Needs Assessment Survey
Anesthesia Assessment Center

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The Anesthesia Assessment Center (AAC) sponsored the Anesthesiology Needs Assessment survey which was conducted December 2011 through January 2012. The purpose of this evaluation was to ascertain the most preferred methods of patient information received by MD Anderson colleagues from the AAC. The on-line survey was distributed to 136 clinical faculty and staff in the field of anesthesiology in order to better understand the importance of lab evaluations and medical status assessment of patients in order to make AAC services more efficient for faculty, staff, and patients. A total of 82 completed the survey, resulting in a response rate of 60.3%.

Concerning lab evaluation and medical status assessments of patients, just over half (53.8%) of respondents indicated that 1 month should be the preferred amount of time for a blood draw to be considered current. Also 74.7% signified that 1 to 3 months should be the most preferred time period for the AAC to consider a pre-operative evaluation as valid if the patient’s medical status has not changed.

When asked what procedures the AAC should define as major, the most often cited was thoracic procedures (97.5%), followed by craniotomy (91.4%), and airway cases (81.5%). Respondents also indicated that the most determining factor for drawing lab test should be the patient’s previous medical history (97.6%), then type of case (87.8%), followed by age of patient (62.2%). Regarding the age range that the AAC should draw the specified lab tests of BUN, CBC, creatinine, electrolytes, glucose, PT/PTT/INR, and other, a large majority (90.9%) of respondents signified that the patients should be at 19 years of age before drawing lab tests. Over half indicated that those aged 19-60 years should have the glucose (55.2%) and PT/PTT/INR (52.8%) conducted, while for those over 60 years, more than half revealed that the BUN (53.5%) and creatinine (53.3%) tests should be administered. Concerning coagulation function tests, 41.9% signified that any patient on anticoagulants should have them documented prior to the day of surgery. Respondents were also asked what type of patient cases could be exempt from having a type and screen drawn, in which the top three listed exceptions were MRIs (91.3%), eye cases (88.8%) and pediatric off site cases (85.0%).

Over 80% of the respondents indicated that information relating to a description or type of prior intubations done at MD Anderson (95.0%) and C-Spine flexion & extension films for all patients with Rheumatoid Arthritis (RA) (80.3%) was a priority for inclusion in AAC documentation. The highest rated area of the AAC was medication list in which 82.2% rated this as very good or good followed by laboratory section (71.2%), while 100.0% of respondents suggested that the inclusion of preoperative evaluation information pertaining to allergies and any list of past medical problems to be very important or important. When asked what patients should be seen by the Internal Medicine Peri-Operative Assessment Center (IMPAC) prior to coming to the operating room, 82.5% noted that a patient who has never been seen at MD Anderson and has multiple co-morbidities, followed by a patient with 3 or more co-morbid conditions (70.0%).

Concerning cardiology assessments for patients with known coronary artery disease/congestive heart failure (CAD/CHF), over half (58.2%) signified that patients with unstable disease/not optimized medically should have a preoperative assessment by MD Anderson Cardiology, while among patients with cardiac stents, 72.2% of respondents indicated that patients with inappropriately managed antiplatelet therapy inconsistent with existing ACC/AHA guidelines should have a preoperative evaluation and be managed by MD Anderson Cardiology.
Of those patients that have a heart murmur, 86.8% of respondents signified that patients that are symptomatic should have an echocardiogram, while among patients with a carotid bruit, 78.2% of respondents specified that patients that are symptomatic should have a carotid Doppler exam administered.

In the area of diabetes, a plurality of respondents (47.5%) suggested that patients with blood sugar levels between 351-500 mg/dl should have elective or semi-elective surgeries delayed. For diabetic patients, 44.4% of respondents indicated that HbA1c levels should be considered current if documented within 3 months. Among patients with thyroid abnormalities, 78.2% of respondents signified that if a patient scheduled for surgery and is hypothyroid and a thyroid function test documented is abnormal, the surgery can proceed if the patient is asymptomatic and on medication. In addition, if a patient scheduled for surgery is hypothyroid and a thyroid function test documented is abnormal, 56.6% of respondents indicated that the surgery can proceed if the patient is asymptomatic and on medication.

When asked about the documents referenced in clinic stations prior to their patients undergoing anesthesia/surgery, 96.3% of MD Anderson staff and faculty indicated that they referenced cardiology consult note, followed by lab procedures/test results (93.8%), and pacemaker check note (92.6%). A majority of respondents specified that the most preferred way for the AAC to notify them would be via Blackberry email (88.6%), then by Blackberry Instant Messaging (IM) at 64.9%. Also, 50.0% of respondents indicated that they would be willing to help evaluate patients for preoperative screening at the AAC.

Those respondents that designated themselves as clinical staff were more likely than faculty to rate higher the performance of the AAC in the different areas of airway evaluation, ASA evaluation section, laboratory section, medication list, and past surgical history. Also, clinical staff were more likely than faculty to agree with the importance of including a listing of surgical history and short synopsis of patient cancer history in AAC preoperative evaluation information. Respondents who had two to five years of experience were more likely than respondents who had eleven to fifteen years of experience to rate higher the performance of the AAC regarding medication list and past surgical history. In addition, those with two to five years of experience were more likely than those with eleven to fifteen years of experience to agree with the importance of including patient’s activity level of functional status, and primary cancer diagnoses in AAC preoperative evaluation information. Within faculty there was one significant difference with assistant professors being more likely that associate professors to consider a patient’s Mallampati score (mall score), as a priority for inclusion in AAC documentation.

The response rate for this survey of 60.3% is not as high as the desired threshold of 70.0%. Having future surveys with 70.0% response rates will allow more certainty to comparisons with the entire population of respondents. The results reveal that over half of the respondents viewed the performance of airway evaluation, ASA evaluation section, laboratory, section, medication list, past medical history, and past surgical history as good, with clinical staff rating these areas higher than faculty. We recommend the continuation of this evaluation so that results can be compared to baseline data in order monitor respondents attitudes and opinions of the Anesthesia Assessment Center.