MPOG QI - Quality Committee Meeting Notes – Monday, February 24th, 2025

Attendance:

Abess, Alex (Dartmouth)	Lalonde, Heather (Trinity Health)
Addo, Henrietta (MPOG)	Liu, Linda (UCSF)
Adelmann, Dieter (UCSF)	Liwo, Amandiy (UAB)
Anders, Megan (Maryland)	Lauer, Kathryn (Froedtert)
Andrew, Ben (Duke)	Lopacki, Kayla (Mercy Health - Muskegon)
Barrios, Nicole (MPOG)	Lozon, Tim (Henry Ford - Wyandotte)
Bauza, Diego (Weill Cornell)	Lu-Boettcher, Eva (Wisconsin)
Berndt, Brad (Bronson)	Malenfant, Tiffany (MPOG)
Bollini, Mara (WUSTL)	McKinney, Mary (Corewell Dearborn / Taylor)
Bow, Peter (Michigan)	Mentz, Graciela (MPOG)
Bowman-Young, Cathlin (ASA)	Milliken, Christopher (Sparrow)
Brennan, Alison (Maryland)	Mirizzi, Kam (MPOG)
Bryant, Ayesha (UAB)	Musulin, Angela (Henry Ford)
Buehler, Kate (MPOG)	Norman, J. Blake (UAB)
Cain, James (University of Florida)	O'Conor, Katie (Johns Hopkins)
Calabio, Mei (MPOG)	O'Dell, Diana (MPOG)
Cassidy, Ruth (MPOG)	Ohlendorf, Brian (Duke)
Chopra, Ketan (Henry Ford - Detroit)	Owens, Wendy (MyMichigan - Midland)
Clark, David (Stanford)	Pace, Nathan (Utah)
Cohen, Bryan (Henry Ford - West Bloomfield)	Pantis, Rebecca (MPOG)
Coleman, Rob (MPOG)	Pardo, Nichole (Corewell)
Colquhoun, Douglas (MPOG)	Parks, Dale (UAB)
Corpus, Charity (Corewell Royal Oak)	Paul, Jonathan (Columbia)
Cuff, Germaine (NYU)	Penningon, Bethany (WUSTL)
Delhey, Leanna (MPOG)	PIlat, Marianne (Sparrow)

Denchev, Krassimir (St Joseph Oakland)	Poindexter, Amy (Holland)
Dewhirst, Bill (Dartmouth)	Ring, Laurence (Columbia)
Domino, Karen (Washington)	Ruiz, Joseph (MD Anderson)
Doney, Allison (MGH)	Schroeck, Hedi (Dartmouth)
Drennan, Emily (Utah)	Schwerin, Denise (Bronson)
Edelman, Tony (MPOG)	Scranton, Kathy (Trinity Health St. Mary's)
Elkhateb, Rania (UAMS)	Shah, Nirav (MPOG)
Esmail, Tariq (Toronto)	Shaygan, Lida (UT Southwestern)
Finch, Kim (Henry Ford Detroit)	Shettar, Shashank (OUHSC)
Gibbons, Miranda (Maryland)	Smiatacz, Frances Guida (MPOG)
Glanding, Kimberly (UAB)	Smith, Mason (MyMichigan)
Goatley, Jackie (Michigan)	Stam, Benjamin (UMHS West)
Goldblatt, Josh (Henry Ford Allegiance)	Stanislaus, Mellany (Johns Hopkins)
Hall, Meredith (Bronson Battle Creek)	Steadman, Randolph (Houston Methodist)
Harwood, Tim (Wake Forest)	Stierer, Tracey (Johns Hopkins)
Heiter, Jerri (St. Joseph A2)	Stumpf, Rachel (MPOG)
Henson, Patrick (Vanderbilt)	Tyler, Pam (Corewell Farmington Hills)
Hyman, Jamie (Yale)	Vitale, Katherine (Trinity Health)
Jewell, Elizabeth (MPOG)	Wade, Meredith (MPOG)
Johnson, Rebecca (Spectrum & UMHS West)	Wedeven, Chris (Holland)
Kaper, Jon (Corewell Trenton)	Weinberg, Aaron (Weill Cornell)
Khan, Meraj (Henry Ford)	Wilson, Blake (MyMichigan)
Kinney, Tyler (Houston Methodist)	Woody, Nathan (UNC)
Kumar, Vikram (MGH)	Yuan, Yuan (MPOG)
Lacca, Tory (MPOG)	Zhao, Xinyi (Sarah) (MPOG)
Lai, Emily (MD Anderson)	Zhu, Shu (Columbia)
LaGorio, John (Trinity Health)	Zittleman, Andrew (MPOG)

Agenda & Notes

Meeting Start: 1001

1. **Agenda**
2. **Roll Call**: Via Zoom or contact Coordinating Center (support@mpog.zendesk.com) if you were present but not listed on Zoom.
3. **Minutes from January 2025 Quality Committee Meeting**
4. **Upcoming Events – 2025 Meetings**
    1. Friday, April 11, 2025 – MSQC/ASPIRE Collaborative Meeting – Novi, MI
    2. Friday, July 18, 2025 – ASPIRE Collaborative Meeting – Henry Execute Center – Lansing, MI
    3. Friday, September 2025 – ACQR Retreat – Location TBD
    4. Friday, October 10, 2025 – MPOG Retreat – San Antonio, Texas
5. **Announcements**
    1. **Update: QI for Learners Committee**
        a. Committee met last Thursday to discuss how MPOG data is currently being used to support residency programs and identified additional opportunities:
            i. Identify MPOG QI measures best suited for resident feedback program
            ii. Identify process for assigning measures to residents at different times throughout residency (separate from overall department measure selection)
            iii. Create additional phenotypes to track resident experience as filters in QIRT
        b. Coordinating Center will meet to determine next steps
        c. Plan to schedule follow-up meeting with QI for Learners Committee to finalize plan within the next couple of months
    2. **Sustainability Workgroup**
        a. All MPOG Sustainability measures due for review at the May QC Meeting
        b. The Coordinating Center is convening a workgroup to review the measures
        c. If interested in participating and not already listed, please contact Nirav Shah (nirshah@med.umich.edu) or Henrie Addo (addo@med.umich.edu)
        d. We will send out a Doodle poll asap and schedule the first meeting in March 2025

Name	Institution
Brady Still, MD	UChicago
Seema Gandhi, MD	UCSF
Ben Stam, MD	Corewell West and UM West
Eva Lu Boettcher, MD	University of Wisconsin
Katie O'Connor, MD, MBA	Johns Hopkins
Nick Dalesio, MD	Johns Hopkins

Lucy Everett, MD	Mass General
Liz Hansen, MD	Seattle Children's

3. **Quality Champion Role**
    a. Implement local QI initiatives supported by MPOG data
    b. Provider feedback and vote on new and reviewed measures
    c. Quality Committee Meeting Attendance
    d. Participation in performance review (mostly in state of Michigan currently)
    e. Provide feedback to Coordinating Center

4. **Quality Champion Vs Quality Member Roles**

MPOG Anesthesia Quality Champion	**MPOG Quality Member**
Anesthesiologist at MPOG Site	Anesthesia provider, administrator, or QI leaders interested in participating in MPOG QI initiatives
Votes on behalf of site at MPOG QI meetings	Serves a backup to champion for MPOG QI votes
Attends MPOG Quality meetings	
Conducts measure reviews	

6. **Measure Review: PONV-05 – Emily Lai, MD – MD Anderson Cancer Center**

Transcription of presentation: My name is Emily Lai, and I have been part of the MD Anderson PONV algorithm committee for the past 6 months. There have been no new consensus guidelines since the one in 2020 that was published by T.J. Gan. One of the more recent systematic reviews shows that there was a decrease incidence of post-op nausea and vomiting with perioperative benzodiazepine administration. The 2020 consensus did mention Midazolam and showed that there were meta-analyses that show reduction in post-op nausea and vomiting after Midazolam administration at induction. The consensus also showed that there is no big difference in PONV between Midazolam and Ondansetron if it was given 30 minutes before the end of surgery. May not be able to administer Midazolam all the time due to the sedation related adverse effects and potential for increased delirium in the elderly population. Midazolam combined with other anti-emetics have increased efficacy over a single agent therapy. Lower and higher doses showed no difference in PONV of the efficacy of PONV incidence was significantly reduced after the administration at the end of surgery. They compared Midazolam 2mg given 30 minutes before end of surgery and it was just as effective as Ondansetron 4mg. There is very limited data suggesting Midazolam is as effective as Zofran for treating established PONV. At MD Anderson we have our own nausea vomiting algorithm. The rationale, inclusion, and exclusion criteria are all appropriate. Our initial recommendation was to modify the measure to include Midazolam in the recommended pharmacologic antiemetics due to the inclusion of in the 2020 consensus. After further discussion with Dr. TJ Gan, who is the first author of the consensus, he recommended not including Midazolam yet due to lack of data comparing it to more established medications. Perhaps something in the future to consider. Currently, there is still a paucity of data, and will not recommend adding it.

MPOG Coordinating Center Review:
Consider minimum duration for propofol infusion (15 minutes)?

1. *Nirav Shah (MPOG Quality Director)*: Currently, any duration of propofol infusion counts as an antiemetic. We wanted to bring this to the committee's attention to know if it makes sense to consider minimum duration for propofol infusion. There is currently no good data on this, but theoretically, one could game the measure by adding a propofol infusion for 1 minute and I am not sure if that is effective or not. Does it make sense to consider a minimum duration for propofol infusion?
2. *Megan Anders (University of Maryland) via chat:* I would not restrict the propofol infusion duration if there's no data to support it
3. *Joe Ruiz (MD Anderson) via chat*: Re: propofol infusion, is it a matter of not having vapor on board which reduces PONV risk
4. *Xan Abess (Dartmouth)*: I do think we shouldn't put a time limit on the propofol in the absence of an evidence base.

Review updated PONV guidelines this year for additional recommendations

1. *Nirav Shah (MPOG Quality Director)*: There may be updated PONV guidelines coming out later this year. If and when those come out, we will look at those and if there's additional recommendations, I want to leave us that opportunity to incorporate those recommendations.

Discussion:

1. *Ketan Chopra (Henry Ford - Detroit) via chat*: Should we also be adding midazolam as a PONV agent for our measure?

2. *Lida Shaygan (UT Southwestern)*: Attendings are reporting that they are getting flagged for intubated patients or patients going to the ICU. I looked in the record and couldn't find any evidence of it. I'm not sure what the disconnect is if some of our patients are going to the ICU and on MPOG, it is saying they are not going to the ICU. That is the only feedback I had.
    1. *Nirav Shah (MPOG Quality Director)*: That is a good point. The exclusion criteria for patients going to the ICU is only as good as the data so there may be some cases that we miss it. If we miss it, we will want to know about those cases.
    2. *Kate Buehler (MPOG)*: It is worth mentioning that this was proposed a couple of years ago when we reviewed the PONV-03 measure and there was recommendation to build a remained intubated phenotype. We are working on building a 'Remained Intubated' phenotype. We had to take a step back and make an extubation times phenotype first, then well make a remained intubated phenotype. By large, this transfer to ICU documentation is weak across most MPOG sites to use it as a true surrogate for remaining intubated. We will work on it and hope to release it in the next couple of months. When we have the remained intubated phenotype; we will change the exclusion to use that instead of transfer to ICU. Anyone who remains intubated will be excluded from the PONV measures. That is our intent. It is taking a bit longer than expected since documentation of extubation is not the same at most sites. So, we will clean it up first and then move on to that phenotype.
    3. *Xan Abess (Dartmouth) via chat*: We had a similar incidence regarding ICU – it came down to mapping issue for our CVCC

4. *Tariq Esmail (University Health Network) via chat*: That sounds awesome – as it would apply to many other measures where transfer to ICU is an exclusion

3. *Katie O'Connor (Johns Hopkins)*: This is more food for thought or would love to hear from the rest of the group. One thing we've been navigating locally is that a lot of our providers are doing poorly and need to do better. Some of our providers are wondering about the disconnect because the outcomes measures, we are all doing relatively better on those, which arguably is the thing that actually matters. It could also be that it is under reported since it's harder to capture those compared to whether a medication was administered. We worry a lot about polypharmacy and over medication and the unexpected or intended consequences every time you give additional medication. Wanted to see if there are any thoughts on the 90% threshold as the right number? Are there other nuances of which cases are included? I agree with the ICU cases needing to be excluded. Other than technical issues, are there other ways we can refine how it is quantified to make sure we are aiming for the right things. Another piece is that I think a lot of us get disenchanted if it's 40 then we feel hopeless and wonder if maybe this is an irrelevant metric. So just make sure we've calibrated this target properly. I don't have any specific recommendation, I just wanted to hear if anyone else is contemplating this.
    1. *Ketan Chopra (Henry Ford - Detroit)*: I look at the numbers at the graph and it shows all the hospitals across MPOG, and when you have any measure where only has 4 hospitals achieving the measure threshold, we need to reconsider what exactly we are looking for with this measure. I am at 88% and trying hard. I am on everyone about this on a weekly basis asking what I can do to help, what are we missing? Our outcome scores do appear to be better. I wanted to echo that when the whole system is missing a measure, we just need to evaluate what are goals are for that measure specifically.
    2. *Brian Ohlendorf (Duke) via chat*: I agree with Katie and Ketan...does anyone have thoughts about why the vast majority of sites are failing to meet the benchmark, is many cases, significantly?
    3. *Nirav Shah (MPOG Quality Director)*: When there is a skewed performance at the bottom, sometimes you would think there is a systemic issue that is preventing people from performing well. Or if performance is skewed at the very top, maybe , its topped out like the old skip measures like antibiotic timing?? In this case, we are seeing significant variation across sites, and it's now skewed one way or the other. We should discuss if the threshold is not appropriate. Especially if we are missing a lot of ECTs or bronchoscopies, or other exclusions are not being excluded, and are they leaking into the flagged cases. That is one reason for modifying the threshold. Another potential thing to consider is in the elderly population. That if someone is in the high-risk category, the guidelines don't make a comment on age and at least modify the number of agents or maybe modify the types of agents that you give. Another component is whether from a practical perspective, smoking as a risk factor. If there is no documentation, the patient is considered a non-smoker, and that adds an additional risk factor. In those cases where we are not capturing smoking documentation, but the patient is actually a smoker and therefore would not have 1 more risk factor, in those cases that patients will be receiving 2 instead of

3 classes of antiemetics. The distribution of performance lends itself to show there is actually variation in practice. Typically, those are the most ripe for quality improvement initiatives. In most cases the threshold we have at MPOG is not a data-driven threshold. We typically set it at 90% for most quality measures, and that is something we can modify.

4. *Ben Andrew (Duke) via chat*: Performance, at least our center, falls off precipitously at the 3-risk factor point, where the addition is a third agent required
    i. *Nirav Shah (MPOG Quality Director)*: Do you think it is an intentional practice issue, or do you think it's just not part of the workflow of providers? Getting the answer behind the question is an important component of the overall discussion about whether there's an issue with the measure or is it a workflow thing.
5. *Xan Abess (Dartmouth)*: One thought on the measure performance at 90%, I understand that some people are saying maybe it's too high. On the other hand, at Dartmouth in our main OR, our performance is at about 70%, and for the same people who go the OSC, our performance is at 90%. I think the measure is attainable and reasonable. I think whether or not you choose to focus on or whether you are meeting the 90% mark is up to shop or not.
6. *Joe Ruiz (MD Anderson)*: Maybe the 90% is too much, but it is certainly not something that should go away, because we can improve on this. It's those metrics that are 95% or 100% with no room for improvement. That's not a quality metric.
7. *Katie O'Connor (Johns Hopkins)*: I agree. If we are not doing well, just lowering the 90% threshold just so we do better isn't what I was angling for. More so to see if there are ways, we can do analyses, because even though there is a distribution across MPOG, are there opportunities to do analyses of where our gaps are and maybe investigate just some of the nuances of the criteria. Are there other ways we can look at these "failures" intentional practice decisions and is there more to investigate or maybe even adjustments to what the measure is applied to with ICU, we know that this is coded, but are there other things that are not coded? That should be, or just a more thoughtful analysis of these trends at a macro level, even though we can all individually do it at the micro level.
    i. *Tariq Esmail (University Health Network) via chat:* With respect to more analysis… The only risk factor which is not automatically captured and relies on a human to input it into the system is the risk factor of PONV or motion sickness and it would be interesting to understand if some of the sites have that WELL mapped and are not meeting the criteria as it is documented in some pre-admission process and not visible to the clinician at the time of the OR or vice versa, it isn't mapped in sites doing well and so they often miss out on one relatively common risk factor… ? I don't know how impactful this would be, just a thought I am having while discussing this.

4. *Jaime Hyman (Yale)*: This was a good discussion, and we grapple with that at Yale as well. I wanted to propose considering another pharmacologic antiemetic addition. I do not know if there's an adequate body of evidence, but I added it to the Google document. The medication is Olanzapine, and it has been used for chemotherapy induced nausea vomiting for about a decade now. There's been 5 RCT trials published since the 2020 guidelines. Small

trials, so still relatively small evidence based, but there were 2 meta-analyses of these small trials. It is something to consider. Maybe we wait until the next iteration of The American Society of Enhanced Recovery guidelines, which I know are going to be imminently published. It is being used clinically at Yale, and the evidence base that does exist for it, at least 3 of the 5 trials, as a third additional antiemetic for the highest risk group. I wanted to put that up for discussion.

    1. *Nirav Shah (MPOG Quality Director)*: We are definitely open to adding new medications. One thing we can quickly do is see if Olanzapine is a mapped concept for us and see if sites are using it right now – we do have a concept for it – MPOG Concept ID: Olanzapine (10848). I am curious to know if Olanzapine is on any PONV algorithm or guidelines for any of our institutions.

5. *Tariq Esmail (University Health Network) via chat*: What's the default with motion sickness or history of PONV...if not available does it assume no risk – I guess it would be a look at the local mapping to know where that information is being incorporated from?
    1. *Kate Buehler (MPOG) via chat*: Correct, if not documented, assume no risk
6. *Xan Abess (Dartmouth)*: I am perplexed on whether or not to consider adding benzodiazepines to the mix or not. A lot of the medications that we use have side effects and risks of side effects. On one hand, I am hesitant to say let's use benzodiazepines as another agent. One one hand, it has been used for a long time, especially in the oncology settings as a therapeutic agent, and there's probably less evidence on the other one. I am mixed on the benzo one. I can see how it can be beneficial, but I can also see how people wouldn't want to encourage people to give it.
    1. *Nirav Shah (MPOG Quality Director)*: Question for Emily and Joe. Any thoughts on the timing of Midazolam? If we people decide we should include it, at what point during the case will it be appropriate to administer?
    2. *Emily Lai (MD Anderson)*: The meta-analyses had a wide range from preoperative, to intraoperative, to postoperative. The majority of them were intraoperative. The actual consensus did mention that Midazolam at induction was associated with reduced PONV.
    3. *Joe Ruiz (MD Anderson)*: In my career I have had maybe 2 or 3 patients who had anticipatory nausea and vomiting and when we arrived at the recovery room and administered a benzo, after everything else failed, it subsided her nausea. At MD Anderson, this was our original quality measure before AQI and before joining MPOG, our surgery center decided to administer 3 antiemetics for everyone. The argument from those doctors was that the drugs were benign. There is a risk associated with everything you administer, and they said the risk is low and we will administer it. I was shocked by our 40% metric performance. I thought we nailed this, as 10-15 years ago, we were at 90% because everyone was aware of it. I think our institution has had such an influx of new people and we've had such little emphasis on PONV education in terms of how important it is to patients.
    4. *Megan Anders (University of Maryland) via chat:* although I am not a big benzo fan, being true to the nature of this measure to me would mean including it (we can monitor brain separately - especially if we could get provider level!
    5. *Josh Goldblatt (Henry Ford Allegiance)*: Given that Midazolam is a potent sedative, and our typical practice is focused on giving agents near the end of the case. Given

that there is no differentiation with the elderly and low GFR patients, we do have some side effect risks by adding this on. Any agent that we add to our success criteria we're kind of endorsing its use in whatever patient population it applies to. The question comes down to just because an agent has antiemetic properties, does it warrant inclusion on this list and de facto encouraging its use?

   i. *Nirav Shah (MPOG Quality Director)*: So, Josh your thought is that the potential for harm with Midazolam may be more than the benefit. Now, if you look at the list, we are also including antiemetics like metoclopramide and other things we don't use commonly but we know that may have side effects but also have antiemetic properties. We have also used antiemetics more frequently in the past than they are now and those kinds of legacy drugs that are used as 3rd and 4th level agents are added to the list. They are given equal weighting as Ondansetron or Dexamethasone and Aprepitant and Propofol infusions. It is tough to navigate because we have medications of varying side effects and efficacy already on the list.

6. *Josh Goldblatt (Henry Ford Allegiance)*: I wanted to ask too, I understand there's some research into our PONV metrics and the correlation between the outcome PONV-03, and our process of PONV-05, does it make sense to wait until that research is in publication or until the guidelines are released?
   i. *Nirav Shah (MPOG Quality Director)*: For the guidelines, it's up to this group. For the research, I can say that those proposals were just made a couple of weeks ago, and for those who have attempted to do multicenter research analysis have figured out that it could take a long time by the time an idea is proposed to PCRC to the time it's published. I think it is fair to see what direction this group wants to go into. I don't necessarily think we have to wait because it can be a long time from now.
      1. *Blake Wilson (MyMichigan) via chat:* Agree with Nirav, current pharmacologic agents that are currently on the list have significant risk of side effects (especially in elderly). I believe midazolam should be included and allow our providers to decide what is most appropriate for individual patients.
7. *Nirav Shah (MPOG Quality Director)*: Comments in the chats are discussing correlating PONV-03, which is the outcome measure, to PONV-05, which is the process measure. I think that's what some of these research projects are aiming at. To see is there a relationship between PONV-05, which is essentially a representation of the 2020 guidelines, with PONV outcomes, as best as MPOG can define it. I am interested in seeing the results of that. I do think, Josh, that the results of that study may significantly affect PONV-05, but that could be a ways off.
   i. *Vikram Kumar (MGH) via chat*: There is a disconnect between outcome and process but drawing from experience from our site we did notice improvement in outcome measures as our compliance with process measures improved. Improvement in PONV05 led to a better PONV 03.
   ii. *Tony Edelman (MPOG) via chat*: we need to pair PONV-5 (process measure) with PONV-3 (outcome measure). while overall PONV-3 is having better

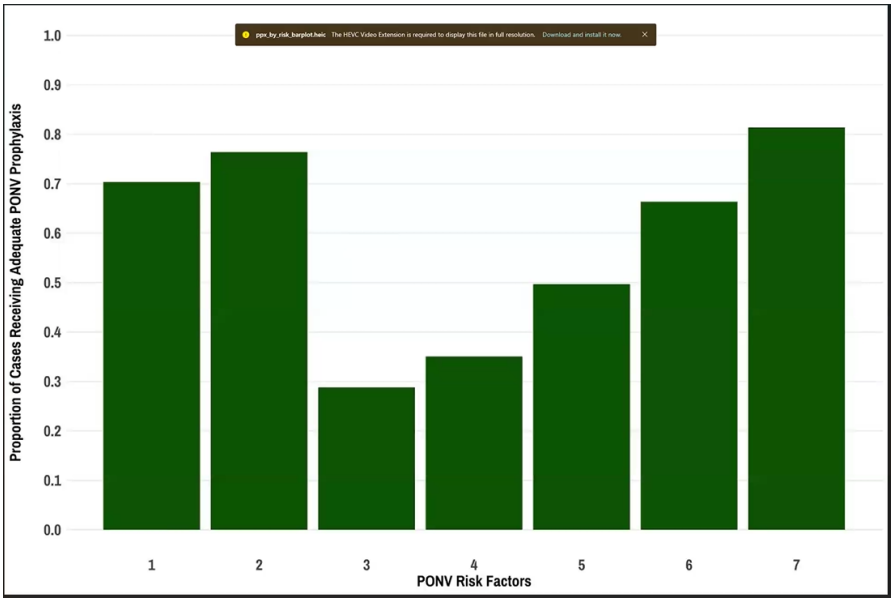
success than PONV-5 there is still significant room for improvement and both should still be reasonable

iii. *Kate Buehler (MPOG)*: I know everyone is focused on PONV-05 in this conversation but would argue that we should spend the same amount of rigor that we are spending on PONV-05 and making sure that this measure is valid, apply that same effort to PONV-03 and PONV-03b. We should spend as much time reviewing PONV-03 and PONV-03b. When we did our initial look and building those measures, especially at U of M data, which was our pilot instance, we found that it was very hard to track down, and I think Dr. O'Conor mentioned this earlier. It is hard to track down all the fields where PONV is documented in the health record and trying to make sure you have all of that in your MPOG extract and mapped appropriately does take a fair amount of work and some conversation with postop nurses. I would say that rigor is worth it before we spend too much time measuring process versus outcome. We should validate that outcome measure just as much as we are validating the process measure. It does take some extra work, and you can't take it at face value. Just like any of the MPOG measures, make sure you validate them and track them back to whatever your EHR is.

    1. *Nirav Shah (MPOG Quality Director)*: Dr. Esmail also mentioned that for motion sickness for PONV-05 as well. Is that there may be a ton of variability in how it's documented and whether or not we capture it.
    2. *Vikram Kumar (MGH) via chat*: I agree with Kate. We did notice a lot of inaccuracies with our PONV-03. There were a lot of questions raised on how the nurses are documenting and the PONV-03b is definitely far more inaccurate when you find evidence of vomiting in the chart that's much lower. When you talk to individual colleagues, they mentioned they improved their process measure, but their outcomes haven't improved. The question remains about the utility of the measure. From an institutional perspective, and we worked on it 3-4 years ago, our compliance rates improved on PONV-05 from about 60% to about 80% range. We noticed a 2% drop in the PONV-03. We didn't go and check what the nurses were charting or the way they were charting. Nurses might administer Haldol or Zofran to someone without any real evidence of nausea and vomiting. Those are the questions raised in the meetings. If the nurse feels like giving it, I get dinged for it. I am sure you have heard that from other institutions as well. That is a sign that things work, and both are statistically significant on the control chart. Clear improvement in the process measure leads to improvement in the process measure. that

7. *Ben Andrew (Duke)*: In both kids and adults there is good compliance where just 1 or 2 agents are required, then as soon as you hit the threshold for requiring a third agent, the compliance drops off and then starts to climb back up as you accumulate more risk factors. I

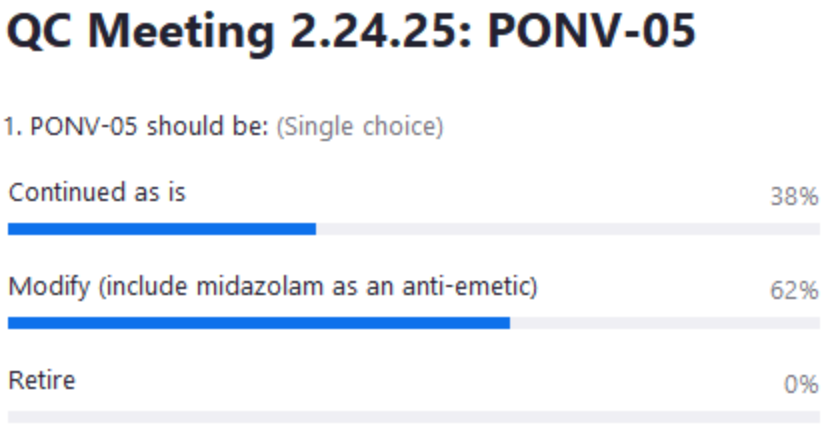
think initially, crossing that threshold, it is not obvious to the clinician that there's one more risk factor that now requires the effort of going beyond typical 5-HT3 Decadron. As you get into the people with 5, 6, 7 risk factors, those are becoming more obvious to clinicians. The pattern in that plot is the same with kids. The addition of a third risk is not recognized soon enough. Then it takes an accumulation of more risk to get them to get back to the third administration.



1. *Joe Ruiz (MD Anderson) via chat*: Ben, what risk factors did you use for the 7?
2. *Ben Andrew (Duke) via chat*: Age < 50, female, history of PONV / motion sickness, non-smoker, opioids, high risk procedure, inhaled anesthetic duration >60 minutes. As listed for PONV-05 on the measure spec

8. *Brian Ohlendorf (Duke) via chat*: Would it be helpful to have representatives from one of the top 4 performing sites to share "success" stories of what has worked for them?
9. *Jerri Hieter (Trinity St. Joseph Ann Arbor) via chat*: I think additional dose of previous med is given as a third
10. *Vikram Kumar (MGH) via chat*: Agree with Ben. We noticed the exact same issue.
11. *James Cain (University of Florida) via chat*: Apologies, came in a bit late. See that there is conversation about benzos for PONV, another medication with antiemetic properties, albeit not likely as a sole agent, is dexmedetomidine. Thoughts on this being included as antiemetic therapy in compliance as pertains to these measures?
    1. *Benjamin Stam (Corewell) via chat*: As far as I understand it, the effective dose for dexmedetomidine as an antiemetic is pretty large.
    2. *Nirav Shah (MPOG Quality Director)*: Dexmedetomidine not as a sole agent, but maybe as another medication with antiemetic properties. I haven't seen the same amount of evidence for Dexmedetomidine as we have for Midazolam or some of the other agents.
    3. *Emily Lai (MD Anderson)*: There were 2 meta-analyses that mentioned it and did show some decreased incidence of PONV. One of the studies was on laparoscopic and bariatric surgery. The other study was on patients undergoing thoracic surgery.

12. *Xan Abess (Dartmouth) via chat*: Scopolamine clearly has antiemetic benefits, but most of us don't use it on elderly patients or neurosurgery patients; I think it's up to the clinicians to decide - regardless of the measures . . .
13. *Kimber Finch (HFHS) via chat*: Do the institutions with high midazolam use have better outcome results for PONV?
14. *Tariq Esmail (University Health Network) via chat:* Is there a "report" that can be run or generated for a specific site to show us if we are missing concepts that are related to a specific measure? (Like a scorecard) or is manual review the only way?
    i. Vote:
        1. 1 vote/site
        2. Continue as is/ modify/ retire
        3. Need > 50% to retire measure
        4. Coordinating Center will review all votes after meeting to ensure no duplication
        5. *Nirav Shah (MPOG Quality Director)*: I think it makes sense to vote on the measure the way it was originally proposed: to keep as is, modify it to include Midazolam, or retire. There were some great points regarding some other things behind the measure itself that's affecting performance. Those deep dives will take a lot more time and thought and may be reliant on future research that comes out. I don't know if we have enough information currently within MPOG to understand if we should be making other significant changes. With the exception that within your institution, doing a deeper dive to see, are there things that you are missing, for example, are there exclusions that are being missed for some reason? Is there documentation of things like motion sickness that are being missed? Are there issues with PONV-03 that we are not capturing? This is a great opportunity or great measure to do the deep dive in, not just PONV-05 but PONV-03 and PONV-03b. To see if there is something that can be done locally or at the coordinating center to improve the accuracy of the measure. To Dr. Andrew's point, maybe there is an inflection point where patient's risk factors go from 2 to 3, we miss that, but as they from 3 to 7, we start to understand. I think there's an opportunity there for education and reinforcement of these guidelines.



ii. Next steps: Coordinating center will work on updating PONV-05 to include Midazolam.

1. *Nirav Shah (MPOG Quality Director)*: I think there is a lot more to this and we'll be excited to see the new PONV guidelines or as research projects are being published. Dr. TJ Gan from MD Anderson has agreed to speak at this year's MPOG retreat on PONV process and outcomes. He was the lead author of the previous guideline. I am looking forward to seeing him share his knowledge and wisdom.

7. We have released 2 new measures, CARD-04 and ABX-06-OB. We will post that in the basecamp chat.

Meeting Adjourned: 1102

Next meeting: Monday, May 19, 2025