The MSA as a Vehicle for Quality Improvement

Michigan Society of Anesthesiologists

www.mymsahq.org

Roy Soto, MD Residency Program Director Beaumont Health

Disclaimers

- President, MSA
- ASPIRE convert
- Safety evangelist

How Do I Reach the Congregation When I'm Preaching to the Choir?

Mission

Michigan Society of Anesthesiologists is the statewide organization of anesthesiologists for the representation, education, and advancement of physicians providing ethical anesthesia care. MSA serves patients, the public, lawmakers, physicians and other professionals by defining and advancing the standard of anesthesia care and supporting the practice of anesthesiology.

Membership

- 1000 active members (~65%)
- 300 resident members (~100%)
- A smattering of medical student members

Annual Scientific Meeting

- Every spring
- CME offerings focusing on
  - Pain management
  - Physician wellness
  - Clinical controversies
  - Emerging treatment options
  - ERAS
- Resident QI Presentations

Safe Treatment of Post-Surgical Pain

A Consensus Statement of the Michigan Society of Anesthesiologists and the Michigan Association of Nurse Anesthetists

1700 opioid related deaths in Michigan in 2016

17 times the rate in 1999

more than **115** opioid prescriptions written for every 100 Michigan residents each year

The opioid crisis affecting so many Americans is frequently linked to post-surgical pain, and the medications provided to treat that pain. As frontline health care providers treating pain when it first occurs, **we present the following tenets for safe perioperative patient care:**

1 **Non-opioid analgesic agents should always be the first option for patients experiencing pain.**

- Non-opioids include acetaminophen, nonsteroidal anti-inflammatory agents, steroids, gabapentoids, NMDA receptor antagonists, alpha-2 agonists, local anesthetics, and others.
- Opioids should be reserved for patients experiencing severe pain, and for those requiring rescue for pain not controlled with the aforementioned agents.
- Opioid-free surgery is a viable option for many minor or minimally invasive procedures
- Opioids should never be given as monotherapy for pain before, during, or after surgery.

2 All surgical patients should be educated **regarding the severity, duration, and nature of expected post-surgical pain.** This education should be given by the surgical provider, and reinforced by the anesthesia and nursing teams caring for the patients during the perioperative period. Anesthesia providers should counsel patients on the appropriate use of scheduled and as-needed non-opioids, and discuss expected side effects of post-operative pain medications.

3 Information **for the proper storage and disposal of unused opioids should be given to all surgical patients, and the risks of drug diversion and abuse should always be provided at the time of prescription.**

Members of the Michigan Society of Anesthesiologists and the Michigan Association of Nurse Anesthetists are resolved to combat the opioid crisis, and to provide safe, quality care to each of their patients.

Michigan Society of Anesthesiologists

MANA
Michigan Association of Nurse Anesthetists

Michigan Is Facing an Opioid Abuse Epidemic

Michigan deaths in 2016

1,699 Opioid related deaths[1]

1,223 Firearm related deaths[2]

1,021 Deaths by automobile accidents[3]

The opioid crisis costs the United States more than **$500 billion** annually[4]

Opioid related deaths in Michigan are **17x** higher than in 1999[5]

According to the CDC, more than **80%** of individuals using opioids for nonmedical purposes stole, purchased, or got them from a friend, relative, or drug dealer[6]

In 2016, there were enough opioids prescribed in Michigan to give every resident in the state **84 pills**[7]

The US has **5%** of the world's population, but Americans consume **80%** of the world's prescription opioids[8]

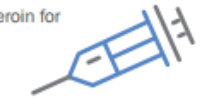
In Michigan, there are roughly **115 opioid prescriptions per 100 residents**[9]

11,000,000 painkiller prescriptions written statewide in 2016[10]

Each day

3,900 people nationwide initiate nonmedical use of prescription opioids for the first time

580 people use heroin for the first time



78 people die from an opioid related overdose[11]

Michigan anesthesiologists are leading the effort to combat our state's prescription drug abuse crisis. For more information, please contact the Michigan Society of Anesthesiologists.

[1] www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4871_76584---,00.html
[2] www.mlive.com/news/index.ssf/2018/01/michigan_gun_ownership_by_the_1.html
[3] www.freep.com/story/news/local/michigan/2017/01/23/michigan-traffic-fatalities-increase-2016/96239084/
[4] www.marketwatch.com/story/how-much-the-opioid-epidemic-costs-the-us-2017-10-27
[5] www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4871_76584---,00.html
[6] www.mlive.com/news/index.ssf/2017/06/michigan_opioid_heroin.html
[7] www.mlive.com/news/index.ssf/2017/06/michigan_opioid_heroin.html
[8] www.mlive.com/news/index.ssf/2017/06/michigan_opioid_heroin.html
[9] www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4871_76584---,00.html
[10] www.mlive.com/news/index.ssf/2017/06/michigan_opioid_heroin.html
[11] USCHHS, via Handout

www.mymsahq.org

Michigan Society of Anesthesiologists

MQIC

Michigan Quality Improvement Consortium Guideline

In Office Use of Sedation

The following guideline recommends core principles that promote safety and quality in the delivery of office-based procedures requiring sedation or analgesia.

Eligible Population	Key Components	Recommendation and Level of Evidence
Providers performing office-based procedures using moderate sedation/ analgesia or deep sedation/analgesia~~, or general anesthesia~~ (excludes minimal sedation and local anesthesia) This guideline does not apply to formally designated ambulatory surgery centers, hospital-based outpatient facilities, or emergency departments.	Accreditation	Moderate or higher levels of sedation must be performed at a practice site accredited by one of the following organizations **[D]**: • The Joint Commission **(jointcommission.org)**; Accreditation Association for Ambulatory Health Care **(aaahc.org)**; American Association for Accreditation of Ambulatory Surgical Facilities **(aaaasf.org)**; American Osteopathic Association and AOA Healthcare Facilities Accreditation Program Anesthesiology group/individual anesthesia provider accreditation by one of the above organizations would be an acceptable alternative to practice site accreditation. The requirement for accreditation is intended to meet the spirit of the American Medical Association's Core Principles for Improving Office-Based Surgery, which are shown in a modified form below.
	Patient selection	Physicians should select patients for office-based procedures using moderate sedation/analgesia, deep sedation/analgesia~~, or general anesthesia~~ by criteria that include the American Society of Anesthesiologists (ASA) Physical Status Classification System, and they should document their ASA status. Physicians should only perform level III[1] surgery for patients with ASA physical status III[2] in a facility setting, not an office setting, unless specifically cleared by a physician **[D]**.
	Informed consent	Procedures requiring moderate sedation or analgesia, deep sedation or analgesia, or general anesthesia must have a written informed consent documented. Consent forms should be specific to each procedure and should meet the guidelines outlined by the Federation of State Medical Boards (FSMB).
	Quality Improvement	Each practice must have a method for tracking and reporting adverse events in a manner consistent with the FSMB. Each practice must implement continuous quality improvement programs that include reducing adverse events and other problems **[C]**. Meetings to review outcomes must be held and documented no less than every six months. Each practice should consider a policy on apologies to patients for adverse or avoidable events.
	Education	Physicians must have completed an accredited post-graduate training program appropriate to the procedure performed.
	Hospital affiliation	Physician practices performing office-based surgery using moderate sedation or analgesia, deep sedation or analgesia, or general anesthesia must have the following: • Admitting privileges at a nearby hospital or a transfer agreement with another physician who has admitting privileges at a nearby hospital. • A current emergency transfer agreement maintained with a nearby hospital.
	Monitoring and resuscitation	Anesthesia providers must keep current credentials in advanced resuscitative techniques (e.g. ACLS, ATLS, PALS) appropriate to the types of services rendered. Post-anesthesia care unit RNs should demonstrate competency in advanced cardiac life support. The site must have immediately available age- and size-appropriate monitoring and resuscitative equipment. Trained personnel must remain present until patient has met criteria for discharge from the facility. Other medical personnel with direct patient contact should at a minimum be trained in basic life support.
	Anesthesia administration	Anesthesia providers administering or supervising moderate sedation or analgesia, deep sedation or analgesia, or general anesthesia should have appropriate education and training in the selection, administration and recovery from anesthetics. Deep sedation or general anesthesia must be performed by either an anesthesiologist, or properly supervised certified registered nurse anesthetist or certified anesthesiologist assistant **[D]**.

[1] Level III office surgery involves or reasonably should require the use of general anesthesia or major conduction anesthesia and preoperative sedation. This includes the use of intravenous sedation beyond that defined for level II surgery; general anesthesia with loss of consciousness and loss of vital reflexes with probable requirement of external support of pulmonary or cardiac functions; and major conduction anesthesia, epidural, spinal and caudal. (See asahq.org.)

[2] ASA Physical Status Classification System: P3 - A patient with severe systemic disease

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core principles. It is based on the American Medical Association's The physician's guide to patient safety organizations, 2009 (ama-assn.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Opportunities

- The reach of the MSA
- Harnessing the downstream power of resident education
- Partnering with other organizations (MANA, AORN, MSMS, MPA)
- Partnering with medical schools (OU, UM, Wayne, CMU, WMU, MSUx2)

MPOG
MULTICENTER PERIOPERATIVE OUTCOMES GROUP

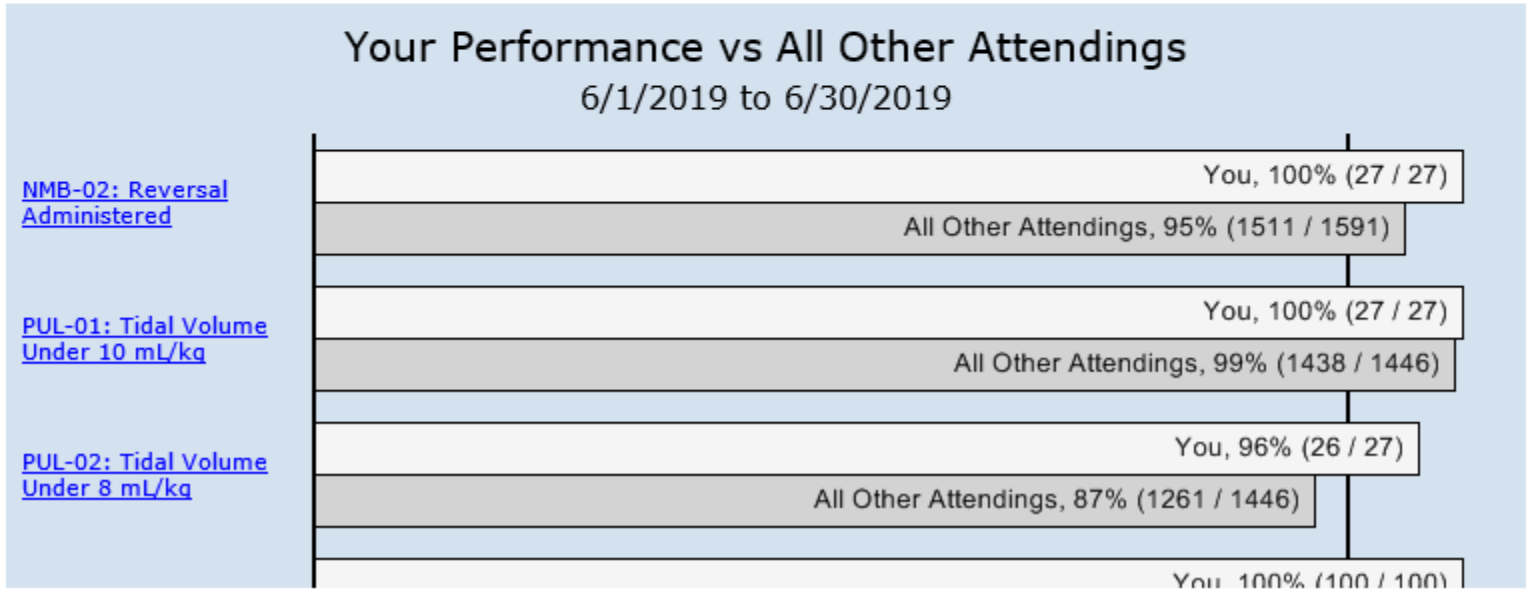
Claim MOCA® Credit

Hello ROY,

Below is your new MPOG Quality performance report. For a case-by-case breakdown of each measure's result, click on the graph's label and you will be taken to our reporting website (login required).

If you have any questions, please read our FAQ or send them to Kathryn.Louzon@beaumont.org. Thank you for your participation in MPOG Quality.

Sincerely,
The MPOG Team



PRESIDENT'S MESSAGE

Roy G. Soto, M.D.
President, Michigan Society of Anesthesiologists
Nirav Shah, M.D.
Quality Improvement Director,
Multicenter Perioperative Outcomes Group

ANESTHESIA QUALITY:

MSA/ASPIRE Collaboration to Improve Michigan Patient Safety

The leaders of the MSA and ASPIRE are excited to announce a new collaboration between the two organizations. The goal is to improve anesthesia quality in the state by providing MSA members with education and benchmarking that has not previously been available to non-ASPIRE members.

WHAT IS HEALTHCARE QUALITY?

HISTORY OF QUALITY INITIATIVES

If we want to track our performance, we have two choices…measure the processes (e.g. how often are we prophylaxing against PONV) and measure the outcomes (how often do our patients develop PONV). These process and outcome measures can be difficult to collect, analyze, and interpret, and various organizations have taken different approaches towards tackling this problem.

ASPIRE FEATURED MEASURE: PUL 02

Nirav Shah, M.D.
Program Director, ASPIRE

Katie Buehler, RN, MS
Clinical Program Manager, ASPIRE

INTRODUCTION

ASPIRE (Anesthesiology Performance Improvement and Reporting Exchange) is a national anesthesia quality improvement collaborative that includes 21 sites across Michigan. Michigan-based sites are a core component of ASPIRE and make up almost 1/2 of all participating sites.

A total of 24 measures make up the ASPIRE database. This is the first in a series of articles that share quality improvement initiatives from

RESULTS

The first graph (Figure A) reveals c
with PUL 02. Each bar represents
participating clinical site/hospital a
ranked from highest to lowest (and
for this article). The goal for this a
ASPIRE measures is 90% complian
currently only one center reaches t
second graph (Figure B) demonstra
improvement in measure complian
since data collection began.

Anonymized Performance for PUL 02 Across ASPIRE sites in Michigan

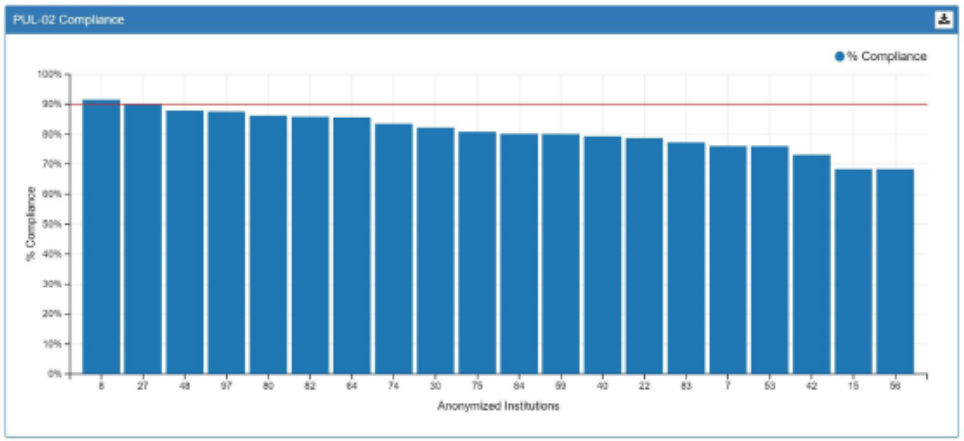


Figure A. Across all ASPIRE sites in Michigan, performance varies from approximately 50 – 90%. Goal performance for this (and most other ASPIRE measures) is greater than 90%.

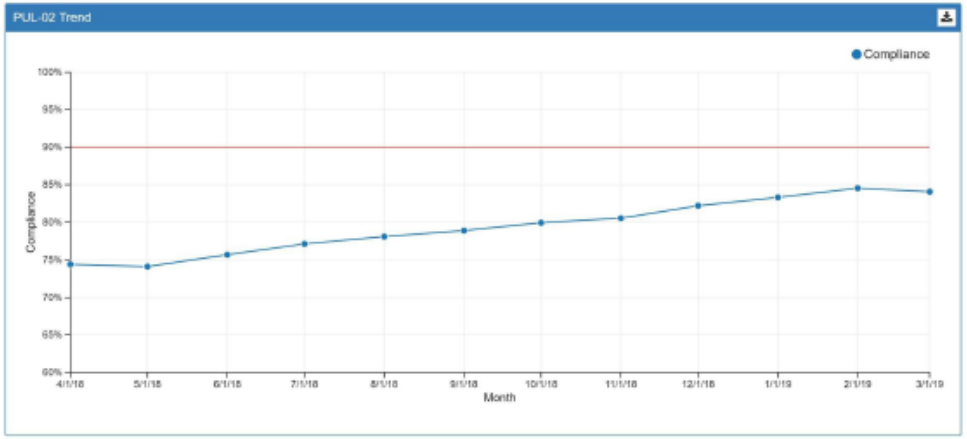


Figure B. Performance trend over the last year for ASPIRE sites in Michigan.

Challenges

- Non-Participators
- Role modeling
- Innovation overload
- Money money money
- Resources
- Dissemination of Information

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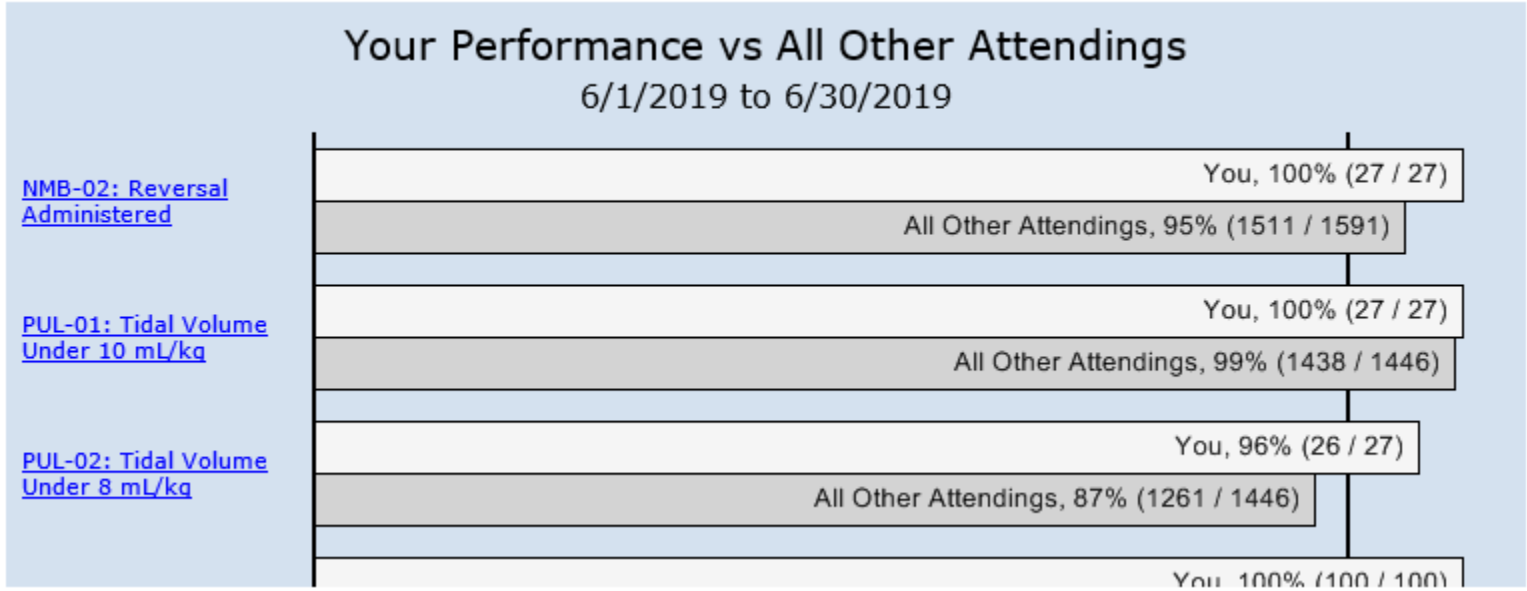

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8:00 a.m. – 8:55 a.m.	**Registration and Breakfast**
8:55 a.m. – 9:00 a.m.	Welcome Tory Lacca, MBA Program Manager
9:00 a.m. – 9:50 a.m.	Michigan Opioid Prescribing Engagement Network (Michigan OPEN) Chad Brummett, MD Michigan OPEN
9:50 a.m. – 10:40 p.m.	Using Machine Learning to Understand Acute Kidney Injury in the Perioperative Setting Karandeep Singh, MD, MMSc Michigan Medicine
10:40 a.m. – 11:00 a.m.	Break
11:00 a.m. – 11:20 a.m.	Implementing Blinded Record Index across ASPIRE ASPIRE Coordinating Center Michigan Medicine
11:20 a.m. – 11:40 p.m.	Michigan Society of Anesthesiologists as a Vehicle for Quality Improv Roy Soto, MD Michigan Society of Anesthesiologists President
11:40 a.m. - 12:00 p.m.	ASPIRE Update Katie Buehler, MS, RN, CPPS ASPIRE

Questions/Discussion?