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American Academy of Otolaryngology—Head and Neck Surgery
JUNE 2015

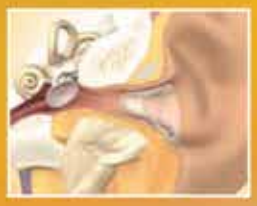
Key tools
for a thriving practice

tmj Next Generation™
comfortable relief

Removable Hollow
Ear Canal Inserts

A Breakthrough in TMJ Pain Relief

Now you can offer your patients the latest technology in TMJ pain relief.
The TMJ NextGeneration™ device is FDA-cleared, safe and effective in reducing TMJ pain.



A New Approach

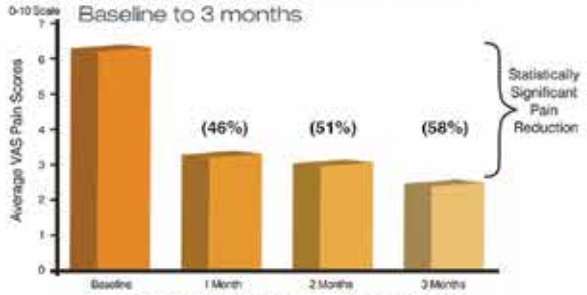
The TMJ NextGeneration™ device consists of custom ear canal inserts that support the temporomandibular joint and reduce pain. It also provides a "cognitive awareness" to the patient that discourages grinding, clenching and other para-functional behavior.

Patient Outcomes

In a clinical trial, subjects experienced statistically significant pain reduction while using TMJ NextGeneration™ devices. Visual Analog Scale scores showed a 58 percent pain reduction after three months of use. At the end of the trial, 100 percent of subjects reported good to excellent results.*

WARNINGS AND PRECAUTIONS: Do not wear devices while showering, swimming or during contact sports. Fluctuations in body weight may require a refitting. You may experience some discomfort when first using the devices. If discomfort worsens, please remove devices and contact your health care provider. Safety and effectiveness has not been established for people with arthritis, and those who have had jaw injuries or jaw or ear surgery. Go to tmjnextgen.com for a full list of risks and warnings.

VAS Pain Reduction Score*



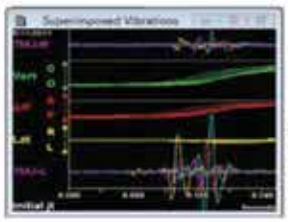
Visual Analog Scale (VAS) scores range from 0 (no pain) to 10 (worst) pain imaginable

TMJ NextGeneration™ Advantages

	TMJ NextGeneration™ Device
• Designed to be worn comfortably 24/7	✔
• No interference with eating or talking	✔
• Barely visible	✔
• No nighttime discomfort	✔
• No negative effect on your bite	✔

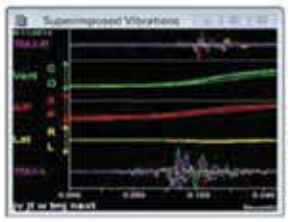
Informal Patient Case Study**

The TMJ NextGeneration™ device supports the jaw joint by preventing the ear canal diameter from collapsing while the jaw opens and closes. This Joint Vibration Analysis (JVA) illustrates the improvement in one patient immediately after insertion.



Initial JVA Summary before insertion of TMJ NextGeneration™

	Average Left	Average Right
Total Integral	26.8	11.7
Integral <200Hz	27.8	16.0
Integral >200Hz	1.8	1.7
>200/<300 Ratio	0.06	0.11
Peak Amplitude	6.1	1.2
Peak Frequency	84	31
Med. Frequency	84	84
Distance to CO	41.8	28.4



JVA Summary after insertion of TMJ NextGeneration™

	Average Left	Average Right
Total Integral	22.2	11.4
Integral <200Hz	23.8	9.7
Integral >200Hz	1.8	1.7
>200/<300 Ratio	0.08	0.17
Peak Amplitude	3.4	0.8
Peak Frequency	82	83
Med. Frequency	74	147
Distance to CO	42.2	28.8

Toll-free number: 855-303-4601

info@tmjnextgen.com • www.TMJNextGen.com

*Tavera A, et al: Approaching Temporomandibular Disorders From a New Direction. A Randomized Controlled Clinical Trial of the TMDes Ear System. J Craniomandibular Practice July 2012; Vol 30, No 3, 172-181.
**This was a single-patient study using JVA to measure the before and after effects with TMJ NextGeneration™ devices; individual results may vary.

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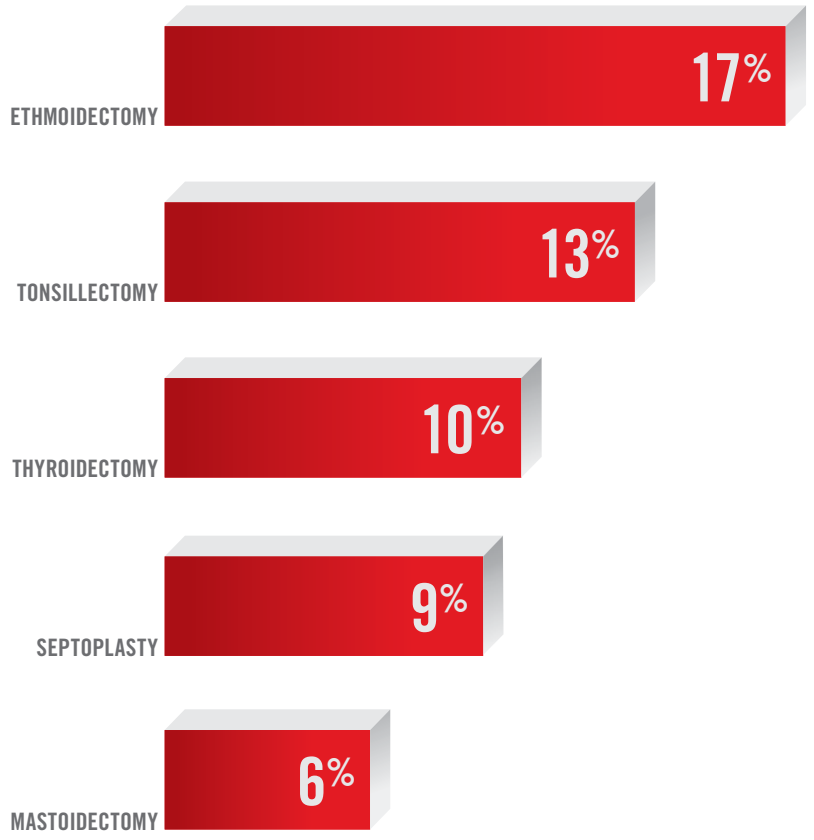

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SEPTEMBER 27 ★ 30, 2015

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I'll take mine with barbecue, please

I don't know about you, but I am *really* looking forward to some good Texas barbecue when we get to Dallas for our Annual Meeting in September. When I was a surgery intern in Baltimore, one of the nurses brought some "barbecue" to a potluck. It was not barbecue. It was ground meat in barbecue sauce (aka a sloppy Joe). Also, you do not "barbecue" a steak when you cook it over a grill. "Barbecuing" is a highly developed process for cooking meat, especially brisket and ribs.

I know this very well because I have deep Texas roots. I was born in Galveston, when my father was a medical student at the University of Texas Medical Center and my mother was a pioneering occupational therapist. I grew up in a small town near the Gulf Coast where my father was the family doctor for nearly everyone I knew. We had quarter horses and I was a barrel racer in summer rodeos. I had barbecue so many times, in so many versions, that it was almost like barbecue sauce flowed through my veins.

But I have not had access to this delicious food for most of my adult life.

I have another reason to feel special about presiding over our AAO-HNSF Annual Meeting in Dallas. This was the city where I attended my very first Academy meeting, in 1979. It was also the very first meeting of the American Academy of Otolaryngology (not yet amended with Head and Neck Surgery) after separating from the American Academy of Ophthalmology and Otolaryngology. I was totally blown away and inspired by that meeting. One of the highlights for me was a movie (in the days before video) demonstrating the use of a laser to remove a cancer from the scalp. The film was produced by **Paul Ward, MD**, a giant in our field who has recently passed away. The movie was quite bloody, and it turned out that the tumor had spread intracranially. (There were no CT scans in those days.) Dr. Ward concluded that the laser was not such a good tool for this lesion! I had great admiration for his courage and honesty in presenting this—an observation that was repeatedly confirmed during the years I knew this man.

Every year, I look forward to the Annual Meeting with great anticipation. One of my mentors, **Gail Neely, MD**, once explained to me that such a gathering is like a baked potato. Allow me to explain this analogy. A potato is very nutritious. There is ample evidence that one could be quite healthy on a diet that consisted of nothing but potatoes and water. (Similarly, you could probably eventually gather all the information presented at the AAO-HNSF Meeting by using journals, textbooks, and online resources.) But the real enjoyment of a baked potato is the other stuff: the sour cream, the cheese, the chives, the bacon. And at the AAO-HNSF Annual Meeting & OTO EXPO℠, we not only hear live presentations and discussions, we can also talk about the issues with friends and colleagues. And to top it all off, we can see all the latest products that we need for our practices and are able to meet personally with the vendors.

So I hope to see you all in Dallas. In addition to barbecue, you should also try chicken fried steak, which I consider to be the "national" food of Texas. I can vouch for the chicken fried steak at our headquarters hotel as being possibly the best that I have ever tasted! ■

Gayle E. Woodson, MD
AAO-HNS/F President

> "At the AAO-HNSF Annual Meeting & OTO EXPO℠, we not only hear live presentations and discussions, we can also talk about the issues with friends and colleagues."

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AAO-HNSF's first Qualified Clinical Data Registry

As the Registry Task Force, chaired by **Lisa E. Ishii, MD, MHS**, completes its work to define what will be otolaryngology's initial Qualified Clinical Data Registry (QCDR), it is appropriate to go over some basics related to clinical registries. Registries can be used for a variety of purposes and can be classified based on the type of data collected, as well as the time frame for collection. The most common are product/device registries, health services registries, and disease process registries. Data collection can be either a single-point collection or longitudinal study format. Providers participate in registries to report quality measures and participate in value-based payment systems; improve quality of care through enhanced population management; participate in recognition and certification programs (MOC); inform treatment decisions; and create data for scientific clinical research.

Probably the task force's most important decision is how otolaryngology would best utilize a QCDR. The range of options includes public reporting; informing guideline development and supporting performance measure development; demonstrating clinical effectiveness; supporting quality improvement; demonstrating payer value; informing alternative payment models; and maintenance of certification and licensure. Once those priorities are determined, the task force will proceed with validation of its decision both internally within the specialty and externally to determine the interest of other stakeholders for the use of clinical data related to otolaryngology. This validation will be done through a combination of surveys and/or interviews with the key stakeholder groups. This will help inform whether the registry will be procedure-based, condition-based, or population-based. The method of data collection will be critical. Ideally, most data can be extracted from existing electronic medical records systems. However, web-based systems can also be quite effective. We also have been conducting interviews with other registry providers to gather information on best practices in registry development, identify key vendors, and gather feedback on lessons learned given the complexity of registry development.

Once these determinations are made, the process of selecting the best vendor begins. The AAO-HNS has retained Avalere as a consultant to assist in this process. There are a number of active QCDRs operating, and their experience and diversity will be beneficial in assisting the task force in narrowing the options. Equally important and challenging will be the selection of the clinical topics that make the most sense and will apply most broadly to otolaryngology. Clinical domains, such as sinusitis, hoarseness, otitis media, tonsillitis, and cerumen impaction, will be considered, as will common procedures, such as laryngoscopy, nasal endoscopy, tonsillectomy, and myringotomy tube placement. After the registry is functioning, additional clinical conditions or procedures can be added in a phased approach so that, ultimately, the registry will represent the full spectrum of our specialty.

One of the great concerns that our Members have revolves around the ability, as well as the difficulty, of reporting quality measures. The recent passage of H.R. 2, repealing the SGR and codifying future quality parameters, consolidated the reporting requirements to center on quality, resource use, meaningful use, and clinical practice improvement. While on the surface this appears to complicate reporting responsibilities for practitioners, the clear commitment to quality as a major feature in future payment models sets the course for physicians to meaningfully participate going forward. The knowledge that this will be required allows us to proceed and develop the tools necessary for our Members to be effective participants in this type of system. This new law also reinforces the roles and utility of QCDRs. QCDR designation is important because it allows those Members participating in the registry to meet Medicare quality reporting requirements by virtue of their participation.

Our timing could not be better in terms of starting this initiative. Many with existing registries today will have to make significant adjustments to their platforms to maximize the registry's utility in meeting these new quality reporting requirements. A specialty-based QCDR can be used to report on all four areas of focus within the new Medicare payment model. The production of new performance measures and practical quality outcomes measures can be expedited and approved using the registry format. This will allow specialties, such as otolaryngology, with a broad spectrum of clinical expertise, the ability to accelerate the production of meaningful reporting and patient improvement instruments representing the needs of our Members and their patients. Look for future articles in the *Bulletin* and ongoing updates through ENTConnect and the Academy website. In addition, we are planning a registry Miniseminar immediately following the Opening Ceremony at the Annual Meeting. ■

James C. Denneny III, MD
AAO-HNS/F EVP/CEO

> "An idea that is developed and put into action is more important than an idea that exists only as an idea."
>
> **Edward de Bono**

Proposed 2015-2016 (FY16) combined budget

Gavin Setzen, MD, Secretary-Treasurer

Budgeting for FY16 represents the collaborative work of both the staff leadership and the members of the Finance and Investment Subcommittee (FISC) to develop a proposed combined AAO-HNS/F budget for the next fiscal year, July 1, 2015, through June 30, 2016 (FY16). The AAO-HNS/F continues to work to support its Members in the most effective and efficient way possible while remaining in compliance with all debt covenants, including the requirement for a balanced budget.

The FY16 budget preparation began in advance of the Boards of Directors strategic planning meeting with staff leaders reviewing their budgets to ensure that all continuing strategic items were able to be funded for FY16. The budget planning process involved each of the business units of AAO-HNS/F submitting their budgets to the financial team that worked with them to assure that revenue and expenses are in line with the mission and priorities of AAO-HNS/F. The financial team is composed of Lynn Frischkorn, director of Budgeting and Special Projects, and Carrie Hanlon, CPA, senior director of Financial Operations. The financial team presented the proposed budget to the FISC for review and approval in March.

The FISC was pleased to see that the strategic goal of identifying $600,000 of cost savings in the FY16 budget was able to be achieved. This allowed for new strategic items developed during the strategic planning meeting to be funded and incorporated into the proposed budget.

The Executive Committees (ECs) of the Boards of Directors (BODs) were presented with the FISC proposed FY16 budget and recommended endorsement for approval by the BODs. During their April meeting the BODs reviewed and conditionally approved the FY16 budget that is presented here for our membership.

In early spring, the FISC also reviewed financial results for the first six months of the FY15 budget year showing that a favorable variance, as compared to budget, is projected for the year.

Highlights of the FY16 budget

The FY16 balanced budget is being presented at $20.86 million and prioritizes the direction of the BODs. As an outcome of the strategic planning meeting the BODs approved up to $3 million of reserves to be used for the implementation of a new data registry and incorporated $2 million into the FY16 pro-

AAO-HNS/F Combined Budgets

	Approved Budget FY15	Proposed Budget FY16
Revenue		
Membership Dues	$6,700,500	$6,855,000
Meetings	6,892,700	6,901,000
Products & Program Sales	1,413,000	1,717,000
Royalties	1,650,000	1,618,100
Corporate & Individual Support	670,000	712,500
Dividends and Interest	220,500	320,000
Miscellaneous	221,700	140,500
Funds Released from Restrictions	831,600	597,700
Funds Designated for Data Registry	0	2,000,000
Total Revenue	**$18,600,000**	**$20,861,800**
Direct Operating Expenses		
Meetings	$1,618,600	$1,603,000
Printing & Production	758,000	695,500
Travel	607,100	547,400
Connectivity & Software	340,700	361,700
Office Expenses	295,100	308,600
Occupancy (DC office space)	111,000	28,400
Grants	672,000	664,300
Consultants & Professional Fees	2,637,900	2,674,200
Data Registry Support	0	2,000,000
Total Direct Operating Expenses	**$7,040,400**	**$8,883,100**
Allocated Costs		
Salaries & Benefits	8,308,000	8,878,900
Occupancy	1,692,000	1,643,000
Shared Support	1,559,600	1,456,800
Total Allocated Costs	**$11,559,600**	**$11,978,700**
Total Expenses	**$18,600,000**	**$20,861,800**

posed budget for this purpose. This addition accounts for the majority of the difference between the FY15 and FY16 total budget.

Proposed FY16 revenue, before consideration of reserves to be used for the data registry, is composed of approximately one-third membership dues, one-third Annual Meeting revenue, and one-third other revenue. Areas where revenue is budgeted to increase include membership dues, as a result of the dues increase in calendar year 2015; product and program sales, as a result of pricing changes; and interest income, as a result of the investment of cash held for repayment of the building debt. Annual Meeting revenue from the Dallas meeting is budgeted to be consistent with the Orlando meeting even with the change to provide Instruction Courses at no additional cost. An increase in EXPO booth sales is expected to make up the shortfall in registration revenue in the first year of the Annual Meeting format change. Miscellaneous income remains largely comprised of sublease income for the lease of unused office space. Revenue from restricted funds varies from year-to-year depending on donor restrictions and timing.

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

Direct Operating Expenses include costs directly related to carrying out the priorities of the strategic plan and on-going mission-related programs. Budgeted costs have been included to allow for the implementation of the new data registry; development of appropriate use criteria based on clinical indicators and guidelines; and development of a consensus on a comprehensive otolaryngology curriculum, including resources for content development.

Allocated Costs relate to staffing and benefits as well as the operating costs that are incurred for the good of the whole organization, such as occupancy and building-related expenses, and organizational-wide HR, financial, and IT costs. Increases in these costs are due to inflation, salary adjustments, and the addition of staff to support the newly approved initiatives.

The complete budget is available to any Academy Member who requests it in writing. Email requests to Carrie Hanlon, CPA, senior director, Financial Operations to **bulletin@entnet.org**. ■

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The long (and winding) road to

The physician community has reason to celebrate. On April 16, President Obama signed into law H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). In one swoop, H.R. 2—perhaps the most critical piece of health-related legislation since the Affordable Care Act—delivered to the physician community not one, but several legislative victories.

Most notably, of course, are the provisions to permanently repeal the flawed Sustainable Growth Rate (SGR) formula used to determine payments to physicians under the Medicare program. Repealing the SGR has long been a top legislative priority for the AAO-HNS and others in the physician community. In fact, it took more than 14 years and laboring through 17 short-term payment "patches" to arrive at the policy agreements that coalesced in H.R. 2.

So, what does the bill do? In regard to Medicare physician payments, H.R. 2 stipulates:

- Immediate repeal of the SGR formula.
- A "period of stability" with a .5 percent increase in physician payments for five years.
- A 5 percent added incentive payment for physicians in new Alternative Payment Models (APMs).
- Increased funding for technical assistance to practices of 15 or fewer professionals.
- Creation of a technical advisory committee to review and recommend physician-developed APMs via an open comment process.

Other "victories" included in H.R. 2 are:

- Consolidation of three existing incentive programs (Physician Quality Reporting System, Value-Based Modifier, and Meaningful Use Electronic Health Records). Combining these programs via a new Merit-Based Incentive Payment System (MIPS) program will help to set performance thresholds and offer flexibility for specialties in achieving the necessary reporting requirements for bonus payments.
- Rescission of the new CMS policy to transition all 10- and 90-day global payment codes to 0-day codes by 2018.

Also noteworthy about H.R. 2 is the manner in which it was passed. In total, 484 lawmakers in both chambers voted in favor of the bill. Given that legislative gridlock and partisan bickering have become the norm on Capitol Hill, the bipartisanship achieved on H.R. 2 was surprising and refreshing.

For so long, the SGR issue has operated as a "vacuum" on Capitol Hill, often inhibiting work on other critical initiatives. In fact, it was frustration relating to the cyclical "doc fix" that led Congressional leaders, namely Speaker John Boehner and Minority Leader Nancy Pelosi, to—finally—begin private negotiations to permanently address the SGR issue.

In reality, the burst of activity to resolve the SGR issue this spring has been two years in the making (see timeline). Throughout the 113th Congress, leaders from the committees with jurisdiction over health issues in both the House and Senate worked in earnest (with the physician community) to craft the Medicare physician payment replacement policies

TIMELINE OF SGR REPEAL ACTIVITIES

113TH CONGRESS

FEBRUARY 2013

- House Energy & Commerce (E&C) Committee holds hearing on SGR issue.
- House Ways & Means (W&M) Committee staff briefs physician community on development of SGR legislation.
- Congressional Budget Office (CBO) reduces cost estimate for SGR repeal.

MAY 2013

- House W&M holds hearing to collect information on potential reform proposals.
- Senate Finance Committee solicits feedback from physician community regarding future of fee-for-service system.
- House E&C briefs physician community on "framework" for SGR repeal legislation.

JUNE 2013

- House E&C releases revised SGR framework.

JULY 2013

- House E&C holds mark-up of SGR bill and unanimously votes to advance the proposal.

OCTOBER 2013

- Senate Finance and House W&M release legislative framework to repeal the SGR formula.

NOVEMBER 2013

- Staff for Senate Finance and House W&M brief physician community on legislative framework.

DECEMBER 2013

- Senate Finance holds mark-up of SGR framework; approved by Committee.
- House W&M holds mark-up of SGR legislation; approved by Committee.
- Two-year budget deal signed into law; includes three-month SGR "patch."

FEBRUARY 2014

- Bipartisan, bicameral legislation (H.R. 4015/S. 2000) to repeal the SGR formula and reform the Medicare physician payment system introduced in Congress.

repealing the SGR

that were ultimately included in H.R. 2. In addition to hearings, briefings, hill meetings, stakeholder sessions, and mark-ups, a key component to the evolution of the SGR replacement policies were myriad comment letters submitted by organizations across the healthcare spectrum. For example, in 2013, at the height of the policy development phase, the AAO-HNS alone submitted seven SGR-related comment letters.

With the SGR replacement policies in place by early 2014, efforts to advance the bill were thwarted by the question of how to pay for the measure. What changed? The answer is that Congressional leaders and rank-and-file lawmakers agreed to view the SGR formula as the budget gimmick it was. The track record for SGR patches was proof that Congress never intended to allow sweeping cuts to take place. So, why not finally fix the problem—even if it meant not funding the whole package. In the end, after substantial negotiations by party leaders, only the add-on provisions included in H.R. 2 (e.g., extension of the CHIP program) were paid for.

Next steps

Is the SGR replacement policy perfect? No. It is, however, a starting point. Now the AAO-HNS will work toward improving upon the foundation set forth in H.R. 2.

For more information regarding H.R. 2, and/or additional AAO-HNS federal legislative priorities, contact legfederal@entnet.org or visit www.entnet.org/advocacy. ■

MARCH 2014
- H.R. 4015 passed by U.S. House of Representatives with partisan offset.
- U.S. House passes 12-month SGR "patch" via voice vote.
- U.S. Senate passes (64-35) 12-month SGR "patch."

APRIL 2014
- President signs 12-month SGR "patch."

NOVEMBER-DECEMBER 2014
- Members of GOP "Doc Caucus" urge leaders to address SGR repeal before adjourning the 113th Congress.
- Congress passes "Cromnibus" bill without inclusion of SGR repeal provisions.

JANUARY 2015
- House E&C Committee's Subcommittee on Health holds two-day hearing to discuss possible offsets for permanent SGR repeal.

FEBRUARY 2015
- CBO increases its estimate of SGR repeal to $177B.
- Senate Finance Committee Chairman Orrin Hatch (R-UT) announces that no SGR-related hearings will be held before the March 31 "patch" expires.

MARCH 2015
- March 10: Rumors of a possible deal on SGR repeal bill become more plausible.
- March 13: Key House Committee (W&M and E&C) Chairmen confirm emerging SGR/CHIP reauthorization deal.
- March 19: Rep. Mike Burgess, MD, (R-TX) introduces H.R. 1470, the SGR Repeal and Medicare Provider Payment Modernization Act of 2015. H.R. 1470 mirrors the bipartisan, bicameral policy agreement from the 113th Congress—H.R. 4015.
- Additional Medicare reform provisions beyond SGR repeal are finalized by Speaker John Boehner and Minority Leader Nancy Pelosi.
- March 24: Rep. Burgess is given the honor of introducing H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).
- March 24: The GOP "Doc Caucus" sends H.R. 2 support letter to leadership.
- March 25: The AAO-HNS sends H.R. 2 support letter to members of the House.
- March 25: The White House signals its support of H.R. 2.
- March 26: The AAO-HNS sends H.R. 2 support letter to members of the Senate.
- March 26: The House passes H.R. 2 in an overwhelming bipartisan vote of 392-37.
- March 27: Unable to "fast-track" its consideration of H.R. 2, the Senate delays voting on H.R. 2 until after its two-week spring recess.
- March 27: CMS instructs its carriers to "hold" for 10 business days any Medicare claims for services submitted on or after April 1, when the current "patch" expires. The hold means April claims will be held through Tuesday, April 14.

APRIL 2015
- April 9: Sen. Ron Wyden, top Democrat on the Senate Finance Committee, announces his support for H.R. 2.
- April 14: Senate leaders reach deal to vote on H.R. 2, including consideration of six amendments.
- April 14: All six Senate amendments to H.R. 2 fail, and the Senate passes the bill in a bipartisan vote of 92-8.
- April 16: President Barack Obama signs H.R. 2 into law.

MAY 2014 | OCTOBER 2014 | MARCH 2015 | 114TH CONGRESS

An era of uncertainty in healthcare

John H. Krouse, MD, PhD, MBA, Professor and Chairman, Otolaryngology-Head and Neck Surgery, Temple University School of Medicine and Editor in Chief, *Otolaryngology–Head and Neck Surgery*

No doubt about it. We are living in an era of uncertainty in healthcare. In medicine in the United States, we have been accustomed for decades to a system that has rewarded volume and intensity of services delivered. While the system has stimulated advances that have enhanced care of patients with acute medical illnesses, access to that care remains spotty and overall health, especially among the most vulnerable, generally lags behind most of the developed world. The cost of healthcare in the United States continues to skyrocket, with expenditures approaching $3 trillion in 2013, or almost 18 percent of the U.S. gross domestic product (GDP), significantly outpacing our nearest comparators. Obviously, this system is unsustainable in its present design.

In this era of uncertainty, transitions in healthcare are underway:

TRANSITION FROM	TO
Fee-for-service	Bundled payments by networks and illnesses
Incentivized for volume	Incentivized for value
Fragmented, individualized care	Aligned, continuity of care
Acute hospital focus	Chronic outpatient disease management
Nonstandardized paper records	IT-based standardized records

Given these transitions, we as otolaryngologists currently live in the "straddle" of this era of uncertainty. We continue to benefit from fee-for-service medicine, yet payer contracts are moving toward a greater emphasis on value, cost-reduction, and improved quality in processes and outcomes. Bundled payment arrangements and ACOs are on the horizon. Physicians continue to practice in an individualistic manner, although the influence of guidelines-based medicine is increasingly felt as a mechanism to decrease variation in care.

Unfortunately, it is in this straddle that we see adverse impact on physician revenue. Payments have declined as payers transition away from fee-for-service, yet incentives for quality are not in place to sufficiently offset this decline. Investment in IT infrastructure has been required, yet physicians have seen little return for this cost. It is unclear exactly how future payment systems will unfold, the timing of implementation, and how to advantageously position ourselves as otolaryngologist-head and neck surgeons.

In the future world of healthcare, the interface of health economics and physician practice is at the point of VALUE. In economic systems, the value of goods or services is understood as an interaction of the quality of those goods or services

The Board of Governors fall meeting: Plan to be there

Peter J. Abramson, MD, Immediate Past Chair, AAO-HNS Board of Governors

We are all excited about the fall Academy BOG meeting. The official start of the AAO-HNSF 2015 Annual Meeting & OTO EXPO℠ is on Sunday, September 27. However, the Board of Governors (BOG) meetings are held the day prior. On Saturday, September 26, the BOG will conduct its fall committee meetings. Over the last several years, the BOG leadership has placed a strong emphasis on educational and informative, yet action-oriented, meetings. This is the "roll up your sleeves and get to work time." As we all are aware, much of the work of committees happens offline before the meetings. These committee meetings are not only the presentation of the work done over the previous six months, but a time to formulate and formalize action plans that will shape the grassroots advocacy efforts for the year to come.

Chair **Ken Yanagisawa, MD**, and Vice-Chair **Hayes H. Wanamaker, MD**, continue to work on strengthening the Socioeconomic and Grassroots Committee's regional representation structure. Regional reports at the meeting create an exciting forum for sharing of issues and trends nationwide. The ever-evolving and strong working relationship with the Academy's Health Policy unit has strengthened the committee's ability to work on the pressing issues affecting otolaryngologists right now.

Chair **Stacey L. Ishman, MD, MPH**, and Vice-Chair **Steven T. Kmucha, MD, JD**, have reinvigorated the newly reminted and redirected Societies and Engagement Committee (formerly Rules and Regulations Committee). They recently have completed the arduous, but necessary task of updating the BOG Bylaws. By switching gears from its focus on rules and regulations to society engagement, this committee will focus on building strong local, state, and regional societies and strengthening the interaction with the Board of Governors.

Under the strong leadership of Chair, **Susan R. Cordes, MD**, and Vice-Chair, **J. Scott Magnuson, MD**, the Legislative Affairs Committee has divided its members into two active task forces—the ENT PAC and Legislative Grassroots. Through greater integration with the legislative advocacy team and the state tracker program, this committee has engaged its Members in a more active role in the committee process.

BOG meetings are an integral part of our focus for a hands-on, action-oriented approach in our mission of grassroots advocacy. It is important to make time to be at the Saturday BOG committee meetings. By attending, you will stay current on pressing legislative, policy, socioeconomic issues, and become integrated into the process of advocating for our specialty and livelihood. ■

and the cost at which they are provided. In other words: **VALUE = QUALITY ÷ COST**.

Specific to healthcare, value can be created by increasing the quality of the care, decreasing the cost of the care, or some combination of both. Implicit in the discussion, however, is that consumers must be able to evaluate the quality of services provided, making public reporting of outcome data a necessary component of any value-based healthcare system. Physicians and health systems will need to create value propositions that reflect the needs of patients and their communities.

So what trends do we foresee? Healthcare will move toward increasing integration and expanded use of multidisciplinary teams. There will be greater transparency in price and quality, as well as mutual accountability with physicians and health systems. Rewards will be based on system outcomes rather than high volumes. At the physician level, incentives will be negotiated with health systems, and may be based on some combination of productivity and achievement of quality and service goals.

Otolaryngologist-head and neck surgeons need to be proactive in this era of uncertainty in healthcare. The AAO-HNSF is participating in the process of identifying low-value services through its "Choosing Wisely" campaign. It is interesting that just one of these 10 principles is specifically related to otolaryngology procedures. Future initiatives must be outcomes-based and define appropriate use of procedural interventions. Otolaryngologists must develop patient-centered quality indicators that define how and when care should be provided. Data and analytics will be critical, and the AAO-HNS is developing performance indicators and a comprehensive data registry that will assist in addressing these important issues of quality and value. Furthermore, *Otolaryngology–Head and Neck Surgery* will continue to expand its content in health policy and economics to support otolaryngologists as key partners in the care of their patients.

So, out of the chaos of this era of uncertainty comes the opportunity for leadership and proactive change. We must define evidence-based performance and quality metrics that allow us to thrive in the changing environment of health reform. We must engage patients and families in their care decisions, with the goals of increased satisfaction, improved outcomes, and reduced costs. With a sharp focus on quality, we, as otolaryngologists, can navigate healthcare uncertainty and take the lead in defining value in otolaryngology care. ■

FROM ACADEMY ADVANTAGE PREMIER PARTNER: HEALTHeCAREERS

Check your references: résumé advice from HR professionals

1 Employers are using social media and technology to assess your references.

Consider your social media choices carefully when looking for a new job. Employers are now looking at social media accounts to get more information about potential employees. Is the content appropriate and does it reflect you in a positive way?

2 References have become more, not less, valuable.

Your résumé may get you the interview, but it's the report your references provide that will win you the job in a close race with another qualified candidate.

3 The format, content, and presentation of references lists have changed.

In the past, the standard approach was to offer a simple list of references and their contact information. In 2015, savvy job seekers are modernizing their reference lists to make a powerful statement of their professional qualifications.

4 Employers will use your peers and subordinates as references.

Don't assume that employers will only check with Human Resources or your former supervisor for reference purposes. Employers are increasingly scrutinizing less traditional references such as peers and coworkers.

5 Keep those workplace bullies off your reference list—they can destroy your chances for new employment.

Despite negative press about bad bosses (or coworkers), bullies still abound in the workplace and can adversely affect your current or future employment.

View the full article at www.healthecareers.com/aaohns/article/5-critical-reference-trends-for-2015-advice-from-hr-professionals/176118 and visit ENT Careers for jobs, career advice, and more. ■

Letting the life and light shine through her new eyes

■ **Javier González-Castro, MD,** Oregon Health and Sciences University, Humanitarian Travel Grant Awardee

As surgeons, we spend what feels like a lifetime training to become who we want to be in our professional careers. Through all of this hard work and study, we sometimes neglect to realize the huge impact we have on the lives of others, not only patients, but also their families and those around them. We overlook how this in turn impacts our lives not as surgeons, but as people. As part of the surgical team of the FACES foundation I travelled to Lambayeque, Peru, with the objective of treating patients with cleft lip and palate deformities, but little did I know that we would be doing so much more than that. We were changing lives!

My name is Javier González-Castro, I am currently training in facial plastic and microvascular surgery at Oregon Health and Sciences University (OHSU). As a fellow I was given the opportunity to be a part of the FACES foundation surgical team, an opportunity for which I am eternally grateful. As part of the group, I traveled to Lambayeque, Peru, where we evaluated 90 patients and operated on 47 between January 25 and 30, 2015. This effort could not have been completed if not for the help of the local Lions Club, the people from Belen Hospital, and the whole FACES team. I would also like to thank the AAO-HNSF Humanitarian Efforts Committee for helping me with many of the costs associated with the trip.

During this trip we treated children of all ages, performing cleft lip repairs, palatoplasties, cleft rhinoplasties, and alveolar bone grafts. Although the babies always leave their footprint in our mind, the patient who stood out the most in my mind was a 12-year-old who had lived her entire life with a wide cleft lip/palate and no access to adequate help. When we saw her before surgery, we saw what everyone else saw: a girl with a terrible deformity who in the eyes of the people of her village was truly a monster. To her family and others who knew her, they saw a developmentally delayed 12-year-old who could not even speak and shied away from making eye contact. When I first met this child, I saw a shy, scared child who was socially delayed due to the deformity that she had to live with all her life. She went into surgery that day not knowing what lay ahead; she had no idea of what she would see the next time she looked in the mirror.

The surgery was a success! The whole team was very happy with the results, but the most beautiful part was when this child looked at herself in the mirror for the first time. Her face filled with joy, she started to hug all those in sight whether she knew them or not. It was as if an incredible weight was lifted off her shoulders; the scarlet letter had been removed. Instantly you could see how she changed from a scared young girl, to a beautiful young girl with so much life ahead of her. Before the surgery her eyes looked like those of a scared old lady; after the surgery you see the eyes of a cute little girl, full of light and love. It is astonishing to think that those eyes belong to the same person. I feel truly blessed to have been a part of that and hope to continue to be a part of it.

It is amazing that by simply giving this child a new smile, we let the life and light shine through her new eyes. ■

Cleft lip/palate surgery changed the outlook for this 12-year-old Peruvian patient.

AAPC selected to provide coding and practice management resources to AAO-HNS Members

As a result of healthcare delivery system reform, otolaryngologist-head and neck surgeons are faced with a rapid transition in the way they will be paid for professional services. It is essential that Academy Members have access to the most current and accurate coding and practice management information. The Foundation is pleased to announce a new partnership with AAPC to offer Foundation-sponsored coding and practice management learning opportunities offered at a discounted rate for Members including live workshops, webinars, and eCourses. In addition, Members will have access to a variety of coding tools and resources available through AAPC.

AAPC is the nation's largest training and credentialing organization for medical coding, billing, auditing, and compliance. With AAPC's two decades of experience in training and credentialing more than 130,000 professionals, the Foundation is confident no one understands coding regulations and documentation requirements better. AAPC trainers are nationally recognized experts and some of the top educators in the country. Each year, AAPC provides training resources to more than 100,000 coders, auditors, compliance officers, and physicians throughout the country.

This new partnership between the Foundation and AAPC will provide six live workshops per year with one in conjunction with the 2015 Annual Meeting & OTO EXPO℠ and another at the spring 2016 Leadership Forum. The other four will be offered regionally throughout the year. These workshops, with Foundation-approved content and faculty, will provide new learning opportunities at the Annual Meeting and Leadership Forum.

In addition to the live events, there will be a minimum of six live (and archived) webinars also developed with content experts from both the Foundation and AAPC. These activities will cover a variety of coding and practice management topics of critical interest to otolaryngologists. Individuals will be able to participate live or view the recorded webinars at their own pace.

Look for this icon.

This summer, the Foundation is excited to offer Members special access to current AAPC online training resources and tools. This will include their excellent recorded webinars and eCourses on ICD-10 to assist you in getting ready for the October transition.

For complete information about all of these practice management training opportunities, please visit **www.entnet.org/coding**. ■

> Through our new partnership with AAPC, Members have access to high-quality coding and practice management courses in formats that suit their needs, including regional live workshops as well as online webinars available on demand.
>
> **James C. Denneny III, MD**
> *AAO-HNS/F EVP/CEO*

Do you have a position, course, or meeting you would like to promote?

The Bulletin is the perfect vehicle to reach your audience. Contact **Suzee Dittberner** today at **913-344-1420** or **sdittberner@ascendmedia.com**.

FROM THE DIVERSITY COMMITTEE

Targeted smoking cessation programs in high-risk populations

■ **Sherilyn Francis,** Morehouse School of Medicine, Atlanta, GA, and **Charles E. Moore, MD,** Emory University, Atlanta, GA

In 2014, it was estimated that there would be 55,070 new cancer cases of the oral cavity, pharynx, and larynx. Additionally, it was estimated that 12,000 of those diagnosed with this cancer would die, thus representing 2.0 percent of all cancer deaths. The five-year survival rate of these cancers is approximately 50 percent. When compared to white populations, black males are almost twice as likely to die from oral cancers. Although early detection has been proved to increase the survival rate; prevention strategies focused on high-risk behavior are critical to eliminate new cases. The high-risk behaviors most frequently associated with head and neck cancer (HNSCCa) are heavy alcohol use, but most importantly tobacco use (cigarette smoking, pipe smoking, or smokeless tobacco use). Also, HNSCCa are most frequently diagnosed in men and persons ages 55-64 years. Due to the increased mortality rate of black males, preventable high-risk behaviors, and a need to intervene in earlier age groups, the purpose of this research is to characterize smoking cessation intervention strategies available to adolescent black males to impact the prevalence rate of HNSCCa among this target audience. The following questions guided the research protocol:

1. How has health education/health promotion been used to engage black men around smoking cessation?
2. What are the barriers and facilitators to the use of programmatic initiatives geared toward smoking cessation among black men?

A structured keyword search of title and abstracts was conducted across a variety of databases representing different academic disciplines. Selected articles met the following inclusion criteria: (1) represented original research; (2) appeared in a peer-reviewed journal/publication; (3) addressed at least one of the two research questions. The methodology of Young and Solomon for Cross-Sectional Studies was used to critically appraise each article. The initial search yielded 189 articles, which were condensed to 21 articles. The chosen publications were entered into a database and stratified by which research question it addressed.

➲ READ MORE ONLINE
References available

Approximately 90 percent of the selected articles focused on a mixed-gender population; 70 percent of the interventions utilized Internet-based or application-based health communication strategies; and none of the interventions reported a study population composed exclusively of adolescent black males. The primary intervention strategies focused on support, with particular emphasis on peer-to-peer communications; motivational interviewing; expert counseling; email counseling; and social network sites. Moreover, the trans-theoretical model of behavior change was a commonly applied behavior change theory. The identified barriers from this analysis were gender; cultural norms; childhood physical abuse; and childhood sexual abuse. Conversely, the facilitators to smoking cessation among the target audience were motivation; health-risk communication; personal responsibility or choice; parental involvement; and government interventions against the tobacco industry.

In summary, these findings illustrate smoking cessation programs geared toward adolescent populations and emphasize the frequent use of evidence-based health communication strategies in conjunction with traditional health behavior interventions. Furthermore, this study highlights the lack of smoking cessation interventions geared toward adolescent black males, while identifying gaps in research regarding black males' smoking behavior and smoking cessation. The Diversity Committee is committed to serving populations that may have less access to care and is devoted to educating our patients and communities. ➲

Otolaryngologists of Indian heritage invited

The President, **Satish Govindaraj, MD**, and the Governing Board of American Association of Otolaryngologists of Indian Heritage invite you to attend the 38th annual dinner meeting Sunday September 27, 2015, at 7:30 pm at the Hyatt Regency Hotel in Dallas, TX.

RSVP your attendance by Wednesday September 23. To join AAOIH please visit our website **www.aaoih.com** or contact Ameet Singh, MD, Secretary AAOIH. RSVP for attendance: 914- 953- 6495; Membership information: 646-620-7792. ■

The "HP Update" newsletter is an invaluable resource.

ENTConnect has a dedicated section where members can share fast-changing practice information within a secure environment.

Key tools for a

From FFS to future payment: 3P and Health Policy achieve Member value through advocacy successes

The Academy's Physician Payment Policy (3P) Workgroup is the senior advisory body to Academy leadership and Health Policy staff on issues related to socioeconomic advocacy, regulatory activity, coding and reimbursement, and practice management.

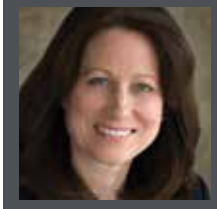
Jane T. Dillon, MD, MBA, serves as 3P Co-chair and Coordinator for Socioeconomic Affairs. Dr. Dillon focuses on coding and payment issues, working closely with the Academy's committees, otolaryngology specialties, and CPT Advisors to develop and refine CPT codes. She represents the Academy on the Relative Value Update Committee (RUC), where, along with other team members, she advocates for fair valuation of physician services included in the Medicare physician fee schedule.

Robert Lorenz, MD, MBA, serves as 3P Co-chair and Coordinator for Practice Affairs. Dr. Lorenz is primarily responsible for private payer issues, including coverage and payment policies. He also provides oversight on the development and maintenance of Academy resources, including the Academy's Position Statements, Clinical Indicators, and ICD-10 educational efforts. Dr. Lorenz plays an important role in fostering communication between 3P and the Board of Governors and is an active participant in the Surgical Coalition leadership meetings sponsored by the American College of Surgeons.

Dr. Lorenz and Dr. Dillon co-chair the Ad Hoc Payment Model Workgroup, which is actively engaged in identifying opportunities for otolaryngologists to participate and lead in development of new payment and care delivery models with both public and private payers. (See article on page 22.)

3P, with the support of Health Policy staff, works to ensure Members' interests are appropriately represented across different settings. As a result of 3P leadership and active engagement of several payers over the past years, key changes in payer reimbursement policies were achieved. On the following pages are a few highlights.

AAO-HNS Physician Payment Policy Workgroup Co-chairs



Jane T. Dillon, MD, MBA
Coordinator for Socioeconomic Affairs

Robert Lorenz, MD, MBA
Coordinator for Practice Affairs

thriving practice

Measuring success: **strong relationships** with payers

The Academy's Physician Payment Policy (3P) workgroup, in conjunction with health policy staff, has placed a high level of importance on developing and fostering relationships with national Medical Directors within both the private and public payer sectors. These relationships have allowed opportunities for dialogue with the highest level executives at the Centers for Medicare & Medicaid Services (CMS) and several private payer organizations, including United Healthcare (UHC). As a result of ongoing efforts to cultivate these affiliations, the Academy leadership has been able to proactively address many potentially problematic policies for otolaryngology members and their patients, working together with these payers to develop appropriate coverage policies. Some specific examples of how the Academy has led joint efforts with payers are noted below.

United Healthcare

There have been many collaborative efforts between the Academy's leadership and UHC over the years. Recently, national Medical Directors at UHC have approached the Academy for input and dialogue regarding several important policies impacting members and their patients, including UHC's balloon sinus ostial dilation medical policy, rhinoplasty policy, and their Premium Designation Program.

Continued balloon sinus ostial dilation coverage

In 2014, UHC reached out to the Academy requesting input for its draft balloon sinus ostial dilation medical policy. The Academy's Rhinology Paranasal Sinus Committee and 3P quickly reviewed the draft policy, providing UHC comments by their deadline and requesting a conference call to discuss the importance of continued coverage for balloon sinus ostial dilation. UHC agreed that it would be helpful for their highest level policy leaders to discuss the proposed policy with Academy leaders, including 3P members as well as experts in rhinology. After a constructive and detailed discussion about the benefits of balloon sinus ostial dilation as an alternative to endoscopic sinus surgery, UHC decided to maintain coverage in their policy, effective April 1, 2015.

Rhinoplasty coverage policy

The Academy's expert input was also requested by UHC in April 2015 to review and provide comment on their proposed rhinoplasty medical policy. This is a version of a previous policy, which has undergone numerous favorable revisions based on Academy's 3P and Rhinology and Paranasal Sinus Committee advocacy and input. UHC's willingness to seek our feedback on this policy is further evidence of the reciprocal relationship that has been developed over the years between UHC and the Academy.

Premium Designation Program

In addition, UHC reached out to the Academy in 2013 to discuss their Premium Designation Program, a type of quality tiering program that assesses otolaryngologist-head and neck surgeons on their quality and cost efficiency as compared to peers in their area. Based on many concerns raised by the Academy and its Members, UHC delayed implementation of the program for otolaryngologists for over a year. In the fall 2014, prior to implementation of the program that included otolaryngology-head and neck surgeons, UHC once again contacted the Academy to continue dialogue regarding significant ongoing concerns about the program. While UHC decided to move forward with assessment and public display of otolaryngologist-head and neck surgeons designations, the national Medical Director leading the program, Mureen Allen, MD, requested additional input from Academy Members. Further, during a follow-up conference call held with Academy Health Policy and Quality and Performance Measurement staff, Dr. Allen noted interest in receiving ongoing feedback from Academy members about the program moving forward. In addition, UHC has indicated willingness to provide Academy leaders with step-by-step clarity about their methodology, and interest in working together to develop helpful resources like talking points about how to review, understand, and appeal (if necessary) the reports.

Tools for you: Member resources

As Members know, the healthcare market is ever-changing with increasing demands placed on physicians in addition to providing quality care. 3P and the Health Policy staff work together to ensure that otolaryngologist-head and neck surgeons are well-positioned to meet the challenges of today, as well as those on the horizon, by providing updated practice management resources. These Members-only resources, such as template appeal letters, CPT for ENTs, and Clinical Indicators, are valuable tools for thriving otolaryngology practices and their patients. We encourage all Members to stay informed about the latest health policy changes and updates via the *Bulletin*, ENTConnect, the HP Update, and weekly news. We also encourage all members with socioeconomic-related questions to utilize the Practice Management Member Inquiry Tool. ■

Medicaid allergy policy changed

In addition to the work with UHC, the Academy's 3P Workgroup, Academy Executive Leadership, and Health Policy staff collaborated with Superior HealthPlan, the largest Medicaid carrier in Texas serving approximately 1 million beneficiaries, to review their credentialing policy regarding allergy testing and immunotherapy services in its network. While the Academy does not usually participate in Medicaid advocacy, 3P leaders determined that the potential impact of the proposed policy required Academy attention. After Academy leaders and colleagues from the American Academy of Otolaryngic Allergy (AAOA) met with the highest level Superior HealthPlan executives to inform them about the extensive training that physicians in the specialty receive, Superior HealthPlan agreed to auto-credential all board certified and board eligible otolaryngologist-head and neck surgeons to perform allergy testing and immunotherapy services in its network. This accomplishment is due to the hard work of Academy leaders, along with that of our colleagues with the AAOA, the American Board of Otolaryngology (ABOto), and Superior HealthPlan.

Ongoing issues with diagnostic imaging reimbursement policies

While the Academy has realized many successes with some public and private payers as mentioned above, there are other coverage issues that continue to provide challenges for our members as they work to provide quality care to their patients. One of these issues relates to restrictive and inappropriate coverage policies for Cone Beam Computed Tomography ("CBCT" or otherwise known as "miniCT"). The Academy is aware of problematic payer policies that are arbitrary in nature, with some payers even going so far as to state that miniCT is investigational and experimental when the technology has been FDA-approved for many years. Some payers are not allowing otolaryngologist-head and neck surgeons to administer and/or interpret diagnostic imaging studies or to receive appropriate reimbursement for billing the professional and/or technical component of imaging services. In response, the Academy has sent several comment letters to payers advocating for changes to these policies, focusing on the numerous benefits of point-of-care imaging for patients and noting that otolaryngologists possess the training, expertise, and knowledge to provide these services. However, the private payers have remained unresponsive to our comments and maintain these restrictive and inappropriate policies.

3P leaders and Health Policy staff continue to work with Imaging Committee leaders and the Intersocietal Accreditation Commission CT-division, to advocate with several private payers to provide appropriate reimbursement for miniCT services. While these advocacy efforts continue, Members are encouraged to utilize the Academy's Template Appeal Letter and Advocacy Statement on Diagnostic Imaging when corresponding with payers, see: **www.entnet.org/content/coding-corner**. In the future, the Academy's clinical data registry and appropriate use criteria will be extremely valuable to Members and benefit their patients in similar instances. In the meantime, the Academy leadership is working diligently to implement a broad strategy, to create positive change with at least one of the payers and their restrictive policy, so that positive momentum with other payers might be achieved as well. Stay tuned for further updates on these important advocacy efforts. ■

> "As a result of ongoing efforts to cultivate these affiliations, the Academy leadership has been able to proactively address many potentially problematic policies for otolaryngology members and their patients, working together with these payers to develop appropriate coverage policies."

Gauging new **payment models** for the future

Ad Hoc Payment Model Workgroup looks to the future with Alternative Payment Models (APMs)

The Academy strongly supported the repeal of the SGR formula and the movement toward development of new payment models in the landmark legislation that became law in April 2015. We believe this effort will add to the momentum in the shift from the traditional fee-for-service (FFS) system to value-based care. As part of the Academy's efforts over the past few years to prepare for this transition, the Ad Hoc Payment Model workgroup was created. Led by co-chairs **Robert Lorenz, MD, MBA**, and **Jane T. Dillon, MD, MBA**, and managed by Health Policy staff, this group is comprised of physician leaders from research, quality improvement, 3P, and the Board of Governors. The main goals of this workgroup include reviewing potential opportunities to improve quality of care and decrease cost for otolaryngology-related services and dissemination of information about alternative payment models. To that end, the Ad Hoc Payment Model Workgroup created a new Member awareness campaign to identify and leverage Member alternative payment model (APM) knowledge.

Member awareness campaign

To assess Member knowledge and participation, the Ad Hoc Payment Model Workgroup partnered with the Board of Governors (BOG) to conduct a survey regarding Members' experiences in states already involved in a new payment model. The survey revealed an eagerness to learn more about alternative payment models, as well as several Members with leadership roles in these new schemas. These leaders were asked to tell their personal stories to help the membership become more familiar with how APMs are affecting the specialty. In addition, these leaders helped to provide Academy members with an introduction to the risks and benefits of the various payment model structures.

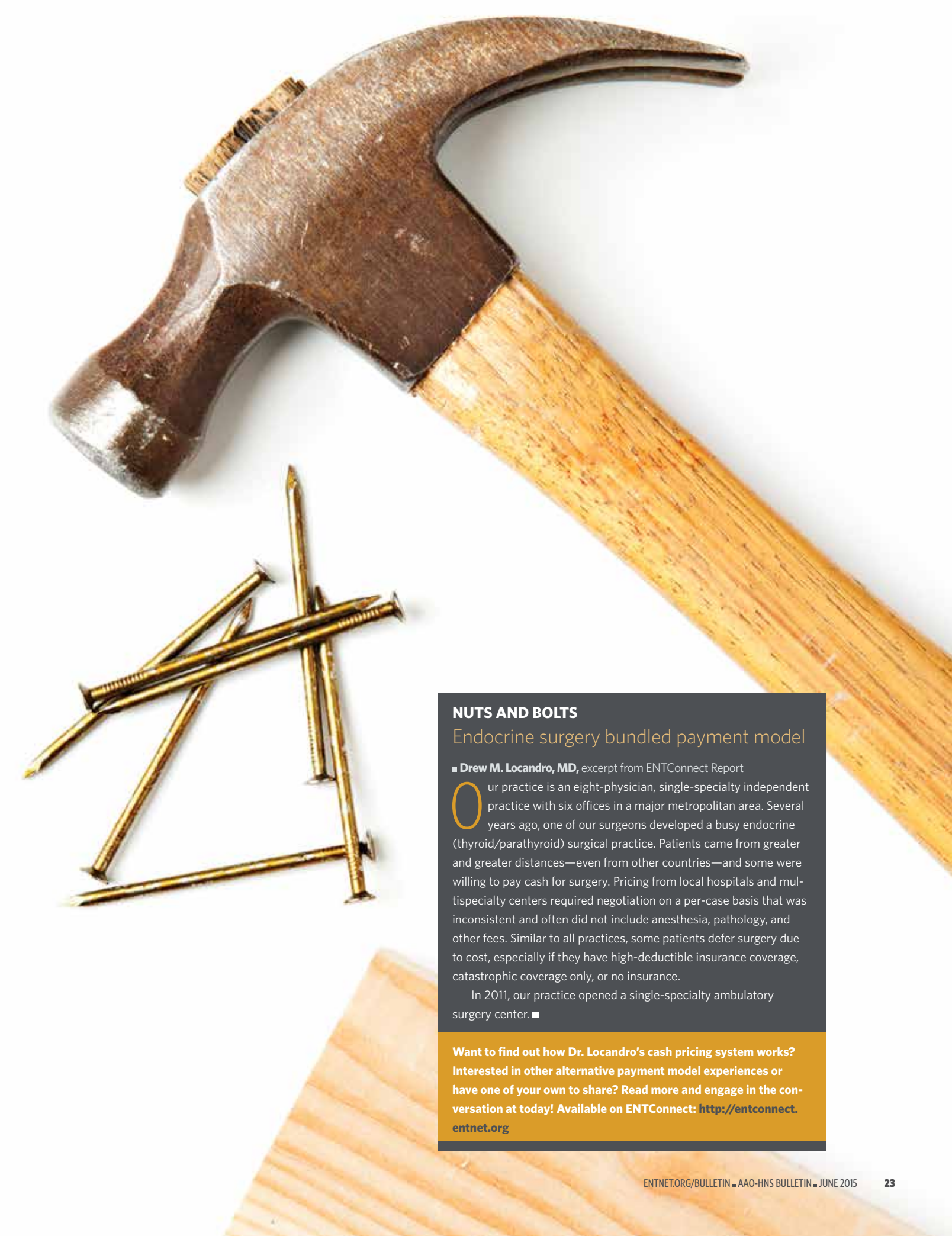
These personal experience reports were distributed to the membership at-large via periodic ENTConnect posts detailing otolaryngology APM involvement. (See "Endocrine Surgery Bundled Payment Model" at far right.)

Looking toward the future of the healthcare system, the Academy will be well-poised to work with private and public payers with the establishment of an Academy-owned registry. An Academy-owned registry will help to inform alternative payment models, help demonstrate clinical effectiveness, and will allow our Members to report quality measures directly to CMS—all crucial elements in value-based care.

Medicare moves to value

The Academy applauds the Department of Health and Human Services (HHS) recent efforts to promote the collaboration of partners in the private, public, and non-profit sectors to transform the nation's health system by

CONTINUED ON PAGE 24



NUTS AND BOLTS

Endocrine surgery bundled payment model

■ **Drew M. Locandro, MD,** excerpt from ENTConnect Report

Our practice is an eight-physician, single-specialty independent practice with six offices in a major metropolitan area. Several years ago, one of our surgeons developed a busy endocrine (thyroid/parathyroid) surgical practice. Patients came from greater and greater distances—even from other countries—and some were willing to pay cash for surgery. Pricing from local hospitals and multispecialty centers required negotiation on a per-case basis that was inconsistent and often did not include anesthesia, pathology, and other fees. Similar to all practices, some patients defer surgery due to cost, especially if they have high-deductible insurance coverage, catastrophic coverage only, or no insurance.

In 2011, our practice opened a single-specialty ambulatory surgery center. ■

Want to find out how Dr. Locandro's cash pricing system works? Interested in other alternative payment model experiences or have one of your own to share? Read more and engage in the conversation at today! Available on ENTConnect: http://entconnect.entnet.org

> The Academy was extremely pleased to participate in the first working session of the Network and looks forward to learning more about best practices and how best to analyze data and report on new payment models.

emphasizing value over volume. Following the announcement of an aggressive goal to have 30 percent of Medicare payments in alternative payment models by the end of 2016 and 50 percent by the end of 2018, HHS launched the Health Care Payment Learning and Action Network (Network). The Network, overseen by a third party contractor so that CMS is a participant in this effort, but not the main driver, will primarily work to enhance value by analyzing data for current APMs, then use that data to create common core issue approaches and implementation guides. The Academy was extremely pleased to participate in the first working session of the Network and looks forward to learning more about best practices and how best to analyze data and report on new payment models.

As part of recent Academy efforts related to informing Members about alternative payment models, the HHS announcement, and the Network, Academy physician payment and quality leaders met with CMS/Centers for Medicare & Medicaid Innovation (CMMI) to continue dialogue with them about the Academy's ongoing efforts to improve quality and reduce costs, and increasing otolaryngologist-head and neck surgeons opportunities to participate in alternative payment models. Academy leaders have developed a good relationship with Patrick Conway, MD, MSc, Deputy Administrator for Innovation and Quality and CMS Chief Medical Officer, that has led to ongoing open dialogue with him and his CMS team members regarding important quality-related issues impacting our physician members and the patients they treat. The open door policy with Dr. Conway and his team members has allowed for several policies to move forward that benefit otolaryngologist-head and neck surgeons and their patients, including CMS'

adoption of the new Sinusitis and Acute Otitis Externa (AOE) measures groups and CMS' decision to include coverage of auditory osseointegrated implants (AOIs) as prosthetics. As many specialty societies including otolaryngology are trying to determine how to be included in the healthcare system transformation, this latest meeting was crucial for the Academy to receive feedback from CMS/CMMI about how societies fit in with the HHS goals.

Thank you

The Ad Hoc Payment Model Workgroup leaders and your AAO-HNS Health Policy staff greatly appreciate the support of our Members, committee volunteers, and other leaders in helping us shape policy in an ever-changing market. As key information, policy changes, and other issues related to alternative payment models that impact the specialty emerge; we will continue to keep Members informed via the *Bulletin*, HP Update, and the weekly news. ■

NUTS AND BOLTS

Meeting of the minds for ongoing dialogue

On May 21, 2015, AAO—HNS/F leaders met with top CMS/CMMI officials who spearheaded the recent launch of the Health Care Payment Learning and Action Network. Academy participants in this critical meeting included **Robert Lorenz, MD, MBA**, coordinator for Practice Affairs and co-chair of the Ad Hoc Payment Model workgroup; **Jane T. Dillon, MD, MBA**, coordinator for Socioeconomic Affairs and co-chair of the Ad Hoc Payment Model Workgroup; **Lisa E. Ishii, MD, MHS**, coordinator for Research and Quality Improvement and Chair for the Registry Task Force, **James C. Denneny III, MD**, EVP and CEO; **Jean Brereton, MBA**, senior director, Research, Quality and Health Policy; **Jenna Kappel, MPH, MA**, director of Health Policy. During the meeting, Academy leaders discussed possible opportunities to partner with CMS in APM development by describing ways that we could improve value, decrease costs, and increase quality. CMS/CMMI was very receptive to several of the ideas and the Academy's leadership will move forward with collaborative efforts. Stay tuned to the website, HP Update, and upcoming *Bulletin* articles for updates: **bit.ly for payment reform page**. ■

Don't get denied!

ICD-10 is a few months away. Here's what you can do to prepare

Uncertainty related to implementation was one of the main reasons many providers postponed preparing for ICD-10. Now that political uncertainty has been all but eliminated, electronic health record (EHR) vendors, clearinghouses, and health plans are all moving forward with preparation for the ICD-10 transition. Otolaryngologists in group or small practices must follow this lead and focus on preparation efforts to ensure that practice revenues will not be interrupted come October 1.

ICD-10 is a few months away, what can I do to prepare?

Communicate with your payers/vendors

One of the most effective things you can do at this point is communicate with all payers and vendors to ensure they are prepared and ask them what you need to do to further prepare. Below is a sample list of questions to ask your payers/vendors to receive ICD-10 information that could be crucial to your practice's workflow after October 1. (This list is just a sample and is in no way all-encompassing nor should it be interpreted as legal advice):

1. Does our license with you include ICD-10 regulatory updates on a moving-forward basis after the ICD-10 go-live date of October 1?
2. Who are the ICD-10 contact people and what is their contact information?
3. What modifications to my EHR must be made to accommodate ICD-10?
4. Will there be any additional fees charged as a result of the ICD-10 upgrade?
5. When will system upgrades for ICD-10 go into effect?
6. Will there be any additional training provided as a result of the ICD-10 upgrade?
7. Is there a charge associated with any additional training that is required?
8. Besides system upgrades, what additional documentation and forms changes (matrices, clickable templates, etc.) will you provide?
9. When can we see updated policy/edit/prior authorization changes for ICD-10?
10. Will system upgrades for ICD-10 require additional hardware to support the software modifications?
11. How will your products and services accommodate both ICD-9 and ICD-10 as we work with claims for services provided both before and after the transition deadline for code sets?
12. What does testing mean to your organization and when will we be able to test ICD-10 claims/transactions?
13. What are your post-implementation contingency plans to ensure accurate provider reimbursement? (e.g., Will you grant "advance payments" in the form of paper checks for risk mitigation purposes?)

Improve documentation practices

While you cannot submit actual ICD-10 codes and receive payment until the deadline has arrived, you *can* submit detailed documentation for your claims as a form of practice in anticipation of the deadline. Several EMR vendors allow ICD-10 coding now, so patient problem lists are being populated with both ICD-9 and corresponding ICD-10 codes. This can help get a practice acquainted with doing the ICD-10 coding, and when the switch is flipped in October, several ICD-10 codes will already be associated with established patients. For a Microsoft Excel list of common ENT ICD-10 codes, visit the Academy website: **www.entnet.org/content/icd-10-coding-resources**.

There are several factors to focus on when

Prepare now

improving the specificity of your documentation. Some examples include (documentation elements will vary by different codes):

- **Anatomy** (e.g., attic, tympanum, mastoid, diffuse cholesteatosis)
- **Anatomical Location** (maxillary, frontal, ethmoidal, sphenoidal, pansinusitis)
- **Disease Acuity** (e.g., acute, subacute, chronic, recurrent)
- **Localization/Laterality** (e.g., right, left, bilateral)

NUTS AND BOLTS

Incorrect versus correct documentation under ICD-10 requirements

INCORRECT DOCUMENTATION UNDER ICD-10	CORRECT DOCUMENTATION UNDER ICD-10
A 3-year-old female presents with unilateral otitis media with a ruptured tympanic membrane.	A 3-year-old female presents with **acute serous** otitis media **(L)** ear with **spontaneous** 60% **central** ruptured tympanic membrane.
Patient presents with adenotonsillitis, dyphagia, laryngitis, obesity.	Patient presents with **chronic** adenotonsillitis **with adenotonsillar hypertrophy**, **oropharyngeal** dysphagia, **acute obstructive** laryngitis, **morbid** obesity **with alveolar hypoventilation.**
Patient presents with hearing loss with history of high doses of IV antibiotics.	Patient presents with **bilateral** hearing loss with a history of high doses of IV **gentamicin**. **Hearing loss secondary to gentamicin.**

- **Infectious Agent** (e.g., scarlet fever, influenza, measles)
- **Type** (e.g., open, closed)
- **Episode** (e.g., initial encounter, subsequent encounter, sequela)
- **Manifestations** (e.g., serous, mucoid, suppurative, non-suppurative, with/without spontaneous rupture of tympanic membranes)
- **Circumstances** (e.g., exposure to environmental tobacco smoke, history of tobacco use, occupational exposure to environmental tobacco smoke, tobacco dependence)

See page 27 for a sample of incorrect versus correct documentation under ICD-10 requirements.

Assess your claims for mapping risk

Knowing your most frequent patient diagnoses and the optional ICD-10 codes will translate to help you assess which claims may be at risk for errors and their potential impact on revenues. See box at right for a few examples of risk levels.

A longer list of common ENT ICD-9 codes and their relevant ICD-10 crosswalks can be downloaded online at **www.entnet.org/Practice/upload/2012-Top-200-Commonly-Used-ENT-Codesbh.pdf**.

Testing

If you have not already, you should be testing claims with payers and/or Medicare Administrative Contractors (MACs). The Workgroup for Electronic Data Interchange (WEDI) has published a comprehensive guide on how to test your claims with ICD-10 at **www.wedi.org/docs/resources/testing-for-small-providers-white-paper.pdf?sfvrsn=0**. Your MAC should already have tested several claims by now. Request that your MAC share any testing results with you and check the CMS website for other published end-to-end testing results. Also remember, the closer you get to the deadline, the higher the likelihood that payer or MAC resources will be occupied by other physicians also trying to test. Test as soon as possible to beat the last-minute rush.

Don't get denied!

The Academy's ICD-10 website page has several resources, including a sample ENT ICD-10 Superbill that will assist your planning and preparation efforts. Visit the ICD-10 website for more at **www.entnet.org/node/740**. ■

NUTS AND BOLTS

Claims that may be at risk for errors

Low-risk claim with 1:1 translation

ICD-9 CODE	DIAGNOSIS	ICD-10-CM CODE	DIAGNOSIS
786.50	Chest pain unspecified	R07.9	Chest pain, unspecified

Moderate-risk claim with 1:4 to translation

ICD-9 CODE	DIAGNOSIS	ICD-10-CM CODE	DIAGNOSIS
380.23	Chronic otitis externa NEC	H60.60	Unspecified chronic otitis externa, unspecified ear
		H60.61	Unspecified chronic otitis externa, right ear
		H60.62	Unspecified chronic otitis externa, left ear
		H60.63	Unspecified chronic otitis externa, bilateral

Higher risk claim with 1: several translation

ICD-9 CODE	DIAGNOSIS	ICD-10-CM CODE	DIAGNOSIS
380.50	Other acute otitis externa	H60.501	Unspecified acute noninfective otitis externa, right ear
		H60.502	Acquired stenosis of left external ear canal, unspecified
		H60.503	Acquired stenosis of external ear canal, unspecified, bilateral
		H60.509	Acquired stenosis of external ear canal, unspecified ear
		H60.511	Other acquired stenosis of right external ear canal
		H60.512	Other acquired stenosis of left external ear canal
		H60.513	Other acquired stenosis of external ear canal, bilateral
		H60.519	Other acquired stenosis of external ear canal
		H60.521	Acute chemical otitis externa, right ear
		H60.522	Acute chemical otitis externa, left ear
		H60.523	Acute chemical otitis externa, bilateral
		H60.529	Acute chemical otitis externa, unspecified ear
		H60.531	Acute contact otitis externa, right ear
		H60.532	Acute contact otitis externa, left ear
		H60.533	Acute contact otitis externa, bilateral
		H60.539	Acute contact otitis externa, unspecified ear
		H60.541	Acute eczematoid otitis externa, right ear
		H60.542	Acute eczematoid otitis externa, left ear
		H60.543	Acute eczematoid otitis externa, bilateral
		H60.549	Acute eczematoid otitis externa, unspecified ear
		H60.551	Acute reactive otitis externa, right ear
		H60.552	Acute reactive otitis externa, left ear
		H60.553	Acute reactive otitis externa, bilateral
		H60.559	Acute reactive otitis externa, unspecified ear
		H60.591	Other noninfective acute otitis externa, right ear
		H60.592	Other noninfective acute otitis externa, left ear
		H60.593	Other noninfective acute otitis externa, bilateral
		H60.599	Other noninfective acute otitis externa, unspecified ear

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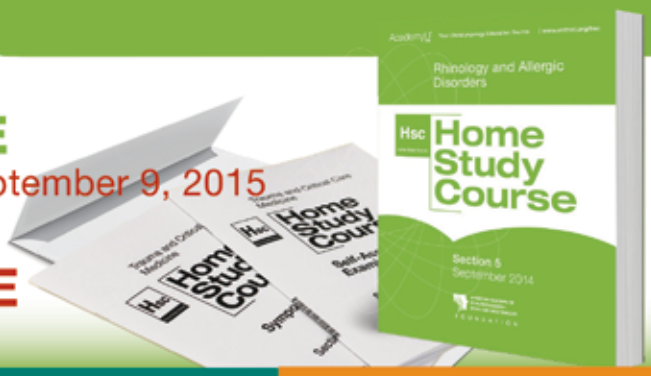

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Registration fee is based on AAO-HNS membership status at the time form is received.

Payment must be received by September 9, 2015, to receive 2015-2016 courses. First packet beings mailing in late August.

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AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION

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To receive the first session on time, registration with payment must be **RECEIVED** by August 5, 2015. Registration closes September 9, 2015. A $200 registration penalty will be applied to all registrations after September 9, 2015.

A recent multi-institutional study showed Botulinum toxin vials safe in multiuse fashion

THE AAO-HNS VOICE COMMITTEE

Demonstrated safety

By **Thomas L. Carroll, MD, Michael J. Pitman, MD,** and **Norman D. Hogikyan, MD**

For over two decades, otolaryngologists have treated spasmodic dysphonia (SD) patients using Botulinum toxin type A (Btx A) in a multiuse fashion from FDA-approved, 100-unit vials among multiple patients. Recently, the Centers for Disease Control and Prevention (CDC) has recommended against this common practice. This action jeopardizes the delivery of appropriate, life-affirming medical care to thousands of patients. This recommendation differs from the typical practice pattern of clinicians who administer the drug in a multiuse fashion.

Another controversy involving the use of BtxA surrounds the manufacturer's purported decrease in efficacy beginning four hours after resuspension of the drug. Evidence and clinical experience suggest Btx A remains effective weeks or months after the vial is initially opened, as long as it is refrigerated for future use. (Liu A, et al. *A. J Am Acad Dermatol* 2012;67: 373–378) A recent multi-institutional study was undertaken to explore and potentially resolve these controversies, utilizing both retrospective and prospective observational data of patients receiving Botox (Allergan Corp., Irvine CA) for spasmodic dysphonia (SD). (Barrow EM, et al. *Laryngoscope*. 2014 Dec 4. doi: 10.1002/lary.25068. [Epub ahead of print])

Led by senior author **Michael M. Johns III MD**, the authors collected data from three high-volume academic laryngology practices (the Emory Voice Center, the University of Pittsburgh Voice Center, and the University of Texas Health Science Center's Voice Center San Antonio) that all use Btx A vials in a sterile, multiuse fashion for SD: "Directly after reconstitution, predetermined amounts of BtxA are drawn up for subject use, using a new needle to puncture the vial with separate syringes for each subject. The needle is discarded after the Btx A is drawn up. The remaining reconstituted Btx A that is not used during the clinic time is refrigerated at 4ºC for use the following week." The study also highlights that otolaryngologists are not alone in this practice by citing a recent survey of the American Society for Dermatologic Surgery. This survey assessed 1,000 physician-members regarding their dermatologic practice patterns, and experiences with single- versus multipatient-use of Btx A stating there were "no instances of local infections ever documented by this group despite using the vials on multiple patients."

The authors used three methods to evaluate the safety of using Btx A vials in a multiuse fashion. All subjects were given Btx A from a vial that had been used in a multiuse fashion per routine clinical practice. First, 179 patients with a collective history of 3,423 Btx A injections from the three study sites were given a paper questionnaire

“Although not the primary focus of the study, an indirect observation on efficacy of reconstituted Btx A lasting longer than the recommended four hours was made by the authors. The clinical practice of the three study sites is to store and refrigerate the unused portion of the vials for future use. With SD Btx A injection clinics happening weekly or biweekly at these centers, they report a 96.64 percent Btx A injection treatment efficacy rate. With this finding, efficacy beyond four hours is clearly demonstrated.”

at the time of their current injection asking them if they had ever experienced potential signs of infection following any past Btx A injection (pain, redness and/or swelling at the injection site, and/or fever). A final question asked if they had ever experienced an injection that did not provide effect. Of all injections given, 5.81 percent were reported to have resulted in at least one of the aforementioned findings. Most of the patient responses were swelling or redness at the injection site. Only one patient out of 179 reported a fever in the post-injection period. Failed injections were reported in 3.36 percent of all injections.

The second method of Btx A multiuse vial safety evaluation involved a prospective phone survey of the same subjects one week after the injection was performed. In the study, 174 subjects participated with 22 (12.64 percent) experiencing pain, redness, swelling, or fever after the procedure. In total, nine (5.17 percent) experienced redness, eight (4.6 percent) experienced pain, and four (2.3 percent) had swelling at the injection site after their most recent Btx A treatment. Only one of the 174 subjects (0.57 percent) experienced fever.

Finally, the Emory Voice Center performed a single-site, retrospective review of nearly 10 years of one-week follow-up phone survey data of injections performed using the multiuse vial technique. The 743 subjects underwent 6,216 Btx A injections. Not a single infection-related adverse event was identified, and there were no unscheduled clinic visits or admissions due to infection following these procedures.

This study specifically demonstrates the safety of reconstituted Btx A vials to be used in a multiuse, multipatient fashion as they have been for decades, without undue concern for increased infection risk as proposed by the CDC and the manufacturer. In laryngological applications, typically for SD, very small amounts (typically 0.625 to 5 units) are used for each patient event. If used according to guidelines, more than 90 percent of the 100-unit Btx A vial would be discarded with each use resulting in enormous waste and increased expense to the healthcare system. The authors of the study also cite prior studies demonstrating the general side effects of Btx A, including nausea, malaise, flu-like symptoms, and rashes, which a patient can report following injection elsewhere in the body. Finally, other cited studies demonstrated pain, redness, and swelling at the injection site at incidences no higher than placebo. Dr. Johns' group concludes that their cohort likely experienced their symptoms due to the injection trauma itself rather than from infectious sequelae.

Although not the primary focus of the study, an indirect observation on efficacy of reconstituted Btx A lasting longer than the recommended four hours was made by the authors. The clinical practice of the three study sites is to store and refrigerate the unused portion of the vials for future use. With SD Btx A injection clinics happening weekly or biweekly at these centers, they report a 96.64 percent Btx A injection treatment efficacy rate. With this finding, efficacy beyond four hours is clearly demonstrated. Furthermore, the current study cites numerous other peer-reviewed papers that demonstrate preservation of both potency and duration of action for periods of a few weeks to six months.

The authors conclude the data they present demonstrates good evidence to support the use of Btx A vials in a multiuse fashion without concern for local or systemic infection. This paper's findings, offered alongside prior studies that offer evidence in a similar strain, afford otolaryngologists another set of data to challenge the CDC and manufacturer recommendations. These recommendations, which have directed local institutional guidelines, have led to significant waste of Btx A, extra effort, and wasted time for clinicians in otolaryngology and pharmacy who must prepare the Btx A and an additional, unnecessary cost to the health system. There is currently a robust societal mandate for cost-effective healthcare, and physicians should be in the lead in defining areas where quality-based medicine can reduce costs appropriately and safely. Physicians must also take the lead when it is possible that a pharmaceutical manufacturer's policy, i.e., single- versus multiuse of a vial, may in fact be rooted in projected sales figures rather than medical efficacy or patient safety. A conversation to challenge the CDC's and manufacturer's guidelines is necessary at every institution that prevents multiuse, multipatient use of reconstituted Btx A. ■

Clip, copy, and share the following pages: Clinical practice guideline plain language summaries for patients

The AAO-HNSF clinical practice guideline (CPG) plain language summaries (PLS) are developed by the guideline development group (GDG), consumers, and AAO-HNSF staff, with final sign-off by the CPG leadership.

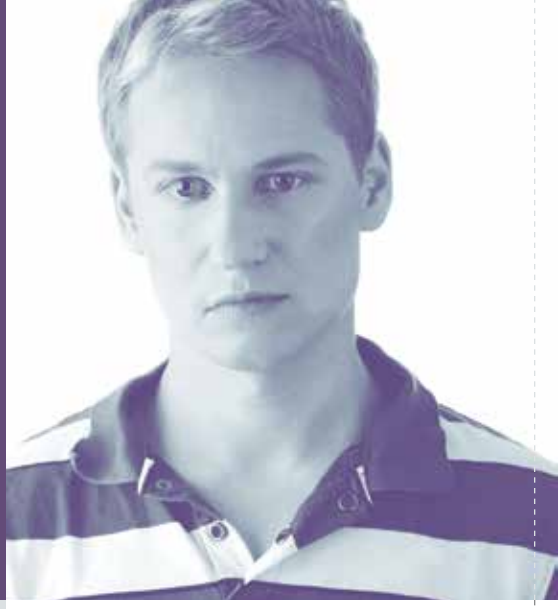
The goal of these derivative products of the CPGs is to provide patients/consumers with the information they need to know from the CPGs to help with shared decision-making.

The following three pages can be reproduced and distributed throughout your practice settings and shared with your referral base. PLSs are currently available for Acute Otitis Externa, Adult Sinusitis, Allergic Rhinitis, Bell's Palsy, and Tinnitus.

As new CPGs are developed and old titles are updated, they are available at **www.entnet.org/guidelines**. ■

WHAT IS BELL'S PALSY

This plain language summary serves as an overview in explaining Bell's palsy. Though the condition is uncommon, it is the most common facial nerve disorder. Bell's palsy affects both men and women across a wide range of ages. The information in this summary is based on the Clinical Practice Guideline of evidence-based research to help with a more efficient diagnosis and treatment of Bell's palsy.



WHAT IS BELL'S PALSY?

Bell's palsy is a condition that causes the facial nerve not to work resulting in paralysis and distortions of the face. The paralysis can appear as sagging, frozen expressions, frowns, droopiness, and other surprising looks. Some patients report a typical day of waking up and feeling normal, then being shocked when looking in the mirror and seeing how one side of their face has changed. In others, Bell's palsy takes several days or even longer to fully develop, before changes in the face stop. Bell's palsy occurs when the facial nerve is damaged by pressure or swelling. The facial nerve controls the muscles of the face, the ears, the saliva glands in the mouth and tears in the eyes, and provides some of the sense of taste on the tongue.

A person's facial paralysis or weakness may range from mild to severe. It may be difficult to smile or make facial expressions. Some people have a hard time eating or drinking due to the facial weakness. Other symptoms may include: facial numbness, drooling; pain around the ears, and loss of the sense of taste. Eyelids may not fully close. The face may feel heavy.

YOUR DIAGNOSIS/HOW DO YOU KNOW IF YOU HAVE BELL'S PALSY?

Bell's palsy is diagnosed in several different ways. It is important that a doctor rule out other, non-Bell's conditions that may be causing the facial paralysis or other symptoms. Your doctor will review your symptoms and medical history to decide if conditions such as stroke, certain tumors, Lyme disease, infection, injury/trauma, or other disorders might be causing the paralysis. Your doctor will suggest proper testing and treatment after evaluation. Your doctor may refer you to a specialist.

What you can and should do: It is important to quickly seek medical attention after the onset of symptoms. Seeking quick medical care will help avoid misdiagnosis or delayed diagnosis and may improve your chances of treatment. If your eyelids are not fully closing, it is very important to hydrate the eye. You can use eye ointment or eye drops to avoid any long-term harm to your sight. You should also protect your eyes. With Bell's palsy, you are more prone to scratches of the cornea, which can be prevented by wearing an eye patch. If you are in pain, seek medical advice.

WHAT CAUSES BELL'S PALSY?

Bell's palsy has an unknown cause. Bell's palsy occurs when the facial nerve becomes damaged, through no known fault or action of the patient. The facial nerve is believed to have been squeezed or somehow swollen by an inflammation. There is no reason why the facial nerve becomes weak or why some people are more affected than others. Some studies have found that the Bell's palsy may be related to a virus or could be a response by your body's immune system. Bell's is more common in the 15 to 45 year age group. You are at increased risk for Bell's if you are pregnant, have severe preeclampsia, are obese, have high blood pressure, diabetes, or upper respiratory ailments.

WHAT CAN YOU EXPECT? WILL YOUR SYMPTOMS GET WORSE?

The recovery time and the severity of symptoms will vary among individuals. However, most people affected by Bell's palsy will recover over a period of time. In some studies, facial function is completely restored in about 70 percent of Bell's palsy patients with complete paralysis within six months, and as high as 94 percent of patients with partial paralysis. Some patients will recover in as little as a few weeks or months. There are a few others who may have some degree of long-lasting paralysis. Some patients experience different levels of severity of symptoms or additional paralysis. Bell's palsy symptoms may make some people want to limit their time with other people due to their face looking different or distorted. Other people may have symptoms that affect their speech, vision or hearing. Some people have reported feeling faint or dizzy, conditions that can interfere with their daily activities. Your doctor may refer you to a specialist for any new symptoms or if your condition worsens.

WHAT TREATMENT IS AVAILABLE?

Several treatment options are available to Bell's palsy patients. Some people will recover over time without seeking treatment. It is important to seek medical attention to discuss a treatment plan and avoid misdiagnosis. Some people benefit by taking prescribed oral steroids—and it may help to get this treatment soon after the onset of Bell's. In the past, doctors may have prescribed antiviral drugs. It is not recommended that Bell's palsy patients who are experiencing symptoms for the first time receive antiviral drugs alone. Doctors may prescribe antiviral drugs with oral steroids. Experimental treatments include electronic nerve stimulation where an electrical current is produced by a device to stimulate the facial nerve for muscle movement; electroneurography, which measures how well your nerves transmit signals; hyperbaric therapy, which administers high levels of oxygen; or acupuncture. There is conflicting evidence about how well some surgical and experimental treatments work. Talk with your doctor about risks and potential side effects with any treatment. For more details and technical information about the science—and lack of science—behind these different treatments, see **http://www.entnet.org/content/clinical-practice-guidelines**

WHAT ELSE CAN YOU DO?

If your condition does not improve over time, there are some procedures that can help reduce the effects of Bell's palsy. For instance, you can get specialized help with closing the eyelids. It is also very important that you watch your mental health and that you seek counseling or support if you feel overwhelmed by the way your face has changed. You should follow up with your doctor, should your symptoms not get better within three months or if symptoms worsen. Your doctor can review your past treatment and explore further options with you to help you treat your symptoms. Your doctor may refer you to a specialist to help with managing your symptoms.

In today's world of social media, there are a number of websites with patients who are sharing life stories and pictures or videos of how they have coped—often with creative humor and good spirit—and how their condition has improved over time. We do not endorse any specific Bell's related website and some sites have bad information. However, you may find comfort in joining online support discussion forums. These online forums offer a place where you can learn and share with others with Bell's, who understand what you are going through. These sites can provide encouragement, useful coping tips, and hope.

Clip and copy to make available in your practice for patients.

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

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

WHAT IS SWIMMER'S EAR

This plain language summary serves as an overview in explaining Acute Otitis Externa (AOE), a condition commonly known as "swimmer's ear." Swimmer's ear affects both males and females across a wide range of ages. It is very common in children. Most cases happen in summer months or in warmer regions due to increased water exposure. The information in this summary is based on the 2013 update of the Clinical Practice Guideline: Acute Otitis Externa. The guideline includes evidence-based research to support more efficient diagnosis and treatment of swimmer's ear.

WHAT IS SWIMMER'S EAR?

Swimmer's ear is an infection of the ear canal, which is a slender channel about one-inch long that leads from the outer ear to the eardrum. Symptoms of swimmer's ear can include pain, redness, and swelling of the ear canal and an itchy feeling in the ear. Pain when tugging the earlobe, or when chewing food, is also a symptom. Some patients report temporary hearing loss or their ears feeling "full." Patients may experience symptoms differently and at different levels of severity. It is important to note that swimmer's ear is different from a middle ear infection, which is common in young children.

WHAT CAUSES SWIMMER'S EAR? ARE THERE RISK FACTORS?

Swimmer's ear is an infection that occurs when water remains trapped in the ear canal. This moist environment is ideal for the growth of bacteria, and, in rare cases, fungus. Some patients get swimmer's ear from swimming, although it can happen from bathing, showering, or even sweating. A lack of earwax due to aggressive cleaning with cotton swabs or small objects can cause swimmer's ear. Earwax limits the growth of bacteria and is a natural barrier to moisture. Skin conditions such as eczema, and chemicals from hairspray or dyes, can also prompt swimmer's ear.

Stress, sweating, wearing hearing aids, and allergies have been linked to the condition as well.

People swimming in pools with poor water quality are more likely to get swimmer's ear. Those living in warmer climates are also more likely to get swimmer's ear because they spend more time swimming or doing water sports. Some studies show that those with Type A blood may be at increased risk for swimmer's ear.

WHAT CAN YOU DO?

Seeking medical care quickly after the onset of symptoms will help avoid misdiagnosis or delayed diagnosis and improve the success of treatment. Untreated swimmer's ear can be very painful and can temporarily affect hearing. If left untreated, swimmer's ear could spread beyond the ear canal, lead to a chronic infection, or even permanently damage the ear.

HOW IS SWIMMER'S EAR DIAGNOSED?

Swimmer's ear is diagnosed by a physical examination and medical history by a healthcare provider. A doctor may examine the ears using a device called an otoscope (pronounced oh-toe-scope), which allows for a good view inside the ear canal. By using this device, a doctor can exclude any other causes of the patient's symptoms, such as excessive ear wax or infection in the middle ear. A doctor may also clean the inside of the ear canal and take a sample of drainage from the ear, if present.

WHAT TREATMENT IS AVAILABLE?

Swimmer's ear should be treated with prescription eardrops, which include antibiotics, steroids, or drugs that reduce inflammation. Sometimes the eardrops contain more than one medication. Swimmer's ear can be very painful, so be sure to let your doctor know if you need additional medication taken orally to relieve pain.

The recovery time and severity of symptoms varies among individuals. Symptoms usually improve within two to three days and pain goes away within four to seven days, but it may take up to two weeks for the ear to feel completely normal.

Patients with ear tubes, a hole in the eardrum, diabetes, or a weak immune system may get modified treatments from their doctor.

Ear candles do not help swimmer's ear and are not recommended for treatment. Studies show use of ear candles can cause more injury to the ears.

HOW CAN YOU PREVENT SWIMMER'S EAR?

During treatment: Patients with swimmer's ear should stay away from water for seven to 10 days during their treatment. Entering a swimming pool may be allowed in mild cases as long as the ears are not submerged under water.

After treatment: Swimmers may return to swimming two to three days after completing treatment if the pain has gone away and they use earplugs. Inserting earplugs can help reduce additional moisture in the ear. Patients who wear hearing aids or use earphones should limit their use until pain and any discharge have stopped.

Other prevention tips: Using eardrops prescribed by your doctor shortly before or after swimming, at bedtime, or in a combination of times is one way to prevent swimmer's ear. Keeping the ear canal dry after water activities can also help defend against swimmer's ear. One idea is to dry the ear by using a hair dryer on the lowest heat setting.

If your symptoms do not begin to improve after a few days with treatment you should inform you doctor to see if an office visit or change in medicine is necessary. A doctor can review past treatment and explore further options to treat the condition.

This plain language summary was developed from the 2014 AAO-HNSF Clinical Practice Guideline: Acute Otitis Externa. The multidisciplinary guideline development group represented the fields of otolaryngology–head and neck surgery, pediatrics, infectious disease, family medicine, dermatology, and consumer advocacy. Literature searches for the guideline were conducted up through October 2012. For more information on Acute Otitis Externa, visit ***http://www.entnet.org/guidelines/guidelines.cfm***

SOURCE

Clinical Practice Guideline: Acute Otitis Externa. Rosenfeld RM, Schwartz SR, Cannon CR, Roland PS, Simon GR, Kumar KA, Hunag WW, Haskell HW, Robertson PJ. *Otolaryngol Head Neck Surg.* 2014 Feb; Vol. 150(1S) S1– S24. doi: 10.1177/0194599813517083

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WHAT IS TINNITUS

This plain language summary serves as an overview in explaining tinnitus and managing its symptoms. Tinnitus is a sensation of noise or ringing in the ears or head, when there is no real sound. Tinnitus (pronounced ten-ih-tus) affects 10-15 percent of adults in the United States. Some people experience tinnitus that goes away on its own. Other people have symptoms that last six months or longer and interfere with their life. The information in this summary is based on the 2014 Clinical Practice Guideline: Tinnitus. The guideline includes evidence-based research to support more effective diagnosis and treatment of tinnitus.

WHAT IS TINNITUS?

Tinnitus can be heard in one or both sides of the head. The noises can sound like they are either from within or outside the head. Tinnitus sounds can include ringing, roaring, buzzing, clicking, beating, whooshing, whistling, humming, or other noises. The person may "hear" their tinnitus all the time, or only in certain situations. Tinnitus can hurt a person's quality of life. Patients may experience symptoms at different levels of severity. Common patient complaints include difficulty sleeping, struggling to understand other's speech, depression, and problems focusing. These experiences could lead to problems with both work and family life.

WHAT CAUSES TINNITUS? ARE THERE RISK FACTORS?

There are two types of tinnitus: primary and secondary. Primary tinnitus has an unknown cause. It may or may not be linked with hearing loss. Secondary tinnitus has a specific known cause. It may be such things like impacted earwax, or diseases or pressure behind the eardrum. Secondary tinnitus can also be related to Meniere's disease or ear nerve conditions. Tinnitus can be caused by more unusual or serious conditions. Some of these rare conditions include tumors, heart problems, or blood vessel problems.

Tinnitus can be seen at any age, in males or females, and in all ethnic groups. Tinnitus occurs more frequently in males, the elderly, and non-Hispanic whites. There is a higher rate of tinnitus among military veterans. Tinnitus is also more likely to occur in people who are overweight, obese, or who have high blood pressure. Other risk factors include diabetes, high cholesterol, or anxiety disorder. Tinnitus is believed to be linked to long-term noise exposure. Exposure to noise, such as firearms or loud music, is also a risk factor.

WHAT CAN YOU DO?

You should seek medical care after you notice symptoms, which may help avoid misdiagnosis or delayed diagnosis. Tinnitus can be very upsetting, and it can even be associated with depression and anxiety. Tell your doctor if you are having a strong emotional response to your tinnitus. Tinnitus patients commonly have trouble sleeping (insomnia). Lack of sleep can reduce the ability to pay attention. It can also lead to anger, frustration, and other negative emotions. Some patients develop a fear of being in noisy places. It is important to tell your doctor if symptoms are affecting your daily life.

HOW IS TINNITUS DIAGNOSED?

A doctor can diagnose tinnitus by reviewing your medical history and performing a physical exam. The examination may rule out other conditions. A doctor may look in the ears using a device called an otoscope (pronounced oh-toe-scope). This device allows for a good view inside the ear canal. Your doctor may also find other treatable conditions that are causing tinnitus. For example, earwax that is obstructing the ear canal can be removed. Fluid behind the eardrum can also be treated. Tinnitus frequently occurs in patients with hearing loss. Hearing tests are often done for people who have tinnitus.

WHAT TREATMENTS ARE AVAILABLE?

Tinnitus may improve on its own, especially when it is mild and has lasted for less than six months. When treatment is needed, patients benefit from individualized treatments to help manage their symptoms. Hearing aids can improve a patient's quality of life by correcting any hearing loss. Hearing aids can also make the tinnitus less noticeable. Patients who have upsetting tinnitus may benefit from counseling and/or medications. Cognitive behavioral therapy is a form of psychotherapy that may be helpful for patients trying to cope with upsetting tinnitus. Sound therapy is sometimes a good option. Smart phones, CD players, MP3 players, and radios can be used for sound therapy.

Studies show that products such as Ginkgo biloba, melatonin, or zinc do not help patients with tinnitus. Therefore, these types of over-the-counter products are not recommended for treatment. Research shows that ear medications injected through the eardrum do not improve tinnitus. Studies also prove that treatments with magnetic stimulation do not improve the tinnitus. Therefore, these treatments are not recommended. There is not enough evidence to either recommend or discourage using acupuncture for treating tinnitus.

WHERE CAN I FIND HELP?

Tinnitus is a symptom, not a disease. There are a number of options that can be offered for your relief. Your doctor can provide information brochures and can suggest self-help books. Also, your doctor can describe counseling and therapy options to you. Your doctor can also explain how medication manages the problem. You may also be referred to support associations and specialists.

This plain language summary was developed from the 2014 AAO-HNSF Clinical Practice Guideline: Tinnitus. The multidisciplinary guideline development group represented the fields of otolaryngology–head and neck surgery, including pediatric and adult otolaryngologists, otologists/neurotologists, a geriatrician, a behavioral neuroscientist, a neurologist, an audiologist, a radiologist, a family physician, a psychiatrist, an internist, a psychoacoustician, an advanced nurse practitioner, a resident physician, and consumer advocates. Literature searches for the guideline were conducted up through April 2013. For more information on Tinnitus, visit ***http://www.entnet.org/content/clinical-practice-guideline-tinnitus***

SOURCE

Tunkel DE, Bauer CA, Sun GH, et al. Clinical Practice Guideline: Tinnitus. *Otolaryngol Head Neck Surg.* 2014;151(S2):S1-S40

Clip and copy to make available in your practice for patients.

21 Position Statements for review in 2015-2016

The American Academy of Otolaryngology—Head and Neck Surgery and Foundation's (AAO-HNS/F) Position Statements are used to designate a statement, policy, or declaration of the AAO-HNS/F on a particular topic or topics. Statements are created to formalize the AAO-HNS/F position on a clinical procedure or medical service with third-party payers, for use in state and federal regulatory or advocacy efforts, or to clarify the AAO-HNS/F approval or disapproval of certain practices in medicine. **Robert Lorenz, MD, MBA**, Coordinator for Practice Affairs and Physician Payment Policy (3P) Workgroup Co-Chair, provides oversight on the development and maintenance of programs that support the services our physicians provide to patients, including the AAO-HNS/F Position Statements, which are reviewed every four years. There are a total of 73 active position statements with 21 last updated in December 2012 and scheduled for review this fall. As part of each committee's charge, it is essential that the relevant AAO-HNS/F clinical committees review the Position Statements to ensure they are updated and relevant. The relevant committee chairs and staff liaisons will receive the Position Statements they are responsible for reviewing by August 2015 so that there is ample time for the review process, and the committees may opt to discuss the position statements under review at the Academy's Annual Meeting and OTO EXPO℠.

Committees will receive a four-month time frame to review assigned statements with additional time given to those committees with more than three statements assigned. The committee will be asked to review, deliberate, and decide among three options: 1) delete the position statement because it is outdated or no longer serves a valid purpose; 2) reaffirm the position statement as written with zero changes; or 3) revise the position statement and draft a track-changes version of the original statement, clearly reflecting specific proposed changes along with rationale for the revisions. Committees are encouraged to assign two or three committee members to review the statement, submit their recommendations to the entire committee, and reach a consensus recommendation with supporting rationale that the staff liaison can submit to the 3P Workgroup for review and approval. Recommendations for new Position Statements by the committees may also be considered on an ongoing basis. (See **www.entnet.org/sites/default/files/PositionStatementTemplateandDevelopmentProcess.pdf** for guidance on creating a new position statement.) Pending 3P approval, the Position Statements are reviewed and approved by the AAO-HNS Boards of Directors Spring or Fall 2016 meeting for final approval. ■

POSITION STATEMENT	CURRENT STATEMENT AVAILABLE	REVIEW PERIOD BEGINS
Foreign Bodies of the Upper Aerodigestive Tract	www.entnet.org/node/937	August 7, 2015
Roles of Flexible Laryngoscopy / Videostroboscopy	www.entnet.org/node/904	August 7, 2015
Micropressure Therapy	www.entnet.org/node/827	August 7, 2015
Ambulatory Procedures	www.entnet.org/node/952	August 7, 2015
Medical Role in Cerumen Removal	www.entnet.org/node/926	August 7, 2015
Hearing Aids	www.entnet.org/node/934	August 7, 2015
Voice Therapy in the Treatment of Dysphonia	www.entnet.org/node/894	August 7, 2015
CDC Immunization Recommendations for Cochlear Implant Patients	www.entnet.org/node/829	August 7, 2015
Implantable Hearing Devices	www.entnet.org/node/932	August 7, 2015
Minimal Test Battery for Cochlear Implants	www.entnet.org/node/923	August 7, 2015
Physician Drug Dispensing	www.entnet.org/node/916	August 7, 2015
Botulinum Toxin Treatment	www.entnet.org/node/951	August 7, 2015
Debridement of the Sinus Cavity after FESS	www.entnet.org/node/946	August 7, 2015
Dilation of Sinuses, any method (e.g. balloon, etc.)	www.entnet.org/node/542	August 7, 2015
Sinus Endoscopy	www.entnet.org/node/908	August 7, 2015
Nasal Surgery and OSAS	www.entnet.org/node/548	August 7, 2015
Submucosal Ablation of the Tongue Base for OSAS	www.entnet.org/node/546	August 7, 2015
Tongue Suspension	www.entnet.org/node/399	August 7, 2015
Treatment of Obstructive Sleep Apnea	www.entnet.org/node/549	August 7, 2015
Uvulopalatopharyngoplasty	www.entnet.org/node/896	August 7, 2015
Head and Neck Surgery	www.entnet.org/node/935	August 7, 2015

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President, ENT and Allergy Associates
rgreen@entandallergy.com

Robert A. Glazer
CEO, ENT and Allergy Associates
914-490-8880 ▪ rglazer@entandallergy.com

ENT Physician Opportunity – AtlantiCare

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Ted Teknos, MD
Professor and Chair
The Ohio State University
Department of Otolaryngology
915 Olentangy River Rd. Suite 4000
Columbus, Ohio 43212
E-mail: mark.inman@osumc.edu
Department Administrator
Or fax to: 614-293-7292
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Please send Curriculum Vitae to:

Mr. Tony Etzel, Vice Chair for Administration
Department of Otolaryngology
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Miami, FL 33136

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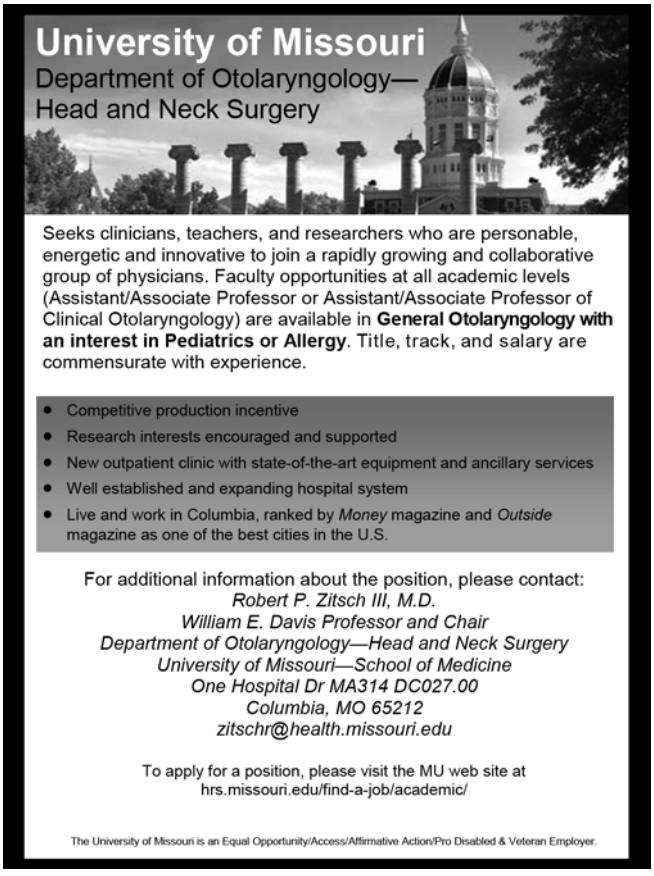
Interested applicants should send CV and letter of intent to:

Lisa Buckmiller MD, Chief Pediatric Otolaryngology
Children's Hospital of San Antonio
315 N. San Saba, Suite 1003
San Antonio, TX. 78207
(210) 704-3391
Lisa.Buckmiller@christushealth.org



Pediatric Otolaryngology

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The successful applicant should be board eligible or board certified in Otolaryngology-Head and Neck Surgery. We expect the successful candidate to develop an active clinical practice in general otolaryngology, be an active teacher of medical students and residents, oversee the clinical program, and (for MCL) maintain an excellent clinical and/or translational research program.

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Lori Abrahamsohn
Faculty Affairs Administrator
Department of Otolaryngology-Head and Neck Surgery
801 Welch Road, Stanford, CA 94305
labrahamsohn@ohns.stanford.edu
650-725-6500 (P) 650-725-8502 (F)

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Vicente Resto, MD, PhD, FACS
Chair, Department of Otolaryngology
The University of Texas Medical Branch,
301 University Boulevard, Galveston, TX 77555-0521
Email: varesto@utmb.edu
Phone: 409-772-2701 Fax: 409-772-1715

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WestVirginiaUniversity.

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Requirements:

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

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

Contact Information:

Contact name: Stacey Citrin, CEO
Phone: (305) 558-3724 • Cellular: (954) 803-9511
E-mail: scitrin@southfloridaent.com

Otology/Neurotology Position in Denver

Denver Ear Associates is seeking a board eligible/board certified neurotologist to join their busy practice in Denver. The practice covers the full range of otology and neurotology including cochlear implants, skull base surgery and radiosurgery along with a busy office practice treating the full range of dizziness and balance disorders and hearing loss. We are presently involved in a number of cochlear implant studies which would be open to a new associate. The opportunity would include salary and benefits with a plan to advance to partnership.

Interested candidates
should submit CV and cover letter to:

Robert Muckle, MD

Email Practice Manager: lbenjamin@denverear.com
Address: Denver Ear Associates
401 West Hampden Place, Suite 240
Englewood, CO 80110
www.denverear.com

Charlotte Eye Ear Nose & Throat Associates, P.A.

UNIQUE OPPORTUNITY TO CONTRIBUTE TO TWO NATIONALLY RECOGNIZED HEALTHCARE SPECIALTY GROUPS!

FELLOWSHIP TRAINED HEAD AND NECK SURGEON

Charlotte Eye Ear Nose and Throat Associates, PA, (headquartered in Charlotte, North Carolina) a physician-owned and operated dual specialty practice is seeking a BC/BE full time fellowship trained head and neck surgeon to practice all aspects of the field. Free-flap expertise is strongly desirable.

The largest provider of Ophthalmological and ENT services in the Charlotte area, CEENTA offers a full range of services including general otolaryngology, pediatric otolaryngology, neurotology, head and neck surgery, laryngology, sleep medicine and facial plastic surgery.

The group, consisting of thirty- nine ENT providers and fifteen clinic locations, has state- of- the-art equipped offices including complete audiology services, allergy clinics, CT scanners, an ambulatory surgery center, a voice and swallowing center with 3 Speech-Language Pathologists, an accredited sleep lab, and an in-house contract research organization.

The successful candidate, as part of the recruitment process, will be interviewed by a search committee that includes senior staff of the Levine Cancer Institute, and subject to privileging at Carolinas Medical Center, will be invited to join the interdisciplinary Head and Neck Cancer team at the nationally recognized Levine Cancer Institute of Carolinas HealthCare System. The Institute integrates and builds upon cancer programs within Carolinas HealthCare System's network of affiliated hospitals and providers to deliver innovative protocols when they are needed most – so where a patient lives will not determine how they fight cancer.

Charlotte, NC is one hour from several lakes, two hours east of the Appalachian Mountains and 3 ½ hours west of the Atlantic Ocean. It is a growing, vibrant city with rich opportunities in the arts and humanities. There are excellent public and private schools and numerous recreational opportunities as well.

This position includes an excellent salary with partnership anticipated, 401(k), professional liability insurance, health insurance, long term disability and life insurance.

For immediate consideration, contact:

Annette Nash, Director-Human Resources
Charlotte Eye Ear Nose and Throat Associates, PA
6035 Fairview Road • Charlotte, North Carolina 28210
Email: anash@ceenta.com • Fax: 704.295.3415
EOE

ENT Physician – Mid Coast Maine

Mid Coast Medical Group in Brunswick, Maine is seeking a full-time BC/BE ENT physician to join an established practice, in a hospital-based position. This position joins two established BC ENT physicians with 1:3 call. Full scope of outpatient and operative work in a community hospital setting. MCMG, a progressive practice in mid-coast Maine, provides unique, high quality care in its nineteen practices; utilizing an integrated EMR to co-ordinate care between specialty and primary care offices.

The successful candidate will have the opportunity to provide exceptional care to patients in a growing region of Maine. Mid Coast Hospital, built in 2001, is a full service community hospital north of Freeport and Portland, located on the coast of Maine. Mid Coast's skilled professionals use the newest technology to meet the healing needs of their patients. Mid Coast Hospital has been recognized as a Magnet Hospital, along with being Joint Commission accredited. Mid Coast Health Services offers generous benefits, including health and disability insurance, retirement savings and vacation package.

Contact Jill Rose, Physician Recruiter
jrose@midcoasthealth.com

MID COAST MEDICAL GROUP

Equal Opportunity Employer

THE UNIVERSITY of TENNESSEE HEALTH SCIENCE CENTER

Head and Neck Surgeon – The Department of Otolaryngology Head and Neck Surgery of University of Tennessee Health Science Center, is recruiting a mid-career Head and Neck Cancer surgeon to lead its Division of Head and Neck Surgery. This individual must, have a proven record of collaborative multi-specialty clinical experience, an interest in clinical translational research, be well published, and nationally recognized. The position will be tenure-track at either the Associate/Professor rank as appropriate. The individual will join another surgeon, and be a leader in a large established multi-specialty Cancer Treatment Team, The West Group, as well as be closely affiliated with Methodist University Hospital.

Responsibilities include continued development of a strong clinical practice with other members of the Head and Neck Oncology Team, resident and medical student education, and clinical or basic science research.

Candidates must be able to obtain a Tennessee medical license.

Letters of inquiry and curriculum vitae should be sent to:

Jerome W. Thompson, M.D., MBA, Chairman
Department of Otolaryngology-Head and Neck Surgery
The University of Tennessee Health Science Center
910 Madison Avenue, Suite 408
Memphis, TN 38163

Or email to: jkeys@uthsc.edu

The University of Tennessee is an EEO/AA/Title VI/Title IX/Section 504/ADA/ADEA/V institution in the provision of its education and employment program and services.

A position is available at the Assistant or Associate Professor level in the Department of Otolaryngology/ Head & Neck Surgery

NEUROTOLOGIST/OTOLOGIST

- Rank commensurate with experience
- Excellent resources are available in this rapidly expanding program
- Fellowship training required

To apply and receive additional information about the support associated with this opportunity, please contact:

Stil Kountakis, MD, PhD, Professor and Chairman
Department of Otolaryngology-Head & Neck Surgery
1120 Fifteenth Street, BP-4109 Augusta, Georgia 30912-4060

Or email skountakis@gru.edu

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Academic Otolaryngologist

UMassMemorial Medical Center, the clinical partner of the University of Massachusetts Medical School in Worcester, MA, is seeking BC/BE

1) General Otolaryngologist

Join an established group of 6 physicians in a busy tertiary care referral center. Responsibilities include clinical care as well as student and resident education. Opportunities exist for clinical and basic science investigation and research. An academic appointment commensurate with education and training is offered. We are looking for dynamic new or recent graduates with energy, desire, and drive to jump start their careers and help expand our scope and presence. UMassMemorial Medical Center is situated in Worcester, MA, a community rich in history. Worcester is the second largest city in Massachusetts and New England, and has a very large patient referral base. Worcester and the surrounding area have a strong and diverse economic base with family oriented communities and excellent school systems. Boston and Providence are only forty miles away, and beaches, lakes, and mountains are all easily accessible.

For consideration and/or additional details, please submit your CV and Letter of Introduction to:

Daniel Kim MD
Department of Otalaryngology-Head and Neck Surgery
UmassMemorial Medical Center
c/o Jennifer Pappas,
Physician Recruiter
Email: jennifer.pappas@umassmemorial.org
Phone: 774-312-0483

UMass Memorial Medical Center and the University of Massachusetts Medical School are equal opportunity employers.

Chief, Otolaryngology

OPPORTUNITY IN SOUTH FLORIDA

Memorial Healthcare System is seeking a Chief for the Division of Otolaryngology. The Memorial Physician Group currently employs two otolaryngologists supporting an established otolaryngology outpatient practice, inpatient hospital consults and emergency room call.

Successful candidates will meet the following criteria:

- Fellowship trained in head and neck surgery
- Minimum of five (5) years leadership experience
- Board certified in otolaryngology
- Experienced in evidence-based medicine
- Excellent communication, interpersonal and team-leadership skills
- Demonstrated success in new program development and the establishment of policies and guidelines to monitor patient progress, evidence-based clinical outcomes and the effectiveness of medical care

This is a full-time employed position with the multi-specialty Memorial Physician Group. The position offers a highly competitive and desirable compensation/benefits package that is commensurate with training, experience and market demand. Professional malpractice and medical liability are covered under sovereign immunity.

ABOUT MEMORIAL HEALTHCARE SYSTEM

Memorial Healthcare System is the third-largest public healthcare system in the country. It is a national leader in quality care and patient satisfaction and has been ranked on *Modern Healthcare* magazine's list of Best Places to Work in Healthcare. Memorial Healthcare System's facilities include Memorial Regional Hospital, Memorial Regional Hospital South, Joe DiMaggio Children's Hospital, Memorial Hospital West, Memorial Hospital Miramar, Memorial Hospital Pembroke and Memorial Manor nursing home. Our facilities are located throughout South Florida, a region known for its high quality of life. In addition, Florida has no state income tax. For more information, visit mhs.net.

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ENT PHYSICIAN

SOUND HEALTH SERVICES, P.C.
One Group. Sound Health. Complete ENT Care.

Sound Health Services, a twenty-three physician Otolaryngology group in St. Louis, MO, has an immediate opening in their South County practice. Sound Health Services is the largest independent ENT group in the St. Louis metropolitan area. We provide full service ENT care including Audiology, Vestibular Testing, Hearing Aid Dispensing, Voice & Swallowing Services, Facial Plastics and CT Scanning.

We offer an excellent salary/bonus with partnership track, health insurance, paid vacation time, malpractice insurance, and CME reimbursement, plus other benefits. Candidate must have strong clinical knowledge, excellent communication skills, be highly motivated and hard working.

Requirements:

- **Board certified or eligible**
- **MD/DO from approved medical/osteopathy school**
- **1:4 Call coverage**
- **Excellent communication and interpersonal skills**
- **Graduation from accredited residency program in ENT**

For more information about this position, please contact our Practice Manager, Rebecca Akers, at 314-843-3828, or by email at **bakers@soundhealthservices.com**.

You may also visit our website at **soundhealthservices.com**.

THE UNIVERSITY OF NEW MEXICO
Department of Surgery, Division of Pediatric Otolaryngology

The Department of Surgery, Division of Otolaryngology, at the University of New Mexico is seeking a Pediatric Otolaryngologist who is trained in all aspects of pediatric otolaryngology surgery. This position will be recruited at the Assistant/Associate Professor level. Research opportunities are available if desired, and clinical research opportunities are readily available. Appointment and salary will be commensurate with level of experience.

The successful candidate will participate in an active Pediatric Otolaryngology practice, as well as provide resident teaching rounds, medical student teaching and participation at local and national conferences. It is an excellent opportunity for a pediatric otolaryngologist interested in academic achievements and good clinical experience. An excellent compensation package is provided.

Minimum Qualifications: Medical doctor who is board certified/eligible in Otolaryngology-Head and Neck Surgery, eligible for licensure in New Mexico, and eligible to work in the U.S.

Preferred Qualifications: Academic/clinical experience and completed fellowship in Pediatric Otolaryngology, or completing a fellowship in the next twelve months.

Interested applicants must apply for this position via UNMJobs website, unmjobs.unm.edu/, Posting# 0824589. Please attach electronic copies of a current CV and a letter of interest to the application.

In addition, please submit three (3) letters of reference to the email address below. Applications will not be considered complete until all three (3) letters of reference are received. This position **will remain open until filled**. For more information and to submit letters of reference, please contact Erica Bennett, M.D., at ***EBennett@salud.unm.edu***.

The UNM School of Medicine is an Equal Opportunity/Affirmative Action Employer and Educator. This position may be subject to criminal records screening in accordance with New Mexico state law. J1 Visas are not eligible for this opportunity. UNM's confidentiality policy ("Disclosure of Information about Candidates for Employment," UNM Board of Regents' Policy Manual 6.7), which includes information about public disclosure of documents submitted by applicants, is located at http://www.unm.edu/~brpm/r67.htm

THE UNIVERSITY OF ARIZONA
COLLEGE OF MEDICINE TUCSON
Otolaryngology – Head & Neck Surgery

Banner
University Medicine

Senior Head and Neck and/or Microvascular Reconstructive Surgeon

The Department of Otolaryngology – Head and Neck Surgery, at the University of Arizona (UA), College of Medicine (COM) in Tucson, Arizona is seeking ***a fellowship-trained, board-certified head and neck and/or microvascular reconstructive surgeon*** to serve in a leadership role at the Associate Professor/Professor level.

The Department has rapidly grown to offer the full breadth of quaternary Otolaryngology – Head and Neck Surgery. Currently, the department consists of 9 clinical faculty and 3 basic science faculty. We have been continuously funded by the NIH and have steadily expanded our residency and fellowship programs.

Funds are available for program building and preference will be given to candidates with funded research backgrounds and/or the ability to recruit funded research programs to the department. Potential senior leadership roles within the department and institution are available for qualified candidates.

Join us during this exciting period of growth. The University COM has recently merged with Banner Health, a $6 billion organization with a hospital network that encompasses all of Arizona, and parts of Colorado and Alaska. There is a tremendous opportunity to establish a state-wide academic program. The University of Arizona and Banner University Medical Center (BUMC) are located in Tucson, Arizona. The Arizona Cancer Center, an NCI designated comprehensive cancer center, is on the BUMC campus as a fully integrated program offering state-of-the-art cancer treatment and research.

The department is seeking an individual who is able to work with diverse students and colleagues, and who has experience with a variety of teaching methods and curricular perspectives. The UA is an EEO/AA Employer.

Apply online at **www.uacareertrack.com**; Job posting 58293.

For additional inquiry, please email and attach a CV to:

Alexander Chiu, M.D., Professor and Chair
Department of Otolaryngology-Head and Neck Surgery
achiu@oto.arizona.edu

Pittsburgh Ear Research Foundation
Division of Otology Research and Neurotology
Allegheny General Hospital, Pittsburgh, Pennsylvania

Presents

Temporal Bone and Microanatomy Hands-on Dissection Workshop

October 23 & 24, 2015

This workshop is intended for otolaryngologists interested in the most recent development in temporal bone surgical techniques.

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Course Co-Directors: Douglas A. Chen, MD, FACS
Todd A. Hillman, MD

For additional information, please contact Allegheny General Hospital, Continuing Medical Education by e-mail to **cjackel@wpahs.org**, by phone at 412-359-4952, or by fax at 412-359-8218. To download a brochure or to register online, please visit our Web site at **www.aghcme.org**. Select Conference Schedule on the left, then scroll until you find the appropriate Temporal Bone Course.

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Lawrence Lustig, MD
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Otolaryngology

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Contact Doug Kenner
866.670.0334 or dkenner@mountainmed.net

The Charleston Course

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How does a busy clinician stay current in our rapidly expanding specialty?

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Paul R. Lambert, M.D., Professor & Chair

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