MESSAGE FROM THE CHAIRMAN:
-SCOTT T. REEVES, MD, MBA

July 1, 2014; It was an EPIC day!

July 1, 2014 was truly a unique day in the history of the department and institution. It was a day that was over two years in the making as we transitioned to an institution wide electronic medical record system called EPIC Enterprise. Susan Harvey and Larry Field lead a team of faculty, CRNA, and resident EPIC Super Users through our perioperative record build and implementation. All of them did an outstanding job.

July 1 also was significant as it was the first day of the new fiscal year for the hospital. This required a complete download at midnight from our old billing program, Keane, for a transition to EPIC by 6 am. Our new CA 1 residents had been in the department for a month undergoing our robust educational programs (lectures, simulation, being buddied with a senior resident plus EPIC training) in preparation for July. However, on July 1st they were solo with a new anesthesia record system. PRICELESS!

The whole department underwent more than eight hours of training plus multiple C ATTS modules in preparation. Cheat sheets were created to hit the highpoints necessary for documentation and billing. Overall it went relatively smoothly. We have now been using the EPIC system for a month and are gradually resolving any bugs. I suspect within a few additional months we will be wondering how we ever did anything without it.

STATE OF DEPARTMENT ADDRESS
BY: SCOTT T. REEVES, MD, MBA

The State of Department address was given by Drs. Reeves and Guldan on July 8, 2014. The department had many accomplishments last year. If you missed the presentation, CLICK HERE to view. (Please view in Mozilla Firefox, unfortunately Tegrity will not work in Internet Explorer).
CONGRATULATIONS DR. LATHA HEBBAR
FOR BEING NAMED THE VICE CHAIR FOR FACULTY DEVELOPMENT

Vice Chair for Faculty Development

• Latha Hebbar, MD

CONGRATULATIONS DR. GEORGE GULDAN
FOR BEING NAMED THE JOANNE CONROY ENDOWED CHAIRMAN
FOR EDUCATION AND LEADERSHIP DEVELOPMENT
WE ARE HONORED TO ANNOUNCE THE FIRST RECIPIENTS OF THE JOANNE CONROY LEADERSHIP DEVELOPMENT SCHOLARSHIPS

Dr. Christopher Skorke

Dr. Michel Sabbagh

Please CLICK HERE to find more information on the Joanne Conroy, MD Endowed Chair for Education and Leadership Development

AAMC MINORITY FACULTY CAREER DEVELOPMENT SEMINAR ON SEPTEMBER 5-8, 2014

This seminar is designed for junior faculty (instructors and assistant professors) who are members of underrepresented racial and ethnic minority groups, and who aspire to leadership positions in academic medicine. The College of Medicine awarded two scholarships this year to attend. Our own Ebony Hilton, MD was chosen. Congratulations!
CONGRATULATIONS MICHELE BALLISTER, CRNA, DNP
FOR JOINING THE AFN AS A NEW FACULTY MEMBER
AND ASSISTANT PROFESSOR

Michele “Micki” Ballister, CRNA will be joining the College of Health Profession's Division of Anesthesia for Nurses (AFN) as a new faculty member and Assistant Professor. Dr. Ballister most recently served as a staff CRNA in the MUSC Main operating room. Micki received her Doctor of Nurse Practice (DNP) degree from Villanova University and has a research interest in simulation education. She has been teaching in the classroom in AFN program since 2010. In addition to responsibilities in classroom and simulation lab instruction, Micki will serve as admissions coordinator for the program. Dr. Ballister will join the faculty on July 21st, 2014 and will be located in the College of Health Professions, office B423.

CONGRATULATIONS TO SCOTT REEVES, MD, MBA FOR BEING ELECTED AS PRESIDENT OF MUSC PHYSICIANS

About MUSC Physicians

MUSC Physicians (MUSCP), formerly known as University Medical Associates, is the physician group of the MUSC Medical Center. MUSCP provides services ranging from prevention and wellness to highly specialized care at outpatient clinics and facilities both on the MUSC campus and extending into the community. MUSCP has the widest range of specialty care available at any medical center in South Carolina.
A Prospective Observational Study of Ethnic and Racial Differences in Neuraxial Labor Analgesia Request and Pain Relief

Sylvia H. Wilson, MD, * Matthew R Elliott, MD, * Bethany J. Wolf, PhD, † and Latha Hebbar, MD, FRCA *

BACKGROUND: As ethnic and racial diversity increases, it is important that anesthesia providers understand the expectations and concerns of this changing population regarding labor analgesia. Our objective was to evaluate ethnic/racial differences in labor analgesia characteristics with regard to the timing of request for neuraxial analgesia.

METHODS: Three hundred ninety-seven parturients were enrolled in this prospective observational cohort study. Term laboring parturients who planned vaginal delivery and requested neuraxial labor analgesia were eligible for inclusion. Data collected included cervical dilation at the time of neuraxial analgesia request, self-identified ethnicity/race, parity, education, insurance status, pain score before and after the initiation of neuraxial analgesia, and mode of delivery. The primary outcome was cervical dilation at the time of neuraxial analgesia request. Ethnicity/race classification was determined by asking the patient, “How would you define your ethnicity/race?” Patients were categorized into the ethnic/racial groups of non-Hispanic White, African American, Hispanic, or other. Univariate associations between cervical dilation and categorical variables were examined. Multivariate analysis was performed for the primary outcome of cervical dilation at the time of initiation of neuraxial analgesia.

RESULTS: At the time of neuraxial analgesia placement, the mean difference in cervical dilation of Hispanic parturients was 0.8 cm compared to non-Hispanic Whites (95% confidence interval [CI], 0.1–1.4; \( P = 0.047 \)). After controlling for education, reason for placement, labor augmentation, and mode of delivery in a multivariate model, Hispanic parturients had 0.5 cm greater cervical dilation compared to non-Hispanic Whites, which was not significant (95% confidence interval, −0.1 to 1.1; \( P = 0.089 \)).

CONCLUSIONS: Our data indicate that ethnicity/race plays a small role in acceptance and request for neuraxial labor analgesia. (Anesth Analg 2014;119:105–9)

MEET THE NEW CARDIOTHORACIC FELLOWS

Parker Gaddy, MD

Brystol Henderson, MD
MEET THE NEW CRNA CHIEFS

ROBIN BUCHANAN, CRNA
RUTLEDGE TOWER

Robin went to nursing school at Marymount University in Arlington, VA. It was there that she obtained an Associate Degree in Nursing. Then subsequently went to the University of Tennessee and obtained at BS in Biology while working in the ICU. Robin attended MUSC in ’92 to fulfill her goal of becoming a CRNA. She was able to graduate with a Master’s in Health Science with a concentration in Anesthesia, and began working at MUSC in May of ’96.

Robin was one of many healthcare providers that opened up Rutledge Tower as MUSC’s Ambulatory Surgical Center. She feels very honored to be part of a great group of CRNAs and attendings. “I am excited about the future of our department under the leadership of Dr. Carlee Clark, and am looking forward to the challenges associated with the transition into this new roll.”

MARIANNE FIUTEM, CRNA
ASHLEY RIVER TOWER

The current chief, Jodi Weber, has decided to step down from her position and enter back into staffing here at ART. We are excited to have another excellent CRNA here on staff with us. Marianne is honored to have been chosen as the Chief Nurse Anesthetist at Ashley River Tower. She graduated from MUSC’s Anesthesia for Nurses’ Program in August 1999 and has been a CRNA here at MUSC since September 1999. In 2008, she came over to Ashley River Tower when it opened. Working in a brand new building from the day it started accepting patients was quite the learning experience. That shared experience contributed greatly to the cohesiveness of the group that we have here at ART today, and the progressive restructuring of our department has been very impressive.

Marianne believes it has created more of a team atmosphere here in our anesthesia department. She looks forward to working with Dr. Clark, Robin, Heather, and of course, my colleagues here at ART in this leadership role. Marianne is dedicated to continuing the excellence that has been established here in our anesthesia department at MUSC.
WELCOME THE NEW PAIN MANAGEMENT NURSE
CATHERINE TORRANCE, RN

WELCOME THE NEW PRE-OP CLINIC NURSE
SARAH AYERS, RN
The ASE annual meeting was well represented by Alan Finley, MD, vice chairman elect for the Council on Perioperative Echocardiography and Scott Reeves, MD immediate past chairman. The meeting had over 2,000 participants from the fields of cardiac sonography, cardiology, CT surgery and cardiac anesthesiology. The following lectures were given:

Alan Finley, MD
- **Special considerations for quantifying mitral regurgitation in the operating room**

Scott T. Reeves, MD
- **Bedside FOCUS examination: Value in the perioperative period**
- **Pre-bypass findings that alter the surgical approach**

For the past three years, the CT surgery program has been participating in an AHRQ funded, patient safety trial with Johns Hopkins called the Cardiac Surgery Translational Study. Yesterday I received this award in the mail from Peter Pronovost and the Hopkins group. Despite misspelling our university name, it speaks to the high quality of care that we deliver on a daily basis. The total number of months without a central line infection in the CTICU was over 36 months - a feat I never would have thought possible 5 years ago. Congratulations to everyone. This is an amazing team accomplishment.

Jake Abernathy, MD
SOCIETY OF PEDIATRICS SEDATION MEETING
BY: DR. JAKE FREELY

On May 19-21, 2014, The Medical University of South Carolina and The Society for Pediatric Sedation jointly sponsored the annual pediatric sedation conference. This year’s meeting was entitled: Great Expectations: Forging A Culture of Safety & Quality in Sedation Practice. The SPS mission is to promote safe, high quality care, innovative research and quality professional education. This year’s conference showcased the “culture” that is being fostered at MUSC to a multidisciplinary audience through a focus on innovative technologies, quality assessments and evidence based advances in the practice of pediatric sedation.

Michel Sabbagh, MD and Jake Freely, MD presented at the Advanced Airway Workshop. This helped familiarize our non-anesthesia colleagues with rescue airway devices like the LMA. They instructed them on better techniques of bag-mask ventilation in children. Scott Walton M.D. led a multidisciplinary panel discussion on “Interesting Sedation Cases.”

The highlight for MUSC and our department was exposing the national audience to the capabilities of our simulation center and the pediatric sedation course that is currently being developed in conjunction with John Schaefer M.D. and our Pediatric ER and PICU colleagues. Many of the conference’s participants spent a full day at the simulation center as part of the SPS Sedation Provider Course.

PEDIATRIC CARDIAC PROGRAM # 30 IN NATION!

I am proud to inform you that once again The Children’s Heart Program of South Carolina has been ranked amongst the nation’s best pediatric cardiology and heart surgery programs by US News and World Report. This year we are ranked #30. This is the 7th consecutive year that we have been ranked; each and every year that pediatric specialties have been reported. Although the scoring methodology changed this year to concentrate less on cardiology specific metrics and more on overall hospital safety and quality metrics, you can take great pride that our outcomes remain some of the best in the country.

I would like to highlight one metric that in particular illustrates the positive growth of our program. When the pediatric subspecialty rankings were first reported in 2008, our program had a reputation score of 0%. We were literally the best program that no one had ever heard of! Due to the hard work of all of you, we are now well known. Our reputation score has improved every year and is its highest yet this year at 11.2%; the 15th highest in the country. This recognition would not be possible without the unique collaboration that our statewide team demonstrates on a daily basis. You all play an integral and valuable part in this team that provides world-class cardiac care for all of the children of South Carolina.


With sincere gratitude,
Andy Atz, MD
Chief, Pediatric Cardiology
Safe OR to ICU Transitions Require Attending Physicians to ENGAGE

"Drop ‘em off over there, we’ll see ‘em on rounds later this morning." This was what you’d often hear when handing off a patient from the operating room (OR) to the intensive care unit (ICU) in 1992. Sometimes the patient would become unstable prior to any physician from the ICU team evaluating the patient. Many times that scenario did not come out well for the patient. Come with me now to 2014.

The practice of pediatric anesthesia and pediatric surgical care requires continual vigilance to avoid harm to our patients. Accidents, oversights, malfunctions, miscalculations, diagnostic errors, technical lapses, undiagnosed co-morbidities, anatomic variants, transfusion reactions and drug reactions are but some of the many sources of risk to our patients’ safety during surgical and anesthesia care. In addition to those, miscommunications and poor communication can easily lead to patient harm during surgical procedures requiring anesthesia.

This newsletter focuses on the transitions most likely to harm our patients when there is poor or miscommunication. That transition occurs when the patient leaves the operating room in transition to the intensive care unit. ICU in this article implies PICU, PCICU, and NICU.

Until recently at MUSC, the OR to ICU transition was considered a mundane task and an attending physician was not always present or involved in the handover of care. Current patient safety literature indicates that this handover of care is critical to patient safety. The current emphasis on safe care and avoidance of preventable complications requires that the anesthesia attending, the surgical attending, and the ICU attending be engaged, attentive, and physically present during these handovers. When possible, the transition of care should be performed face to face by the attending physicians themselves. The perfect execution of the handover leaves the ICU team completely informed and abreast of the freshly arrived patient’s situation with care plans mutually discussed and agreed upon.

There are different ways to ensure a proper handover occurs. We wanted to let you know that as part of a new initiative, we at MUSC Children’s Hospital are engaging all parties involved to deliver OR to ICU handoffs in a consistent, “best practice” method.

The handover is an opportunity to “tell the story.” Tell the story of the patient, the story of the disease process, the story of the surgical procedure and the story of the anesthesia care. With all stories, people are naturally inclined to listen to enthusiastic story tellers. Once the surgeon and anesthesiologist have given their part of the story, the intensivist gets to summarize the important parts and plan where the story will go next. When all the storytellers are satisfied that everything important has been discussed the handover is complete.

Some attending physicians have said “I can’t always be there because I am too busy.” There will occasionally be unavoidable conflicts in which the attending must weigh the risk in being present for one patient and not another. Thankfully these conflicts that compromise patient safety are rare. The OR to ICU handover should be considered a high priority patient “safety event.” Like any critical patient event, the attending physician needs to be present and engaged.

“I can have my resident do that” is another common reason attending physicians believe their presence is not needed at the OR to ICU handover. It is true, our residents and fellows do need to learn this critical skill. But, first the resident or fellow sees it done properly by the attending staff and then they can begin performing the OR to ICU handover under the attending physician’s supervision.

A virtuous cycle: Attending physicians engage in handovers → ICU patients have a safer and smoother course → Residents see value in handovers → Attention to and enthusiasm for handovers is practiced widely at MUSC and subsequently wherever our alumni go to practice → Primum non nocere by being engaged in handovers!
MUHA AND DEPARTMENT OF ANESTHESIA AND PERIOPERATIVE MEDICINE FY 2015 GOALS

Each year the department jointly develops a set of performance goals with the hospital. Our metric for FY 15 is below. Together we can do great things, and look forward to the department achieving all of them.

<table>
<thead>
<tr>
<th>Weight</th>
<th>20%</th>
<th>15%</th>
<th>5%</th>
<th>20%</th>
<th>20%</th>
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<tbody>
<tr>
<td>Target: Patient Satisfaction</td>
<td>Physician Satisfaction</td>
<td>Teamwork</td>
<td>ERAS</td>
<td>NORA expansion</td>
<td>Anesthesia InRoom Start Times</td>
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| Goal: Maintain or improve the mean patient satisfaction score for the 2 survey factors in which Anesthesia has significant control or influence (1. Anesthesia Provider showed concern and sensitivity to my needs and, 2. Anesthesia provider explained my anesthesia in a way I could understand). All do not perform at the four star level (1 standard deviation above the mean). Achieve a Physician Engagement score of 4.06 for FY15 in areas of responsibility. Achieve a Teamwork composite score of 3.0. Implement ERAS protocol for ENT / Colorectal / Pancreas. Expand the number of NORA locations by two sites (3 ART, 1 UH) in order to reduce backlogs of DDC and radiology patients respectively. Achieve an average of 85% compliance with 1st case start times for Anesthesia faculty. |

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<th>Rating Ranges:</th>
<th>5 ≥ 97.00</th>
<th>5 ≥ 4.16</th>
<th>5 ≥ 4</th>
<th>5 = September 2014</th>
<th>5 = September 2014</th>
<th>5 ≥ 95</th>
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<td>4 = 95.15 - 96.99</td>
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<td>4 = 3.5 - 3.99</td>
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<td>4 = November 2014</td>
<td>4 = 90 - 94.9</td>
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<td>3 = 91.94 - 95.14</td>
<td>3 = 4.06 - 4.1</td>
<td>3 = 3.0 - 3.49</td>
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<td>2 = 90.26 - 91.88</td>
<td>2 = 4.01 - 4.05</td>
<td>2 = 2.5 - 2.99</td>
<td>2 = March 2015</td>
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<td>2 = 80 - 84.9</td>
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<td>1 = 4</td>
<td>1 = 2.49</td>
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<td>1 = 79.9</td>
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<td>Final Rating Based On:</td>
<td>Average</td>
<td>Last Observation</td>
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<td>Last YTD rate</td>
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DR. CHARLES WALLACE’S RETIREMENT CELEBRATION

[Image of Retirement Invitation]

Dr. Charles Wallace

Retirement Celebration

For Dr. Charles Wallace

August 5, 2014
5:30 PM – 7:30 PM
Upstairs at Halo
470 Ashley Avenue

Please join us to honor Dr. Wallace in recognition of his 41 years of service 1973-2014.
DEPARTMENT WEATHER EMERGENCY STAFFING

During weather emergencies, the Rutledge Tower ambulatory surgery facility will be closed to surgical procedures. The University Hospital Operating Room will be staffed by the following members of the Activation Team (designated, essential personnel) if it is a Category 1, 2 or 3 Hurricane

**Faculty**: Two faculty scheduled to cover the date of the anticipated Weather Emergency (Step 3 above) will be assigned in house call.

- If the scheduled in-house call attending is pediatric capable (peds, peds CT) then the second in house attending will be the **Bold 1** faculty.
- If the in house call attending is **not** peds capable then the second faculty in house person will be determined by the following order. The first available pediatric capable faculty will assume the in house duty.

**Bold 1**(peds, peds CT,)

**Bold 2**(peds, peds CT,)

**Peds**

**Residents**: The designated CA 3, CA 2, and CA 1 call residents plus the late CA 1 and liver call resident scheduled for duty on that date will also come in house.

**CRNAs**: The scheduled 24 hour call CRNA. A second 24 hour CRNA volunteer will be designated. The Chief CRNA will make this determination during the Step 1 (weather watch) planning stage.

**Anesthesia Technicians**: Two anesthesia technicians will remain in the hospital commencing with Step 3 conditions. These individuals will be named by the Anesthesia Technician supervisor from anesthesia tech “Team A” during the Step 3 planning phase.

If the hurricane is a class 4 or 5 storm, in addition to the above:

- The in house attending, bold 1 and bold 2 attending will be in house (1 of the attending has to be a general peds or peds CT attending)
- Residents remain the same
- A third 24 hour CRNA volunteer will be designated.

The Ashley River Tower Operating Room will be staffed by the following members of the Activation Team (designated, essential personnel) if it is a Category 1, 2 or 3 Hurricane:

**Faculty**: The cardiothoracic anesthesia and critical care attending scheduled to cover the date of the anticipated Weather Emergency (Step 3 above).

**Residents**: Upper level ART on call (can not also be assigned at the University Hospital). The MSICU night float residents on call will also report for duty.

**CT and Critical Care Fellow**: The on call CT and Critical Care fellows will stay in house. If no CT or Critical Care fellows are assigned on call, one of the fellows will be assigned as determined by the CT and CC Fellowship Program Directors.

**CRNAs**: The late CRNA will stay in house. The Chief CRNA will make this determination during Step 1 (weather watch) planning stage.
Anesthesia Technicians: One anesthesia technician will remain in the hospital commencing with Step 3 conditions. This individual will be named by the Anesthesia Technician supervisor from anesthesia tech “Team A” during the Step 3 planning phase.

If the hurricane is a class 4 or 5 storm, in addition to the above:

- In addition to the CT attending and critical care attending, the general attending will also come in house
- Residents and fellows remain the same
- A second 24 hour CRNA volunteer will be designated.

After the “all clear” notification is made and “return to work” is mandated via the website or above telephone call line, the recovery team (call teams) is expected to return to the hospital to relieve the Activation Team.

Please Click Here for Full Department Hurricane Plan
2014 DEPARTMENT CELEBRATION AND RESIDENT WELCOME PARTY AT BLACKBAUD STADIUM
2014 DEPARTMENT CELEBRATION AND RESIDENT WELCOME PARTY AT BLACKBAUD STADIUM
GRAND ROUNDS FOR THE MONTH OF AUGUST

“Cardiac Medically Challenging Case Conference”
August 5, 2014
Jake Abernethy, MD, Associate Professor
Ryan Gunselman, MD and George Guldan, MD,
Assistant Professors
Medical University of South Carolina

“Update on AICD’s/Pacemakers”
August 12, 2014
Eric Nelson, DO
Assistant Professor
Medical University of South Carolina

“Adult Congenital Heart Disease for Non-Cardiac Surgery”
August 19, 2014
Ilka Theruvath, MD
Assistant Professor
Medical University of South Carolina

“Review of Basic and Advanced TEE Guidelines”
August 26, 2014
Scott Reeves, MD, MBA
Professor and Chair
Medical University of South Carolina
I HUNG THE MOON

Don’t forget to nominate your co-workers for going ‘Beyond the Call of Duty’. I Hung The Moon slips are available at the 3rd floor front desk, and may be turned in to Kim Crisp. Thanks so much!!

Hercules Brown, Anesthesia Tech: Being a great team player during a busy day! Great Job!

Ray White, CRNA: Explaining epic to his co-workers. Learned so much in just 30 minutes.

Kim Warren: Thank you for taking care of all the non-clerical staff that allows us to do our job! Make my life so much easier!

Kyle Comley, CRNA: Volunteering his down time to help with a cardiac patient that received a non-cardiac procedure. Your expertise was greatly appreciated.

Amy Leatherman CRNA: Excellent and professional assistance entering all details of a very busy trauma case. Great job with Epic!

Dr. Charles Wallace’s Retirement: August 15, 2014, 5:30-7:30 at Upstairs Halo

Christmas Party: Friday, December 12, 2014 Carolina Yacht Club at 7:00pm

We Would Love to Hear From You!
If you have ideas or would like to contribute to Sleepy Times, the deadline for the August edition will be August 25, 2014.