STRATEGIES FOR IMPLEMENTING SEDATION POLICIES

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CAPS-RIP?

CONFLICTS

- None
- Currently employed by TeamHealth Anesthesia, a publicly traded practice management company with over 19,000 clinicians in EM, AN, HM, Specialty Care, and Post-acute care.
LEARNING OBJECTIVES

- Identify CMS conditions of participation affecting sedation policies
- Identify key ASA and other standards impacting sedation policies
- Address clinical scenarios
- Understand strategies for implementing policies that focus on patient safety

SPECIFIC CHALLENGES

- Know your organization
- Competing standards
- Deep sedation
- "Outsourced" credentialing
- QA

KNOW YOUR FACTS

- CMS Regulations
- TJC Regulations
- ASA Statements
- Statements from other professional societies
- Pharmacology and Physiology
BEYOND THE FACTS…….

- Facts are important but communication is critical
- Identify your allies
- Define competing interests
- Know your institution’s command structure
- You must show up….

IQ VS. EQ

DO YOU SERVE OR HAVE YOU SERVED AS A DIRECTOR OF ANESTHESIA SERVICES?

1) Yes

2) No
WHO'S IN CHARGE HERE?

THE ROLE MODEL

YOU NEED STRUCTURE

- Committee
- Designated Leader
- Agenda, Minutes
CMS INTERPRETIVE GUIDELINES

- Are issued to provide guidance to organizations as part of the hospital conditions of participation (CoP)
- Are there ground rules that everyone understands?

WHAT DO THE IG STATE?

- The anesthesia services must be under the direction of one individual who is a qualified doctor of medicine (MD) or doctor of osteopathy (DO).
- Anesthesia services throughout the hospital (including all departments in all campuses and off-site locations where anesthesia services are provided) must be organized into one anesthesia service.

ANESTHESIA SERVICES-2009 INTERPRETIVE GUIDELINES
KNOW YOUR ORGANIZATION

- VP Patient Safety?
- Chief Nursing Officer?
- Director of Quality?
- Key Physicians, including anesthesiologists?
- How is ‘Sedation’ organized?

KNOW YOUR ORGANIZATION

- Single hospital?
- Academic medical center?
- Private practice, multiple sites?
- Integrated health system, multiple anesthesiology departments?

REAL LIFE CHALLENGE-MODERATE SEDATION

- An Interventional Dermatologist administers oral midazolam to his patients who are undergoing MOHS procedures and Botox injections. He wishes to be exempt from the privileging requirements of the Minimal/Moderate Sedation policy.
- Anecdotal feedback indicates that some patients become so sedated that they do not remain conscious without strong stimulation.
**ASA GUIDELINES**

- Practice guidelines for sedation and analgesia for non-anesthesiologists
- Standards for basic anesthesia monitoring
- Statement on respiratory monitoring during endoscopic procedures
- Sedation credentials checklist
- QA Indicators
- Statement on granting privileges for administration of moderate sedation to practitioners who are not anesthesia professionals
- Statement on granting privileges to non-anesthesiologists for personally supervising administration of deep sedation
- Continuum of depth of sedation

**WHAT DO THE IG STATE?**

- ......because the level of sedation of a patient receiving anesthesia services is a continuum, it is not always possible to predict how an individual patient will respond.... hospitals must ensure that procedures are in place to rescue patients whose level of sedation becomes deeper than initially intended.... “Rescue” from a deeper level of sedation than intended requires an intervention by a practitioner with expertise in airway management and advanced life support

**OPTIONS?**

1) Continue to require moderate sedation privileging
2) Remove requirement for moderate sedation privileging
3) Split the policy into separate minimal and moderate policies
BENEFITS

- Shines light upon definition, and restrictions, of minimal sedation
- MD responsible for prescribing, management, and supervision
- Separate quality report

DOES YOUR ORGANIZATION HAVE A DEEP SEDATION POLICY?

1) Yes

2) No

REAL LIFE CHALLENGES: DEEP SEDATION

- As the Chief of Anesthesiology, you are asked to review a case in which an ER physician administered 30mg Etomidate for a closed reduction of an ankle fracture.
- The patient experienced a transient decrease in oxygen saturation that required bag-mask manual ventilation for five minutes.
- During the QA discussion, the ER physician states that "we administer this type of conscious sedation all the time"...
ANOTHER ROLE MODEL

“I KNOW IT WHEN I SEE IT”

-Potter Stewart,
US Supreme Court
1959-1981

REAL-LIFE CHALLENGE: DEEP SEDATION

- A traveling RN in the Emergency Room refuses to ‘push’ propofol for a closed reduction procedure. She argues that her RN license does not allow her to administer medications for Deep Sedation.
- As the Chief of Anesthesiology, you are asked for your opinion.

CAN THE RN ADMINISTER PROPOFOL?

1) Yes

2) No

3) Not sure: it depends upon the organization’s policy and/or state statutes
**REAL-LIFE CHALLENGES: DEEP SEDATION**

- Who can “administer” propofol?
- Is administration of propofol de facto “deep sedation”?
- Is a second licensed practitioner necessary for deep sedation?
- What should be the standard for privileges in deep sedation?

**ASA STATEMENTS**

- ASA Statement on safe use of propofol
  - Care should be consistent with deep sedation
  - Non-Anesthesia personnel qualified to rescue from brief general anesthesia

- AANA-ASA Joint statement regarding propofol administration
  - Administered only by those who are trained in general anesthesia and not involved in the surgical or diagnostic procedure

**ASA STATEMENT ON GRANTING PRIVILEGES FOR NONANESTHESIOLOGISTS ON PERFORMING OR PERSONALLY SUPERVISING DEEP SEDATION (2012)**

- Because of the significant risk that patients who receive deep sedation may enter a state of general anesthesia, privileges for deep sedation should be granted only to non-anesthesiologist physicians who are qualified and trained in the medical practice of deep sedation and the recognition of and rescue from general anesthesia.
- Non-anesthesiologist physicians may neither delegate nor supervise the administration or monitoring of deep sedation by individuals who are not themselves qualified and trained to administer deep sedation, and the recognition of and rescue from general anesthesia.
WHAT DO THE IG STATE?

- Because of the potential for the inadvertent progression to general anesthesia in certain procedures, it is necessary that the administration of deep sedation/analgesia be delivered or supervised by a practitioner as specified in 42 CFR 482.52(a).
- Defined as an Anesthesiologist, MD/DO, Dentist/Oral Surgeon/Podiatrist, CRNA, or AA

OTHER PLAYBOOKS EXIST

- Multisociety sedation curriculum for gastrointestinal endoscopy (2012)
  - “Balanced sedation”
- ACEP: Procedural sedation and analgesia in the emergency department (2013)
  - “Minimal, moderate, deep, and dissociative sedation”
  - “ACEP is the authoritative body for the establishment of guidelines for sedation of patients in the emergency setting”
- Monitoring RN is qualified to administer propofol, ketamine, and other sedatives

WHAT DO THE IG STATE?

- .....there is often no bright line, i.e., no clear boundary, between anesthesia and analgesia..... Consequently, each hospital that provides anesthesia services must establish policies and procedures, based on nationally recognized guidelines, that address whether specific clinical situations involve anesthesia versus analgesia.
WHAT TO DO?

- Insist on a second qualified provider
  - ER Staffing is not an anesthesia problem
- RNs do not have the training or medical judgment to administer deep sedation
- Establish privileging criteria for deep sedation

PRIVILEGING CRITERIA-DEEP SEDATION

- ACGME or AOA accredited training program that includes deep sedation training
- Performance of 15 intubations and 15 deep sedation cases within the past 2 years;
- Ability to manage potential complications of deep sedation...may be met through Advanced Cardiac Life Support (ACLS) certification or Pediatric Advanced Life Support (PALS) certification, as applicable.
- Review and recommendation by the Chief of the physician’s respective Department (i.e., ER, Critical Care, Neonatology, Pulmonology) to the Chief of Anesthesiology.

ASA SST DEEP

- Education developed and approved by ASA
- Currently awaiting beta site testing
- Components
  - Didactic Learning
  - Hands-on Mentoring
  - Simulation
REAL-LIFE CHALLENGE: OUTSOURCING PRIVILEGING

- A gastroenterologist argues that he deserves ‘core privileges’ in moderate sedation.
- He has “administered more fentanyl and midazolam than the anesthesiologists”
- He has had no documented complications
- He has had “plenty of airway experience” over the years
- Administration states that the “CRC has criteria for core privileges in Moderate Sedation”

WHAT DO THE IG STATE?

- The regulation…. establishes the qualifications and, where applicable, supervision requirements for personnel who administer anesthesia.
- However, hospital anesthesia services policies and procedures are expected to also address the minimum qualifications and supervision requirements for each category of practitioner who is permitted to provide analgesia services, particularly moderate sedation.

EZ COMPETENCY
+ **EZ COMPETENCY**

- 30" online modules in pediatric, moderate, and deep sedation, and rapid sequence intubation
- Developed by two anesthesiologists in Lincoln, NE
- $10/module
- Hospital assigns modules to the providers; reminders sent until the exam is passed
- Reports sent automatically to the hospital
- “Online and available 24-7. No lost packets!”

+ **HC PRO CREDENTIALING RESOURCE CENTER**

- Access to more than 270 Clinical Privilege White Papers
- Access to 30 core privilege forms
- Benchmarking Reports (including Moderate and Deep Sedation)
- Policy and Procedures Library (including a Conscious Sedation test)

+ **CORE PRIVILEGING FORMS-SOURCES**

- Residency core curriculum requirements from AMA Graduate Medical Education Directory
- CRC Clinical Privilege White Papers
- Position Papers from Medical Societies
- Board Certification Requirements from the ABMS
WHITE PAPER RESEARCH

HCPro, Inc. has conducted high-level research into clinical privileging criteria for over fifteen years through our work with the Clinical Privileging White Papers and the CRC. Our editors have developed a process for developing recommended criteria that brings together extensive research on the clinical nature of the procedure or practice area with the positions of the leading specialty societies and boards involved. We go beyond searching society Web sites to contacting experts within the organizations; and will frequently find that published positions by these expert sources are outdated and undergoing review and rewrite. When that is the case, our editors will work with the society, board, or other organization to obtain the most current position available—often before it is made public.

DISCLAIMER

The sample core privileging forms that follow include a large amount of controversial information—particularly concerning criteria for determining competence for specific specialties and procedures. These forms should be considered sample drafts only—they are not specific or definitive recommendations by the authors.

Before adopting these forms, carefully review and modify them to meet the specific needs and environment of your hospital or healthcare facility. The descriptions of the core, the special procedures, the procedure lists, and the criteria should all be customized to your organization. The forms should be consistent with your organization’s current medical staff or health plan bylaw providing governing the credentialing and privileging processes. Have the forms reviewed by knowledgeable legal counsel to ensure that they comply with relevant local, state, and federal laws and regulations.

WHAT TO DO?

Ask to see the actual White Paper and its sources

Use the White Paper as one source of information, not the definitive privileging document

Emphasize that the ultimate responsibility for privileging lies with the committee and the Director of Anesthesia Services
QA-WHAT DO THE IG STATE?

Finally, it is expected that the anesthesia services policies and procedures will undergo periodic re-evaluation that includes analysis of adverse events, medication errors and other quality or safety indicators related not only to anesthesia, but also to the administration of medications in clinical applications that the hospital has determined involve analgesia rather than anesthesia.

QA PROGRAM?

As Director/Chief of Anesthesia services, I regularly review sedation QA data from other departments

1) Yes
2) No

SEDATION PERFORMANCE IMPROVEMENT

- Patient outcomes and adverse events
- Assess ongoing competence
  - Knowledge
  - Skills
- Peer Review
WHY YOU NEED A STRONG QA PROGRAM IN SEDATION

- Patient safety
- Policy compliance: "Trust and Verify"
- Identify what is working and what is not.

QUALITY METRICS-PROCEDURAL SEDATION

- Volume
  - Type and number of procedures performed
    - Minimal sedation
    - Moderate sedation
    - Deep sedation

- Clinical outcomes
  - Sentinel events
  - Airway
  - Cardiovascular
  - Neurologic
  - Head/Neck
  - Miscellaneous
QUALITY METRICS - PROCEDURAL SEDATION

- Discharge Planning
  - Cases completed, no complication
  - Cases cancelled
  - Unplanned next depth of sedation
  - Unplanned hospital admission or ER transfer
  - Unplanned ICU admission

QUALITY METRICS

- Clearly defined
- Documented
- Reported
  - Home department
  - Department of Anesthesiology
  - Hospital MEC
  - Corporate Board QA Committee
- Accountability

NEW CHALLENGES?

- Requests for “limited privileges in general anesthesia”
- Requests to privilege non-anesthesia midlevel providers in administration of sedation
- CAPS?
CONCLUSIONS

- IQ Important; EQ more so!
  - Know your facts
  - Know what others consider facts
  - Understand the perspectives of non-anesthesiologists
  - Acknowledge areas of dispute
  - Remain humble, but not apologetic
  - https://youtu.be/nfAbTyAcgpE?t=8m45s

THANK YOU

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