

ANESTHESIA NEWSLETTER



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Web site address: <http://www.uth.tmc.edu/anes/> Anne Starr, Editor

Chairman's Corner

1. There are new charge sheets which include the transport ventilator circuit on the forms. Please remember to check this off when using a transport ventilator. Also, do not forget to check off the Troop Elevation Pillow, if used.
2. Congratulations for a job well done during our JCAHO visit! ! We are continuing to make improvements regarding compliance issues which pertain to our drug cassettes and room set-ups.
 - a. There are now plastic bags which are stocked with necessary medications that will be used for all outside locations. Pedi trays will continue to be used for pedi outside locations. We will soon have similar trays for the adult cases in lieu of the plastic bags.
 - b. The OR is considered a secured area and the level of activity is high until 7 p.m. After 7 p.m. and on the nights & weekends, when the level of activity is low (we hope, anyway), we cannot leave any cassettes out. We will use the pedi trays that are stocked with medications similar to the bags in our outside locations.
 - c. You can get syringes and draw up your medications, but you must lock them in the top drawer of the cart, along with the drug tray, when you are not present in the room. You cannot leave any controlled substances (BZs, narcotics) drawn up and in the cart. They must always accompany you. If you are in a room, you may put them on the top of your cart or in the top drawer.
 - d. OB will utilize the drug trays and keep them locked up in the top drawer, along with drawn up medications, at all times.
 - e. HVI will use their regular HVI cassettes and after 7 p.m., these cassettes will be stored in a locked area.
3. A new method system is going to be established ("big brother, big sister") in which all residents will be mentored. If you are interested in being a mentor to members of the CA1 class, please let your chiefs know. Rebecca Carroll is in charge of

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this project.

4. If you have not yet picked up your jackets, please do so and give your scrub sizes to Arlene Rust.
5. There will be many changes made in the Anesthesia Clinic, some of which will begin this month. The Clinic Resident will need to:
 - a. Wear professional clothes under your white coats (button down shirts & tie preferred for men). You should bring a pair of scrubs and keep in your locker just in case you are called to the OR.
 - b. Check in with 892 each a.m. before lecture Tu-Th and before 7 a.m. Mon. & Fri. to ensure that you do not have any other responsibilities.
 - c. Staff the clinic 7:30 am until clinic finishes (average end time 3:30-4:30), unless relieved by faculty or resident. Your faculty will relieve you for lunch. You will not be relieved for a coffee break. Please make sure you *(Chairman's Corner cont. on pg. 2)*

2009 Seniors



Residency Director's Corner

By Mary Rabb, M.D.

1. Our site visit results are in. We have full accreditation with a 3 year cycle! Thank you to all of the residents who have filled out their case logs for me every 3 months, as well as ALL of the goals and objectives the residents reviewed and signed. We must keep up these efforts. Also I want to say thank you to Drs. Hagberg, Pivalizza and all of the faculty for their hard work.
2. MD Anderson Cancer Center has discontinued the on call meal ticket program for the residents
3. Congratulations to the following residents for scoring >75 percentile on the recent ITE! These residents will receive an additional \$500.00 award. Keep up the hard work.
>90th Percentile
 Lance LaFleur, David Leiman, Supriya Prabhu, Srikanth Sridhar, and January Tsai
75th Percentile – 89th Percentile
 Lisa Caplan, Brandon Fields, Sam Gumbert, Shannon Hancher, Reginald Hence, Brad Keneson, Omonole Nwokolo, Olga Pawelek, Scott Roethle, and Christopher Strouse
4. Case logs are due every 3 months. Please submit initials of the patient, along with the case type for verification of the cases. The next set will be due July 1, 2009.
5. In preparation for a new Anesthesiology Case Log System that will go into effect on July 1, anesthesiology residents are encouraged to complete a tutorial on the new system. The tutorial can be accessed at this link: <http://www.acgme.org/residentdatacollection/documentation/tutorials.asp>. You are encouraged to use the online tutorial so you can practice using the new system.
6. The banquet is set for June 20, 2009. Please make plans to attend. It will be a blast.
7. Currently I am working on the rotation assignments for the next year. Please be patient a little while longer. I am almost finished!!

"We have full accreditation with a 3 year cycle."

Chairman's Corner cont.

- d. Review educational materials for the clinic on the blackboard prior to starting the rotation.
- e. Will not take weekday call during their 2 week clinic rotation. You will only have a B/U for Fri or Sat calls on this 2 week rotation. You cannot take vacation during this rotation.
6. The new resident relief system appears to be working. One change that will begin this June is that the Tues Call Team will serve as the Friday lates.
7. The PACU rotation will be more organized under the direction of Dr. Ken Hiller. There is a new quality assurance sheet that will need to be completed for every case. The PACU resident will perform the final patient assessment and complete this form (see attached on page 6). This form will need to be returned with the billing records.
8. We will begin to rotate one Acute Pain and one Chronic Pain resident at MHH, effect July 1. Dr. Krishna Boddu will be the Director of Acute Pain Service and Dr. Syed Nasir will be the Director of the Chronic Pain Service.
9. More information has been obtained for anesthesia start time. It is not as black and white as first thought. Since both the preoperative evaluation and routine transport of patients is built into our base units, we cannot charge for time taken in these efforts. Nonetheless, if your patient receives premedication or you begin monitoring your patient, your continued presence until time in the OR can be billed, as long as there is documentation on the anesthetic record.
10. Finally, keep up your hard work and efforts!! The Anesthesiology Department is doing well in regard to its efficiency measures, with the exception of anesthesia transports. Dr. Steve Koch and Dr. William Daily continue to work with Tom Flannigan to improve this process. Stay tuned.

"There will be many changes made in the Anesthesia Clinic..."

Political Corner

By Evan Pivalizza, MBChB

1. National: Leaders in Washington have set a target date for House and Senate passage of respective 'health care reform initiatives' by August. Round-table discussion topics have included delivery system reform, health insurance coverage and health reform financing. Two options papers, 'Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans, and "Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs' from these discussions have been released (available at www.ASAhq.org). ASA leaders and representatives continue involvement in every step of the process. They have expressed concern to our legislators about physician reimbursement elements of a "public plan option" as ANY link to current Medicare payment structure (facing a 21% payment reduction by 2010) is not sustainable and will harm patient access to care.
2. State: Among the last minute flurry of bills is a carefully negotiated bill with TMA and retail health clinics that has a potentially dangerous

rider attached for advance practice nurses (APNs) to use as a vehicle to grant them the authority for independent practice (hope you all responded to your Senators). Retail health clinics were designed to give patients access to fast, convenient, and affordable health care. However, since the clinics are staffed by APNs or physician assistants (PAs), they do not provide the same level of care as physicians' offices, urgent care clinics, or minor emergency centers. TMA's primary concern is on patient safety and supports an integrated care model, where APNs and PAs are appropriately supervised by a physician, refer the patients back to their regular physicians to ensure continuity of care, refer patients appropriately for additional or follow-up care, and practice within their scope of practice.

For health insurance, many positive bills are still moving, including transparency of the information and products provided by health insurers as well as settling disputes for out-of-network facility-based (that's us) physician claims.

"Many positive bills are still moving, including transparency of the information & products provided by health insurers..."

Coding/Billing Issues

By Shirley Hillman

ANESTHESIA TIME REPORTING

Quoted from the CPT 2009

Professional Edition by the AMA.

"Anesthesia time begins when the anesthesiologist begins to prepare the patient for induction of anesthesia in the operating room (or in an equivalent area) and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient maybe safely placed under postoperative supervision." After much controversy and research, we must now all agree what is going to be standard of practice for our group.



Billing for routine care is considered double dipping, according to the Medicare Carrier Manual. **National Correct Coding Initiative (NCCI)** specifically lists transport of the patient as a bundled service in the base units. We will use - in the OR as our anesthesia start time due to the fact we are not supposed to charge

time for transport. Nonetheless, there are always exceptions, and when there are, the medical necessity must be documented. If you have a combative patient who must be sedated in order to move to him/her to the OR, and you give the patient 2 mg of versed, you have truly begun your anesthesia. It would not be safe to leave the patient. Anesthesia, therefore, would be entitled to bill for this time, but the record must justify the medical necessity. Again, one would not expect this to occur on every patient. Our anesthesia start time for ICU patients would begin when preparing a patient for transport from the ICU, and this is not considered routine care.

"Start time begins when the anesthesiologist begins to prepare the patient..."

Chief Chat

The month of May has been full of news and great events.



As the new chiefs, we would like to continue to thank all the residents and faculty for their support and patients. We are filling some very big shoes but are hopeful we can contribute to the residents' experience at UT Houston.

As we are nearing the end of the year, the seniors are anxiously preparing to leave the program. I know our seniors are well trained, knowledgeable, and can handle anything that comes into an operating room. We will miss their companionship and their leadership.

The new CA-1s can look forward to changes to our didactic program. We will be integrating simulation training into the curriculum over the next year. The new CA-1s will take their first steps in the simulation lab during orientation. The curriculum will now incorporate key words and board prep questions in an effort to strengthen our in training scores. Additionally, the interns will now have a month of ENT training. This month will allow residents to become familiar with head and

neck anatomy, basic fiberoptic skills, and will afford residents the opportunity to perform tracheostomies in a controlled setting.

Jack Craig's Kentucky Derby/Crawfish Boil on May 2nd and Rebecca Carroll's birthday pool bash on May 3rd were both a great success. The seniors enjoyed a day at the lake with Dr. Hagberg. Fun, sun, and water skiing were the order of the day. Senior graduation banquet is a couple of weeks away...please submit pictures for the slide show.

We would like to extend our congratulations to Dr. Maheen Wardak's new addition to the department. Zayna Wardak arrived May 20th and weighed in at 6 lbs 1 ounce.

Best wishes,
The UTHSC Chiefs

"This month residents will become familiar with head & neck anatomy, etc. & afford them the opportunity to perform tracheostomies..."

Faculty News

Articles:

Hagberg C, Melnikov V, Scarborough T, Luong K: An evaluation of the rapid airway management positioner in obese patients undergoing laparoscopic gastric bypass or gastric banding surgery. Accepted for publication in Obesity Surgery.

Poster Presentations:

Zhou SF, Estera AL, Ignacio C, Panthayi S, Safi H, Miller C, Sheinbaum R: Platelet Rich Plasma Transfusion Reduces Blood Product Requirements in ascending aortic aneurysm repair with profound hypothermia. Society of Cardiovascular Anesthesiologists Meeting, San Antonio, TX, April 18-22, 2009

FACULTY OF THE MONTH

Chuck Gilmore, M.D. is our faculty of the month. Dr. Gilmore has a great sense of humor, is well organized and is on top of all that is happening at all times!!! He works hard and is a good problem solver. Dr. Gilmore is always available, and he's funny.

RESIDENT OF THE MONTH

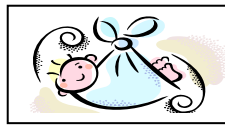
Emily Hamilton, M.D. is our resident of the month. "She did a great job during PACU month. She showed great enthusiasm and had excellent post-op patient care. Dr. Hamilton is a great asset to our residency program.

Announcements

Congratulations!



- To Dr. Tammy Norwood for passing her American Board of Anesthesiology.
- To Dr. Scott Roethle for his appointment as an adjunct member to the ASA Practice Management and to the ASA Educational Track Subcommittee on Cardiac Anesthesia.



Zayna Wardak arrived May 20th weighing in at 6 lbs 1 ounce. Congratulations to Maheen and Aimal Wardak.



Freedom is never more than one generation away from extinction. We didn't pass it to our children in the bloodstream. It must be fought for, protected, and handed on for them to do the same, or one day we will spend our sunset years telling our children and our children's children what it was once like in the United States where men were free.

Ronald Reagan

You and I have a rendezvous with destiny. We will preserve for our children this, the last best hope of man on earth, or we will sentence them to take the first step into a thousand years of darkness. If we fail, at least let our children and our children's children say of us we justified our brief moment here. We did all that could be done.

Ronald Reagan

Attention Faculty & Residents!

All faculty and residents who have broken zippers on your jackets, please return them immediately to Arlene Rust so they can be returned for replacement. The company has now promised a quick turn around.

If you have NOT picked up your jacket, please do so as soon as possible so we can move on to the next project of ordering scrubs. Thank you!

When the conduct of men is designed to be influenced, persuasion, kind unassuming persuasion, should ever be adopted. It is an old and true maxim that 'a drop of honey catches more flies than a gallon of gall.' So with men. If you would win a man to your cause, first convince him that you are his sincere friend. Therein is a drop of honey that catches his heart, which, say what he will, is the great highroad to his reason, and which, once gained, you will find but little trouble in convincing him of the justice of your cause, if indeed that cause is really a good one.

Abraham Lincoln

The best way to keep children home is to make the home atmosphere pleasant--and let the air out of the tires.

Dorothy Parker

"Life's tragedy is that we get old too soon and wise too late." Benjamin Franklin

Please place patient sticker here.

QUALITY ASSURANCE

- o Administration of wrong unit of blood, drug, fluid or dose of drug
- o Aspiration
- o Complication of line placement
- o Corneal abrasion
- o CPR performed
- o Death
- o Delayed emergence
- o Dental damage
- o Drug reaction (adverse, allergic)
- o Dysrhythmia (newly developed)
- o Epidural hematoma and paralysis
- o Epidural wet tap
- o Equipment failure
- o Glucose abnormality (Hyperglycemia >250 mg/dl, Hypoglycemia <60 mg/dl)
- o Hemodynamic significant changes >5 min (SBP>30% above baseline, SBP>30% below baseline)
- o High Spinal
- o Hyperthermic >38° C (uninduced)
- o Hypothermic <35° C (uninduced)
- o Inadvertent extubation
- o Incomplete reversal of muscle relaxant
- o Myocardial ischemia or suspected MI
- o Narcotic overdose; respiratory depression, requiring ventilator support
- o Nasal, lip or mouth bleed or trauma
- o Peri-operative stroke
- o Peripheral nerve injury
- o Post-op blindness
- o Post-op delirium
- o Post-spinal headache
- o Pneumothorax
- o Pulmonary edema
- o Recall of intraoperative events
- o Re-intubation in OR or PACU
- o Respiratory failure (Hypoxemia<90 mmHg and >5 min, Hypercarbia >55 mmHg and >5 min)
- o Seizure
- o Severe post-op pain; pain score >7
- o Severe post-op anemia, less than 5-6 gm
- o Skin lesion (tapes, positioning)
- o Stridor, laryngospasm, obstruction
- o Toxic reaction (vascular injection of local anesthetic or overdose)
- o Transfusion reaction
- o Unexpected admission to ICU (not for surgical reasons)
- o Failed intubation
- o Unnecessary blood transfusion
- o Vocal cord injury
- o Wrong medication or dose administered
- o Other: _____

Comment _____

Attending Physician Signature (PRINT & Sign)

Resident Signature (PRINT & Sign)