned by the AAA, presumes a "preventative savings" and directly contradicts previous reports regarding direct access, including a 2007 report by the Centers for Medicare and Medicaid Services that concluded direct access would actually increase costs for the federal government.

In the same week, the Academy of Doctors of Audiology (ADA) announced their "18 By 18" campaign, a comprehensive effort to obtain a "limited license physician" status by amending Title XVIII (18) of the Social Security Act to provide for the treatment of audiologists as "physicians" for purposes of furnishing audiology services under the Medicare program, and to provide for a broadened scope of audiology services available for coverage under the Medicare program.

Given passage of the ACA and the President's subsequent reelection, there is a slightly more favorable environment on Capitol Hill regarding efforts to expand access to nonphysician healthcare providers to help fill "gaps" in care. The AAO-HNS will be aggressive in the 113th Congress to ensure new and returning Members of Congress are well educated in regard to the potential dangers and patient safety concerns associated with direct access.

Medicare Physician Payment

Overall, Members of Congress continue to support the notion of reforming the Medicare physician payment system. However, efforts to repeal the flawed Sustainable Growth Rate (SGR) formula continue to elude Congress due to the exorbitant cost associated with full repeal. At the time of printing, Congress had not yet acted to avert the 26.5 percent

cut in Medicare physician payments scheduled to take effect on January 1, 2013. Since Medicare physician payments continue to cause instability in the Medicare system, it is still possible that substantial reform and/or repeal of the SGR may be included in a broad deficit reduction plan. The physician community, including the AAO-HNS, has put forth principles by which a new system should be based. An optimist could conclude that reform of the system is perhaps more likely to occur in the 113th Congress than in the last several years.

Medical Liability Reform


The AAO-HNS has long supported comprehensive medical liability reform efforts. However, the politicized nature of the issue has prevented any meaningful progress from being made. In the 113th Congress, discussion regarding medical liability reform may increase due to ongoing efforts to develop a robust deficit reduction plan. However, the focus of reform discussions may shift away from standard “cap” legislation to include a more

diverse “menu” of reform mechanisms, perhaps including medical courts, safe harbor exceptions, alternative dispute resolution plans, and further exploration of “disclosure and offer” programs.

Graduate Medical Education Funding

Due to the heightened fiscal scrutiny anticipated in the 113th Congress, the AAO-HNS expects some Members of Congress and the Administration to continue putting forth proposed reductions in Graduate Medical Education (GME) as a means to reduce costs within the Medicare program. The continued attacks on GME come with some level of irony given well-documented instances of physician shortages across the nation. The AAO-HNS and others in the physician community will continue to aggressively promote the importance of (at least) maintaining existing GME funding levels in the 113th Congress.

If you would like more information regarding AAO-HNS federal legislative

priorities, please email legfederal@entnet.org. In addition, to receive timely updates on the aforementioned federal issues, as well as state legislative priorities and grassroots programs, AAO-HNS members are encouraged to join the ENT Advocacy Network. To join, email govtaffairs@entnet.org. 

The AAO-HNS will be aggressive in the 113th Congress to ensure new and returning Members of Congress are well educated in regard to the potential dangers and patient safety concerns associated with direct access.

www.entnet.org/committees

Want to get more involved with your Academy?

Apply to become a committee member!

The 2013 application cycle is now open—go online to www.entnet.org/committees to apply.

You can join an education committee to become more involved in the Foundation’s education activities, Board of Governors (BOG) committee to become more involved in the grassroots arm of the Academy, or one of our Academy or Foundation committees that fits your area of expertise.

The benefits of serving on a committee:

- Network with colleagues in your field of expertise
- Influence the body of medicine
- Become more involved in leadership
- Earn Honor Points for service on committees

Important Dates

February 1, 2013
Online Applications Due
June 1, 2013
Applicants are Notified
October 1, 2013
2 Year Term Begins



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Academy Summary of the Final CY 2013 Medicare Physician Fee Schedule (MPFS)

On November 1, 2012, the Centers for Medicare & Medicaid Services (CMS) released the final Medicare physician fee schedule (MPFS) rule for calendar year (CY) 2013. The Academy submitted comments to CMS on the final rule, which can be viewed at <http://www.entnet.org/Practice/Summaries-of-Regulations-and-Comment-Letters.cfm#CL>.

Some key provisions finalized in the 2013 rule included:

Medicare Sustainable Growth Rate (SGR)

The Medicare law includes the standard statutory formula that will require (absent congressional intervention) a CMS projected reduction of 26.5 percent to the MPFS conversion factor (CF), which would result in a CF of \$25.0008 in 2013. Contractors are required to issue fee schedule files to their participating physicians in their locality, which include the estimated SGR cut that you may receive. Since Congress has not taken action for 2013 to fix the SGR at press time, the contractors cannot show payment rates that assume the problem will be resolved until legislation has actually been passed to do so. Thus, the fee schedules from contractors may assume the SGR cuts to all services for 2013. As in previous years, however, it is expected that Congress will take action to avoid the impending cut due to the sustainable growth rate (SGR) before the January 1, 2013, deadline.

Impact for Otolaryngology-Head and Neck Surgery

Overall, our specialty fared well regarding the impact of policy changes within the Medicare physician fee schedule for CY 2013. Otolaryngology-head and neck surgery saw a 2 percent cumulative increase in allowed charges for 2013, but physicians may see fluctuations in the Practice Expense

(PE) for some services due to several policy changes. Other related specialties that saw an increase were allergy, plastic surgery, and oral-maxillofacial. Unfortunately, audiology saw a slight decrease. Depending on the make up of services provided in your practice, the affects of these changes will vary in their effect on reimbursement rates. One modification in the final rule is the change in formula for determining a maximum interest rate for equipment-related PE RVUs. In addition, increases to some PE RVUs for otolaryngology-head and neck surgery services may also occur as a result of the last of a four year transition of the Physician Practice Expense Information Survey (PPIS) data used to calculate practice expense RVUs for services.

Improving Valuation of the Global Surgical Package

Since 1992, CMS has applied the concept of payment for a global surgical package under the PFS. This means that for each surgical procedure, they establish a single payment, which includes payment for all related services typically furnished by the surgeon providing the procedure during the global period. The global surgical package payment rate is based on the work necessary for the typical surgery and related pre and post-operative work. CMS noted that different methodologies have been used in valuing global surgical services and more recently reviewed codes tend to have fewer evaluation and management (E/M) visits in their global periods. They observed that codes reviewed less recently did not appear to have the full work RVUs of each E/M service in the global surgical package, resulting in inconsistent numbers of E/M visits during the post-operative period across families of procedures.

Under current policy, a surgeon is not required to document in the medical record what level of E/M

visit is provided. CMS believes this practice makes it difficult to determine whether the number and type of visits provided in association with a surgical procedure is appropriate. As a result, CMS requested input in the proposed rule on how best to obtain accurate and current data on E/M services typically furnished as part of a global surgical package. Within the final rule they received a wealth of public feedback regarding methods to verify the number of E/M services provided within the global surgical period. In response, ***CMS stated it will carefully review and consider all input provided by commenters, and did not finalize any new requirements for tracking or reporting E/M visits associated with the global surgical period for CY 2013. The Agency was clear, however, that it intends to finalize new requirements during CY 2014 rulemaking.***

Potentially Misvalued Services Under the Fee Schedule

Within the final rule, CMS identified 16 Harvard valued codes with annual allowed charges of greater than or equal to \$10 million that warrant review as potentially misvalued services. Of these 16 codes, five were already scheduled for RUC review in 2012 and four had been referred to the CPT Editorial Panel. For the remaining codes, CMS stated that they are such low volume codes it may make gathering information on physician work and direct PE inputs difficult via the usual survey method. Given this, CMS encourages use of valid and reliable alternative data source to develop recommended values. **Three of these codes had minor Otolaryngology use, including: 66180 Implant eye shunt; 67036 Removal of inner eye fluid; and 67917 Repair eyelid defect. The Academy staff and RUC team will monitor the review process for these procedures and determine if direct Academy involvement is warranted.**

Validating RVUs of Services

Under the Affordable Care Act (ACA), CMS was directed to validate a sampling of RVUs for services. RAND and the Urban Institute will research processes for validating RVUs for potentially misvalued codes under the PFS. CMS notes they will provide additional detail on the validation contracts in future rulemaking. In the past, the Academy has expressed concern about the Agency's engagement of an outside contractor and strongly urged CMS to be transparent with this process.

Therapy Caps and Changes to Reporting Requirements for Therapy Services in 2013

CMS announced the therapy cap amounts for CY 2013, \$1,900 for occupational therapy services and \$1,900 for combined physical therapy and speech-language pathology services. CMS also finalizes several key changes to reporting requirements associated with the provision of therapy services, including speech-language pathology services, with a test phase starting January 1, 2013, with non-payment enforcement starting on July 1, 2013. For more details on the new reporting requirements, see the Academy's summary online.

Physician Quality Reporting System (PQRS)

CMS includes many overarching changes to the PQRS system, with highlights of those potentially affecting Academy members below:

- **Changes to Group Reporting:** CMS changes the definition of a "group practice" from 25 or more eligible professionals to two or more eligible professionals.
- **Modification of Reporting Periods:** CMS allows the continuation of a 6 month reporting period (July 1–Dec. 31) for reporting measures groups via registry in 2013 and 2014 only.
- **Satisfactorily reporting for 2013 and 2014 to avoid penalties in 2015 and 2016:** CMS will allow individuals and group practices to report only one PQRS individual measure or one measures group to avoid the 2015 and

2016 penalty adjustment. The penalty adjustment will be a -1.5 percent in 2015 and -2 percent in 2016 and subsequent years.

- **Individual Quality Measures:** CMS added 13 new measures for reporting individual quality measures in 2013 and 45 new individual measures for 2014. However, the newly approved "Adult Sinusitis" measures were not included in any of their proposals.

Physician Compare

CMS finalized lowering the threshold of patients for reporting PQRS quality measures under the group practice reporting option to 20 beginning in 2013. This data is used to compile the published performance rates posted on the Physician Compare website. CMS finalized a policy allowing the reporting of measures that have been developed and collected by specialty societies to be reported on Physician Compare. CMS notes that they have begun to include physician information, such as successful participation in the Medicare E-prescribing (eRx) Incentive Program and PQRS. CMS also plans to publish additional information, a list of which is available in the Academy's summary available online.

Electronic Prescribing (eRx) Incentive Program

CMS finalized reducing the minimum group practice size for participation in the eRx incentive program from 25 to two Eligible Professionals (EPs) for 2013. This is consistent with changes to the PQRS program for 2013. Groups of two to 24 EPs who wish to participate must have reassigned their Medicare billing rights to a single TIN to be eligible. **CMS reduced the eRx reporting threshold for groups to 75, rather than the proposed 225, meaning groups of 2-24 will have to report the eRx numerator code during a denominator-eligible encounter at least 75 times from January 1 through December 31, 2013. CMS also lowered the 2014 reporting threshold for groups during the six month reporting period to 75.**

Value-Based Payment Modifier

Beginning January 1, 2015, the ACA requires the Secretary to establish a value-based payment modifier (incentive or penalty) to specific physicians and groups of physicians. **The incentive or penalty is based on measuring quality of care furnished as compared to cost of that care for Medicare beneficiaries with certain chronic conditions.** The agency will begin a three year phase-in of the program that would apply the incentive or penalty (up to potential -1 percent) in 2015 based on 2013 performance for groups of 100 or more providers. CMS proposes that incentives or penalties in 2016 based on 2014 performance for groups of 100 or more providers. **The program is voluntary the first two years, but not later than 2017, the value-based payment modifier will apply to all physicians, regardless of group size.**

Physician Feedback Reporting Program

As part of the Value Based Payment Modifier program, the Secretary is required to provide Physician Feedback reports to providers that measure the resources used in providing care to beneficiaries and the quality of care. In 2013, CMS plans to circulate reports to all groups of physicians with 25 or more EPs (based on their TINs) and to individual physicians that satisfactorily reported measures through PQRS in 2012 regarding their performance on 15 administrative claims based measures. Finally, in the fall of 2014, CMS plans to issue reports based on 2013 data that show the amount of the VBP modifier, and the basis for its determination, to groups with 25 or more EPs. CMS will consider issuing reports to groups of less than 25 professionals, as well as individual professionals, in the future.

For a more detailed summary on the final requirements for the programs highlighted above, visit the Academy's CMS Regulations and Comment letter page at <http://www.entnet.org/Practice/Summaries-of-Regulations-and-Comment-Letters.cfm#CL> or email Academy staff at HealthPolicy@entnet.org.

Academy Highlights Success: Changes in Coding and Reimbursement for ENT Services in 2013

It is critical that Academy members keep in mind that maintaining value for otolaryngology-head and neck surgery services is an enormous success in light of the rigorous review and cost-saving focus of both the AMA RUC and CMS. Therefore, the Academy is

pleased that we were able to maintain, or increase, relative value units for nearly all codes reviewed in the 2012 RUC cycle. The table below includes values approved by CMS for CY 2013.

As was mentioned in the November 2012 edition of the *Bulletin*, members

can expect several coding changes for ENT services in CY 2013. Many of these changes are discussed in our summary of the 2013 final Medicare Physician Fee Schedule, which is posted on the Academy website at <http://www.entnet.org/Practice/>

Year	CPT Code	Descriptor	Work RVU
ENDOSCOPY / SURGERY			
2012	31231	Nasal Endoscopy, Dx	1.10
2013	31231	Nasal Endoscopy, Dx	1.10
COMPLEX REPAIR / SURGERY			
2012	13132	Cmplx rpr f/c/c/m/n/ax/g/h/f	6.58
2013	13132	Cmplx rpr f/c/c/m/n/ax/g/h/f	4.78
2012	13150	Cmplx rpr e/n/e/l 1.0 cm/<	3.85
2013	13150	Cmplx rpr e/n/e/l 1.0 cm/<	3.58
2012	13151	Cmplx rpr e/n/e/l 1.1-2.5 cm	4.49
2013	13151	Cmplx rpr e/n/e/l 1.1-2.5 cm	4.35
2012	13152	Cmplx rpr e/n/e/l 2.6-7.5 cm	6.37
2013	13152	Cmplx rpr e/n/e/l 2.6-7.5 cm	4.90
EXCISION / SURGERY			
2012	40490	Biopsy of lip	1.22
2013	40490	Biopsy of lip	1.22
AUDITORY			
2012	69200	Clear outer ear canal	0.77
2013	69200	Clear outer ear canal	0.77
2012	69433	Create eardrum opening	1.57
2013	69433	Create eardrum opening	1.57
SLEEP MEDICINE			
2012	95782	Polysom <6 yrs 4/> paramtrs	n/a
2013	95782	Polysom <6 yrs 4/> paramtrs	2.60
2012	95783	Polysom <6 yrs cpap/bilvl	n/a
2013	95783	Polysom <6 yrs cpap/bilvl	2.83
NEGATIVE WOUND PRESSURE THERAPY			
2012	G0456	Neg pre wound <=50 sq cm	n/a
2013	G0456	Neg pre wound <=50 sq cm	Carrier Priced
2012	G0457	Neg pres wound >50 sq cm	n/a
2013	G0457	Neg pres wound >50 sq cm	Carrier Priced

Summaries-of-Regulations-and-Comment-Letters.cfm. The Academy also provided comments to CMS on all provisions of the final fee schedule that affect our members, including the valuation information for 2013.

Specific fluctuations in reimbursement for these services are demonstrated by the table below this article. The Academy participated either directly, or via comment and/or monitoring, in the development of recommendations

to the AMA RUC for all of the following procedures. For several codes, such as the complex wound repair family of codes, the Academy was asked to collaborate with other specialty societies (e.g., American Society of Plastic Surgery and American Academy of Dermatology) to develop relative value and practice expense recommendations. Those recommendations are then reviewed by the AMA RUC and either approved or

modified. CMS is then presented with the AMA RUC's value recommendations and may either approve or modify the values for these services. They then post their final determinations in the final Medicare physician fee schedule final rule each year.

In the event members have any questions regarding the above information or modifications to specific codes, please email us at healthpolicy@entnet.org. [b](#)

	PE Non-facility RVU	Malpractice RVU	TOTAL RVU	Change in RVUs	% Change in RVUs
	4.57	0.12	5.79		
	5.38	0.12	6.60	0.81	12%
	9.49	0.98	17.05		
	8.77	0.71	14.26	-2.79	-20%
	6.06	0.61	10.52		
	6.89	0.57	11.04	0.52	5%
	6.76	0.67	11.92		
	7.64	0.65	12.64	0.72	6%
	9.16	0.95	16.48		
	8.70	0.73	14.33	-2.15	-15%
	2.42	0.18	3.82		
	2.52	0.18	3.92	0.10	3%
	2.87	0.10	3.74		
	2.93	0.10	3.80	0.06	2%
	4.28	0.22	6.07		
	4.48	0.22	6.27	0.20	3%
	n/a	n/a	0.00	n/a	n/a
	28.46	0.29	31.35	31.35	100%
	n/a	n/a	0.00	n/a	n/a
	29.67	0.33	32.83	32.83	100%
	n/a	n/a	0.00	n/a	n/a
	Carrier Priced	Carrier Priced	Carrier Priced	Carrier Priced	Carrier Priced
	n/a	n/a	0.00	n/a	n/a
	Carrier Priced	Carrier Priced	Carrier Priced	Carrier Priced	Carrier Priced

They Are Our Patients and Our Data

Rahul K. Shah, MD, George Washington University School of Medicine, Children's National Medical Center, Washington, DC

There are myriad databases reporting on a physician's outcomes, or a surgeon's complications, your partner's length of stay, and many other types of data being collected by societies, institutions, government, and commercial insurers, just to name a few. However, many of these databases and the data are not owned by the patients or the physicians that care for the patients. Hospitals, and in some cases, practices, submit data, often times mandatory, that is then collated and put together in aggregate. From there, the data is compiled at a national level to make meaningful analysis statistically significant.

We are excited to soon launch a patient safety event web portal on the AAO-HNS website. This is the end result of an attempt to develop a mechanism where we can have our physicians securely and confidentially report on near misses, adverse events, and medical errors.

The original idea was to consider forming an otolaryngology-specific Patient Safety Organization (PSO) that would serve such a role. There are significant administrative burdens to forming PSOs, and the investment did not appear to provide real value to members. Under the guidance the AAO-HNS quality improvement staff, the Patient Safety and Quality Improvement Committee has created a secure patient safety event web portal that enables physician members to enter events.

Academy staff have gone to great lengths to ensure the protection of the

reporting physician's information and the subsequent report. Furthermore, none of the fields in the reporting form allow for identification of a particular patient, location, venue, etc.

It is exciting to consider the potential of an event reporting database. The Federal Aviation Administration has the most robust reporting system where pilots and crew are mandated to complete such a report when specific events occur. No such system exists in healthcare or our specialty.


The power of some aggregate level data cannot be over-emphasized. The rare frequency of events that we are looking at may only happen in 1:30,000 instances, or less. An individual practitioner, for example, may have heard and known about a case of misadministration of concentrated epinephrine, but they may not have personally ever experienced such an occurrence. Does this make the problem less of a latent systems defect? Of course not. It just makes it much harder for physicians to see the magnitude and the scope of the issue.¹

This is precisely where the reporting system becomes valuable. By surgeons reporting events that are of concern to them, we will have the ability to immediately identify zones of risk. Once these areas are identified, we can proactively study them to attempt to put

measures in place to assist in mitigating future events.

The major caveat of this platform is that the data is only as good as the input.



For example, if we have 1,000 reports (one per every four physician members) in our first year, we are confident that there would be actionable alerts and possibly interventions that would come from these reports. However, we do fear that if there are only five reports all year, then the database becomes meaningless. This is our opportunity to report on instances of near misses, adverse events, and medical errors that directly influence our practice and our patients. Rarely do we have such an ability to affect the safety and quality of the care provided to our patients. We look forward to periodically sharing the data with members. 

References

1. Shah RK, Hoy E, Roberson DW, Nielsen D. Errors with Concentrated Epinephrine in Otolaryngology. *Laryngoscope*. 2008 Nov;118(11):1928-30.

We encourage members to write us with any topic of interest. We will try to research and discuss the issue. Members' names are published only after they have been contacted directly by Academy staff and have given consent to the use of their names. Email the Academy at qualityimprovement@entnet.org to engage us in a patient safety and quality discussion that is pertinent to your practice.

Clinical Consensus Statement: Tracheostomy Care

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Tracheostomy

Tracheostomy is one of the oldest and most commonly performed surgical procedures among critically ill patients.¹⁻⁵ Tracheostomy creates an artificial opening, or stoma, in the trachea to establish an airway through the neck.⁶ The stoma is usually maintained by inserting a tracheostomy tube through the opening.^{7,8}

Tracheostomy is increasingly performed on adults in intensive care units (ICU) for upper airway obstruction, prolonged endotracheal intubation, and

for those requiring bronchial hygiene.⁹ In adults, the traditional surgical tracheostomy has been accompanied by the emergence of percutaneous dilatational techniques (PDT). Adult tracheostomy can be performed in the operating room or at the bedside in an intensive care unit. In children, other than on rare emergencies, tracheostomy is performed in the operating room with the child intubated under general anesthesia. In children, tracheostomy is most frequently performed in the first year of life due to the increased survival of premature infants requiring prolonged ventilation.¹⁰

A review of the literature on the care and management of tracheostomy shows a paucity of both well-controlled studies and high-quality evidence. The majority of publications are book chapters, expert opinion, and small observational studies. There are essentially no controlled studies or peer-reviewed papers to guide care or practice in this field.

As evidence-based research is lacking, the current literature does not support the development of a clinical practice guideline, but favors a consensus of expert opinions.

Consensus Statement Development

A consensus panel was therefore convened by the American Academy of Otolaryngology—Head and Neck Surgery Foundation (AAO-HNSF) to create a clinical consensus statement (CCS). An organized group of multidisciplinary experts was selected to review the literature, synthesize information, and clarify specific areas of controversy or ambiguity regarding the care and management of patients with a tracheostomy. Despite significant differences between pediatric and adult tracheostomy care, the panel concluded there are sufficient similarities to justify a single document for both groups of patients.

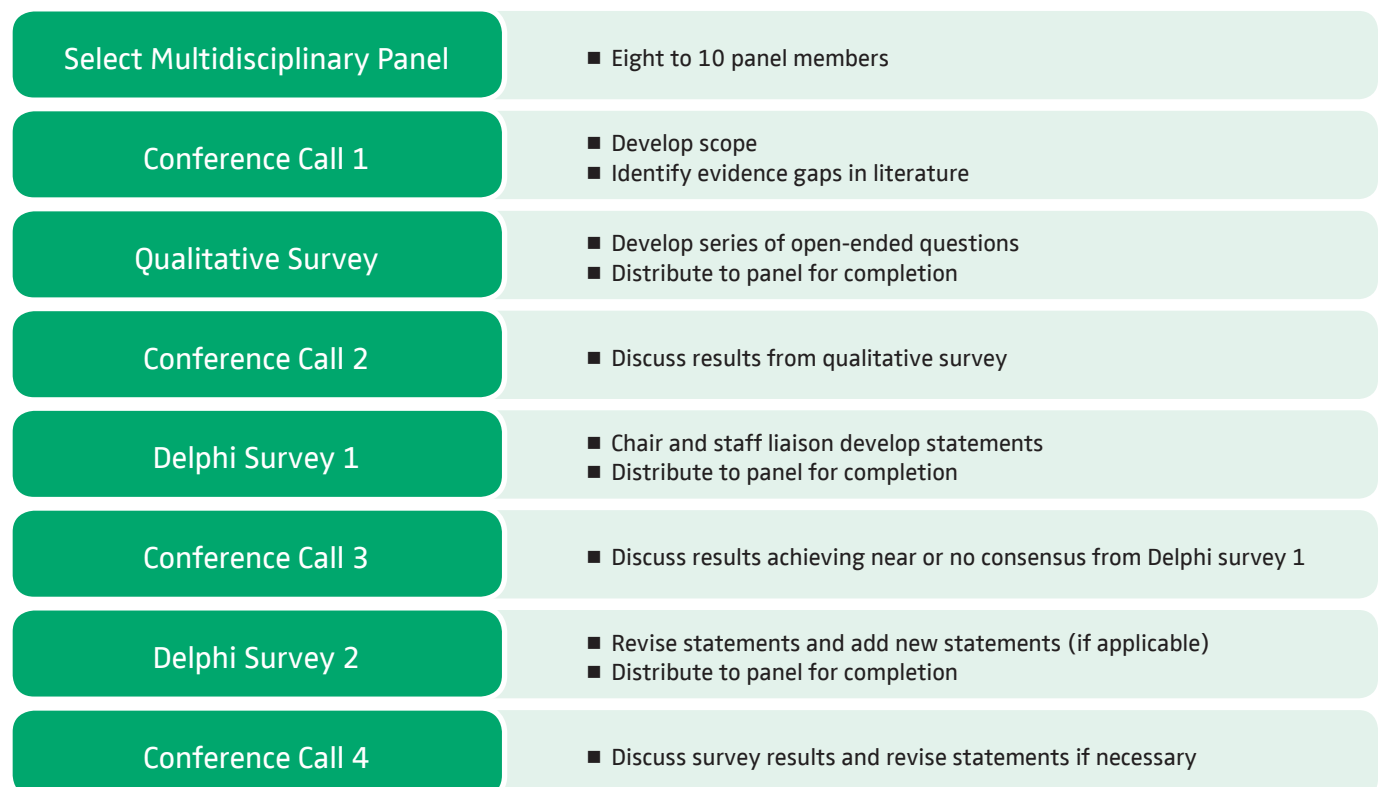


Figure 1. Modified Delphi method for achieving consensus.

The findings of this consensus group are stated as opinions or suggestions, not as recommendations. Clinicians should always act and decide in a way they believe will best serve their patients' interests and needs, regardless of consensus opinions. They must also operate within their scope of practice and according to their training. The consensus panel made suggestions about a large number of statements that dealt with a variety of subjects including the most appropriate tracheostomy tube type, suctioning, humidification, patient and caregiver education, home care, emergency care, decannulation, tube care (including use of cuffs and sutures), as well as overall clinical airway management. The panel also dropped a number of statements on utility of tracheostomy ties or sutures, cleaning methodology, specific circumstances when the tube should be changed, utility of cuffs, and desired frequency of changing the tube.

This consensus statement was developed using a modified Delphi method, a systematic approach to achieving consensus among a panel of topic experts. Initially designed by the RAND Corporation to better utilize group information in the 1950s, this methodology has been modified to accommodate advances in technology and is used widely to address evidence gaps in medicine and improve patient care without face-to-face interaction.^{11,12} Figure 1 provides an overview of the consensus process used to create this CCS.

Panel members were asked to complete two surveys utilizing a nine-point Likert scale to measure agreement (see Table 1). An outlier was defined as any rating at least two Likert points away from the mean.

Each survey was followed by a conference call during which results were presented and statements discussed. Statements were categorized as follows:

- **Consensus:** Statements achieving a mean score of 7.00 or higher and have no more than one outlier.

- **Near consensus:** Statements achieving a mean score of 6.50 or higher and have no more than two outliers.
- **No consensus:** Statements that did not meet the criteria of consensus or near consensus.

Key Consensus Statements

Of the 77 statements that achieved consensus, 13 were considered the most important for day-to-day tracheostomy care in adults and children and are presented in Table 2.

Research Needs


Further research is needed in a number of areas highlighted in this document:

- To define quality metrics related to tracheostomy care, (optimal tracheostomy tube size, role of tracheostomy tube cuffs, role of sutures and ties in preventing accidental decannulation, cleaning and suctioning techniques, frequency and timing of tracheostomy tube change) that correlate to early hospital discharge.
- To define important factors in patients with a tracheostomy that may influence the frequency of site infections, accidental tube displacement, emergency room visits, and re-admission to hospital. Important factors may include optimal cleaning and suctioning techniques, patient and caregiver education, frequency of follow up care, training, and competency of home care nurses.
- Determine whether trained Advanced Practice Providers (APPs) are able to perform initial tracheostomy changes with similar or fewer complication rates compared to experienced physicians.

More Information

This article is freely available to AAO-HNS members and the public at *Otolaryngology—Head and Neck Surgery*, visit <http://oto.sagepub.com>.

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12. Dalkey NC. *The Delphi Method: An Experimental Study of Group Opinion*. Santa Monica: RAND Corporation;1969. RM-5888-PR. 

Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree
1	2	3	4	5	6	7	8	9

Table 1. Likert scale used to measure level of agreement among respondents for both Delphi surveys.

Table 2. Key statements achieving consensus.

#	Statement	Mean	Median	Mode	IQR	Range
1	The purpose of this consensus statement is to improve care among pediatric and adult patients with a tracheostomy.	8.56	9	9	1	8-9
2	Patient and caregiver education should be provided prior to performing an elective tracheostomy.	8.22	9	9	2	7-9
3	A communication assessment should begin prior to the procedure when non-emergent tracheostomy is planned.	7.67	7	7	2	7-9
4	All supplies to replace a tracheostomy tube should be at bedside or within reach.	8.78	9	9	0	7-9
5	An initial tracheostomy tube change should normally be performed by an experienced physician with the assistance of nursing staff, a respiratory therapist, medical assistant, or assistance of another physician.	8.22	8	9	1.5	7-9
6	In the absence of aspiration, tracheostomy tube cuffs should be deflated when a patient no longer requires mechanical ventilation.	8.22	9	9	2	7-9
7	In children, prior to decannulation, a discussion with family regarding care needs and preparation for decannulation should take place.	8.67	9	9	1	8-9
8	Utilization of a defined tracheostomy care protocol for patient and caregiver education prior to discharge will improve patient outcomes and decrease complications related to their tracheostomy tube.	8.11	8	9	2	7-9
9	Patients and their caregivers should receive a checklist of emergency supplies prior to discharge that should remain with the patient at all times.	8.89	9	9	0	8-9
10	All patients and their caregivers should be evaluated prior to discharge to assess competency of tracheostomy care procedures.	8.89	9	9	0	8-9
11	Patients and their caregivers should be informed of what to do in an emergency situation prior to discharge.	8.89	9	9	0	8-9
12	In an emergency, a dislodged, mature tracheostomy should be replaced with the same size or a size smaller tube or an endotracheal tube through the trach wound.	8.44	9	9	2.5	7-9
13	In an emergency, patients with a dislodged tracheostomy that cannot be re-inserted should be intubated (when able to intubate orally) if the patient is either failing to oxygenate, ventilate, or there is fear the airway will be lost without intubation.	8.11	9	9	2.5	5-9

AcademyU® Education Opportunities: A Great Member Value

By now, you should have discovered the *AcademyU® Education Opportunities* catalog that is included with this issue of the *Bulletin*. The catalog contains a complete description and listing of the education and knowledge resources available to members through the AAO-HNS/F. In total, these resources are a great value for all Academy members, including physicians and physicians-in-training in otolaryngology-head and neck surgery, general practice physicians, physician extenders, and medical students.

In the December *Bulletin*, we launched the new *AcademyU®, Your Otolaryngology Education Source*. This single source brings you hundreds of education and knowledge resources covering a variety of topics organized by the eight specialties within otolaryngology-head and neck surgery. *Education Opportunities* is an easily accessible and comprehensive look at all of these resources.

As described in *Education Opportunities*, the Foundation's education and knowledge resources span several learning formats and designs. This diversity should appeal to members' different education needs, learning styles, and desires whether they are live events, subscriptions, online education, eBooks, or knowledge resources.

■ **Live Events:** The Annual Meeting & OTO EXPOSM and the regional Coding and Reimbursement Workshops offer interaction with experts and networking with colleagues and an opportunity to earn continuing education credit.

■ Subscriptions:


Patient Management Perspectives in OtolaryngologySM and Home Study Course are subscription products offering in-depth and comprehensive learning opportunities and continuing education credit.

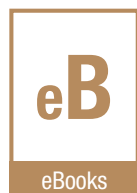


to trauma. Each is easily accessible and downloadable from the Academy website.

■ **Knowledge Resources:** Products that assist with test preparation, applying new skills, resident education, and enhancing presentations include AcademyQTM, ENT Exam Video Series, COCLIASM, and the ImageViewer.

During the course of the next year, we will be taking an in-depth look at each of the elements that fall under these categories. Through these *Bulletin* articles, you will see that each resource, developed by leading experts, is designed to deliver relevant education and knowledge that is meaningful to your practice.

"AAO-HNSF is dedicated to providing the highest quality education elements to meet member learning needs throughout all phases of your professional career. Please use the 2013 *Education Opportunities* and take advantage of the exciting education offerings available through the Foundation" emphasized **Sonya Malekzadeh, MD**, AAO-HNSF Coordinator for Education. 



■ **Online Education:** The Foundation offers nearly 200 self-based and interactive online courses, including the Online Lecture Series and COOL cases; most provide continuing education credit for physicians and physician assistants.

■ **eBooks:** There are currently five eBooks published by the Foundation that can be used as references and guides in the care of patients. They cover the gamut from geriatric care

The AAO-HNS Foundation is committed to increasing member awareness and engagement in the education and knowledge resources available from AcademyU®, the Foundation's otolaryngology education source.

AAO-HNSF ANNUAL MEETING & OTO EXPO

CALL FOR PAPERS 2013 DEADLINES:

Instruction Course
Submissions Closed
Notifications Sent: Late March 2013

Miniseminar
Submissions Closed
Notifications Sent: Late March 2013

Scientific (Oral & Poster)
Submission Open: January 21, 2013
Submission Closes: February 18, 2013
Notifications Sent: Late April 2013

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International Conference on Head and Neck Cancer, Toronto a Huge Success

*Eugene N. Myers, MD, FRCS Edin (Hon)
Distinguished Professor and Emeritus Chair
University of Pittsburgh*

Eugene N. Myers, MD, FRCS Edin (Hon), was the guest of honor at the 8th International Conference on Head and Neck Cancer at the Metro Toronto Convention Center in Ontario, Canada, July 21-25, 2012. The conference was a huge success with 1,860 participants attending from more than 70 countries. There were seven keynote speakers, 406 oral presentations, 1,030 posters, and 39 instructional courses, including a full-day ACS hands-on ultrasound course.

Carol R. Bradford, MD, president of the American Head and Neck Society, presided over the meeting. The conference chair, **Jeffrey N. Myers, MD, PhD**, assembled an astonishingly broad-based and energized meeting and introduced his father, Dr. Eugene N. Myers, as guest of honor.

The program chair was Jonathan Irish, MD, MSc, FRCSC, and other conference leadership was provided by **Robert L. Ferris, MD, PhD**, chair for proffered papers, **Eben L. Rosenthal, MD**, poster sessions chair, and **Bert W. O'Malley, Jr., MD**, fundraising chair. [b](#)



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International Reception, Washington, DC, with African and Bahraini guests. International Visiting Scholar Muluken Bekele, MBBS, Ethiopia (far left), Catherine Lincoln, Academy senior manager, international chair, third from left.

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XIII Belinov Symposium, Bulgaria

*Eugene N. Myers, MD, FRCS Edin (Hon)
Distinguished Professor and Emeritus Chair
University of Pittsburgh School of Medicine*

The XIII Belinov Symposium took place in the Melia Grand Hermitage Hotel, Golden Sands, Varna, Bulgaria, on September 28-30, 2012, sponsored by the Bulgarian National Society of Otorhinolaryngology-Head and Neck Surgery and the Association of Otorhinolaryngologists' Professor Dr. Stoyan Belinov-Isul.

Thanks to the leadership of Rumen Benchev, MD, PhD, organizing committee chair and president of the Bulgarian National Society, and to the outstanding contribution of Dr. Dilyana Vicheva and Prof. Haruo Takahashi (Japan), the symposium was well organized with 231 delegates including speakers from the U.S., Israel, Germany, and Japan.



Dr. Dilyana Vicheva, Bulgaria (L), and Prof. Haruo Takahashi, Japan, at Belinov Symposium.



Prof. Dan Fliss, Israel (R), and Dr. Mario Milkov, Bulgaria.

Diana Popova, MD, PhD, was chair of the scientific committee and of the Association of Otorhinolaryngologists. Papers were given in both Bulgarian and English with simultaneous translation and the delegates paid a great deal of attention to the academic lectures.

The meeting opened officially with a Plenary Lecture by myself, on "The Changing Role of the Surgeon in the Era of Chemoradiation," followed by other interesting papers on "Turbinate Surgery, Concepts and Techniques—Conservative Surgical treatment of the Turbinates" by **John F. Pallanch, MD**, Mayo Clinic; "Pathophysiologic Mechanism of Fungi in Chronic Rhinosinusitis" by Dr. Vicheva; "Hearing Improvement Operations in Otosclerosis" by Ivan Tsenev, MD; and "Benefits of Nasal Douches" by Dr. Benchev, all from Bulgaria.

In his informative lecture, Dr. Benchev told of the increasing popularity of nasal douches, stimulated by those who participate in yoga. Other noteworthy lectures were presented by **Dan Fliss, MD**, (Israel) on "Treatment of Paranasal Sinus Tumors;" Prof. Takahashi on "Pathogenesis and Management of Cholesteatoma from the Viewpoint of Middle Ear Pressure Regulation;" and **Prof. Karl Hoermann, MD**, on "Challenges of the Frontal Sinus" and "Snoring and OSAS—New Aspects."

The next two days were primarily dedicated to rhinology sessions in cooperation with the Bulgarian Rhinological Society. In addition, there were plenary sessions on laryngology and otology. The Bulgarian hospitality was superb, including a cocktail reception after the opening session and a splendid gala dinner in the Hotel Admiral, Golden Sands. [b](#)



Dr. Karl Hoermann, Germany.

Surgical Humanitarian Trip to Moi University Teaching and Referral Hospital, Eldoret, Kenya

Mark C. Royer, MD

My recent surgical outreach trip to Moi University Teaching and Referral Hospital (MTRH) in Eldoret in western Kenya was a continuation of the strong relationship that has developed between the otolaryngology departments at MTRH and Indiana University School of Medicine (IUSM), Indianapolis, IN, as part of the institution-wide partnership, the IU-Kenya Program.

The otolaryngology relationship commenced when **Susan R. Cordes, MD**, traveled to Eldoret to search for ways the IUSM otolaryngology department could develop an international presence. Since this initial visit, Dr. Cordes and surgeons from our department have taken part in several surgical and teaching trips.

I was fortunate to be included in the February 2012 trip and performed a variety of otolaryngology procedures including pediatric cleft lip and palate repairs, osteosarcoma resection with pectoralis flap reconstruction, endoscopic sinus surgery, and various otologic procedures. The physician team consisted of four from IUSM— Dr. Cordes (residency program director), **Taha Z. Shipchandler, MD**, (facial plastics and reconstructive surgery), **Charles W. Yates, MD** (neurotology), and myself (PGY-5), and **Kimberly Rutherford, MD** (PGY-5, University of Connecticut).

In addition to seeing patients in clinic and performing surgeries, Dr. Rutherford and I spent time teaching Moi University medical students. During this trip, I especially enjoyed the camaraderie between the IUSM team and the Kenyan otolaryngologists, meeting patients and their families from all across western Kenya, and developing the requisite problem-solving skills necessary to perform complicated procedures within the limitations of developing world operating rooms.



Dr. Royer examines a cleft lip patient in the ENT clinic at Moi University Teaching and Referral Hospital, Eldoret, Kenya.



Pre-operative picture (left) and Dr. Royer on post-operative ICU rounds (right) caring for a 25-year-old patient after resection and pectoralis flap reconstruction of a large facial mass.



Dr. Royer with a post-operative cleft lip patient and mother at Moi University Teaching and Referral Hospital, Eldoret, Kenya.

A highlight of the trip was again seeing and working with my friend, **Henry N. Nono, MD**, a Moi University otolaryngologist, who was awarded an AAO-HNSF International Visiting Scholarship to attend the AAO-HNSF 2011 Annual Meeting & OTO EXPOSM and spent several weeks with the IUSM otolaryngology department. With our support, Dr. Nono hopes to complete a head and neck fellowship to increase the acuity of care he can provide for patients in western Kenya.

The IUSM-Moi otolaryngology partnership continues to develop the scope and patient care abilities for the future. I look forward to participating in and supporting these efforts for years to come. Many thanks to the AAO-HNSF Humanitarian Efforts Committee and the Alcon Foundation, for their support which made my participation in this trip possible. [b](#)

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The Department of Otolaryngology/Head & Neck Surgery at West Virginia University is seeking a general otolaryngologist to join a thriving academic practice in the summer of 2013. Applicants must be board certified/eligible by the American Board of Otolaryngology. Responsibilities include teaching of residents and medical students, patient care and clinical/basic research.

The department currently has ten physician faculty members and fifteen residents and has an active NIH-funded research division with three PhD members.

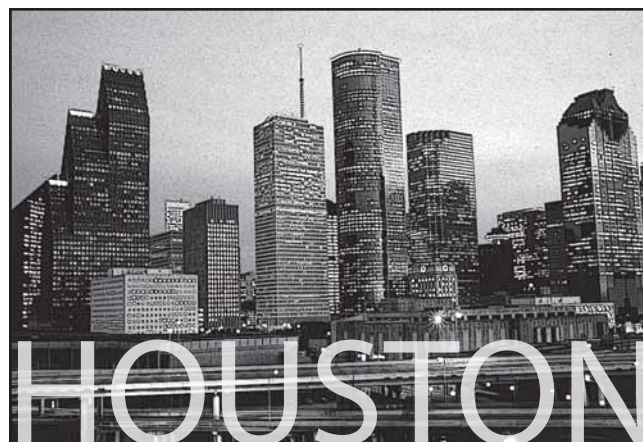
With a metro area population of over 115,000, Morgantown, WV, is consistently rated as one of the best small cities in the U.S., with affordable housing, excellent schools, a picturesque countryside, many outdoor recreational activities, and close proximity to major cities, such as Pittsburgh, PA, and Washington, DC.

The position will remain opened until filled. For more information please contact:

Laura Blake
Director, Physician Recruitment
blakel@wvuhealthcare.com
Fax: 304.293.0230

<http://www.hsc.wvu.edu/som/otolaryngology/>

West Virginia University is an AA/EO Employer. WVU Health Sciences is a tobacco free campus. West Virginia University is the recipient of an NSF ADVANCE award for gender equity.



Pediatric Otolaryngology - Academic Position

The Department of Otorhinolaryngology is recruiting a third Pediatric Otolaryngologist to join a busy, tertiary Pediatric Otolaryngology practice. This is a unique opportunity to join a rapidly growing Department at a major University Children's Hospital with a large Level III NICU and a Level I Trauma Center. Excellent compensation and benefits. Academic appointment commensurate with experience. Strong interest in resident and medical student teaching and research is encouraged.

Applicants should forward a CV and statement of interest to:

Soham Roy, MD, FACS, FAAP

Director of Pediatric Otolaryngology

The University of Texas Medical School at Houston

Department of Otorhinolaryngology-Head & Neck Surgery
713-383-3727 (fax)

Soham.Roy@uth.tmc.edu

<http://www.ut-ent.org>



UTMSH is an equal opportunity employer.

The University of Kansas Department of Otolaryngology-Head & Neck Surgery is seeking a laryngologist, a head and neck surgeon, and a rhinologist/skull base surgeon who are interested in full-time academic positions.

The successful candidate will have fellowship training with expertise in their specialty and is BC/BE. The candidate will join as an Assistant or Associate Professor and will be involved with resident and medical student education while developing a strong clinical practice and research interests.

Laryngologist

Position Number M0204650

Join a busy voice and swallow team with a state-of-the-art laryngeal lab and experienced speech pathology support.

Head and Neck Surgeon

Position Number M0203642

Join a division of four head and neck surgeons. Fellowship in microvascular surgery, surgical oncology and an interest in oncologic research preferred.

Veterans Affairs Clinician/Scientist

The Department is looking for a full-time VA position with potential for VA research funding. Ideally this position will allow 50% protected time for research.

Head and Neck Fellowship

Clinical Focus: Head and Neck Surgical Oncology, Skull Base Surgery, Endoscopic Laser Surgery, Minimally Invasive Endocrine Surgery, Microvascular Reconstructive Surgery and Robotic Surgery.

Applications are accepted through the American Head and Neck Society: www.ahns.info.



To view position online, go to <http://jobs.kumc.edu>
(Search by position number.)

Letters of inquiry and CV may be mailed to:

Douglas Girod, MD, FACS, Professor and Chairman

The University of Kansas School of Medicine

Department of Otolaryngology-Head & Neck Surgery

3901 Rainbow Blvd. MS 3010, Kansas City, KS 66160

The University of Kansas School of Medicine is an Equal Opportunity/Affirmative Action employer.



Purchase ENT, a well-established regional ENT practice in Western Kentucky, is actively searching for physicians to join our practice. Paducah, Kentucky offers everything from Broadway shows at the Carson Center to festivals like the annual BBQ on the River. Located a short 20 minute drive from Kentucky and Barkley Lakes, and the Land Between the Lakes National Recreation Area, where great recreational opportunities are offered, and also just a short two to three hour drive to larger cities like Nashville, Memphis, St. Louis and Louisville, Paducah is a great community. There is something for everyone in the region.

Purchase ENT is well respected in the medical community and is a very progressive practice offering in-office Allergy, Audiology, CT Scan, and Ultrasound. Additionally, there is an investment opportunity in a successful ambulatory surgery center. Although we are seeking candidates to practice general ENT, a fellowship in Otology or Head and Neck would be welcomed. For the successful candidate, the opportunity is a one year partnership track. For additional information about this great opportunity, contact Jim Wring, Practice Administrator at jwring@purchaseent.com or 270-408-3208.

WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE

Faculty Positions

THE DEPARTMENT OF OTOLARYNGOLOGY -
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ACADEMIC OTOLARYNGOLOGISTS

With training and/or interest in either microlaryngology
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The successful candidates must demonstrate experience and capability. Academic appointment and compensation commensurate with training and experience. Practice income available to augment negotiated salary.

Send letter of interest and CV to:

Robert H. Mathog, M.D.
Professor and Chair
Department of Otolaryngology
540 E. Canfield, 5E-UHC
Detroit, MI 48201
(313) 577-0804

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OTOLARYNGOLOGIST OPPORTUNITY

Geisinger Wyoming Valley (GWV) Medical Center, Wilkes-Barre, Pa., is seeking a BC/BE Otolaryngologist.

Geisinger's otolaryngology specialists treat a wide range of conditions of the head and neck by providing the latest technologies in diagnostic, medical, surgical and rehabilitative techniques. We have board-certified and fellowship-trained specialists who collaborate to ensure the most comprehensive care.

About the Position

- Take part in the growth of this dynamic department
- Pursue research in your area of interest

Geisinger Wyoming Valley (GWV) Medical Center, Wilkes-Barre, Pa., is an acute care hospital that is licensed for 243 beds and houses the only Level II Trauma center in Luzerne County. The campus includes the Frank M. and Dorothea Henry Cancer Center, The Richard and Marion Pearsall Heart Hospital, the Janet Weis Children's Hospital Pediatric Unit, a transplant program and the Brain & Spine Tumor Institute. Geisinger South Wilkes-Barre (GSWB) is GWV's ambulatory campus.

**Discover for yourself why Geisinger has been nationally recognized
as a visionary model of integrated healthcare.**

For more information
or to apply for this
position, please contact:

Autum Ellis,
Department of
Professional Staffing,
at 1-800-845-7112 or
amellis1@geisinger.edu



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Mayo Clinic • Scottsdale, Arizona • April 3-6, 2013

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Prof. Piero Nicolai (Italy)

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Peter H. Hwang, MD
Juan Fernandez-Miranda, MD
Carl H. Snyderman, MD
James A. Stankiewicz, MD

Course Director: Devyani Lal, MD**Mayo Clinic and Arizona Faculty:**

Stephen F. Bansberg, MD
Timothy W. Haegan, MD
Joseph M. Hoxworth, MD
Erin K. O'Brien, MD
John F. Pallanch, MD
Naresh P. Patel, MD
Ryan M. Rehl, MD

Endoscopic Sinus and Skull Base Surgery 2013 is our second state-of-the-art course designed for otolaryngologists and endoscopic skull base surgeons. The curriculum will focus on inflammatory sinus disease on April 3-4, highlighting advanced, salvage and novel treatment strategies. Endoscopic skull base surgery will be the focus April 5-6. The curriculum is designed to introduce the novice surgeon to basic techniques, and provide advanced training for the more experienced surgeon. Hands-on dissection sessions will be conducted in our world-class laboratory with fresh frozen cadavers, powered instrumentation and image guidance.

Accommodations: Westin Kierland Resort • www.kierlandresort.com

• (480) 924-1202 • Residence Inn Phoenix Desert View at Mayo Clinic
• www.marriott.com/phxmh • (800) 331-3131

Meeting Location: Mayo Clinic's Phoenix and Scottsdale campuses

To Register, Contact MSCPD: www.mayo.edu/cme/otorhinolaryngology

• email: mca.cme@mayo.edu • (480) 301-4580

Featuring: Hands-on dissection, live prosection and endoscopic 3D anatomy



The Department of Otolaryngology at West Virginia University

is seeking a fellowship-trained head and neck surgeon to join a well established head and neck oncology service in the summer of 2013. Expertise with both ablative and reconstructive procedures is desired. Responsibilities include education of residents and medical students and patient care. Opportunities are available for those interested in clinical/basic research.

The department currently has ten physician faculty members and fifteen residents and has an active NIH-funded research division with three PhD members.

West Virginia University is located in beautiful Morgantown, which is rated one of the best small towns in America in regard to quality of life. Located 80 miles south of Pittsburgh and three hours from Washington, DC, Morgantown has an excellent public school system and offers culturally diverse, large-city amenities in a safe, family setting.

The position will remain opened until filled. Please send a CV with three professional references to:

Laura Blake

Director, Physician Recruitment

Fax: 304-293-0230

blakel@wvuhealthcare.com

<http://www.hsc.wvu.edu/som/otolaryngology/>

West Virginia University is an AA/EQ Employer. WVU Health Sciences is a tobacco free campus. West Virginia University is the recipient of an NSF ADVANCE award for gender equity.

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Presbyterian Medical Group is seeking two BC/BE otolaryngologists to join our outstanding, well-established group of ENT providers. Have a satisfying full-spectrum ENT practice with a large built-in referral base while at the same time enjoying a great quality of life in the beautiful Southwest. ER call 4 days/month. Practice call shared equally among group. Our medical group employs more than 600 primary care and specialty providers and is the fastest growing employed physician group in New Mexico.

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Albuquerque thrives as New Mexico's largest metropolitan center and has been listed as one of the best places to live in the United States by several major publications. A truly diverse and multicultural city, Albuquerque offers you and your family a wide variety of experiences, outdoor activities and entertainment. It is also home to the University of New Mexico, a world renowned institution.

Contact Michael Criddle, MD at mcriddle@phs.org or Kay Kernaghan, Physician Recruiter, kkernagh@phs.org or 505-823-8770 for more information or to forward CV. Please visit our website at www.phs.org

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*AAFP RS	American Academy of Facial Plastic and Reconstructive Surgery
ABEA	American Broncho-Esophagological Association
AHNS	American Head and Neck Society
ALA	American Laryngological Association
ANS	American Neurotology Society
AOS	American Otological Society
ARS	American Rhinologic Society
TRIO	The Triological Society

**AAFP RS will be participating in COSM 2013.*

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For questions, contact Beth Faubel at
(312) 202-5033 or visit www.cosm.md



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ENT – RHINOLOGIST

The Department of Otolaryngology-Head and Neck Surgery is seeking a full-time Rhinologist to join the Center for Sinus and Rhinology. The physician will provide the highest level of quality patient-centered healthcare while treating a broad spectrum of rhinology disease. Recently recognized as 11th in the country by US News and World Report, the Department offers a candidate an outstanding opportunity to join our team of highly specialized otolaryngologists who practice in a modern state-of-the-art facility at the Medical Center and in our satellite practices. In addition, the Rhinologist will enhance the teaching of medical students and residents, as well as participate in clinical research.

The candidate is required to have a medical degree, board certified or board eligible, and able to obtain a New York medical license.



PLEASE SEND INQUIRES AND CURRICULUM VITAE TO:

Eric M. Genden, MD
Mount Sinai School of Medicine
Department of Otolaryngology-
Head and Neck Surgery
One Gustave L. Levy Place
Box 1189
New York, NY 10029
or
Email: Lucille.Caputo@msm.edu



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SCHOOL OF MEDICINE

Department of Otolaryngology-Head and Neck Surgery

GENERAL OTOLARYNGOLOGIST/RHINOLOGIST

The Department of Otolaryngology-Head and Neck Surgery invites applications for a full time faculty position at the Assistant or Associate Professor level on the Clinician/Educator track. Fellowship training or experience in rhinology and sinonasal surgery is required. This position carries a full academic appointment at Washington University School of Medicine. Clinical responsibilities will include inpatient and outpatient responsibilities within the Department of Otolaryngology at Barnes-Jewish Hospital and St. Louis Children's Hospital. This position includes responsibility for direct patient care and supervision of residents and medical students, as well as teaching and interdisciplinary collaborations in a very supportive and stimulating academic department. Candidates must be board certified or eligible for certification. Applicants may send their curriculum vitae to: Richard A. Chole, M.D., Ph.D., Lindburg Professor and Head, Department of Otolaryngology, Washington University School of Medicine, 660 South Euclid Avenue, Box 8115, St. Louis, MO 63110 or rchole@wustl.edu or alternatively to Anne E. Getz, M.D. at getza@ent.wustl.edu.



2013 Pediatric Otolaryngology Continuing Education Webinar Series

www.aspo-cme.us

The **2013 Pediatric Otolaryngology Continuing Education Webinar Series** is co-sponsored by the American Academy of Otolaryngology – Head and Neck Surgery Foundation (AAO-HNSF) and the American Society of Pediatric Otolaryngology (ASPO). Over the course of the year expert faculty will address ten pertinent pediatric otolaryngologic topics relevant to the practicing physician.

Register for the webinar series at www.aspo-cme.us.

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February	Gresham Richter, MD
March	Robert Naclerio, MD
April	Sally Shott, MD
May	Kenny Chan, MD
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 Otitis Media Update
 Assessment and Management of Velopharyngeal Dysfunction
 Evaluation of Pediatric Sensorineural Hearing Loss

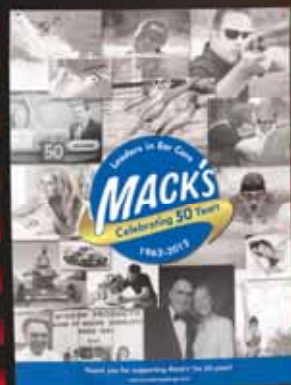
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