Defense Health Agency

ADMINISTRATIVE INSTRUCTION

NUMBER 6025.07
November 08, 2023

DAD MA

SUBJECT: Utilization of Anesthesia Services in the Military Medical Treatment Facilities

References: See Enclosure 1

1. PURPOSE. This Defense Health Agency-Administrative Instruction (DHA-AI), based on the authority of References (a) and (b), and in accordance with the guidance of References (c) through (i), establishes the Defense Health Agency's (DHA) procedures to:

a. Provide responsibilities for the management of Military Medical Treatment Facilities (MTF) Anesthesia Services.

b. Provide Anesthesia Quality and Clinical Outcomes Reporting Guidance.

c. Require all Anesthesia Services to transition to and utilize the DHA consent form.

d. To delineate the roles and responsibilities of anesthesia professionals within the DHA and to establish the relationship between physician anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs).

2. APPLICABILITY. This DHA-AI applies to the DHA Enterprise (components and activities under the authority, direction, and control of the DHA) to include: assigned, attached, allotted, or detailed personnel.

3. POLICY IMPLEMENTATION. It is DHA's instruction, pursuant to References (a) through (e), to support a high reliability organization that defines the standard practice of care for Anesthesia Services within the DHA.

4. RESPONSIBILITIES. See Enclosure 2

5. PROCEDURES. See Enclosure 3

6. PROPONENT AND WAIVERS. The proponent of this publication is the Deputy Assistant Director-Medical Affairs (DAD-MA). When Activities are unable to comply with this publication the activity may request a waiver that must include a justification, to include an analysis of the risk associated with not granting the waiver. The activity director or senior leader will submit the waiver request through their supervisory chain to the DAD-MA to determine if the waiver may be granted by the Director, DHA or their designee.

7. RELEASABILITY. **Cleared for public release**. This DHA-AI is available on the Internet from the Health.mil site at: https://health.mil/Reference-Center/Policies and is also available to authorized users from the DHA SharePoint site at: https://info.health.mil/cos/admin/pubs/DHA%20Publications%20Signed/Forms/AllItems.aspx.

8. EFFECTIVE DATE. This DHA-AI:

a. Is effective upon signature.

b. Will expire 10 years from the date of signature if it has not been reissued or canceled before this date in accordance with Reference (c).

CROSLAND.TELITA.1017383040
Digitally signed by CROSLAND.TELITA.1017383040
Date: 2023.11.08 09:35:43 -05'00'

TELITA CROSLAND
LTG, USA
Director

Enclosures
1. References
2. Responsibilities
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Glossary

ENCLOSURE 1

REFERENCES

(a) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD (HA))," September 30, 2013, as amended
(b) DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013, as amended
(c) DHA-Procedural Instruction 5025.01, "Publication System," April 1, 2022
(d) DoD Instruction 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," February 7, 2011, as amended
(e) DHA-Procedural Manual 6025.13, "Clinical Quality Management in the Military Health System," August 29, 2019
(f) American Society of Anesthesiology National Anesthesia Quality Institute Website, "Clinical Outcomes Registry Data Definitions,"[1]
(g) DHA-Administrative Instruction 5010.01, "Forms Management Program," January 12, 2021
(h) DHA-Procedural Instruction 1025.02, "Education Training and Clinical Readiness Activities in the MHS," November 14, 2022
(i) DHA-Procedural Instruction 1025.04, "Graduate Medical Education," May 18, 2022

[1] "This reference can be found at: https://www.aqihq.org/MACRAOverview.aspx

ENCLOSURE 2

RESPONSIBILITIES

1. DIRECTOR, DHA. The Director, DHA, will:

a. Be responsible for the administration and management of each MTF, including policy and procedure development, direction for budgetary, projected manning requirements information technology, and other healthcare administrative functions required to support DHA Anesthesia Services.

b. Monitor implementation of this DHA-AI to achieve the stated purpose.

c. Ensure systems and tools are in place to collect data and measure compliance with this DHA-AI to achieve the stated purpose.

2. ASSISTANT DIRECTOR, HEALTHCARE ADMINISTRATION. The Assistant Director, Healthcare Administration, will ensure the necessary functions are in place to support compliance with this DHA-AI.

3. DAD-MA. The DAD-MA will:

a. Provide oversight and support execution requirements outlined in this DHA-AI.

b. Establish and oversee the Anesthesia Services Committee.

c. Provide oversight of anesthesiology graduate medical education and nurse anesthesia graduate health education across the DHA.

d. Coordinate with MTF Leadership to ensure the information set forth in this DHA-AI is comprehensively communicated to ensure the successful implementation of this DHA-AI.

e. Monitor and evaluate effectiveness of Anesthesia Services through defined performance improvement initiatives.

f. Coordinate with Military Department Speciality Consultants/Speciality Leaders (SCs/SLs) to ensure:

(1) Collaborative delivery of anesthesia in a team concept that refers to the collaboration of Anesthesiologists and/or CRNAs working together.

(2) Anesthesia is recognized as a speciality by both nursing and medicine and both Anesthesiologists and CRNAs are recognized as licensed independent practitioners based on

their respective scope of practices and will be held to these standards in credentialing and medico-legal issues.

(3) The DHA benefits from the subject matter expertise of the SCs/SLs to include receiving guidance regarding force distribution, readiness issues, and anesthesia practice.

4. DIRECTOR, EDUCATION AND TRAINING (J-7). The Director, J-7 will ensure that the training of all graduate medical education and graduate health education members, including Student Registered Nurse Anesthetists, Anesthesiology residents, Oral Maxillofacial Surgery residents, and all other rotating providers is supported in accordance with References (h) and (i).

5. DIRECTORS, DEFENSE HEALTH NETWORKS. The Directors, Defense Health Networks will:

a. Ensure MTFs under their authority, direction, and control develop guidance and procedures that conform to this DHA-AI.

b. Communicate, as needed, any recommended revisions to this DHA-AI to the DAD-MA for inclusion in future versions of the DHA-AI.

6. MTF DIRECTORS. MTF Directors will:

a. Utilize the MTF clinical chain of command to provide oversight for implementation and execution of this DHA-AI.

b. Implement the developed procedures for Clinical Operations.

7. CHIEF OF ANESTHESIA (CoA), MTF ANESTHESIA DEPARTMENT. The CoA, MTF Anesthesia Department will:

a. Develop, implement, and maintain administrative responsibilities, policies, procedures, and practices that serve and support the vital operational, healthcare, and educational requirements of the MTF in the provision of anesthesia services.

(1) The CoA will be a privileged anesthesia provider.

(2) The CoA will develop policies that ensure safe, efficient, and high-quality delivery of anesthesia care provided by the department.

(3) The CoA will monitor and evaluate staffing levels, funding, and anesthesia scope of practice to ensure alignment with mission requirements.

(4) The CoA will be an anesthesiologist at an MTF where an Anesthesiology Residency Program is administered. In MTFs without an Anesthesiology Residency, CoA may be a Certified Registered Nurse Anesthetist (CRNA), provided compliance with 7. a. (5). below.

(5) When Anesthesia Services include CRNAs and one or more anesthesiologists, an anesthesiologist will assume the role and duties of Medical Director of Anesthesia Services.

(6) In instances where the role of Medical Director is assigned separately from the CoA, authority over clinical matters must rest with the designated Medical Director of Anesthesia Services.

(7) In instances where the CoA and Medical Director are assigned separately, both are expected to work together to coordinate administrative and clinical efforts to optimize patient safety and department workflow.

(8) The Chief Nurse Anesthetist will be assigned in accordance with the Joint Table of Distribution and in coordination with the respective service Human Resources Command. It is recommended the MTF Chief Medical Officer (CMO) or designee work in concert with the Service Consultants/Specialty Leaders for Anesthesiology and Nursing Anesthesia in determing the most qualified individual.

(9) The CoA will be assigned in accordance with the Joint Table of Distribution and in coordination with the respective service Human Resources Command. It is recommended the MTF CMO or designee work in concert with the Service Consultants/Specialty Leaders for Anesthesiology and Nursing Anesthesia in determing the most qualified individual.

b. Provide oversight of anesthesia care and MTF Anesthesia Services.

c. Coordinate and collaborate with the Service-specific operational units to facilitate anesthesia provider operational readiness for deployment and practice of anesthesia.

d. Uphold and enforce all hospital policies, procedures, and bylaws pertaining to credentialing and privileging, to include developing a peer review process to provide regular feedback, outcomes, and recommendations on anesthesia providers and clinical activities to the Medical Chief of Staff or other designee.

e. Ensure a system is in place for daily assignments appropriate to clinical level and patient care which is coordinated with the Operating Room Supervisor and the attending surgeons.

f. Collaborate with the pharmacy on a program to manage controlled substances delivered by providers in the anesthesia department.

g. Identify and pursue opportunities for performance improvement and value-added activities aligned with higher level guidance and initiatives, to include: efforts to minimize or eliminate errors, increase access as appropriate, and enhancing patient satisfaction.

h. Depending on local MTF needs and at the direction of MTF Director or Chief of Medical Staff, some Anesthesia Departments may assist in providing Quality Improvement/Patient Safety oversight of general anesthesia care rendered by Oral Maxillofacial Surgery providers.

i. Assist the MTF CMO with Ongoing Professional Practice Evaluations and Focused Professional Practice Evaluations of anesthesia providers.

8. SURGICAL SERVICES CLINICAL COMMUNITY. The Surgical Services Clinical Community will review clinical standards and policies for implementation throughout the enterprise to reduce variation and improve consistency in the use of evidence-informed practice across MTFs and networks of care.

9. ANESTHESIA SERVICES COMMITTEE. The Anesthesia Services Committee will act as Subject Matter Experts on topics relating the administration and provision of anesthesia within the DHA, as well as establish and maintain necessary policies and procedures to support the anesthesia and surgical communities.

ENCLOSURE 3

PROCEDURES

1. ANESTHESIA QUALITY AND CLINICAL OUTCOMES REPORTING

a. The CoA or Medical Director will ensure instances of potential or actual patient harm are reviewed and reported in accordance with their institution's medical bylaws and guidelines. Events must be tracked and finalized within 30 calendar days of the event. The purpose of this quality assurance review is to identify and address systems, processes, and practices in need of improvement to reduce the overall probability of these events. Medical Directors will work in conjunction with the CoA to develop a corrective plan of action to reduce risk of future occurrences. This corrective plan may be reported to Clinical Quality Assurance Committee as appropriate. These actions may include provider and/or department education, changes to system-based processes, addressing equipment malfunction and/or deficiencies, or addressing other aspects of quality improvement and patient safety.

b. A list of mandatory reportable anesthesia incidents are listed in Table 1. These events must be tracked by the CoA or Medical Director and reported to the Clinical Quality Assurance Committee.

Table 1. List of Mandatory Reportable Anesthesia Incidents

Amniotic Fluid Embolism	Local Anesthetic Systemic Toxicity	Procedure Site Infections
Anaphylaxis	Malignant Hyperthermia	Spinal Hematoma Following Spinal or Epidural Anesthesia
Blood Administration Compatability Error	Medication Error	Unanticipated Extracorporeal Membrane Oxygenation Requirement
Cardiac Arrest (Need for Intraoperative CPR)	Missed Positive Pregnancy	Unanticipated Intensive Care Unit (ICU) Admission
Death (within 72 hours)	Myocardial Infarction	Unanticipated Reintubation
Dental Injury	Operating Room Fire	Unanticipated Ventilation for More Than 24 Hours Post Procedure
Extracorporeal Membrane Oxygentation Salvage Need	Perioperative Falls	Wrong Patient Procedure
Failed Intubation	Peripheral Neurologic Deficit After Regional Anesthesia	Wrong Site Regional Anesthesia
High Neuraxial Anesthesia Requiring Intubation	Positioning Related Injury	Wrong Site Surgery
Intraoperative Awareness During General Anesthesia	Procedure Related Complications	

c. A broad list of perioperative incidents which may be reportable as established by The Anesthesia Quality Institute, National Anesthesia Clinical Outcomes Registry, are included in

Table 2. These incidents will be defined according to Reference (f). Anesthesia Medical Directors and the MTF CMO may use discretion in the selection of additional items from this list or elsewhere.

Table 2. List of Anesthesia Quality Institute, National Anesthesia Clinical Outcomes Registry Anesthesia Incidents

Acidemia	Acute Kidney Injury	Adverse Drug Reaction
Airway Obstruction	Airway Trauma	Amniotic Fluid Embolism
Anaphylaxis	Arrhythmia	Aspiration
Awareness	Bradycardia	Burn Injury
Cannot Ventilate	Cardiac Arrest	Case Cancelled Before Anesthesia Start Time
Case Cancelled Before Anesthesia Induction Time	Case Cancelled After Anesthesia Induction Time	Case Delay
Central Line-Associated Bloodstream Infection	Central Line Placement Injury	Cerebrovascular Accident
Coagulopathy	Coma	Corneal Injury
Death	Deep Vein Thrombosis	Delayed Emergence
Delirium	Difficult Intubation	Difficult Mask Ventilation
Electrolyte Abnormality	Emergence Delirium	Equipment/Device Failure Or Malfunction
Failed Intubation	Fall	Fat Embolism
Hemodynamic Instability	High Spinal Or Epidural	Hypercapnia
Hyperglycemia	Hypertensive Episode	Hyperthermia
Hypoglycemia	Hypotensive Episode	Hypoxemia
Inadequate Pain Control	Inadequate Reversal Of Neuromuscular Block	Infection Following Epidural Or Spinal Anesthesia
Infection Following Peripheral Nerve Block	Injury Related To Sensory Or Motor Deficit After Local Or Regional Anesthesia	Itching
Intravenous Catheter Infiltration	Kidney Failure	Local Anesthetic Systemic Toxicity
Malignant Hyperthermia	Medication Error	Multiple Organ Failure
Myocardial Infarction	Myocardial Ischemia	Operating Room Fire
Perioperative Visual Loss	Peripheral Neurologic Deficit After Regional Anesthesia	Pneumonia
Pneumothorax	Positioning Injury	Postdischarge Nausea And Vomiting
Postdural Puncture Headache	Postoperative Cognitive Dysfunction	Postoperative Nausea And Vomiting
Prolonged Neuromuscular Block	Pulmonary Edema	Pulmonary Embolus
Respiratory Arrest	Respiratory Failure	Seizure

Sepsis	Shivering	Skin Or Mucous Membrane Injury
Spinal Cord Injury	Spinal Hematoma Following Spinal Or Epidural Anesthesia	Surgical Site Infections
Transfusion Reaction	Ulcer	Unanticipated Transfusion
Unplanned Conversion To General Anesthesia	Unplanned Dural Puncture	Unplanned Electric Shock
Unplanned Endobronchial Intubation	Unplanned Esophageal Intubation	Unplanned Hospital Admission
Unplanned Hypothermia	Unplanned ICU Admission	Unplanned Postoperative Ventilation
Unplanned Reintubation	Unplanned Reoperation	Unplanned Tracheal Extubation
Vascular Injury	Venous Air Embolism	Ventilation For More Than 24 Hours Post Procedure
Wrong Patient	Wrong Procedure	Wrong Site Regional Anesthesia
Wrong Site Surgery		

2. SEPARATE ANESTHESIA INFORMED CONSENT

a. Having a separate informed consent for anesthesia services is not universally required in all states and is implied by the surgical consent. Within the DHA a separate informed consent is required for all anesthesia services and performed through procedures outlined by the DHA.

b. The TriService Anesthesia Consultants and DAD-MA require informed consent in accordance with American Society of Anesthesiologists and American Association of Nurse Anesthetists professional guidelines that comply with all applicable federal and state laws.

c. Informed consent involves a dialogue between a patient and provider about the nature of the proposed procedure, risks, benefits, and alternatives to the procedure. Having a separate anesthesia consent provides an opportunity to engage patients in a dialogue to specifically address the risks, benefits, and alternatives of an anesthetic treatment plan for the proposed surgery. MTFs are authorized to use a locally generated Anesthesia form. This must follow Reference (g).

d. At the time of this publication an enterprise approved anesthesia consent is available in Essentris®. An enterprise approved MHS GENESIS consent will be developed in the future.

GLOSSARY

ABBREVIATIONS AND ACRONYMS

ACT	Anesthesia Care Team
CMO	Chief Medical Officer
CoA	Chief of Anesthesia
CRNA	Certified Registered Nurse Anesthetist
DAD	Deputy Assistant Director
DHA	Defense Health Agency
DHA-AI	Defense Health Agency-Administrative Instruction
J-7	Education & Training
MA	Medical Affairs
MTF	military medical treatment facility
SC	Service Consultant
SL	Specialty Leader