BIDMC- Milton Anesthesia
New Clinical Staff Orientation

The Hospital
BID-Milton is a community Hospital with approximately 85 inpatient beds and 8 ICU beds, with generally about 80 - 90 ED visits per day. The operating rooms handle about 400 cases a month – usually around 20 cases a day, a large percent of the cases are total joint surgeries, although we also do general surgery, robotics, bariatrics and some urology and gynecology. Like most community private practices many surgeons are pretty fast and efficient – although as with anywhere else we do have some outliers.

Anesthesiologists take call from home – we do not stay overnight. The medical inpatients are covered by the in-house hospitalist service and there are also surgical PAs in house 24 hours covering many of the surgical patients. The PAs are great and help trouble shoot surgical patients – making sure add-ons are ready, taking care of immediate post op issues – kind of like a chief resident in surgery. The ICU is covered by intensivists (including some of our own) doing week long shifts – they are in house 8am to 5pm and take beeper call overnight.

The ORs
There are 6 ORs and a new one due to open in April – so a total of 7 ORs. The Holding and PACU are immediately adjacent – 18 patients slots combined. The ORs have all the usual equipment - anesthesia machine like downtown, glidescopes, mcgrath, and an ultrasound for nerve blocks. Each room has a dedicated pyxis. There is one anesthesia tech (Ramero) from 6:30 to about 3pm – he turns over rooms and stocks equipment – also helps with positioning patients for spinals as well as prone, lateral etc.

Endoscopy Center
There are also 4 endoscopy rooms on a separate floor, we usually cover 3 endo rooms per day – simple EGD / Colonoscopies (8-10 cases/day/room) , and in the next few months we will probably be adding a few bronchoscopy sessions with one of the ICU MDs in the 4th room. There is a central pyxis for propofol. We provide propofol anesthesia – almost never use any other meds – and it’s all boluses, we don’t use pumps.

Care Team Model for Anesthesia coverage:
Anesthesia at Milton is provided using the care team model with Anesthesiologists working with 3-4 CRNAs during the day. All our CRNAs are experienced and dedicated to providing excellent care. Milton has 13 CRNAs who work a variety of days every week, they do not rotate downtown.

CRNAs either work 8 hours: 7 to 3p or 10 hours: 7 to 5pm, usually we need 8-9 CRNAs each day. We try to have at least 3- 4 10 hour CRNAs in the mix each day for the later rooms. Dan Marrigi
is the head CRNA and he does the scheduling for the CRNAs and handles all requests for time of, changes in shifts and other schedule related questions.

The Day
Arrival is 7:00 am, on time start is 7:30 – we usually start 4-6 rooms at 7:30 and then have a staggered start for the joint ortho service – so total 5-6 rooms running from 7:30 to about 3:30 pm. At 3 pm we usually try to go down to 3 rooms (for nursing) – although this will increase to 4 in the next few months. Endo has similar hours with a goal to be ‘done’ in endo by 3:30pm usually averages 25-28 cases/ day if 3 rooms, including addons.

Assignments
The staffing goal is 3 Anesthesiologists and 8-9 CRNAs per day. 85-90% of cur cases are MD / CRNA supervision, occasionally an MD will be solo – but this is not common during regular hours.

2 MDs share coverage for the ORs –usually 3 rooms each, occasionally 4 if we are short a CRNA and need one MD to be solo. The 3rd MD covers 3 endo rooms with CRNAs. We try to avoid having the Endo MD also covering an OR, although sometimes this is necessary.

The On-Call Anesthesiologist ‘runs’ the board with the OR Charge nurse. This is just like downtown – responsible to triage / assign add-ons, watch the turnover time and make sure breaks etc happen. The on-call MD also stays in touch with the Endo team to make sure all going well - sometimes Endo MD needs help with breaks etc depending on the volume and speed of the GI MDs.

There is a daily huddle at 10 am with OR scheduling that includes a 5 day look ahead at the schedule – one anesthesiologist attends. The numbers of rooms can change so it is important to stay on top of this.

Preoperative assessment
There is a PAT clinic with one NP and 2 RNs, about 35 % of surgical patients have an in person visit to PAT with an NP who does the preanesthesia assessment ( similar to downtown), the rest of the patients get a telephone interview with the RN and the preanesthesia evaluation is completed on the day of surgery by the Anesthesiologist. In general all joint replacement, robotic and bariatric patients are seen in PAT – these are our biggest cases.

The OR Anesthesia Record including the Preoperative assessment is a paper triplicate copy record (at the moment). In the Endo suite we use a combination of paper preop and digital reasoning tablet based computer intraoperative record.

Paperwork : On the day of surgery, the Anesthesiologist finishes the preoperative assessment and the consent in the holding area. The MD must sign the consent and the final preop sign out per the hospital by-laws. In general the MD will see their own patients first- but then the 2 OR MDs help each other out to make sure all is completed – for example one attending may be tied
up doing a block or with a challenging patient. The CRNAs will help with the preop if needed but the expectation is the MD does the preop while the CRNA sets up for the first or next case.

Orders : See separate handout on Meditech too
- Post op all patients need online PACU orders on Meditech. Usually after the first wave of cases the 2 OR attendings split the orders. Patients cannot leave PACU without an electronic order so even if patient’s need nothing they still need PACU orders.
- Preop: Before any attending leave for the day the Preop orders should be done. These are done in Meditech – all patients (EXCEPT Bariatric Surgery ) get 650-1gm of po acetaminophen and then some cases will get scopolamine ( e.g. the young laparoscopic or bariatric patients)

Holding Area and PACU
Patients are admitted by the nurses in the holding area – nurses do vital signs, the IV and the usual OR nursing assessment. Patients receive Tylenol +/- scopolamine patch in the holding area ordered the afternoon before by the OR day team.

Blocks : These are done in the holding area. Mostly upper extremity blocks and some ortho surgeons like popliteal blocks too. The assigned Anesthesiologist has the priority for the block but if not comfortable can switch with the other anesthesiologist. We no longer do any blocks for the knee replacement patients. See also surgeon preference and block handout.

Case Mix
Probably 50% of cases are orthopedic and these are mostly joint replacement cases. Many days of the weeks we will do 5- 8 replacements in a day (and this may increase with a new surgeon in April 2018). We always plan a spinal – and only if there is contraindication will we do a general anesthesia. The other ‘big’ service lines are robotics and bariatrics. Then in addition we have a hand surgeon who is ramping up (so more blocks soon) and several general surgeons with the usual array of cases like colonic resections, Lap chole, Lap appys etc ..

On call (see also on call handout)
During the week the goal is to be down to one room at 5pm, and the attending goes solo. It is not that common to be stuck late past 6 or 7 - although probably about once a week there is an after hours or very late case when someone gets called back in. It is a community hospital and in general most surgeons try to do the cases the next day or in the early evening. Running the board well really impacts getting out on time – definitely more in charge of your own destiny than downtown.

Weekends Beeper call Friday 5pm to Monday 7am. There are almost always 2 -3 cases, often spread over both days, although it is unusual to have cases during the night. Usual addon cases are ether hip fractures, cysto / stent for stones or simple general surgery. Sometimes there is a sick SBO and ex-lap. For sicker patients and late evening cases we have a VERY low threshold to leave patients intubated and recover in the ICU. For attendings new to Milton we usually work
out an arrangement for a CRNA to be available for trouble shooting equipment or give breaks etc.

**Location and Hospital:** Milton - I had never been to Milton until I started 18 months ago – surprisingly nice area - but depending where you live the commute is important. The hospital is easy to get to from south or west of Boston - Newton, Brookline, Boston etc - you are usually against the traffic so not a bad drive. I live in Newton – often its quicker to get home from Milton in the evenings versus the grid lock from downtown. Parking is free – and a few staff actually uber back and forth.

**Current Milton Team:**

- **Anesthesiologists:** Barnett, Koropey, Ma, Mollov, Ngo, Levy, Zimmer, Krajewski
- **ICU staff:** Neves, Pannu, Bose, S plus several pulmonologists at Milton and BIDMC.
- **Pain:** Yazdi, Rana

**Questions?** contact Sheila Barnett – 617 699 9477