ASPIRE Collaborative Virtual Meeting Summary
Friday, July 17, 2020

Anesthesia Considerations & Precautions for Ramp Up of Operations following COVID 19 Peak Pandemic

Gary Loyd, MD
Henry Ford Health

Presentation Notes:

- 8000 cases backlogged while ORs were closed
    - Completed these cases by mid-July as some patients opted to not have their surgery during COVID
- Created space to do COVID testing
    - Try to do rapid testing for patients who haven't been tested – performed outside; case gets bumped until COVID results available
    - If testing is not completed, we assume they are COVID positive and we do not allow them to enter preop
    - Installed machine filters and protection
- Developed induction and intubating policies
    - Intubated in ICU before transport to the OR if COVID positive
    - PPE use
- Created 100 new beds across health system during COVID crisis. Anesthesia redployed to staffed them leading to issues with ramping up ORs as they were still staffing beds. Ambulatory CRNAs furloughed, HFHS need to present OR numbers to justify bringing them back from furlough.
- No one can come in or out of the room after extubation for 35-minutes before or after for COVID patients.
- Turnover times increased to 1 - 1.5 hours between cases.
- All of preop is done in patient rooms for inpatients rather than in preop as there aren't enough preop beds
- Converted ASCs to be able to handle the same case type as the main OR
- Still experiencing pushback on new policies due to constant updates to policies and needing to update all staff on changes
- Still seeing fear in providers and staff to be around COVID patients
- Virtual meeting fatigue- extra burden
- Ultimately, you need to take care of your own people, especially if they're experiencing fatigue/PTSD. They cannot provide care in that state.

Discussion / Questions:

Will you give us more information on testing? Do you require tests to be done at Henry Ford or can a patient obtain a test at another institution?

- We will accept testing from any institution, we just want the patient to have documentation. If a patient does not have a test, we will do rapid testing, which takes approximately 12-hours. If they cannot wait, then we treat them as a COVID positive patient.

If people come in as unknown, do they physically have to wait? Do you hold them or do they have to leave until the test is completed?

- All patients are checked at the door to determine if they have completed a test. If they do not, they are not allowed into preop. They are sent to be tested and there is a waiting lounge for them to wait for their results. The rapid test typically 12-hours but have been completed as quickly as 4-hours. Once we receive the results, the patients are then put back into the queue.
    - We contact the patient prior to surgery and if they do not have a test completed, we try to have them come in early so they get their surgery done on time.

Do you collect QI Data from your ACS?

- Yes, we are collecting data and are constantly expanding the data we collect.

Why Diversity Matters

Matthew Wixson, MD
Michigan Medicine

Diversity: Condition of having or being composed of differing elements

Diversity leads to a better organization – 'The Diversity Bonus' (Book by Scott Page) presents argument that diversity:

- Leads to better outcomes
- Innovation
- Greater problem solving
- Improve financial outlook

Under-represented minority providers are more likely to participate in providing care to underserved areas

Studies need a more diverse patient population as we can't necessarily extrapolate results to all patient populations if we're only studying one patient race/ethnicity/gender/socioeconomic status, etc.

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Only 4% of US physicians are African American although the US population is 13% African American. The healthcare workforce does not match the makeup of the US population

Questions / Discussion

Why is it so hard to implement a diverse workplace?

- Failure to align diversity practices with organizational goals
- Mismatch between policies and implementation

Strategies for Success

- Clearly identify what one is trying to achieve: what is the goal? Where are we headed and what do we want to be as an organization or group?
- Don't copy and paste: what works at one organization may not work at the next
- Good design and good implementation
- Win 'hearts and minds': Just like quality improvement, this requires relationships and love- must create

Question to group: What do you think of when you think of diversity?

- Different thoughts
- It's a good thing, positive
- I think diversity is looking at things from various points of view

When you see this picture of me and my family, what do you think?

- Beautiful family, through the lens of America, we've had conversations on how your kids will grow up. Looks like a wealthy family and from a good background.

- Looks like a loving family
- See hard work
- Incredibly happy
- Looks like you're incredibly happy, and it's a product of work, love and education

My background: I was adopted into a white family outside Jackson, Michigan. I was the only person of color in the entire town. My family was a humble family who were blue collar and worked hard. You never know someone's story. I suggest that you take the time to get to know people because they are going to bring a lot of diversity to you and your organization.

Questions / Discussions:
In our current role, what are the most frustrating parts of the work?

- Most frustrating part is that the minority tax is real. The idea that it's up to the people of color to help change the problem. I have a fantastic Chair that has shown up and supports diversity in our department. We need allies. Someone like me cannot do all the work. We need leaders to help advance diversity. What we've seen is that it is falling to a small group of people to do all the work and creates burnout. It will take everyone to help it get better.

I see you as someone who has a compelling story and can be a compelling leader. There is some tension that an organization makes people of color leaders and they are only seen as a token leader. How would you encourage people from diverse backgrounds to pursue a leadership role?

- There is definitely that tension that exists, especially in academia. The practical thing you can do as a leader is to create a diverse team and provide training.
- Find ways to invest and mentor people around you. Leaders can start by putting diversity at the forefront and be active in making the change. They need to be cognizant and forthright in providing mentorship and training.

Quality Performance Review

Moderated by Nirav Shah, MD
MPOG

PONV 03/03b: Percentage of patients, regardless of age, who undergo a procedure and have a documented nausea/emesis occurrence OR receive a rescue antiemetic in the immediate postop period

- Exclusions:
    - Patients transferred directly to the ICU

- Liver Transplant
- Organ Harvest
- Labor Epidural

PONV 03b: nursing documentation of Nausea/Vomiting only (does not include antiemetic treatment in PACU)

- What are your practice patterns?
  - High performing site: Have a long standing protocol with administering 2,3, or 4 antiemetics preop based on risk factors; worked through barriers
  - PACU nursing have standing order sets based on the last dose given that allow them to give rescue antimemetics
  - Had to work through barriers of routinely giving antiemetics as prophylaxis and move towards giving them for only rescue
  - PACU Nursing not documenting nausea/vomiting or antiemetic administration- need to start educating providers to start documenting this to get an accurate score
  - No issues with supply chain shortages of antiemetic drugs
  - Low performing site: Nursing documentation for nausea/emesis was nested within a number of dropdown menus, making it hard to document. Many nurses weren't documenting, just giving an antiemetic. We corrected the documentation and let the nurses know where to find it, which seems to be going well

- Is there a correlation with PACU n/v and prophylaxis?
  - Middle performer- We did a lot of work to make sure PONV 03 data is correct. We did experience med shortages and changes in protocols. When trying to compare with PONV 01, there is not a direct correlation. We may need to do more digging about the patient populations to find out who is really at risk for PONV
  - Middle performer- Finding that PONV 01 and PONV 03 populations are different. The cases that are passing or excluded from PONV 01 are failing PONV 03
  - Middle performer- one of the hardest things is to judge if the nurse is giving antiemetic prophylactically or if there is true nausea/vomiting. Some nurses give immediately after giving a narcotic because they assume that the patient is going to need it. We are not finding a correlation between
  - Middle performer- Agree, that is what I see too

PONV 01: Percentage of patients, aged 18 years and older, who undergo a procedure under an inhalational general anesthetic, AND who have three or more risk factors for post-operative nausea and vomiting (PONV), who receive combination therapy consisting of at least two

prophylactic pharmacologic antiemetic agents of different classes preoperatively or intraoperatively.

- Low performing site: Historically, providers routinely administer only one antiemetic at the end of the case- trying to change this perspective; Also getting pushback from providers around giving decadron to diabetic patients and from surgeons who don't want the patient to get steroids

NMB02: NMB reversal administered before extubation

- Sugammadex administration: About half of the Michigan sites still predominantly still using neostigmine over sugammadex
    - Formulary restrictions and cost restraining use at several sites
        - Sugammadex approved for use in pediatrics & high-risk patients only
        - Most providers would use it all the time if given the option
    - UM was able to present studies using its own data that sugammadex administration reduced reintubations by 50%
    - STRONGER study presents that sugammadex does actually prevent pulmonary complications: https://anesthesiology.pubs.asahq.org/article.aspx?articleid=2764527

TOC 01: Intraop Transfer of Care

- Most improved: Not sure this checkbox is reflective of the quality of handoff but emailed providers to remind them to document their handoff if they actually performed it.
- High performer #2: Improved EHR accessibility to document handoff of care- not sure they actually improved the quality of the handoff
- Is this just a check-the-box measure? Is it actually ensuring safer care for patients?
    - This measure could or should help drive sites to build a structured tool to assist with the intraop handoff
    - Could be used in conjunction with local QA events to determine if intraop handoff improvement is actually reducing QA events

BP 03: MAP<65mmHg for 15 minutes or less

- What are practice patterns?
    - High performer: Intraoperative use of ketamine instead of propofol; use lots of nerve blocks which decrease the number of general anesthetics required which helps with maintaining BP; about 80% of patients receive a nerve block as part of their anesthetic plan

- Low performer: Low denominator in the last two months and patient load with extremely high acuity. Hoping that as normal patient population returns, can work on improvement for BP 03 scores