



# bulletin

The official member magazine of the **American Academy of Otolaryngology-Head and Neck Surgery**

DECEMBER 2020/JANUARY 2021

## 2020 ANNUAL REPORT

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for Sleep Surgery in 2022

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Radiofrequency Ablation  
for Benign Thyroid Nodules

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Human Error Is Inevitable—  
So How Do We Reduce the  
Risk of Harm?

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1. Lupo MA, et al. *Diagn Cytopathol.* 2020;1-11. <https://doi.org/10.1002/dc.24564>. 2. Steward DL, et al. *JAMA Oncol.* 2019;5(2):204-212. 3. Patel KN, et al. *JAMA Surg.* 2018;153(9):817-82. 4. Banizs AB, et al. *Diagn Cytopathol.* 2019;47(4):268-274.



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# bulletin features

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# CHANGES ARE COMING TO E/M CODING IN JANUARY 2021

**You may know  
about them, but  
does your EHR?**

Our EHR system, EMA<sup>®</sup>, was designed to help make January 2021's E/M changes easier on you and your practice. EMA auto-suggests medical coding based on your clinical documentation and MDM.

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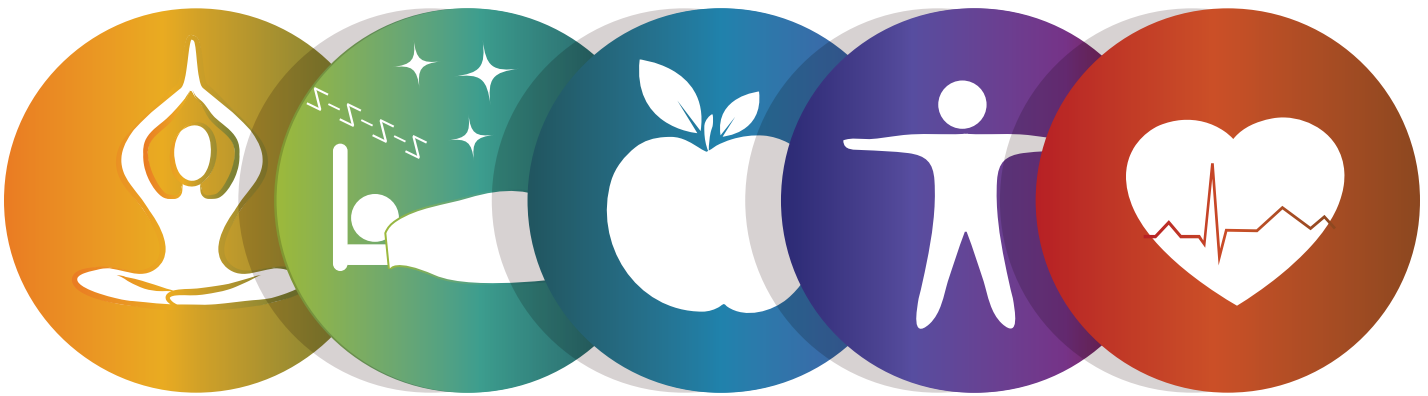
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# Put Your Oxygen Mask on before Helping Others: The Importance of Wellness

Before taking off in an airplane, we have all heard this all-too-familiar safety message: a reminder to put your own oxygen mask on before helping others. As caregivers, we give much of ourselves to ensure the well-being of our patients. Our profession can bring stress. We bear witness to human suffering. The hours are long. Sometimes we wish we could offer more to patients and families who suffer from conditions when we do not have all the answers and cannot offer a cure. With the COVID-19 pandemic, we also may be putting ourselves in harm's way as we offer life-saving care and treatment to those afflicted.

It is well recognized that the complexities and stress of the healthcare environment can compromise the well-being of the workforce. Further, we, as clinicians, are subject to increasingly time-consuming administrative activities. It can, at times, be more difficult to maintain a healthy work-life integration. Burnout and other mental and physical health concerns can be a direct result of these challenges.

One of my primary initiatives as your President is to focus on how to foster the wellness of our community. **Dr. Dana Thompson** is leading the work group focusing on wellness initiatives as part of our 125th Anniversary Giving Campaign, "Shaping Our Future Together: 125 Strong Campaign." She, along with colleagues, will bring

forward recommendations about what we, as a society, can do to foster the health and wellness of our members. There are a number of strategies that we can consider. These include:

- Finding meaning and purpose in our work
- Using our vacation time
- Paying attention to our health
- Incorporating a healthy balanced diet and regular exercise into our routines
- Getting enough sleep
- Developing and utilizing a robust social support network
- Engaging in hobbies, which can be very therapeutic
- Nurture the spiritual aspects of our lives

The pandemic has resulted in tremendous social isolation as well as financial challenges. Further, COVID-19 has highlighted health disparities within our society. Many people, including our patients, are experiencing increased fear and anxiety. Never has a clearer focus on the importance of wellness been more important. I encourage each of us to reach out to a colleague, a family member, or a friend. It may not be apparent, but they may be feeling stressed, unwell, or could simply use a helping hand. I encourage us all to offer words of support and a listening ear to colleagues, friends, and families. We all need each other to get through these challenging times. ■



**Carol R. Bradford, MD, MS**  
AAO-HNS/F President

“  
Never has a clearer  
focus on the importance  
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each other to get through  
these challenging times.

”

# NOW OPEN



## AAO-HNSF 2021 ANNUAL MEETING & OTO EXPERIENCE LOS ANGELES, CALIFORNIA | OCTOBER 3 - 6 WE ARE ONE TWENTY-FIVE

MAKE YOUR MARK AT THE 125<sup>th</sup> CELEBRATION BY  
SUBMITTING YOUR #OTOMTG21 EDUCATION PROPOSAL

# CALL FOR SCIENCE

Each year, the AAO-HNSF receives and reviews thousands of abstracts and proposals submitted by otolaryngologists and healthcare professionals. It is the goal to ensure education programs offered at the Annual Meeting are engaging, significant, relevant, and of high quality, leaving attendees feeling equipped with the knowledge, tools, and resources to advance patient care and implement real change within the otolaryngologist-head and neck surgery community.

AAO-HNSF encourages submissions that endorse inclusion of minorities and women in the sessions, as well as topics relevant to diversity and that contribute to cultural competence for all members.

### **This timeframe is inclusive of all program formats:**

- International Symposium
- Scientific Posters
- Flash Talks
- Expert Lectures
- Master of Surgery  
Video Presentations
- Panel Presentations
- Scientific Oral Presentations

**Deadline: January 18, 2021**

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# Your AAO-HNS Community of Support: You Will Never Walk Alone

When you walk through a storm  
Hold your head up high  
And don't be afraid of the dark

At the end of a storm  
There's a golden sky  
And the sweet silver song of a lark

Walk on through the wind  
Walk on through the rain  
Though your dreams be tossed and blown

Walk on, walk on  
With hope in your heart  
And you'll never walk alone

You'll never walk alone

Walk on, walk on  
With hope in your heart  
And you'll never walk alone

You'll never walk alone

Songwriters: Oscar Hammerstein II / Richard Rodgers  
You'll Never Walk Alone lyrics © Concord Music Publishing LLC

This year's Annual Report provides us the opportunity to ruminate in amazement one of the most unpredictable and impactful years most of us will encounter. While experiences varied regionally, nationally, and internationally, we were all tied together by the disruptive healthcare issues, economic hardships, underlying social issues, and lack of consensus on how to deal with the pandemic itself. The report in this month's *Bulletin* provides only the highlights of the many activities and projects that our organization accomplished this year, many of which were unforeseen and unplanned for at the beginning of the year.

Your staff in Alexandria, Virginia, embraced their

role as integral team members charged with providing otolaryngologists with the information and tools needed to successfully traverse the unknown road all were traveling. Their passion and commitment to our mission was obvious from the rapid transition to teleworking as they provided daily updates on late-breaking events while also continuing their normal workload. This is a testament to the faith your staff has in you as you serve your patients. We witnessed unprecedented intraspecialty as well as interspecialty communication and collaboration on a worldwide basis as all worked toward the same goals.

While the "roller coaster" ride we have all experienced triggered by the COVID-19 pandemic is not over, as signaled by ongoing waves of resurgence of new positive tests, there appears to be light shining at the end of the tunnel. Recent announcements by several pharmaceutical companies about successful vaccine trials and their imminent release and widespread availability brings great hope for control and resolution of the pandemic in the near future. As we all begin the journey back to "normalcy" in all areas of life, there will be numerous opportunities to draw upon the lessons learned in 2020 and act on inadequacies, inequities, and technology failures brought to the forefront during the crisis we've all experienced. Additionally, immediate needs due to consequences of the pandemic brought to light significant value of virtual technology to education, particularly access to lectures from world-renowned experts not usually possible. Telemedicine also stepped to the forefront as an important adjunct increasing access to care that will likely be utilized more frequently in the future.

As we move forward into 2021, no doubt there will continue to be unexpected "bumps in the road" related to full recovery from the pandemic, healthcare reform, tackling societal issues in healthcare, and possibly another completely unexpected event. As you, your families, your staffs, and patients continue to make your way forward through the current storms and periods of darkness, remember the rainbow that will follow the storm and that "you will never walk alone." Your staff and colleagues will be there to support you as a community through both good and bad times. ■



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

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# ■ at the forefront

Information, resources,  
and updates in this  
section

**SECTION SPOTLIGHT: WIO**  
Disturbance and Recovery:  
Inspiration for 2021

Cleft Care in Kijabe, Kenya

➔ **READ MORE ONLINE**

Cleft Care in Kijabe, Kenya

2019-2020 Committee  
Highlights



## SECTION SPOTLIGHT: WIO

### Disturbance and Recovery: Inspiration for 2021

Jamie R. Litvack, MD, MS

Nalini Nadkarni, PhD, a forest ecologist and tree canopy specialist and guest speaker at the WIO General Assembly, held during the AAO-HNSF 2020 Virtual Annual Meeting & OTO Experience, described the process of “disturbance and recovery,” which to me is a good summary of 2020—unexpected disturbances, feelings of loss and isolation, maybe a crisis of identity. However, these disturbances, while uncomfortable in the present, can lead to new consequences and a new state. I like to think that is where we are today, experiencing disturbances that will help inspire



Jamie R. Litvack,  
MD, MS

and motivate us to evolve to a new and better state.

So how are we going to get there? What skills, tools, and resources will we need to succeed in this new state? What can we, as the women of otolaryngology, do to lead this new and better state? In my year as WIO Chair, I see three major themes: relationships, knowledge, and achievement.

**First and foremost is our relationship with each other.** Our connectivity is a powerful source of strength, inspiration, and synergism. Isolation this past year has inspired innovation and virtual connectivity in a way we never experienced before. Our first-ever virtual WIO networking event was met with enormous enthusiasm, and it triggered second- and third-level connectivity. Keep an eye out for recurrent virtual networking events over the coming months.

#### Second is knowledge.

As Dr. Nadkarni pointed out, “Knowledge enhances recovery.” In addition to Expert Lectures and Annual Meeting programming, we will have leadership and negotiation workshops in person and virtually this year that will enhance our knowledge and growth.

#### Third is achievement.

In 2020 we celebrated the 10th anniversary of the establishment of WIO. We reflect on and celebrate the tremendous achievements women otolaryngologists have made at the Academy and in healthcare leadership across the country. As we go forth in this coming year and the second decade of WIO, let us celebrate what we have accomplished with grace and gratitude and what we will accomplish in this new and better state. ■

## HUMANITARIAN TRAVEL GRANT

### Cleft Care in Kijabe, Kenya

For the past 20 years, teams of otolaryngologists have provided continuous cleft care for patients in Kijabe, Kenya, through Samaritan’s Purse World Medical Mission and partnering with IAC-CURE Children’s Hospital and Smile Train. With the support of the AAO-HNSF Humanitarian Travel Grant, **Heather A. Koehn, MD**, was able to serve with a team of talented surgeons and compassionate caregivers, including **Lisa M. Buckmiller, MD**, **Charles W. Ford, MD**, **John J. Christophel, MD, MPH**,

**Patrick D. Munson, MD**, **Ryan H. Belcher, MD**, and **Ashley D. Baracz, MD**.

Of the 72 surgeries that were performed over five days, Dr. Koehn noted the lifelong impact of one patient’s story. A 22-year-old mother of three, Jackline, traveled to Kijabe from a rural Maasai village. She was brought by a local missionary who heard of the team’s visit to provide cleft surgery free of charge. Jackline was the only person in her village with a cleft and constantly kept her lower face covered because of

the deformity. Once arriving at the AIC-CURE Children’s Hospital, she saw the many children with clefts and immediately felt a sense of community and trust and uncovered her face. Two days after the surgery, she left the hospital with a big smile, and no covering on her face.

For Dr. Koehn, “There is a lasting impression of this opportunity to provide cleft care as an otolaryngologist internationally. As a future pediatric otolaryngologist, I hope to establish a long-term service



relationship like the team I was privileged to join and inspire others to do the same.” ■

➔ **READ MORE ONLINE**  
Longer article available



# Spotlight: Humanitarian Efforts

## Tamer A. Ghanem, MD, PhD

The Spotlight on Humanitarian Efforts

recognizes AAO-HNS members who are contributing their time and expertise to otolaryngologic patient needs around the globe. These individuals demonstrate integrity and devotion to humanity through a self-giving spirit. They are outstanding models to emulate in fostering a global otolaryngology community. For this spotlight, the AAO-HNSF International Affairs Program would like to spotlight **Tamer A. Ghanem, MD, PhD**, for his work with the Kenya Relief Organization (KRO) and the Syrian American Medical Society (SAMS).



### What got you started in committing your time and practice to humanitarian efforts?

Twelve years ago, medical humanitarian relief was not on my radar as I was working on building my head and neck/microvascular surgery practice at the Henry Ford Hospital. I was invited by one of our certified registered nurse anesthetists (CRNAs) at the hospital who leads medical missions for KRO to go on a mission trip. Up to that point, I had not had any experience with medical missions, but the possibility of using my surgical skills to help others who need the service was of a strong interest to me. I went on my first mission trip in September 2011, and it was a life-changing event. I was amazed by how many patients had endemic goiters and were seeking surgery to help them with their breathing and cosmesis. It was very gratifying to see the difference the surgery made in their lives. After that trip, medical humanitarian relief became a major interest of mine. Since then I have gone on two other missions to Migori, Kenya, with KRO and four missions with SAMS—two trips to Turkey and two trips to Lebanon. I was supposed to go to Kenya again this past March, but the trip was canceled last minute due to the COVID-19 pandemic.

### How does your work impact the communities you serve, and how does it impact you as a person?

The work we are involved in has multiple impacts on the different communities we serve. For the work in Kenya, the majority of these patients can't afford thyroid surgery at private practices, and many government hospitals won't take their cases as they have long lines of patients who need operations. For Syrian refugees, the CBS show *60 Minutes* aired an episode of the activities of SAMS during a multispecialty

medical mission in Turkey (<https://www.cbsnews.com/news/when-hospitals-become-targets/>). For refugees in Lebanon, they have no medical care except for cash for service with private practices. Thus they rely heavily on the SAMS clinics in various parts of Lebanon to get routine medical care, as well as subspecialty care. The types of Syrian refugee patients are very different—from the pediatric population with tonsillar hypertrophy and chronic tonsillitis to young adults with late effects of facial trauma in need of reconstructive surgery.

### What would you say to encourage others to support humanitarian efforts around the world?

From my experience, those that give get more back than they give. The feeling of being able to use your skills that you have spent years learning to help another human being in their plight, and witnessing directly their results, is like no other. Also it can be a very rewarding growth experience, seeing different cultures and operating in an unfamiliar environment with conditions that one is not used to.

I recommend for those without experience in medical mission work to find a team of surgeons or anesthesiologists whom they know and go with them on a mission trip. It is important to find out as much information as possible in terms of what types of patients they see, cases they do, accommodations, and instrumentation needs prior to going on the mission trip to be well prepared.

### Any other final comments or thoughts?

As physicians we have a tremendous opportunity to make a difference in people's lives, and medical mission work is a tremendous way to experience that. The opportunity to travel and experience a different culture is very enlightening. ■

### Where do you currently practice and what is your specialty area?

I work at the Henry Ford Health System in the Department of Otolaryngology – Head and Neck Surgery.

### What humanitarian efforts are you involved with? And what do these programs do?

I have been involved with two humanitarian organizations: KRO ([www.Kenyarelieff.org](http://www.Kenyarelieff.org)) and SAMS ([www.sams-usa.net](http://www.sams-usa.net)). KRO was founded by Steve James, CRNA, to provide humanitarian relief to Migori, Kenya, in the form of an orphanage, private school, and hospital that supports multispecialty medical missions with providers from the United States and other countries. SAMS provides medical relief to Syrian refugees in multiple countries, including Egypt, Jordan, and Lebanon.



# Focused on Collaboration and Inclusion

Nausheen Jamal, MD

The YPS kicked off an exciting new year of activities with an engaged and well-attended General Assembly at the AAO-HNSF 2020 Virtual Annual Meeting & OTO Experience, hosted by **David S. Cohen, MD**, our Immediate Past Chair. Dr. Cohen highlighted some of the YPS accomplishments from the last year, including extending the Academy's reduced membership rate for early career otolaryngologists from one to two years and the introduction of travel grants for YPS members, which has been provided for the Section for Residents and Fellows-In-Training in years past. This was followed by a fantastic and engaging presentation titled "FAIL is Not a Four-Letter Word: Why Success is More Likely When You're Willing to Fail," by Jennifer M. Heemstra, PhD, assistant professor of chemistry at Emory University. Her talk struck a chord with the YPS members in attendance and generated a great deal of interactive discussion during the Q&A portion of the hour.



Nausheen Jamal, MD

Looking ahead the YPS has several exciting projects planned throughout the year, all of which will incorporate this year's theme of diversity and inclusion.

In spite of the unusual circumstances 2020 has brought about, the YPS is energized to bring great programming and activities to life on behalf of our members. We look forward to a productive year ahead of collaboration and inclusion. ■

<p><b>Programming Task Force</b> Planning for sponsored seminars and Panel Presentations at the 2021 Annual Meeting, immediately followed by planning programs for the AAO-HNSF Leadership Forum &amp; BOG Spring Meeting</p>	<p><b>Practice Management Task Force</b> Continuing to expand our existing (and very popular) Practice Management Toolkit with new podcasts, planning to feature one per month</p>	<p><b>Communications Work Group</b> Expanding the YPS outreach and engagement on social media</p>	<p><b>Engagement Task Force</b> Actively collaborating with the AAO-HNS Board of Directors Awards Task Force to formalize a plan to identify nominees for the YPS Model Mentor and Impact Awards</p>
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## 2021 YPS Governing Council

As the new YPS Chair, it is my great honor to introduce the 2021 Governing Council:

### Chair

Nausheen Jamal, MD, The University of Texas Rio Grande Valley School of Medicine

### Chair-Elect

Yi-Chun Carol Liu, MD, Texas Children's Hospital / Baylor College of Medicine

### Member-at-Large

Nikhila P. Raol, MD, Emory University

### Secretary

Manan Shah, MD, Advanced ENT & Allergy Center

### Nominating Committee:

Claire M. Lawlor, MD, Children's National Hospital  
Matthew Smith, MD, Cincinnati Children's Hospital Medical Center

### BOG Governor (Governance and Society Engagement Committee and Chair, YPS Nominating Committee)

David S. Cohen, MD (Immediate Past Chair), Southern California Permanente Medical Group

### BOG Alternate Governor (Socioeconomic & Grassroots Committee)

Kristan P. Alfonso, MD, Emory University

### BOG Alternate Governor (Legislative Affairs Committee)

Boris Paskhover, MD, Rutgers New Jersey Medical School

### American Board of Otolaryngology-Head and Neck Surgery Liaison

Lyndy J. Wilcox, MD, Vanderbilt University Medical Center

### American Medical Association YPS Delegate

Michael Schlewet, MD, Carney Hospital

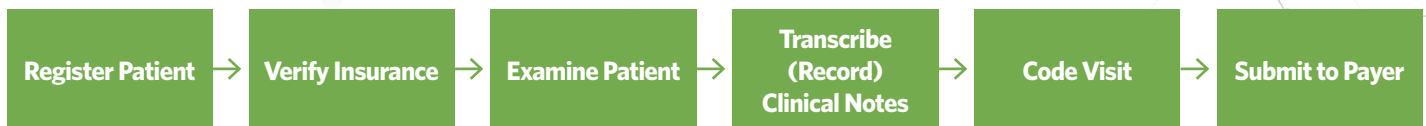
### ENT PAC Delegate

Ann W. Plum, MD, State University of New York Downstate Medical Center

# Tech Talk

## Business Processes – Precursor to EMR Selection

### Bill Patient Workflow



**Mike Robey, MS**, AAO-HNS/F Senior Director,  
Information Technology

Selecting the right electronic medical record (EMR) software solution is critical. The wrong choice can be devastating. These implementations are not just IT projects but require participation and effort from everyone—users, clinicians, and technologists alike. Without a full team effort and proper project oversight, these endeavors can easily spiral out of control on many fronts. So, where do you start? A successful implementation of enterprise-wide software solutions starts with understanding your business processes, the very reason these technology tools exist.

Enterprise-wide software solutions, whether commercial-off-the-shelf (COTS) or software-as-a-service (SaaS) offerings, are collections of automated business processes designed to support your practice. Insights from many customers have enabled the software developer to add features, fix bugs, support regulatory requirements, and provide training to a wide variety of users. It would be virtually impossible from time and cost perspectives to develop such robust capabilities yourself.

A business process is the end-to-end chain of activities, from the initial triggering event through to the outcome, to produce the customer's expected product, service, and/or experience. Other stakeholders of the process also expect discrete results, but the customer's expectation is paramount.

Think of a business process as a workflow, a sequence of steps, decisions, and handoffs to the next activity until the expected outcome is

achieved. For this discussion, review the Bill Patient Workflow graphic above. This illustrates the sequence of activities culminating with billing for services. Although there may be missing activities relevant to your practice, the important takeaway is each block describes **what** the activity does. Notice the action verb–noun naming convention. By flipping this convention around to “noun is verb,” for example, “insurance is verified,” one can easily determine the outcome of each activity.

Notice that this first-level diagram does not convey **who** does the work nor does it say **how** the work is to be accomplished. It is vital to identify **what** needs to be accomplished before diving into the **who** and **how**. Peter Drucker, leadership and management consultant, best summarized this point when he said, “There is nothing so useless as doing efficiently that which should not be done at all.” Another way of thinking about this is **what** defines the capabilities needed by the software solution, while **who** defines the users and **how** maps out the training for the solution.

Identifying your business processes is a prerequisite for looking at potential software solutions. Perspective software solutions should include a list of business processes that the offering supports. These might be advertised as modules or capability areas. For example, patient registration, appointment scheduling, medical transcription, accounts receivable, and denial management are EMR capability areas. Knowing your own business processes and the expected outcomes will help drive the discussion with potential vendors and ensure the selection decision is based on best fit and not best demonstration.

A gap analysis, aligning your needs with the capabilities of competing solutions, is an essential step in the decision-making process. Do you have business processes that a particular solution cannot support? Does a solution only provide partial support for necessary workflows? Keep in mind there is never going to be a perfect fit. As a rule of thumb, if you find a solution that fits 80-90% of your needs, ask the bigger question: Are your remaining 10-20% really necessary? Other considerations for a well-balanced software solution decision are projected operational, training, ongoing support, and hosting costs. Most likely you will want to include a cost analysis over the next three to five years to determine the most economical solution. The ultimate choice should be the solution that is the best balance of available features and affordability. Tangential to all this, do not forget to understand how to get your data out of the solution when the time comes to move on to something new.

Choosing the right enterprise-wide software solution is hard work. Find a business analyst who is skilled in helping organizations discover and analyze their business processes (your needs) and is agnostic to any packaged solution. This will preferably be an analyst who understands the different perspectives of **what**, **who**, and **how** in the right order and can diagram your workflows to provide visibility. Discovering and understanding your business processes are important first steps to choosing the right solution to support your practice. Software technology is the tool. Executing your business processes is the reason for the tool. ■



# New Category I CPT Codes for Sleep Surgery in 2022

**A**t the October 2020 American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel meeting, the AMA accepted new Category I CPT codes for both hypoglossal nerve stimulation (HGN) and drug-induced sleep endoscopy (DISE). These new codes will become part of the CPT code set in 2022.

For CPT, 'Category' refers to the division of the code set. CPT codes are divided into three categories. Category I is the most common and widely used set of codes within CPT. It describes most of the procedures performed by healthcare providers across various sites of service.

Due to the public health emergency, the October CPT meeting was held virtually. Academy advisors and clinical experts participated in the new virtual format to advance these codes on behalf of the specialty. The creation of Category I codes is a critical first step to adoption of new procedures and services frequently performed by otolaryngologist-head and neck surgeons. However, much advocacy work remains to be done.

Prevalence rates of obstructive sleep apnea have increased substantially over the last two decades. It is now estimated that at

least 25 million adults in the United States (26% of adults between the ages of 30 and 70 years) have sleep apnea. Other estimates suggest the total number of adults who suffer from sleep apnea is much higher with a total number of 54 million cases. Of this patient population, approximately 13% of men and 6% of women have moderate to severe obstructive sleep apnea (apnea-hypopnea index or AHI  $\geq 15$ .)

## Hypoglossal Nerve Stimulation (HGN)

Currently HGN is reported using CPT code 64568 [*Incision for implantation of cranial nerve (e.g., vagus nerve) neurostimulator electrode array and pulse generator*] with both 64569 and 64570 utilized for replacing or removing the device. The codes were originally created for other stimulators and are also used to define placement of stimulators on other nerves, most commonly the vagus nerve. The placement of the electrode array and pulse generator on the vagus nerve, as compared to the hypoglossal nerve, differs with the latter procedure being more difficult and requiring more dissection of the nerve to identify those branches that protrude the tongue.

The only hypoglossal nerve stimulator with current U.S. Food and Drug Administration (FDA) approval includes a sensor that is



implanted into the chest wall intercostal muscles through a separate incision, with a subcutaneous attachment to the pulse generator to pace tongue extrusion with inspiration. Category III CPT code +0466T and supporting codes 0467T and 0468T were established in 2016 to capture the additional work required to implant the inspiratory sensor, as well as its replacement or removal. The new codes create a new code family that is specifically for HGN.

Although the nerve stimulation codes are being separated into their own codes, the code structure was written so that the two neurostimulator code families will be similar to the current codes. Additionally, the AMA does not create CPT codes for specific devices. While there is currently only one FDA-approved HGN device, new devices are also reportable under the new codes as long as they fit under the code descriptors. The current device, produced by Inspire Medical Systems, has been implanted thousands of times since its FDA approval in May 2014. However, the lack of a dedicated CPT code created reimbursement obstacles at many institutions.

As the new CPT codes cover the procedure in its entirety and are specific to HGN, the Category III add-on codes (0466T, 0467T, 0468T) used to report these codes will be deleted from the code set in 2022. It is important to note that the Centers for Medicare & Medicaid Services has a technical correction in the calendar year 2021 Medicare Physician Fee Schedule proposed rule changing the global status of CPT code 0466T to ZZZ. The purpose of this proposed change, which is supported by the AAO-HNS, is to clarify that the code is an add-on code that cannot be separately reported for Medicare patients. If included in the final rule, it would take effect January 1, 2021, and then be rendered obsolete for 2022 when the new CPT codes become active.

### Drug-Induced Sleep Endoscopy (DISE)

The second new sleep surgery code created by the CPT Editorial Panel for the 2022 code set describes DISE. DISE is currently reported using either CPT codes 31575 (*Laryngoscopy, flexible; diagnostic*), 31622 (*Bronchoscopy, rigid or flexible*), or 92502 (*Otolaryngologic exam under general anesthesia*). None of these codes, either alone or in combination, accurately capture the work involved in examining the dynamic nature and site(s) of airway obstruction within the nasal cavity, nasopharynx, oropharynx, hypopharynx, and larynx while under anesthesia in an operative setting, nor are they inclusive of the examination of the effects of positional and head and neck manipulation on the obstruction. The AAO-HNS estimates that DISE is performed under 10% of the time any of these three codes are reported.

DISE has been performed by otolaryngologists for almost 30 years. Utilizing the new code will assist sleep surgeons in obtaining appropriate reimbursement for the work performed in the procedure. Since 2014, DISE has become increasingly more prevalent, as the FDA has deemed it a necessary prerequisite to HGN implantation. Additionally, the new code eliminates the issues with 31575 by including sedation, with 31622 by accounting for maneuvers that may alleviate proximal airway obstruction, and with 92502 as an endoscopic service that captures the dynamic patency of the upper airway. ■

### Hypoglossal Nerve Stimulation

**Accepted addition** of codes 645X1, 645X2, 645X3 to identify hypoglossal versus vagal nerve stimulator services; **Revision** of codes 64568, 64575, 64580, 64581 to separately identify hypoglossal nerve stimulator service from vagus nerve stimulator services; and **Deletion** of Category III codes 0466T, 0467T, 0468T

### Drug-Induced Sleep Endoscopy

**Accepted addition** of code 42XXX to report drug induced sleep endoscopy flexible, diagnostic

Note: Codes that contain an 'X' (e.g., 1002X4, 234X2X, 0301XT) are placeholder codes that are intended, through the first 3 digits, to give readers an idea of the proposed placement in the code set of the potential code changes.

Please visit the Academy's Coding Corner at <https://www.entnet.org/content/coding-corner> for additional updates, as well as the newest coding and reimbursement tools for members.

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# Audiology and Speech-Language Pathology Interstate Compact

## History of the ASLP Interstate Compact

Several years ago the Council of State Governments (CSG) was asked to develop a model compact for allied health professionals, in this case, audiologists and speech-language pathologists. CSG is an organization committed to working with state officials to shape public policy and includes a program dedicated to developing interstate compacts. CSG received funding from the American Speech-Language-Hearing Association and the National Council of State Boards of Examiners to draft their compact. Two years ago the American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS) was invited to share comments on the proposed draft of the Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC). Unfortunately the Academy's stated comments and concerns on the draft were ignored. The flawed compact was subsequently introduced in 12 state legislatures beginning in January 2020.

## Advocacy

Unable to have our concerns heard, the AAO-HNS worked with the American Medical Association (AMA) to craft amendatory language that would clarify and improve the compact. Wherever possible the Academy works with state otolaryngology societies and state medical societies to urge state legislators to add the AAO-HNS/AMA amendments to the bill.

## What Is the ASLP-IC?

The proposed ASLP-IC is distinctly different than most of the other health professional licensure compacts. It is a "privilege to practice" compact that gives legal authority for the practice of audiology/speech pathology in a remote state without an

additional license. This is achieved by simply applying to notify another member state in the compact that the individual will be practicing there. This model is very different than the Medical Licensure Compact that creates a voluntary expedited license.

## What Are the Major Issues with the ASLP Compact?

Briefly, there are seven major issues with the compact.

- 1. The proposed compact creates a Commission with the power to override state laws.** The states participating in the compact will have the ability to adjust scope of practice to mirror the requirements of the least restrictive states. This would allow members of the compact to bypass those states with stronger standards of practice in place designed to protect the public and maintain patient safety. Therefore, under the section titled "Establishment of the Audiology and Speech-Language Pathology Compact Commission," a new subsection should be added: *D. The Commission shall have no authority to change or modify the laws of the member states, which define the practice of audiology and speech-language pathology in the respective states.*
- 2. A lack of transparency by the Commission.** There are no requirements in the compact for minutes of the Commission to be made available to the public. A sentence should be added to the language addressing the meetings of the Commission and the Executive Committee meetings: *All minutes and documents of meetings, other than closed meetings, shall be made available to members of the public.*
- 3. Weak definition of telehealth and practice statement.** There should

be assurances that the application of telecommunication meets the **appropriate standard of care** by amending the definition of telehealth to include the additional wording: "Telehealth means the application of telecommunication, *audiovisual or other technologies that meet the applicable standard of care* to deliver..." In alignment with this, it should be specified that compact licensees providing telehealth services must follow the telehealth laws and regulations of the client's locale. **Many states already have telehealth standards in place for the protection of the patient.** These existing state provisions should be recognized by adding an additional paragraph under the section titled "Compact Privilege to Practice Telehealth": *A licensee providing audiology or speech-language pathology telehealth services in a remote state under the compact privilege shall function within the laws and regulations of the state where the patient/client is located.*

- 4. Inadequate oversight of the Commission.** Of concern in the section titled "Oversight, Dispute Resolution and Enforcement," the section on "**Oversight**" is **conspicuously missing** and is therefore not addressed. Written information is needed on how the Commission plans to conduct oversight.
- 5. Physician members are excluded.** By statute, physicians are appointed members of the audiology/speech pathology licensing boards in 24 states. Despite this requirement, in the section titled "Establishment of the Audiology and Speech-Language Pathology Compact Commission" that describes eligible delegates to the Commission, physician members are excluded. This means the composition of the Commission will not



mirror the required board representation in nearly half the states. This omission sacrifices valuable collaboration and oversight that is in place to protect the public.

**6. Universal licensure.** Unlike the medical licensure compact where a physician must already be licensed to practice in a state, this compact creates and dictates uniform licensure for two very different professions. This is detailed in the section titled “State Participation in the Compact.” Some of the organizations that helped craft the compact language have had universal licensure as a goal for many years. The rationale has been that it would increase accessibility to and reimbursement from third party payer sources. This is an unusual and inappropriate vehicle to use to establish such licensure.

**7. Active duty military.** The compact calls for active duty military (most of whom are already exempted in state occupational licensure laws) or their spouse to retain their home state designation. This is an unnecessary provision in the compact despite being used to garner support for the compact; most states have already addressed this issue. According to the U.S. Department of Defense, 39 states have already enacted laws that allow for endorsement of a current license from another state, 42 states have passed temporary licensure laws, 31 states now

have laws for expedited applications procedures, and 24 states have laws that utilize all three methods on behalf of military spouses. In addition the National Defense Authorization Act allows up to \$1,000 for relicensure and costs related to relocations.

#### How Is the Compact Financed/How Will It Impact the States?

The Compact Commission will levy and collect an annual assessment from each member state or impose fees on other parties to cover the cost of operations. The amount will be formulated by the Commission and will be binding upon all member states. At the present time, **the amount that this will impose upon each state’s budget is unknown.** Fiscal concerns have been noted in multiple states, particularly as **the compact would commit state agencies to unknown amounts that cannot be budgeted.** This is also onerous on a state that wishes to withdraw from the compact. In addition to a legislative repeal of the statute, the state’s withdrawal is not effective until **six months after the enactment of the repeal.** The state would likely still have to continue to pay its membership fee for half a year even after it has withdrawn from the compact.

Some state legislative analysts also noted that for the processing of the new “privilege to practice” applications, there will be little

time savings and a likely **increase in the overall regulatory burden.**

#### How Many States Must Join the Compact to Become Effective?

This interstate contract must be agreed to and passed by **10** state legislatures to become effective.

#### What Is the Current Status of Compact Legislation?

During the tumultuous 2020 sessions, 12 states introduced the compact in their legislature. The following is the current status:

- Five bills were killed or died in Alabama, Kansas, Kentucky, Maryland, and Nebraska.
- Six bills passed in various forms:
  - Utah and West Virginia passed with the AAO-HNS/AMA amendments
  - Georgia’s bill was vetoed by the governor
  - Louisiana, North Carolina, Oklahoma, and Wyoming passed unamended
- Bills that have been prefiled for the 2021 session:
  - Kentucky – BR 244
  - New Hampshire – LSR 136

If you need additional information, please contact the AAO-HNS Advocacy Team at [stateleg@entnet.org](mailto:stateleg@entnet.org). ■

# Radiofrequency Ablation for Benign Thyroid Nodules

Ralph P. Tufano, MD, MBA; Lisa A. Orloff, MD;  
Jon O. Russell, MD; Catherine Sinclair, MD

Thyroid nodules are quite common and typically benign. Nonetheless they can be troubling in many ways to patients who then seek treatment, which often results in thyroid surgery. Thyroid surgery comes with some generally accepted risks, and quality of life may become significantly altered in several ways. The possible need for thyroid hormone supplementation or replacement is one of the major concerns for these patients undergoing surgery. A new way to treat these nodules without surgery, and likely without any need for thyroid hormone medication, is with radiofrequency ablation (RFA).

## Ultrasound as the Foundation to Performing RFA

The practice of ultrasonography (US) has become widespread in otolaryngology-head and neck surgery. US is invaluable not only for diagnostic applications, but also for interventional procedures in diseases affecting the thyroid, parathyroid, salivary glands, and lymph nodes. The cost-effectiveness of US, along with its point-of-care capability, dynamic assessment in real time, and lack of radiation, have contributed to its popularity. A thorough understanding of sonographic anatomy and technique are the foundation upon which appropriate patient selection and precisely guided procedures, including RFA, are based.

Thyroid pathology is the most common indication for US in the neck, and ultrasound-guided fine needle aspiration is the most frequently performed image-guided procedure for cytologic evaluation of neck

masses including thyroid nodules. More than 90% of thyroid nodules are benign. About half of all adults over 50 years of age have thyroid nodules, and a proportion of these nodules cause compressive symptoms, cosmetic deformity, or hormonal imbalance. It is no wonder that thyroidectomy is one of the most commonly performed surgical procedures, with an estimated 150,000 thyroid operations per year in the United States. However, a new era of minimally invasive, nonsurgical treatment of benign thyroid nodules with RFA has dawned as an outgrowth from expertise attained in US imaging and US-guided procedures.

## Office Requirements for RFA

RFA requires minimal office equipment other than an ultrasound machine with Doppler capabilities, a radiofrequency generator, and an RFA needle probe. The RFA probes are internally cooled and require continuous irrigation with cold injectable fluid (saline or dextrose). Other equipment includes local anesthesia (1% or 2% lidocaine, 10-30 mL), a 25-gauge needle, a 20-22-gauge long spinal needle, injectable dextrose 5% solution (for hydro-dissection), skin prep, and drapes.

## Technique of RFA

An advantage of RFA is the basic technique is familiar to clinicians who perform ultrasound-guided thyroid biopsies. Using a traditional thyroid ultrasound device (usually 7-15MHz), the nodule is identified. Lidocaine (1%-2%) and, when necessary, 5% dextrose are used to hydrodissect along the thyroid capsule under sonographic visualization. This step is a “practice run” for the ablation and allows the clinician to

make strategic ablation plan adjustments prior to inserting the larger RFA probe. An RFA probe is selected—an 18-19-gauge needle with a 7-10 mm active tip is a typical starting range. A trans-isthmic approach is utilized with the RFA probe usually entering on a line at about the midpoint of the nodule to be treated. Ablation then proceeds in a systematic fashion (moving shot technique), beginning at the deepest levels of the nodule. One must always visualize the probe tip before and during activation of the device. This helps to avoid ablating too close to critical anatomic structures, such as the trachea, esophagus, and recurrent laryngeal nerve, and to avoid a skin burn. When treated, the surrounding tissue will become hyperechoic.

During ablation the patient should be asked to vocalize at various intervals to assess vocal quality, particularly when ablating adjacent to the “danger zone” at the posteromedial thyroid capsule. Post-procedure the patient is typically given an ice pack and is able to resume most normal activity the next day. Patients should be examined by ultrasound at various time intervals (e.g., one, three, six, and 12 months post-RFA) to assess percent volume reduction and assess for nodule regrowth.

## Final Thoughts

Ultrasound-guided RFA enables the otolaryngologist-head and neck surgeon to further personalize treatment for patients with benign thyroid nodules and with minimal morbidity when carefully adopted. The future is here for benign thyroid nodules with further investigation of RFA for other lesions of the head and neck on the horizon. ■





# 2020 ANNUAL REPORT

Access online at  
[www.entannualreport.org](http://www.entannualreport.org)

**Annual Report**  
Calendar Year 2020

**Financial Report**  
Fiscal Year 2020  
(July 1, 2019 - June 30, 2020)

# MESSAGE FROM LEADERSHIP



**Duane J. Taylor, MD**  
*AAO-HNS/F President  
September 2019 - September 2020*



**James C. Denny III, MD**  
*AAO-HNS/F Executive Vice President  
and Chief Executive Officer*

The exemplary and extraordinary actions of the healthcare community's response to the COVID-19 pandemic define 2020. We want to extend our sincere appreciation to our amazing physician community and the healthcare teams they work with for their dedication to research and best practices and incorporating them in the rapidly changing scenario worldwide.

In addition to the traditional programs and services provided to the members, 2020 also thrust the Academy into action to provide the global otolaryngology community the resources, tools, and support for practices and patient care. The AAO-HNS/F 2020 Annual Report provides a snapshot of those as well as highlights the work that aims to support you, your practice, and patient care.

## THE GLOBAL OTOLARYNGOLOGY COMMUNITY COMES TOGETHER

In the face of the crisis the pandemic created and at a time when the world was calling for guidance, the Academy, its leadership, members, and staff proved to be the reliable source needed for ever-evolving challenges. Putting patient care and healthcare team safety first created a common challenge that led to exceptional collaboration in the house of otolaryngology.

Leadership from the Boards of Directors and our committees rose to the challenge

with expeditious responses, providing the otolaryngology community, both domestic and international, access to timely information, resources, and guidance to deal with COVID-19 issues related to patient care and practice management. Relationships developed through our 75 International Corresponding Societies also proved invaluable.

From new Position Statements focusing on tracheotomy, elective surgery, and urgent and nonurgent patient care to reporting tools and research on anosmia, the COVID-19 podcast series, publication of COVID-19 related papers in *Otolaryngology-Head and Neck Surgery*, and resources like the Guidance for Return to Practice for Otolaryngology-Head and Neck Surgery, we found many avenues to disseminate information throughout the specialty and healthcare community at large.

During this critical time, our members' commitment to excellence in patient care through engagement with the Academy has been remarkable. The unselfish collaborative efforts we shared with our colleagues has been particularly gratifying as we worked hand-in-hand with our specialty societies within and outside of the otolaryngology family to produce education and scientific information that is consistent and that has and will continue to affect policy favorably.

In this day of advanced technology offering multiple ways to connect, dissemination of information and collaboration exist successfully and productively on a day-to-day basis, preventing the pandemic from disrupting our essential operations aimed at supporting our members and the specialty.

Advance preparation over the past several years, led by our Information Technology team, allowed the Academy to transition to a complete "work from home" setting over a weekend, which enabled us to continue to serve our members without missing a beat. Rapid adoptions of technologies like Skype and Zoom facilitated effective communication across the spectrum of healthcare and supplied the information our members and their patients needed.

The COVID-19 pandemic has created unprecedented disruptive societal consequences that have necessitated public health measures dramatically changing the way all facets of society operate, including healthcare. Financial consequences weigh heavily on our members and all physicians and their practices in all settings. Our organization is sensitive to the extreme pressures that the pandemic has placed on our members and society in general, and we do not intend to magnify the current situation.

## THE VALUE OF LEADERSHIP

What we have witnessed this year is the ability of the medical community at all levels to focus on a common problem with a collaborative and productive resolve to address this millennial event. The rapid response of leadership and members alike in identifying and prioritizing not only the immediate concerns and needs raised by the pandemic, but also the short-term, intermediate, and long-term ramifications was made possible by marshaling the resources available from many sources, not the least of which was the medical association community.

The willingness to share information and best practices transcended national and state borders, specialty designations, and levels of training. These efforts predominantly involved patient and provider safety, accumulating real-time scientific information, education and training concerns, and short-term economic issues. Equally important have been the aggressive, unified advocacy efforts on behalf of all healthcare providers and their patients. These efforts resulted in unprecedented legislative and regulatory policies that changed the course of the disease and benefited providers and patients alike.

The collaborative network of the global otolaryngology community as well as the house of medicine has demonstrated extraordinary initiative and leadership in addressing the paramount COVID-19 challenges. It is our belief that this peer-to-peer connection that transcends from organization to organization, practice to practice, and physician to physician, is the value that propels the healthcare community through crises such as this.

The pandemic also served to put a clear focus on critical deficiencies in our healthcare delivery system. The lack of a well-developed, coordinated public health system magnified the needs of underserved patient populations, particularly in the underrepresented minority communities, and the significant disproportionate impact resulting from this shortcoming in addition to failing to adequately account for social determinants of health in our treatment paradigms. The urgency for recognition and change was heightened following a series of killings that highlighted the dire need for social justice, meaningful dialogue, and peaceful change across America. The AAO-HNS remains

committed to providing the best care for all patients regardless of ethnicity, gender, race, religion, sexual orientation, or social status and advocating for equal access and treatment for all people.

A statement was issued by the Academy on June 3, “to denounce the individuals, elements, and institutions in our society that perpetuate the racism, social injustice, and disparities that exist.” Read the full statement by President Taylor at [www.entnet.org/content/statement-aaohns-president-duane-j-taylor-md](http://www.entnet.org/content/statement-aaohns-president-duane-j-taylor-md).

## THE COVID-19 PANDEMIC'S FINANCIAL IMPACT ON YOUR ACADEMY

One of the biggest impacts on the Academy this year was the evolution of the AAO-HNSF Annual Meeting & OTO Experience from an in-person, four-day meeting to one that was a virtual six-week program with live and new on-demand content. Leadership and staff transitioned quickly once informed that we no longer could hold our meeting in Boston, Massachusetts, due to the pandemic.

The AAO-HNS/F operates following best fiscal practices under the guidance of the AAO-HNS/F Executive Committee, Secretary-Treasurer, and Finance and Investment Subcommittee. This ensures that when something like the COVID-19 pandemic impacts a reliable revenue source such as the Annual Meeting, we have a strategic plan in place to absorb the impact in a way that doesn't create a financial burden on our members. We have been able to build our financial reserves through operational savings over the past several years and that has allowed us to maintain the current level of services that members expect as well as offer a \$100 voucher that practicing physicians could use to offset dues or education offerings. The Foundation also lowered the price of its new flagship education product, FLEX, compared to the previous Home Study Course. In fact when we made the decision to transition the AAO-HNSF 2020 Annual Meeting & OTO Experience to one that was virtual, we decided to do it in a way that attendees could get the greatest value for their financial investment. We provided a free 2020 Virtual Annual Meeting registration for those who signed up for FLEX by October 25.

As we address the ongoing challenges that the COVID-19 pandemic presents us as a medical society serving members who are on the front lines of this public health crisis, we aim to overcome these obstacles through new initiatives already underway and innovation rather than seeking to add to the financial burden our members are already experiencing.

Disruptive change brings opportunity for the prepared. The COVID-19 pandemic accelerated trends that were already emerging and that certainly have long-lasting impact in the way we do so many things as a society. After witnessing the exceptional response of our members when asked to serve during the worst of times, we are confident in the future of the organization. We will continue to adapt, innovate, and overcome obstacles to deliver relevant programs and services and overall value in this fluid “new normal world.”

Collaboration, cooperation, and community are three essential elements that will shape the future of otolaryngology-head and neck surgery around the globe. Our “We Are One” philosophy guides the inclusion of all otolaryngologists—regardless of demographics or location—that the AAO-HNS/F employs in partnering with the international otolaryngology community in the bidirectional sharing of education resources, which will help us all provide the best patient care.

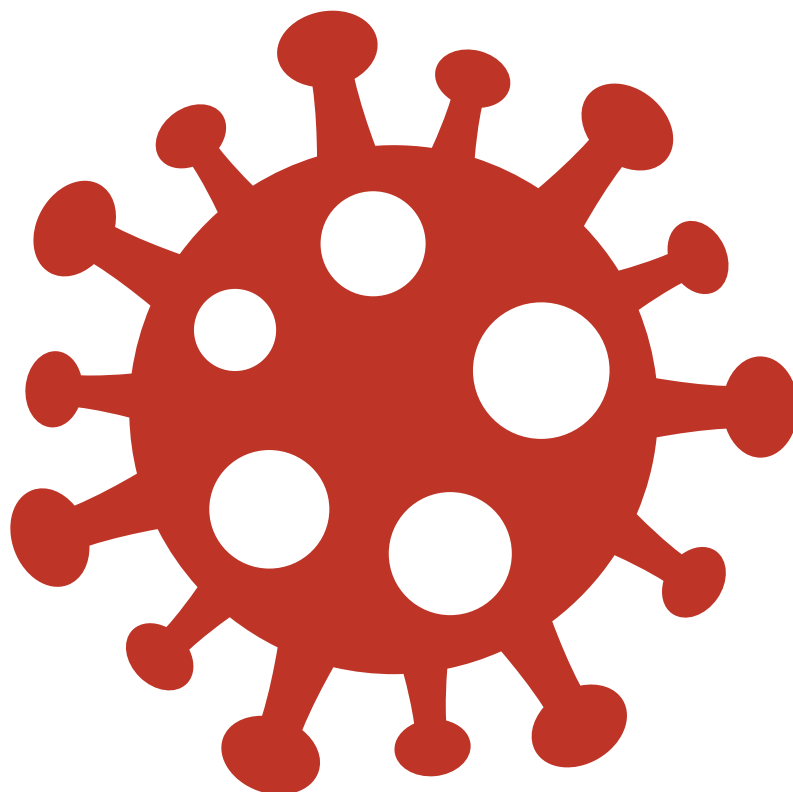
We have accomplished a great deal this year during particularly difficult circumstances because of the tireless work of your elected officers, physician volunteers, and staff. Your dedicated staff worked continuously during the worst of the pandemic to provide you with vital information necessary for you and your patients in addition to carrying out all areas of our Strategic Plan to continue to move our specialty forward.

2021 marks the 125-year anniversary of the AAO-HNS/F. As we turn away from 2020 and head into this upcoming commemorative year as a united specialty, the Academy will continue our focused efforts creating a **diverse and inclusive** global otolaryngology community that not only enhances **education** opportunities internationally but also builds upon our strong foundation for **physician wellness** and **leadership development** of tomorrow's pioneers in the field. 🌍

# COVID-19 RESPONSE

## *Global Otolaryngology Community Comes Together in the Face of the COVID-19 Pandemic*

During 2020 the AAO-HNS/F provided the global otolaryngology community, including nonmembers, the resources and tools to address the varying impacts of the COVID-19 pandemic on practice and patient care through *OTO News*, emails, social media, and audio/video podcasts on a continual basis. The following encompass those efforts:



### **GUIDANCE FOR RETURN TO PRACTICE:**

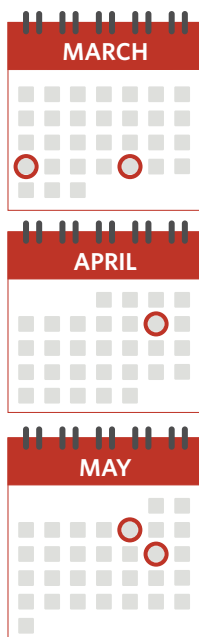
The AAO-HNS, with the collaboration of the otolaryngology specialty societies, developed recommendations for a safe return to practice, presented in two parts and to be updated as necessary:

#### **PART ONE released on May 7**

Focused on comprehensive general considerations that are applicable to all practice settings and specialty areas of otolaryngologists' practice.

#### **PART TWO released on May 15**

Focused on specific recommendations encompassing prioritization and special circumstances related to surgical procedures for all specialty areas.



### **ANOSMIA AND DYSGEUSIA ACTION EFFECTING CHANGE:**

Recognition of anosmia and dysgeusia as symptoms followed comprehensive Academy initiatives carried out in a few short weeks. Actions included:

**PUBLIC STATEMENT** released on March 22

**REPORTING TOOL** launched for data collection on March 26

**PUBLIC OUTREACH** achieved through substantial media coverage

**PATIENT INFORMATION** included on ENThealth.org

**PUBLICATION** of initial reporting tool findings in *Otolaryngology-Head and Neck Surgery* on April 10

### **LEADING VOICE ON ANOSMIA AS A SYMPTOM:**

Domestic and international media quoted the Academy extensively about anosmia and the data collected through the AAO-HNS COVID-19 Anosmia Reporting Tool. Starting in March and continuing throughout the summer and fall, media coverage included an initial surge with *USA Today*, *The New York Times*, *Fox News*, *Associated Press*, and *NPR* and then continued with the *Sinclair Broadcast Group* television report "Spotlight on America" that ran on 191 stations in 89 markets across the country with a reach of 5-7 million viewers, *WFAA* in Texas, *The Washington Post*, *U.S. News & World Report*, *Prevention*, *HealthDay*, *Medscape*, and more.



## RESEARCH PUBLISHED IN OTOLARYNGOLOGY-HEAD AND NECK SURGERY



making this research available to the healthcare community in response to the COVID-19 pandemic

more than 150 coronavirus-related articles have been published, with a special-focused issue in July

## COVID-19 PODCAST SERIES



peer-to-peer connection on COVID-19 pandemic related topics

**18** episodes    **27,382** downloads    **64** participants

## COVID-19 EMAIL SERIES

information, updates, and resources to the global otolaryngology community



**1,018,742** emails sent    **41%** open rate    **14%** click rate

## COVID-19 RESOURCE WEB PAGE

housed on [entnet.org](https://entnet.org) serves as a repository of information

the latest federal and state financial relief information

updates from federal agencies (CDC, FDA, NIH, HHS, CMS, SBA)

shared clinical research and information from medical societies

access to all of the resources and materials developed by the AAO-HNS/F

## COVID-19 VIDEOS

created for both the otolaryngology community and to the public/patient community and accessed on ENThealth.org

**9 podcasts via video format**  
4,732 views

**2 video messages from AAO-HNS/F president**  
2,855 views

**Proper Procedures of COVID-19 Testing**  
701 views

**How ENT Practices Have Prepared to Treat Patients During the COVID-19 Pandemic**  
87 views

## ENGAGEMENT ON ENTCONNECT

- provided peer-to-peer support
- triggered Academy policies and Position Statements
- shared resources
- provided a sounding board for what individuals and the collective community are experiencing

participation is up over **80%** compared to the same time last year

## EDUCATION PROVIDED



**AcademyU**  
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### → Statements and Position Statements

The Academy issued these statements during the weeks following the start of the COVID-19 pandemic:

- Position Statement: Tracheotomy Recommendations During the COVID-19 Pandemic (REVISED: April 2, 2020)
- AAO-HNS Responds to CMS Statement on Adult Elective Surgery and Procedures Recommendations (UPDATED: March 26, 2020)
- Position Statement: Otolaryngologists and the COVID-19 Pandemic (March 23, 2020)
- Anosmia, Hyposmia, and Dysgeusia Symptoms of Coronavirus Disease (March 22, 2020)
- AAO-HNS New Recommendations Regarding Urgent and Nonurgent Patient Care (March 20, 2020)

### → Advocacy and Financial Relief

- Successfully advocated for COVID-19 relief provisions for otolaryngologists and their practices included in H.R. 748, the "Coronavirus Aid, Relief, and Economic Security Act" or the "CARES Act," which was signed into law on March 27, 2020.
- Launched impactful grassroots campaign advocating for COVID-19 relief for physicians on April 16, resulting in AAO-HNS members sending 1,004 emails to Congress. AAO-HNS reached 197 Senators and Representatives through this effort.

### → Financial Relief

- Academy Cares: The Academy offered a token of financial relief to practicing physicians by providing a \$100 voucher to be applied toward membership dues, education offerings including FLEX, the Virtual Annual Meeting, or a donation back to the foundation.

### → AAO-HNSF 2020 Virtual Annual Meeting & OTO Experience

Due to the cancellation of the in-person meeting scheduled to be held in Boston, Massachusetts, the Annual Meeting transitioned to a virtual platform, offering a six-week specialty-focused program:

- Included were five special live Panel Presentations with Q&A that covered:
  - The Current Status of COVID-19 Testing, Transmission, and Immunity
  - The Future of Otolaryngology Practice
  - The Future of Telemedicine in Otolaryngology
  - Shifting Sands: The COVID-19 "Science" That Informs ENT Practice in the Fog of War
  - Well-being: It's Time for a 360° Approach

### → Information Technology

In response to the COVID-19 pandemic, led the transition to virtual operations of the AAO-HNS/F overnight. Provided staff seamless access to technology resources, including voice communications and online conferencing, to keep the organization working at a high level to serve members during these difficult times.

# ADVOCACY

## ..... 2020 ACHIEVEMENTS .....

- Opposed CMS proposal in the 2021 Physician Fee Schedule on the value of E/M codes in the global surgery package that would negatively impact otolaryngology practice.
- Continued the fight in Congress to stop inappropriate federal scope of practice expansions, including the “Medicare Audiologist Access and Services Act” (H.R. 4056/S. 2446), which would inappropriately grant audiologists unlimited direct access to Medicare patients without a physician referral.
- Opposed CMS prior authorization proposals for certain outpatient department services and successfully advocated for the removal of CPT code 21235 (*obtaining ear cartilage for grafting*) from the prior authorization list.
- Collaborated with national, regional, and local insurers seeking positive coverage changes to policies relating to:
  - Surgical treatment of obstructive sleep apnea including hypoglossal nerve stimulation
  - Balloon dilation of the eustachian tube
  - Functional endoscopic sinus surgery
  - Balloon sinus ostial dilation
  - Cochlear implants
  - Minimally invasive treatment of the posterior nasal nerve to treat rhinitis
  - Postoperative sinus endoscopy
- Worked with state advocates and state medical societies to successfully:
  - Amend the Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC) legislation in Utah and West Virginia, to reduce the potential for scope of practice abuse and increase transparency. Halt compact action in Alabama, Kansas, Kentucky, Maryland, and Nebraska.
  - Convince state legislators in Virginia to require insurance coverage of hearing aids for children **when recommended by an otolaryngologist** under SB 423, Health Insurance Coverage of Hearing Aids for Minors.
  - Amend and pass the Hearing Aid Sales Amendment Act of the District of Columbia (B23-565), which requires minors to receive initial hearing loss evaluations and medical clearance from an otolaryngologist. Also under the new law, adults with new hearing loss must receive medical clearance from a physician prior to a hearing aid purchase.

## NEW CPT CODES effective in January 2021

- Eustachian tube balloon dilation
- Absorbable nasal implant repair

### WORKED WITH RUC TEAM AND OTHER ACADEMY LEADERS



## NEW CPT CODES effective in January 2022

- Hypoglossal Nerve Stimulation (HGN)
- Drug Induced Sleep Endoscopy (DISE)
- Bone Anchored Hearing Aids (BAHA)

### WORKED WITH CPT TEAM, RUC TEAM, ACADEMY LEADERS AND COMMITTEES, AND THE REPRESENTATIVE SISTER SOCIETIES

*The American Neurotology Society and the American Otological Society were particularly helpful on the BAHA codes.*



## 173 PHYSICIAN VOLUNTEERS

via the State Tracker Network worked on 2,290 state legislative and regulatory proposals

Please see the COVID-19 page for additional efforts and highlights related to Advocacy.

Please see the COVID-19 page for additional efforts and highlights related to Research & Quality.

# RESEARCH & QUALITY

## 2020 ACHIEVEMENTS

### REG-ENT REGISTRY

- Finalized partnership with OM1 and commencement of Reg-ent data validation and curation.
- Integrated Epic, Modernizing Medicine, Allscripts, eClinicalWorks, and Waiting Room Solutions EHR-based practices.
- Launched new dashboard, MIPS reporting module, and sign-up portal.
- Developed a group of 25 practices committed to mapping, validating, and supporting specialty-specific QCDR measures with the goal of increasing utilization of our specialty measures.
- Integrated seven new academic medical centers.
- Achieved Qualified Registry and Qualified Clinical Data Registry designations with CMS in 2020 for the fourth year.

### CLINICAL PRACTICE GUIDELINES (CPG) & EXPERT CONSENSUS STATEMENTS (ECS)

- Published the following CPGs, CCS, and ECS in *Otolaryngology-Head and Neck Surgery*:
  - **CPG**: Nosebleed (Epistaxis)  
→ Published January 2020
  - **CPG**: Ménière's Disease  
→ Published April 2020
  - **CCS**: Ankyloglossia in Children  
→ Published April 2020
  - **ECS**: Pediatric Drug-Induced Sleep Endoscopy (DISE)  
→ Pending publication date
- Began work on the following CPGs:
  - **CPG**: Opioid Prescribing for Analgesia After Common Otolaryngology Operations
  - **CPG**: Tympanostomy Tubes in Children (Update)
  - **CPG**: Manual Update

### QUALITY MEASURES

- Met with CMS regarding MIPS Value Pathways (MVPs) as an alternative to MIPS reporting for the specialty. Under consideration by CMS are three otolaryngology draft clinical pathways on Chronic Rhinosinusitis, Hearing Loss, and Early Oral Cavity Cancer.
- Developed and programmed the first Reg-ent Patient-Reported Outcome Measure for Age-related Hearing Loss.

### CORE GRANTS

- Held the first virtual CORE Study Section on March 21, with 62 reviewers and three chairs participating.
- Reviewed 157 grant applications, with 28 meritorious CORE grants awarded.
- Funded \$500,000 in CORE grant awards, supported by AAO-HNSF and specialty societies.



### HARNESSING THE POWER OF DATA



**DEPLOYED**  
Reg-ent's  
**FIRST**  
Patient-Reported  
Outcome Survey  
Tool on Age-Related  
Hearing Loss



**GREW**  
data to  
**7 MILLION**  
unique patients  
and approximately  
**26 MILLION**  
patient visits



**SUPPORTED**  
184 practices and  
1,244 clinicians in  
MIPS reporting  
  
*The highest level  
of support to our  
members in four years*



**17**  
OTOLARYNGOLOGY-RELATED  
**QUALITY MEASURES**  
developed by and for  
AAO-HNS members

**41**  
**REPORTABLE MEASURES**  
in the Merit-based Incentive  
Payment System (MIPS)

# GLOBAL EDUCATION, MEETINGS, & STRATEGIC PARTNERSHIPS

Please see the COVID-19 page for additional efforts and highlights related to Global Education, Meetings, & Strategic Partnerships.

## 2020 ACHIEVEMENTS

### CORPORATE DEVELOPMENT

- Sold \$590,000 in sponsorships to the AAO-HNSF 2020 Virtual Annual Meeting & OTO Experience. Sponsorships included virtual booths, advertising on the platform, and Industry Thought Leadership Series opportunities.
- Launched an ad retargeting campaign through the Annual Meeting website that generated over \$50,000 in advertising revenue in three months.
- Met with five of our largest industry partners at their headquarters to discuss options and lay the groundwork for mutually beneficial collaborative relationships via the new Corporate Champions program.

### GLOBAL EDUCATION

- Launched FLEX, our new flagship education product developed to replace the Home Study Course, which was retired in August after more than three decades, with 3,000 subscribers.
- Unveiled OTO Logic, the successor to AcademyU®, to reflect the Foundation's growing network of digital products. There has been a 614% surge in enrollments in online courses over the past year.
- Continued ABOHNS initiatives to support CERTLink™ and rebuild the Self-Assessment Models (SAMS) to offer CME that counts for MOC as a newly launched AAO-HNSF series titled, "Otolaryngology Patient Scenarios."

### AAO-HNSF 2020 VIRTUAL ANNUAL MEETING & OTO EXPERIENCE

- Launched the 2020 Virtual Annual Meeting & OTO Experience on September 12. The conference spanned six-weeks with focused specialty-week programming.
- Registered 5,095 individuals – 3,149 from FLEX and 1,946 Annual Meeting registrants.
- Launched over 200 On-demand education sessions for immediate access on September 13.
- Presented over 70 Live education sessions.



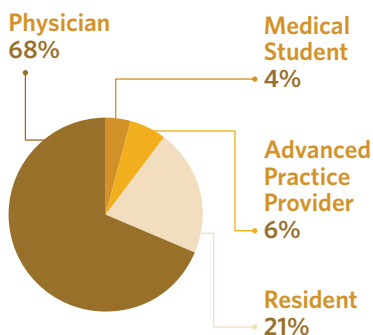
#### VIRTUAL AUDIENCE



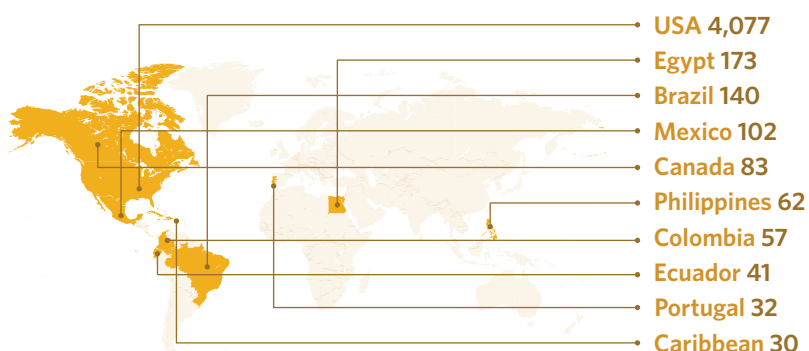
80% Domestic  
20% International

77% Member  
23% Nonmember

#### ATTENDEE PROFESSION



#### TOP TEN REPRESENTED COUNTRIES/REGIONS



### OTOLOGIC

OTOLARYNGOLOGY LEARNING NETWORK

16,381  
Course Enrollments

266,243  
CME Credits Issued

110 CME/MOC Courses Available



### FLEX

FOCUSED LIFELONG EDUCATION XPERIENCE

8  
SECTIONS  
EACH YEAR

presented in a variety of creative and contemporary learning modalities

100+  
CME/MOC  
credits offered





EXCEEDED revenue  
budget for membership  
renewal by approximately

**\$100,000**



GREW dues-paying membership to

**10,447**

Fourth Consecutive  
Year of Growth:

2017	2018	2019	2020
9,949	10,011	10,373	10,447

INCREASED  
international paid  
membership by

**6.19%**

Primarily from physicians from World Bank  
designated lower tier countries.



2019	2020
1,050	1,115

## WOMEN IN OTOLARYNGOLOGY

Celebrated the 10th anniversary of the Women in Otolaryngology (WIO) Section and the WIO Endowment with the documentary film "Four Days in Boston: A History of the AAO-HNS Section for Women in Otolaryngology (WIO)," which premiered at the 2020 Virtual Annual Meeting. (1,368 views)

Launched the virtual History of Women in Otolaryngology exhibit, showcasing the impact women in the specialty have made beginning in the late 1800s and continuing through today.

## SECTION FOR RESIDENTS AND FELLOWS-IN-TRAINING

Established a new International Delegate position to coordinate global activities and act as liaison with other residency and training programs outside the U.S. The delegate will focus on strengthening collaborations with current international members and help recruit new international members.



Elections for section officers for the SRF, WIO, YPS, and BOG were held virtually with special web pages developed to house the candidate statements and online voting to section members attending the Virtual Annual Meeting. Overall, voting was consistent with in-person rates from past years.



## YOUNG PHYSICIANS SECTION

Approved proposal to streamline dues. First-year member dues were reduced for U.S. and international young physicians from 50% to 66% off regular practitioner dues.

Developed a second-year category as an additional step discount (33%) before reaching full practicing physician dues (\$945/\$625).

## BOARD OF GOVERNORS

The Socioeconomic and Grassroots Committee completed work on its Category III and Unlisted Codes toolkit.

The Governance and Society Engagement Committee launched its online interactive map, providing the most up-to-date contact information for national, state, and local member OTO societies.

The Legislative Affairs Committee made a concerted push to increase member participation as grassroots advocates by using the One-Click platform on the ENT Advocacy Network website, [www.entadvocacy.org](http://www.entadvocacy.org).

# MEMBERSHIP & GLOBAL AFFAIRS

## 2020 ACHIEVEMENTS

- Transitioned committee application, appointment, and approval process to 100% digital.
  - Received record number of application submissions.
  - Reviewed and streamlined the Committee Handbook in time to release for the 2020 application opening on November 1.
- Launched the widely attended Virtual Regional Roundtable discussion groups for Africa, Asia, Europe, Latin America, and the Middle East.
  - Co-chaired by AAO-HNSF Regional Advisors and global leaders, Roundtables provide a forum to engage, network, and share experiences and best practices among the International Corresponding Societies affiliated network and the International Advisory Board leadership.
- Recruited 91 volunteer faculty members for global Joint Meetings in collaboration with the International Steering Committee.
- Developed an International Observership database of U.S.-based otolaryngology-head and neck surgery observership programs and opportunities.
  - The list is posted on the International Outreach web page to provide a resource for International Visiting Scholarship applicants and international young physicians planning to attend AAO-HNSF Annual Meetings.

Please see the COVID-19 page for additional efforts and highlights related to Membership & Global Affairs.

# COMMUNICATIONS

Please see the COVID-19 page for additional efforts and highlights related Communications.

## 2020 ACHIEVEMENTS

### DIGITAL AND PRINT COMMUNICATIONS

- *Otolaryngology-Head and Neck Surgery* reached its second highest Impact Factor of 2.341 for 2019. It also achieved its highest Five-Year Impact Factor with 2.592.

RESIDENT REVIEWER DEVELOPMENT PROGRAM	
COHORT 3	COHORT 4
30 Mentors & 30 Mentees	23 Mentees & 23 Mentors

- *OTO Open* has been accepted to Scopus, a comprehensive, curated abstract and citation database with enriched data and linked scholarly content.
- *Bulletin*: Added five new series in 2020: Transition to In-office Treatment by specialty area, clinical content from the AAO-HNSF Education Committees, How to Incorporate AAPs into Your Practice, Wellness, and Tech Talk.
- *Meeting Daily*: Produced three eDailies and five eWeeklies for the AAO-HNSF 2020 Virtual Annual Meeting & OTO Experience.
  - Average open rate 67.5%, an increase of 33.1% from 2019.

### MULTIMEDIA

- The AAO-HNS received the 2020 APEX Award for Publication Excellence Competition in "Electronic Media" for "Where Experts and Science Converge."
- Expanded reach of podcasts by releasing podcast channel on Apple podcasts, Spotify, Amazon Music, Android, iPhone, Microsoft Windows Non-COVID-19 podcasts published this year (downloads are as of 11/18/20):
  - Unconscious Bias: 449 downloads
  - HPV Status: Updates in Head and Neck Cancer: 739 downloads
  - BOGcast: RUC, CPT, 3P & U: 301 downloads
  - YPS Roundtable: ParENTal Responsibilities: 462 downloads
  - Insurance Considerations for Young Physicians: 863 downloads
  - Allyship and How to Unlock the Power of Diversity: 549 downloads
  - Craniofacial Trauma Management: 608 downloads
  - #OTOMTG20: Discussion with the Experts: 1,025 downloads
  - FLEX - Focused Lifelong Learning Xperience: 709 downloads

### PUBLIC OUTREACH AND PATIENT INFORMATION

- Social Media: Launched ENTHealth Twitter profile [@BeENTsmart](#).
- ENTHealth: Developed new content for ENTHealth, including new conditions and treatments, Be ENT Smart articles, and resources for patients.
  - *The Wall Street Journal* article "Pixel Buds? AirPods? How to Choose the Best Wireless Earbuds for You," referenced the ENTHealth Be ENT Smart article, "Your Ear Gear and Hearing Health."

 **OTO Journal**

**41,066**

**PODCAST DOWNLOADS**

January 1, 2020 - September 30, 2020

**918,482**

**FULL-TEXT ARTICLE DOWNLOADS**

2020 YTD (as of September 30, 2020)

**47% increase over 467,808 full-text downloads through the end of July 2019**

**INCREASED**  
podcast downloads by  
**1,258%**



**83 VIDEOS | 25 PODCAST EPISODES**



**INCREASED**  
YouTube channel  
views by  
**201%**

### DEVELOPED videos:



Virtual Annual Meeting  
Opening Ceremony  
→ 2,204 VIEWS



Virtual Annual  
Meeting Promotion  
→ 1,350 VIEWS



Congratulations 2020  
Graduating Residents  
→ 985 VIEWS



History of Women in  
Otolaryngology Exhibition  
→ 477 VIEWS

**LAUNCHED 531\***  
unique email messages



**39% OPEN RATE | 13% CLICK RATE**

**2,211,320\***  
total emails sent



\* total number includes all COVID-19 emails referenced on page 19.

# TECH TALK

**STARTED** the bimonthly Tech Talk article in the *Bulletin*, providing members insights on technology subjects:

2020

- FEB → **Protecting Data against Equipment Failure**
- 
- APR → **User-centric Cybersecurity Foundation**
- 
- JUNE → **Demystifying the Cloud**
- 
- AUG → **Work-from-Home Cybersecurity and Performance**
- 
- OCT → **ADA Website Compliance**
- 
- DEC → **Business Processes – Precursor to EMR Selection**

## INFORMATION TECHNOLOGY

### 2020 ACHIEVEMENTS

- Completed the reengineering of the Committee Application process, which culminated with a much smoother President-Elect final selection session.
- Replaced the PDF worksheet with an online app for chairs to vet new applicants to their respective committees, saving time and effort for both chairs and staff.
- Created interactive map for the Board of Governors, which allows members to choose a state and see the rosters for the state-wide and local societies.
- Simplified the online Disclosure Form by eliminating all the many different cells to easier-to-use drop-down selections.
- Operationalized the registration for FLEX including the complementary registration for the Virtual Annual Meeting. FLEX purchasers were enrolled in the Virtual Annual Meeting within one hour of subscribing.
- Developed back-office processes to support the Virtual Annual Meeting.
- Wrote new web services to support single sign-on to the virtual platform.
- Worked with multiple registration systems including the complementary registration for FLEX subscribers.
- Provided technical support to members and staff.
- Implemented the automatic credit card renewal option for annual membership dues.

*Please see the COVID-19 page for additional efforts and highlights related to Information Technology.*

## 125 YEARS AS A SPECIALTY ORGANIZATION

### A Celebration of Our History and Accomplishments



Look for more details in our commemorative 125th Anniversary *Bulletin* issue in January 2021.

# FINANCIAL HIGHLIGHTS

## ..... FISCAL YEAR JULY 1, 2019 — JUNE 30, 2020 (FY20) .....

Despite the COVID-19 pandemic, FY20 revenues were approximately at budget. Most FY20 revenue was received before the COVID-19 pandemic took hold in March 2020. A combination of below budget expenses and a positive return on investments resulted in an addition of \$2,490,000 to Net Asset Reserves for the fiscal year ended June 30, 2020 (FY20). Because of the positive operating results, there was no need to use reserves for certain non-operating expenses as had been budgeted.

Membership dues and Annual Meeting related revenues accounted for 40% and 38% of total revenues, respectively. Membership growth came in the areas of international and student members and dues revenue was approximately 1% above budget. The FY20 Annual Meeting, held in New Orleans, Louisiana, in September 2019, had the highest total attendance of any meeting in the last five years, achieving overall budgeted revenue expectations. Other income came from the sale of education materials, publications, royalties from Academy Advantage partners, individual donations, and Reg-ent fees. In total, these made up the remaining 22% of revenue.

Expenses were below budget, in part due to pandemic-related reductions in the last quarter of the fiscal year. Savings

in salaries and benefits, accounted for 40% of the positive addition to reserves from operations. All staff positions were maintained as budgeted, the savings largely due to extended vacancies over the course of the year. Occupancy and other operating costs were 20% below budget and no contingency funds were used. Reserves had been budgeted to pay for \$1,700,000 of consulting expenses, the majority related to the technology costs for the Reg-ent data registry. Through negotiation of a new work order, this expense was substantially reduced.

Investment performance for the fiscal year was just over 2% on the long-term portfolios and just over 3% on the operating reserves, leading to a \$720,000 addition to reserves from non-operating investment activity. The Foundation's Finance and Investment Subcommittee (FISC) monitors investment performance and adherence to the Foundation's Investment Policy Statement (IPS).

As of June 30, 2020, net asset reserves without donor restrictions were \$29,600,000. In addition, net asset reserves with donor restrictions totaled \$7,140,000 of which \$4,800,000 are the corpus of the Hal Foster, MD Endowment.

For a copy of the independent audit of AAO-HNS/F FY20 financial statements contact [CHanlon@entnet.org](mailto:CHanlon@entnet.org).

In May 2020 the Boards of Directors approved a balanced fiscal year 2021 (FY21) budget with revenue and expenses both equal to \$18,783,000. This budget was established before the full implications of the COVID-19 pandemic were known. Together, Annual Meeting revenues and Membership dues account for 70% of the FY21 revenue budget. The FY21 Annual Meeting (AM20), planned to be in Boston, Massachusetts, was cancelled and replaced with a Virtual Annual Meeting. The AM20 net revenues are expected to be received in the range as budgeted through a combination of net revenue from the Virtual Annual Meeting and coverage from the meeting's cancellation insurance policy. Membership dues are more of an unknown. While we believe that the value of Academy membership has been demonstrated, financial strains and restrictions may nonetheless impact membership renewals.

Finding ways to maximize resources and build in efficiencies has been, and continues to be, a focus of budget management. The budgeting process is integrated with the AAO-HNS/F Strategic Plan and involves the efforts of elected leadership, the Boards of Directors, Executive Committee, and the FISC.

## DEVELOPMENT BY THE NUMBERS (2020)

**\$91,000**  
in contributions to the  
*af* annual fund

**\$22,000**  
in contributions to  
DONOR  
RESTRICTED FUNDS



**\$114,000**  
in contributions to the  
WIO ENDOWMENT  
as a result of the 10-Year  
Anniversary WIO2.0 Campaign

**\$110,000**  
Endowment Investment Earnings

**+1**  
NEW LIFETIME  
DONOR  
  
millennium  
society



# UNAUDITED (ROUNDED) CONSOLIDATED STATEMENT OF ACTIVITIES FOR THE FISCAL YEAR ENDED JUNE 30, 2020

Description	BUDGET FY20	%	ACTUAL FY20	%	BUDGET FY21	%
<b>REVENUE AND SUPPORT</b>						
Membership Dues	\$ 6,925,000	36%	\$ 7,003,000	40%	\$ 6,950,000	37%
Annual Meeting Revenues	6,741,000	35%	6,726,000	38%	6,438,000	34%
Education and Other Product Sales	1,858,000	10%	1,776,000	10%	1,349,000	7%
Publication Revenues and Other Royalties	1,756,000	9%	1,757,000	10%	1,704,000	9%
Annual Fund	150,000	1%	91,000	1%	150,000	1%
Corporate Support	-	0%	-	0%	300,000	2%
Other Revenue	45,000	> 1%	149,000	1%	65,000	1%
<i>Subtotal</i>	17,475,000	91%	17,502,000	99%	16,956,000	90%
Use of Donor Restricted Net Assets	258,000	1%	198,000	1%	262,000	1%
Use of Board Designated Net Assets	1,700,000	9%	-	0%	1,565,000	8%
<b>Total Revenue and Support</b>	<b>\$ 19,433,000</b>	<b>100%</b>	<b>\$ 17,700,000</b>	<b>100%</b>	<b>\$ 18,783,000</b>	<b>100%</b>
<b>OPERATING EXPENSES</b>						
Salaries and Benefits	\$ 9,125,000	47%	\$ 8,406,000	53%	\$ 9,180,000	49%
Occupancy	1,003,000	5%	936,000	6%	985,000	5%
Other Operating Expenses	2,231,000	11%	1,642,000	10%	2,175,000	12%
Annual Meeting Costs	2,161,000	11%	2,694,000	17%	3,564,000	19%
Consultants & Professional Fees	3,983,000	20%	1,876,000	12%	1,984,000	11%
Grants	480,000	2%	376,000	2%	445,000	2%
Contingency Expense	450,000	2%	-	0%	450,000	2%
<b>Total Expenses</b>	<b>\$ 19,433,000</b>	<b>100%</b>	<b>\$ 15,930,000</b>	<b>100%</b>	<b>\$ 18,783,000</b>	<b>100%</b>
<b>Revenue and Support in Excess of Expenses</b>	<b>\$ -</b>		<b>\$ 1,770,000</b>		<b>\$ -</b>	
<b>Net Investment Activity</b>			<b>\$720,000</b>			
<b>Increase in Net Assets without Donor Restriction</b>			<b>\$2,490,000</b>			

# Human Error Is Inevitable—So How

## The Event

*We had just finished the composite resection, and it was late in the evening as the case had gotten off to a later start. We were done with the case, the drapes were off, and I had just removed the anode tube to insert the cuffed tracheostomy tube. I pulled on the upper stay suture to pull the trachea into view and it immediately came loose—obviously the tracheal ring had been broken during its placement. Undeterred I pulled on the lower stay suture to stabilize the trachea as I attempted to insert the tracheostomy tube, and to my horror, it also pulled out before the tube was successfully passed into the trachea. Filled with a sense of impending doom, I peered into the incision—I could see nothing but pink tissue—and realized I had no idea where the tracheal opening was. There followed a flurry of activity with rising level of pandemonium. The anesthesia resident and I were the only physicians in the room. I asked the scrub tech to quickly find me two Army-Navy retractors in the pile of instruments and the circulator to turn the OR lights back on and call my attending. I asked the anesthesia resident to hand me their suction since ours was already off the field. It seemed like an eternity, but it was probably less than two minutes to get the retractors into the incision, visualize the trachea and pull it up with a double hook, and successfully insert the tracheostomy tube. By the time the two attendings had returned into the room, the airway was secure, and all was well—except for the residual adrenaline rush from the terror I had experienced.*

David E. Eibling, MD; Matthew M. Smith, MD; and members of the AAO-HNS Patient Safety and Quality Improvement Committee

At the time, a quarter century prior to release of the 1999 Institute of Medicine report *To Err is Human*, pulling out the remaining stay suture while changing a tracheostomy tube would have been interpreted as a sign of a “bad resident.” The term *near miss* was restricted to aviation and, with a few exceptions, medicine had not yet begun to appreciate that a *near miss* might someday be a *hit*.

“No harm, no foul” was the oft-repeated theme—and in fact the event was never presented at our department’s M&M conference. Other than a brief explanation to the attending as he rushed back into the room, there was no attempt to review the event in the context of what might be done to avoid a repeat of the event, with potentially catastrophic consequences for the patient, not to mention the hapless resident and his department.

James Reason, author of the well-known book *Human Error*, was among the first to emphasize that the capacity for error accompanies all human endeavors, and no one is immune. His well-known Swiss cheese model describes that when errors occur, there are multiple barriers that must be violated between the error and the potential victim. When the holes in sequential barriers line up, the error can then lead to harm. The fishbone diagram we are familiar with helps to visualize the multiple contributing factors leading to an untoward event.

The recognition that error is a characteristic of all humans, and that all barriers to harm have holes, informs us that there are no simple fixes. This is not surprising to any of us, as most of us are aware of wrong-site surgery cases that occurred despite a preoperative time out. Hence, interventions to reduce harm must consist of multiple barriers, in the hope that many layers of protection will reduce the chances that human error will result in harm. This is a difficult concept, as considerable effort has been invested in promulgating some new policy that will prevent human error.

The error tolerance pyramid (Figure 1) is one such useful tool that can assist in organizing our thinking regarding what are typically numerous potential interventions. Some are stronger than others, a concept that has been illustrated as different barrier materials in the Swiss cheese diagram—from window screen to reinforced concrete.

# Do We Reduce the Risk of Harm?

But even reinforced concrete can be broken. Hence, multiple interventions that function at different levels to stop the error sequence are more likely than a single solution to the challenge of human error. The visualization, utilized in the U.S. Department of Veterans Affairs (VA) National Center for Patient Safety (NCPS) teaching materials on the topic of harm reduction, stratifies interventions into three (overlapping) epochs. The base of the pyramid is the design of the environment and crosses the entire domain of human-technology interface. Over the past 70-80 years, human factor researchers and engineers have taken an active role in studying and designing infrastructure to reduce the likelihood of error occurring.

The midsection of the pyramid addresses interventions that stop the sequence of error. Perhaps the most vivid example in surgical practice is the preoperative time out. It is such an integrated part of practice now that it is surprising to recognize that the step was only introduced about 15 years ago.

The top of the pyramid, and the smallest segment, is our back-up plan that seeks to reduce harm if an error does occur despite design processes developed to interrupt the error sequence. Attention to this step is an integral characteristic of a high reliability organization (HRO). HROs expect that errors and failure will occur and that harm is best mitigated by a back-up plan that has been considered previously.

## Error Tolerance Pyramid



Figure 1. Error Tolerance Pyramid from the teaching materials of the U.S. Department of Veterans Affairs National Center for Patient Safety, 2019 Clinical Team Training Curriculum PowerPoint.

## Error Tolerance Pyramid



Figure 2. Our case can illustrate the utilization of the three-level harm reduction pyramid.

Applying the error tolerance pyramid to our case illustrates how an appreciation of the possibility of a stay suture pulling out drives not only the development of policy, but also training of others who might be called on to assist in finding the tracheal opening in a fresh incision. The policy could include a requirement for a second time out to ensure that the patient is adequately oxygenated and sedated, and adequate personnel and instruments are available in the room should they be needed.

To summarize, strategies that employ multiple levels of harm reduction barriers will be more successful in preventing harm due to (inevitable) human error. The error tolerance pyramid that is taught by the VA NCPS is a framework that may assist in the development of a multilevel harm reduction program.

### Additional Readings:

Institute of Medicine Committee on Quality of Health Care in America. *To Err is Human: Building a Safer Health System*. National Academies Press; 2000.

Reason J. *Human Error*. Cambridge University Press; 1990.

Woods D. *Behind Human Error*. CRC Press; 2010.

Dekker S. *The Field Guide to Understanding "Human Error."* CRC Press; 2014. ■

*Excerpted from the AAO-HNSF 2019 Annual Meeting & OTO Experience Panel Presentation by the Patient Safety and Quality Improvement Committee: Near Misses, Never Events, and Just Plain Scary Cases*



## FROM THE EDUCATION COMMITTEES

# New Horizons in Diagnosis and Treatment of Pediatric Obstructive Sleep Apnea

**Meredith Merz Lind, MD**, For the Pediatric Otolaryngology Education Committee

Obstructive sleep apnea (OSA) is a common condition in children and one that most otolaryngologists are familiar with. Pediatric OSA has an estimated prevalence of 1%-4% in the United States.<sup>1</sup> In most cases adenotonsillectomy (T&A) is the first-line therapy. About 500,000 of these procedures are performed annually in the U.S.<sup>2</sup> Pediatric OSA is associated with behavioral issues (enuresis, aggression, hyperactivity, depression, and anxiety), poor school performance, and decreased quality of life, as well as increased healthcare utilization and risk for neurocognitive and cardiovascular morbidities. In 2019 the AAO-HNSF published an updated Clinical Practice

Guideline for Tonsillectomy in Children, with recommendations for tonsillectomy for children with sleep disordered breathing and comorbid conditions and for children with confirmed OSA on polysomnogram.<sup>3</sup> There is evidence that early T&A for OSA improves behavior, quality of life, and polysomnogram findings when compared with patients in a watchful waiting group.<sup>4</sup>

While most children have significant improvement or resolution of OSA after adenotonsillectomy, 25%-40% of patients may have residual obstruction and apnea. Residual OSA is more prevalent when severe obstruction was noted on preoperative polysomnogram and in children with obesity, craniofacial anomalies, hypotonia, and Down syndrome. For children with residual symptoms after adenotonsillectomy, an overnight polysomnogram is the standard for evaluation. Continuous positive airway

pressure (CPAP) remains the criterion standard for treatment of residual OSA. However, CPAP is often poorly tolerated in pediatric patients with high prevalence of noncompliance. Because of this challenge, additional evaluation and treatment methods have recently been described.

Individualized therapies should always be considered in appropriate patients. Weight loss can be highly effective in improving obstruction in patients with obesity. For patients with craniofacial abnormalities, orthodontic appliances or craniofacial procedures may ameliorate symptoms. In addition, addressing nasal obstruction medically or surgically may reduce obstruction in some patients.

In many patients with residual OSA after T&A, the site(s) of ongoing obstruction may not be obvious. Drug-induced sleep endoscopy (DISE) was first described in



the 1990s as an improvement over awake nasopharyngoscopy to better capture the dynamic upper airway collapse that may occur during sleep. DISE has been studied increasingly in pediatric patients in recent years. Most providers describe use of DISE for children with continued moderate or severe OSA after T&A. However, some have advocated DISE for pre-T&A evaluation in patients who are high risk for residual OSA postoperatively or for children with OSA and small tonsils and adenoids.<sup>5</sup> Multiple pharmacologic protocols for DISE have been described, but none replicate REM sleep perfectly. Many pediatric institutions prefer a protocol of dexmedetomidine and ketamine because of a lower risk of respiratory depression that can be seen with propofol.<sup>5</sup> Otolaryngologists and their anesthesia colleagues should work together to define the best protocol for their institutions. After initiation of drug-induced “sleep,” a flexible fiberoptic endoscope is inserted via the nose and passed through the rest of the upper airway to evaluate potential obstruction in the nasal cavities, nasopharynx, palate/velum, oropharynx, tongue base, lingual tonsils, and supraglottis and glottis. There are at least six DISE scoring systems that have been described; none of them are considered superior or universally accepted among pediatric otolaryngologists.<sup>6</sup> It is recommended that a provider consistently use the same scoring system to evaluate patients in DISE.

Cine MRI is another methodology described to identify sites of obstruction after T&A by MRI during sedation and with spontaneous ventilation. Advantages of cine MRI include simultaneous assessment of multilevel airway obstruction and improved definition of lingual tonsil tissue from primary base of tongue obstruction.<sup>5</sup> It is less widely used than DISE, primarily due to scheduling considerations and the ability of surgeons to both complete assessment and intervene under the same anesthetic procedure with DISE.

After airway evaluation with DISE or cine MRI, targeted intervention can be performed based on the identified site(s) of obstruction. Many providers discuss the possibility of interventions with families


prior to DISE so that the intervention can be performed at the time of evaluation. If obstruction is noted at the level of the palate, uvulopalatopharyngoplasty or expansion sphincter pharyngoplasty may be recommended. If tongue base obstruction is noted, lingual tonsillectomy, posterior midline glossectomy, or hyoid suspension may be appropriate. Sleep dependent laryngomalacia may also be noted, and epiglottopexy or supraglottoplasty may be of benefit. The degree of improvement in OSA after these directed interventions is variable but has been described in various studies in the range of 50%-80%.<sup>7</sup>

The hypoglossal nerve stimulator was first described by Alan R. Schwartz, MD, in a pilot study in 2001. Since that time it has become a widely used procedure in adults with severe obstructive sleep apnea, with many studies showing significant improvement in AHI, oxygen desaturations, arousal index, and quality of life indices.<sup>9</sup> Pilot studies are now underway to evaluate the safety and efficacy of hypoglossal nerve stimulator implantation in pediatric patients. To date, the device has been implanted in children and adolescents with Down syndrome and severe OSA after T&A. Caloway et al. published a series of 20 patients, aged 13-17 years, who underwent the procedure with no long-term complications. All patients completed a two-month postoperative sleep study with excellent nightly utilization, significant reduction in AHI, and moderate improvement in QOL measures.<sup>10</sup>

While many children with OSA have resolution of symptoms with adenotonsillectomy, management of residual disease is complicated and involves understanding of evolving diagnostic and treatment procedures. To learn more about these issues, consider enrolling in FLEX, the AAO-HNSF new multimodality lifelong learning platform, where pediatric obstructive sleep apnea will be explored in the February 2021 module. ■

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The AAO-HNSF Clinical Practice Guideline: Tonsillectomy in Children (Update) was published as a supplement to *Otolaryngology-Head and Neck Surgery* in February 2019. To access the guideline, executive summary, plain language summary, patient handouts, podcasts, and more, go to <https://www.entnet.org/tonsillectomyCPG>.

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# Differences in Parathyroid Surgery around the World

**Jonathon O. Russell, MD; Antonio Bertelli, MD; Avi Hefetz-Khafif, MD; and Ralph P. Tufano, MD, MBA**

**A**t the AAO-HNSF 2020 Virtual Annual Meeting & OTO Experience, head and neck endocrine surgeons from around the world met virtually to discuss techniques and differences in the management of primary hyperparathyroidism. Differences in resources and access to care highlighted various opinions across the topic. The virtual format was new, but the conversation covered some notable differences in management. **Ralph P. Tufano, MD, MBA**, from John Hopkins University in Baltimore, Maryland, served as the moderator for the session.

**Antonio Bertelli, MD**, from São Paulo, Brazil, began the discussion by highlighting the presentation and management of hyperparathyroidism in Latin America. “Patients with hyperparathyroidism in Brazil are more likely to present with classic symptoms of nephrolithiasis and are more likely to have a single parathyroid gland that is problematic,” he said. He described the typical preoperative evaluation of patients and the fundamental role of ultrasound. Whereas other countries might have a higher incidence of multigland parathyroid disease, most of the cases that he sees are single adenomas that can be treated with a focused surgery. He mentioned that patient characteristics, hospital resources, and expectations are highly variable depending on where he might see a patient and what their background is.

**Jonathon O. Russell, MD**, from Johns Hopkins University, focused on adenomas and intervention in the United States. As opposed to Brazil, he described that it is more common for patients in North America to be asymptomatic, with disease often first noted incidentally during routine lab evaluation. He stressed that while there are many imaging methods that can be used to localize a parathyroid adenoma, the decision to operate or not is based on biochemical

values and well-defined operative indications. If surgery is needed, he stressed that surgeon-performed ultrasound is the most available and most generally valuable instrument in his practice. When considering remote access approaches, such as scarless vestibular approach parathyroidectomy, this is especially important.

While parathyroid surgery is generally completed via a cervical incision, **Avi Hefetz-Khafif, MD**, from Assuta Medical Center in Tel Aviv, Israel, highlighted his results using the scarless vestibular approach to the parathyroid glands. With a combination of videos and photos, he demonstrated the potential benefits to patients of all ages who are able to have surgery without a cutaneous incision. In presenting his work, he was able to demonstrate that his outcomes have been similar when using both this new approach and the more traditional cervical incision. “Patients have a choice about whether or not they are okay with a scar,” he said. Learning the technique has also allowed him to offer scarless options to patients interested in other cervical procedures. For a patient to be considered for an endoscopic parathyroidectomy via the vestibular approach, he must have a well-localized adenoma by two imaging studies (usually a high-quality ultrasound and sestamibi scan). Only patients with concordant localization should be candidates.

In a virtual roundtable, Dr. Tufano posed several questions that got to the heart of differences between the practices. He led by asking about the use of intraoperative parathyroid hormone (IOPTH). Not surprisingly, this topic generated a robust response from the group. For Dr. Hefetz-Khafif, “When my patients have a well localized gland, I know confidently that I will cure them with a focused parathyroid surgery. It is hard to justify the extra hour of anesthesia time that it takes at my hospital for a full set of IOPTH values to result.” Dr. Bertelli agreed: “More than 95% of patients will be cured when a parathyroid gland is localized on

two or more studies.” He added that access to this IOPTH could be limited for some of his patients, depending on the hospital in which he may be operating.

Despite these comments, Dr. Tufano clarified that in the United States it is difficult to develop a high-volume parathyroid surgery practice without the extra protection IOPTH provides to help avoid missing that additional 1%-2% of patients who may have multigland disease. “While you may cure almost all of your patients with a focused surgery, it is important to make sure that patients understand the inherent limitations of focused surgery without IOPTH.” He also reminded participants that recent surgical guidelines go so far as to make IOPTH a recommendation for surgeons who are performing focused parathyroid surgery. Dr. Hefetz-Khafif agreed that with a shorter IOPTH time and lower cost, it should be recommended for all focused surgery.

The panelists also had variations with regards to their preferences for imaging. While some preferred to get a CT scan for all patients, other members felt that an ultrasound was sufficient in some cases. All agreed that the addition of a second imaging modality did increase surgeon confidence and often improved the experience for patients.

The panel agreed that focusing as a team on parathyroidectomy was the key to excellent outcomes. “Surgeons have the opportunity to receive immediate feedback when they perform a surgeon-directed ultrasound right before surgery,” said Dr. Russell. “Because radiologists and endocrinologists do not get that immediate feedback, closing the loop is an important way to help the entire team improve.” Dr. Bertelli added, “No matter where you practice and what resources you have, you improve as a parathyroid surgeon with experience, and that applies to everyone on the team.” ■

*This topic was presented as part of the International Symposium of the AAO-HNSF 2020 Virtual Annual Meeting & OTO Experience.*



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314-956-4060 mobile | 314-722-4549 office  
[dhinkle@soundhealthservices.com](mailto:dhinkle@soundhealthservices.com)  
[Soundhealthservices.com](http://Soundhealthservices.com)

**SOUTH FLORIDA ENT ASSOCIATES**



**South Florida ENT Associates**, a fifty plus physician group practice operating in Miami-Dade, Broward and Palm Beach Counties, has immediate openings for full-time ENT Physicians. Established since 2001, South Florida ENT Associates has been a market leader in ENT services in a dynamic, multicultural community. We provide full service ENT including Audiology, Hearing Aid Sales, Allergy, Facial Plastics, Robotics, CT services and more.

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

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

This position will include both office and hospital settings.

**Requirements:**

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

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**Contact Information:**



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



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[lgraham@cadentcare.com](mailto:lgraham@cadentcare.com).

### CLINICAL FELLOWSHIP IN LARYNGEAL SURGERY AND VOICE DISORDERS Massachusetts General Hospital

The Division of Laryngeal Surgery is seeking applicants for clinical fellowship positions. The fellowship training covers all aspects of laryngeal surgery, voice disorders, and management of the professional voice. The curriculum will provide a wide range of experiences, including phonosurgery (cold instruments and lasers), laryngeal framework surgery, novel operating-room and office-based laser (Pulsed-KTP, Thulium) treatment, complex laryngeal stenosis with aortic homograft transplantation, and the use of botulinum toxin injections for spasmodic dysphonia. The fellow will participate in the management of voice disorders and clinical research as a member of a multidisciplinary team (voice scientists and speech pathologists) that has access to state-of-the-art voice clinic and surgical engineering laboratory facilities. The research fellowship provides numerous opportunities to focus on grant-funded (NIH and private foundations) clinical and basic science research projects in collaboration with interdisciplinary teams of scientists and clinicians at the Massachusetts Institute of Technology and the Wellman Laboratories of Photomedicine at the Massachusetts General Hospital. The option to collaborate with local music conservatories is also available. Qualified minority and female candidates are encouraged to apply. Send curriculum vitae and three letters of recommendation. The Massachusetts General Hospital is a teaching affiliate of Harvard Medical School.


**Direct inquiries to:**  
**Steven M. Zeitels, MD, FACS**  
**Eugene B. Casey Professor of Laryngeal Surgery**  
**Harvard Medical School**  
**Director: Center for Laryngeal Surgery & Voice Rehabilitation**  
**Massachusetts General Hospital**  
**One Bowdoin Square, 11th Floor**  
**Boston, MA 02114**  
**Telephone: (617) 726-0210 Fax: (617) 726-0222**  
**zeitels.steven@mgh.harvard.edu**



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## Weill Cornell Medicine

### Sean Parker Institute for the Voice



**THE SEAN PARKER FELLOWSHIP IN LARYNGOLOGY:  
CLINICAL TRAINING WITH MASTER'S DEGREE IN CLINICAL &  
TRANSLATIONAL INVESTIGATION**

The Sean Parker Institute for the Voice offers a unique training opportunity in laryngology for individuals with strong interest in an academic career. A two-year fellowship combines comprehensive clinical training with formal coursework and mentored clinical research leading to a Masters of Science in Clinical & Translational Investigation. Clinical training is offered in all aspects of laryngology, with particular strengths in office procedures, neurolaryngology, laryngeal microsurgery and framework surgery, endoscopic management of malignancy, and care of the performing voice. The Master's Degree program is offered by Weill Cornell Medical College's Clinical & Translational Science Center.

Admission to fellowship is contingent upon completion of residency in Otolaryngology, and eligibility for a medical license in New York State. The position is offered through the American Laryngological Association Match.

**Candidates should email CV, letter of interest and arrange 3 letters of reference to be sent to:**  
**Lucian Sulica, MD**  
**Sean Parker Institute for the Voice**  
**240 East 59th Street, New York, NY 10022**  
**lus2005@med.cornell.edu**

*Diversity is one of Weill Cornell Medicine's core values and is essential to achieving excellence in patient care, research, and education. We welcome applications from candidates who share our commitment to fostering a culture of fairness, equity, and belonging. Weill Cornell Medicine is an Equal Employment Opportunity Employer, providing equal employment opportunities to all qualified applicants without regard to race, sex, sexual orientation, gender identity, national origin, color, age, religion, protected veteran or disability status, or genetic information.*

### Private Practice Opportunity General Otolaryngologist

Wooster Ear, Nose, and Throat is seeking a BC/BE fulltime otolaryngologist to join a successful, well established private practice to replace a retiring physician in Wooster, Ohio. We provide a full range of ENT services including General ENT, Allergy, Audiology and Hearing Aid Sales.

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- Partnership track with options for buy in.

Interested candidates please submit CV and letter of interest to:

Amy Gonzales, Practice Administrator  
amgwent@aol.com



**Board Certified, Director of GME Education  
Department of Otolaryngology – Head & Neck Surgery  
Worcester, MA**

UMass Memorial Medical Center, the clinical partner of the University of Massachusetts Medical School in Worcester, MA, is seeking a **Board Certified Otolaryngologist** to serve as the **Director of GME Education** with a minimum of 3 years of clinical practice in the specialty post-residency/fellowship, a minimum of 1 year of experience as an associate program director of an ACGME accredited Otolaryngology program or 3 years of participation as an active faculty member of an ACGME accredited Otolaryngology program, and evidence of periodic updates of knowledge and skills to discharge the roles and responsibilities for teaching, supervision, and formal evaluation of residents. The appropriate candidate must have a proven ability to develop and enhance the educational program for UMMS medical students, as well as playing a vital role in the development of a new residency program as directed by the Department Chair.

UMass Memorial Health Care is the largest healthcare system in Central Massachusetts. As the clinical partner of UMass Medical School, you will have access to the latest technology, research and clinical trials. Come join an established group of eight physicians in a busy tertiary care referral center. We are looking for ideal candidates with energy, desire, and drive to ramp up their careers and help expand our scope and presence. There are ample opportunities for clinical and basic science investigation and research. An academic appointment commensurate with education and training is offered.

Centrally located, Worcester is just miles from Boston, Providence, Berkshire mountains, mountains of Vermont and New Hampshire, Cape Cod beaches, Martha's Vineyard and Nantucket. The diverse city of Worcester has nine colleges and universities including the University of Massachusetts Medical School that overlooks Lake Quinsigamond. As the second largest city in New England, it has powered a rise of biotechnology, research, manufacturing and healthcare industries. Worcester is also home to the Hanover Theatre for Performing Arts, Worcester Art Museum, Mechanics Hall and the family-friendly Ecotarium.

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**Interested applicants should submit a letter of interest and curriculum vitae addressed to:**

**Daniel Kim, MD, FACS  
Chairman and Professor  
Department of Otolaryngology - Head and Neck Surgery  
UMass Memorial Medical Center  
c/o Adriana Dietlin, In-House Physician Recruiter  
Department of Human Resources  
Email: [Adriana.Dietlin@umassmemorial.org](mailto:Adriana.Dietlin@umassmemorial.org)**

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