Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE)

Quality Committee Meeting Notes – Monday, September 23rd , 2024

Attendance:

Abess, Alex (Dartmouth)	**Lacca, Tory (MPOG)**
Addo, Henrietta (MPOG)	**LaGorio, John (Trinity Muskegon)**
Adelmann, Dieter (UCSF)	**Lalonde, Heather (Trinity Health)**
Anders, Megan (Maryland)	**Liu, Linda (UCSF)**
Armstrong-Browder, Lavonda (Henry Ford)	**Liwo, Amandiy (UAB)**
Balfanz, Greg (North Carolina)	**Lewandowski, Kristyn (Corewell)**
Barrios, Nicole (MPOG)	**Lopacki, Kayla (Mercy Health - Muskegon)**
Berndt, Brad (Bronson)	**Loyd, Gary (Henry Ford)**
Bollini, Mara (WUSTL)	**Lozon, Tim (Henry Ford - Wyandotte)**
Bow, Peter (Michigan)	**Lu-Boettcher, Eva (Wisconsin)**
Bowman-Young, Cathlin (ASA)	**Maldonado, Yasdet (Cleveland Clinic)**
Brennan, Alison (Maryland)	**Mathis, Mike (MPOG)**
Buehler, Kate (MPOG)	**Mack, Patricia (Weill Cornell)**
Cassidy, Ruth (MPOG)	**Malenfant, Tiffany (MPOG)**
Charette, Kristin (Dartmouth)	**McComb, Joseph (Temple U)**
Chopra, Ketan (Henry Ford - Detroit)	**McKinney, Mary (Corewell Dearborn / Taylor)**
Clark, David (MPOG)	**Mentz, Graciela (MPOG)**
Cohen, Bryan (Henry Ford - West Bloomfield)	**Milliken, Christopher (Sparrow)**
Coleman, Rob (MPOG)	**Nurani, Shafeena (Corewell Troy)**
Collins, Kathleen (St. Mary Mercy)	**O'Conor, Katie (Johns Hopkins)**
Colquhoun, Douglas (MPOG)	**O'Dell, Diana (MPOG)**
Corpus, Charity (Corewell Royal Oak)	**Ostarello, Claire (ASA)**
Cuff, Germaine (NYU)	**Owens, Wendy (MyMichigan - Midland)**

Cusick, Jordan (OHSU)	**Pace, Nathan (Utah)**
Denchev, Krassimir (St Joseph Oakland)	**Pantis, Rebecca (MPOG)**
Dewhirst, Bill (Dartmouth)	**Pardo, Nichole (Corewell)**
Doney, Allison (MGH)	**Parks, Dale (UAB)**
Doyal, Alex (UNC)	**Paul, Jonathan (Columbia)**
Drennan, Emily (Utah)	**Pimentel, Marc Phillip (B&W)**
Dutton, Richard (US Anes Partners)	**Poindexter, Amy (Holland)**
Edelman, Tony (MPOG)	**Roselinsky, Howard (Yale)**
Elkhateb, Rania (UAMS)	**Rozek, Sandy (MPOG)**
Esmail, Tariq (Toronto)	**Saffary, Roya (Stanford)**
Everett, Lucy (MGH)	**Samba, Sindhu (Michigan)**
Falzon, James (Trinity Health)	**Schwerin, Denise (Bronson)**
Finch, Kim (Henry Ford Detroit)	**Scranton, Kathy (Trinity Health St. Mary's)**
Goatley, Jackie (Michigan)	**Shah, Nirav (MPOG)**
Goldblatt, Josh (Henry Ford Allegiance)	**Smiatacz, Frances Guida (MPOG)**
Greenblatt, Lorile (U Penn)	**Stanislaus, Mellany (Johns Hopkins)**
Gregory, Stephen (WUSTL)	**Stewart, Alvin (UAMS)**
Gupta, Ruchika (Michigan)	**Stewart, Margaret (Michigan)**
Hall, Meredith (Bronson Battle Creek)	**Stumpf, Rachel (MPOG)**
Heiter, Jerri (St. Joseph A2)	**Toonstra, Rachel (Spectrum Health)**
Irwin, Brittany (Cleveland Clinic)	**Tung, Avery (Chicago)**
Jacobson, Cameron (Utah)	**Tyler, Pam (Corewell Farmington Hills)**
Janda, Allison (MPOG)	**Vaughn, Shelley (MPOG)**
Jewell, Elizabeth (MPOG)	**Vitale, Katherine (Trinity Health)**
Jiang, Silis (Weill Cornell)	**Wade, Meredith (MPOG)**
Johnson, Rebecca (Spectrum & UMHS West)	**Wedeven, Chris (Holland)**

Kaper, Jon (Corewell Trenton)	**Weinberg, Aaron (Weill Cornell)**
Karamchandani, Kunal (UT Southwestern)	**Wilson, Blake (MyMichigan)**
Kheterpal, Sachin (MPOG)	**Woody, Nathan (UNC)**
Kirke, Sarah (Nebraska)	**Yuan, Yuan (MPOG)**
Krauss, Kristin (Temple)	**Zhu, Shu (Columbia)**
Kumar, Vikram (MGH)	**Zisblatt, Lara (Michigan)**
	Zittleman, Andrew (MPOG)

Agenda & Notes

Meeting Start: 1001 EST

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 July 2024 Quality Committee Meeting**
4. **Announcements**
    1. Congratulations to Dr. Griffee & Team on their recent publication in the Canadian Journal of Anesthesia
        a. Intraoperative hypoglycemia among adults with intraoperative glucose measurements: a cross-sectional multicentre retrospective cohort study
    2. Congratulations to Dr. Fischer & Team on their publication in Anesthesiology and Analgesia
        a. Opioid Dose Variation in Cardiac Surgery: A Multicenter Study of Practice
    3. Congratulations to Dr. Lele & Team on their publication in Anesthesia & Analgesia
        a. Identifying Variation in Intraoperative Management of Brain-Dead Organ Donors and Opportunities for Improvement: A Multicenter Perioperative Outcomes Group Analysis
    4. Featured Member – September and October

a. Matthew Price, MD, FASA – OWUB Corewell Health

5. **2024 Meetings**

    1. Friday, October 18, 2024: MPOG Retreat, Philadelphia, Pennsylvania

        a. Please register. In-person and Virtual options available

    2. **Upcoming Events**

6. **QI features for learners – request for feedback**

    1. Background: MPOG's ABA MOCA Part IV program has now enrolled ~ 1000 anesthesiologists over the last several years
    2. We have received feedback that it would be helpful for learners (residents and SRNAs) to have a similar program
    3. MPOG is committed to use its platform to help learners reflect on their practice
    4. MOCA Program built off provider feedback email process (see slides for screenshots)
    5. Would a similar program for learners be useful?

        a. Can help fulfill the practice-based learning and improvement components of residency training

        b. Allow residency program leaders to assess engagement in practice improvement

        c. Help build lifelong practice reflection skills

        d. Are there other programs that enable this? Is there a current gap?

    6. Discussion:

        i) *Nirav Shah (MPOG Quality Director):* As an example, here at the University of Michigan, Lara Zisblatt, Education Lead Coordinator and expert in residency education, and I have a lecture series with our CA1'sover several months, that introduces new residents to MPOG QI. We ask the residents to pick a measure, follow that measure performance over time, reflect on their practice, and then we come back and ask them to document those practice changes, and we review them. This puts more rigor and structure around practice reflection.

ii) *Eva Lu-Boettcher (University of Wisconsin)*: This is an excellent idea. The biggest thing we found successful at our institution is if there is already a larger QI effort amongst the department, for example we focused on sustainability last year, and tying in our resident education with ASPIRE metrics so we can follow and teach along with that. We've had the biggest success in our department when we utilized this as an overall staff practice change model and used this as an adjunct to our teaching tool and allowing our residents to see how their feedback has impacted their practice. We have made small scale efforts with the change cycles of 3 months at a time focusing on the July – September residents to change their practice when some of these residents are susceptible to changing their practice. We focus on one measure at a time and that has been the most helpful at our institution.

iii) *Ketan Chopra (Henry Ford Hospital System)*: I think standardizing this would be extremely helpful if thought of from a resident's perspective. When I was a resident and was told things like this, it went over my head and my focus was trying to get the room set up among other things. Piggybacking on standardizing some type of didactic education at the beginning of the year, especially for the new trainees, can carry forward. Now, when I speak to residents, they may not understand the value of MPOG QI practice management. If they see it as a reimbursement, it doesn't resonate with them. Some type of structure emphasizing the importance that it is not only about value-based reimbursement but rather about standard of care, they can also carry that with them for the rest of their career.

iv) *Lara Zisblatt (Michigan Medicine)*: I want to also talk about the fact that this meets ACGME requirement where you need to learn about practice-based learning and improvement, so this is a way to check that box, which was something we struggled with before we started this. How the residents react to this data in training sets them up with how they are going to react when receiving data further down in their career. I remember a resident saying they were having difficulty with monitoring gaps, and he said in front of the whole class that he knew exactly what was happening, and it gave everyone the ability to look at their data, learn something, and move on without any uncomfortable feeling around data. When we have our talks, we try to steer away from the discomfort of having data and rather how to productively use it.

    a. *Eva Lu-Boettcher (University of Wisconsin) via chat*: Thanks Allison, Lara could you provide a little more detail on what UMich is doing?

b. *Lara Zisblatt (Michigan Medicine)* via chat: Poster final

v) *Nirav Shah (MPOG Quality Director)*: The way the MOCA program is currently structured for practicing anesthesiologists, it is something you can do completely independently so you may lose a little bit of what happens when you have residents or other learners talk about it in front of their peers. If we were to repurpose this, it would be nice to retain some of the classroom components as well or make it complimentary. Imagine having a button on the MOCA program that faculty selects, and it takes them to the MOCA app page, but when a learner selects it, it brings up flagged cases that gives the learner the opportunity to review those cases and attest that they reviewed them, and have them document what practice changes they made or what they learned from reviewing the data. This will give program leaders the ability to review the information and share back their comments with the learners.

vi) *Ruchika Gupta (Michigan)*: I am the program director for the Peds fellowship. We have all this data, and our fellows don't receive it. I met with Meridith recently to talk about having a way we can introduce them, like what Nirav has done in a classroom setting, by introducing them to MPOG and reviewing the metrics. My idea for this year is choosing one or two metrics and meeting with them a couple times during the year to discuss how they can improve their metrics. Then meeting with them again to discuss what barriers are, and a have a third meeting to discuss how they can carry this out into their practice. It is important to get to them early in year one. If they realize that these are the metrics we are watching, and it is important to their general practice, then it may instill in them some quality improvement and personal quality improvement. Another idea I had for next year is to get some of our fellows to pick one or two metrics to introduce to our division itself.

vii) *Mike Mathis (MPOG Research Director)*: I agree with all of this. Maybe this goes beyond the scope of this quality improvement forum, but imagine for learners, not just quality metrics, but identifying very salient cases that advance the resident's education and give them education modules or feedback. For example, the work that Dr. Matt Caldwell is doing looking at massive transfusions and identifying cases where 20 units were transfused and discussing massive transfusion and protocols and gets you the education at this moment. Once we tackle introducing quality improvement to learners, there's the scope of this that can be much broader than simply just QI for learners.

viii) *Nirav Shah (MPOG Quality Director)*: For the program leaders and residency fellowship program leaders on this call, are there other infrastructure or programs or other platforms which enable some of this? If MPOG was to invest time and effort into this, will that be duplicative or redundant with other efforts that folks know about? A reason we want to bring this up as we think about our roadmap over the next couple of years is where we want to spend our resources. We want to know if putting resources and time and effort and software development into this would be helpful. If via chat or via email, if others are interested or think of the contrarian view that it's not a good use of MPOG resources at this time, please let us know. We usually have this yearly exercise at the end of the year where we start to plan out the following year's work that we do. This would be a good time to hear feedback either in support or hearing that there's tons of stuff we maybe need to be focusing on, and this is not the right area.

a. *Kunal Karamchandani (UT Southwestern) via chat*: A portal for learners where they not only review their cases, but also have access to educational resources around the quality metric
b. *Greg Balfanz (North Carolina) via chat*: UNC would be interested
c. *Eva Lu-Boettcher (University of Wisconsin) via chat*: U Wisconsin is definitely interested!
d. *Jonathan Paul (Columbia) via chat*: Columbia is interested
e. *Alving Stewart (UAMS) via chat*: UAMS would be interested, too.
f. *Krassmir Denchev (Trinity St Joseph – Oakland) via chat*: Please sign in Trinity Health Oakland/Wayne State University in
g. *Katie O'Connor (Johns Hopkins) via chat*: Johns Hopkins interested in the residency topic
h. *Tariq Esmail (University Health Network - Toronto) via chat*: Could you include University Health Network for the resident support committee please. I will endeavor to have our resident coordinator join for information and insight as we build up our use here
i. *Kunal Karamchandani (UT Southwestern)* via chat: UTSW would be interested as well
j. *Nirav Shah (MPOG Quality Director)*: Sounds like there's some interest. More to come. Will probably be reaching out to some folks that have volunteered in the chat to be part of this ad hoc committee. I know WashU and others are interested but some of them were not able to make it today.

ix) *Josh Goldblatt and Kim Finch (Henry Ford Health System) via chat*: To focus administrative time, does it make sense to create a Residency Support Committee?

a. *Nirav Shah (MPOG Quality Director)*: I don't think we would make these decisions on how to do this on our own at the Coordinating Center. Many of us work with residents, including myself, but we're not experts in residency education, so we would rely on the collective wisdom of the group and those that are experts. I know there's some on the call or maybe your colleagues to figure out how we can come up with a program, ideally using as much of existing MPOG infrastructure as possible, to be useful, and then also think of where the program could go outside of what we already have.

7. **Next Steps:**

i) MPOG Coordinating Center team will reach out to sites interested in participating in and ad hoc Resident Education Committee.

7. Dissemination of anonymized performance data for non-research purposes

1. Background
    a. 9/9 PCRC discussed review process for disseminating aggregate anonymized multicenter data
    b. Recent requests from Research Teams:
        1. Table showing # of times ketorolac was administered for pediatric tonsillectomies at each anonymized MPOG site
        2. Line graph showing monthly performance trend for NMB-05 (use of quantitative twitch monitoring) for all MPOG Institutions
2. Previous use case supported by QC – SUS-01 (see slides for screenshot)
3. Rationale for MPOG QI & Research Committee Review
    a. Scientific Rigor – ensure robust development of research products and QI measures reflecting a diverse expertise & applicability across a range of patient populations
    b. Participation in data use decisions – ensure decisions to provide access to multicenter data are made in democratic fashion

c. Transparency – provide forum for establishing shared understanding of how MPOG data is used

4. Proposed Policy: Expedited Review Pathway

	Expedited Review Pathway	QC Review Pathway
Data Sensitivity	Low-risk (anonymized, aggregate data)	Anything not satisfying all *Expedited Review Pathway* criteria
Data Quality	Curated phenotype, QI measure, or *commonly* used MPOG concept	
Complexity	No coordinating center programmer effort required	
Analysis Complexity	Descriptive statistics only (counts, %, mean/SD, median/IQR), typically resulting in a *single table or figure*	

5. Specific Use Case

   a. Anesthesiology Quality Institute (AQI) has requested approval to receive screenshots from MPOG to show variation in care with elderly patients receiving midazolam (BRAIN-01), and antibiotic redosing for cardiac surgery (ABX-03-C)

   b. AQI may submit these screenshots to CMS as part of their QCDR measure submission

   c. Demonstrating variation in care could help the AQI measures obtain approval as QCDR measures

6. Discussion:

   i) *Alexander Doyal (North Carolina)*: What are the concerns of data sharing? What sort of ethical conundrums give people pause.

      a. *Nirav Shah (MPOG Quality Director)*: Part of it is just the concept of data ownership. MPOG's perspective is that the data is owned by the participating MPOG sites. Potential investigators and quality champions use their data and anonymized data from other sites for quality improvement. Part of asking whether all such questions come to Quality Committee or not is just in recognition of that. There could potentially be controversial measures, measures where we are not

100% sure of the science behind, measures where folks may have some disagreement on whether it should be considered best practice. In most cases, those never get to the level of a quality measure. Our mortality measure which looks at 30-day in-hospital mortality shows some wide variation. It is anonymized but sites may feel that it shouldn't be shared with an outside entity unless the Quality Committee has had a chance to weigh in on who that entity is and why they are interested in using that data. There may be other situations (i.e. if we're showing sustainability measure performance at Michigan Society of Anesthesiology website or newsletter) that are relatively low risk and of interest to folks outside of MPOG. Something that highlights the work that sites are doing. We may not need to bring something like that to the Quality Committee. I think you that the perspective we have at the Coordinating Center and that's the one that we want to get some feedback on. Those are things thing that we can save time from the agenda or maybe share via email, an update versus a vote, which is what we typically have anytime we want to share data, as our bylaws currently require about sharing aggregate data or disseminating it outside of MPOG.

ii) *Katie O'Connor (Johns Hopkins)*: Let me preface that whenever I'm asked are there any issues, I try to come up with some so I'm not as adversarial coming up with a few questions, just trying to put my hat from a health equity DEI perspective. How could things that seem like they are going to be okay not end up okay. One of the thoughts I had is around how certain data is interpreted. One of the things we navigate when we are looking at health disparities is the nuance of interpretation, where, if there is a disparity between 2 groups, are we viewing that as a system issue like the care is different versus are we viewing this as an innate difference between different demographics from biological perspectives. As you can imagine that is a very controversial topic and there might be a variety of opinions on this call about that. That's something that whenever we are presenting health disparities data, we always have a lot of discussion around, even if the measure itself is innocuous, like AKI, we always have a lot of discussion around what does this say? Are we saying these groups are different? Or are we saying that care is different? If there's no governance on how we present that, there kind of a potentially rare by potentially problematic unexpected sequelae of unreviewed sharing. That's one thought I had just on DEI sensitivity. And maybe you already addressed these, but one would be, are

we saying that on the expedited review pathway that the investigator is the potential person sharing that data that makes those determinations of what qualifies under the expedited review, or there's still some minimal review person. It just doesn't go through a more detailed review. The second part is that did you say that the current DUAs between institutions do allow for this? If we decide to go forward.

a. *Nirav Shah (MPOG Quality Director)*: My perspective is that anything related to disparity or health equity would not fall under low risk. I think the Coordinating Center, both on the research and quality end, are areas that would want to bring up for Quality or PCRC review before we share broadly. We are proposing that at the Coordinating Center would make those calls based on our experience of use and curation of the data to determine if it was low risk, if it was good quality data, and of low complexity. We would make that call and then discuss it with the person or entity that's requesting it. From a DUA perspective, we do allow the dissemination of data. The DUA relates to the type of data that's submitted to MPOG. From a DUA, IRB, and BAA perspective, all of this is acceptable.
b. *Katie O'Connor (Johns Hopkins)*: Your answer aligns with my second question that there's still some objective 3rd party in the central Coordinating Center who is deciding that an investigator's low risk is actually low risk. All your answers made me feel better so thank you.
c. *Nirav Shah (MPOG Quality Director)*: This is something that we are asking for feedback on. I think it makes sense for low-risk data, and I think at the Coordinating Center we would be very careful about what we determine to be low risk. If we decide to do this, it is also okay to share without a QC vote. This discussion is about what the group feels comfortable with.

iii) *Josh Goldblatt (Henry Ford Allegiance) via chat*: I think if anonymized data is shared publicly, it opens the question locally potentially with a news outlet, "Where are you on this"

a. *Nirav Shah (MPOG Quality Director)*: We need to be careful about how it is disseminated. Whatever path we decide, especially if we decide to do the expedited path, which would be something new, we will run that by the Executive Board as well.

iv) *Nirav Shah (MPOG Quality Director)*: I do want to get into a specific use case, and I'll open the poll. Our colleagues at Anesthesiology Quality Institute (AQI) who we work in collaboration with on several different areas related to

measures and other QI work, requested approval a couple of months ago to receive screenshots from MPOG that shows variation in care with our BRAIN-01, which looks at the elderly patients receiving midazolam, and also our antibiotic redosing for cardiac surgery, ABX-03-C, as part of their submissions for CMS for QCDR approval of a measure related to best practices in elderly patients at risk of cognitive impairment, with the thought that demonstrating variation in care can help these measures obtain approval. QCDR measures which can potentially affect reimbursement for practices around the country that submit data for this program. This could be very useful for our specialty as part of a future submission for those measures to CMS. We think it is reasonable to help with something like this if MPOG data is represented appropriately. Cathlin from ASA is on the call, and I want to give her the opportunity to make any comments about this particular request.

a. *Cathlin Bowman-Young (ASA)*: after all my years running clinical registries, I appreciate and understand data use confidentiality. We would greatly appreciate just those screenshots as they could be so incredibly useful in making our case to CMS that a gap actually exists. We don't currently have access to gap data within these 2 topic domains. Being able to share those 2 screens captures with CMS would go a very long way as we would appreciate being able to do so. We look forward to building a deeper relationship in this regard. There may be other opportunities for us to collaborate and we would be interested in that. Thank you for your time and for your consideration.
b. *Nirav Shah (MPOG Quality Director)*: Any comments or concerns about this?
c. *Tariq Esmail (University Health Network - Toronto) via chat*: Is the intent to send a screenshot of only US institutions?
    i. *Nirav Shah (MPOG Quality Director)*: Right now, we include all institutions. We could remove all non-US institutions
    ii. *Tariq Esmail (University Health Network - Toronto) via chat*: I know we aren't the only non-US
d. *Nathan Pace (Utah) via chat*: is showing the MPOG threshold useful? It is the variation of care that is shown by the histogram
    i. *Nirav Shah (MPOG Quality Director)*: I don't know if the performance threshold would be useful for submission to ASA

ii. *Nathan Pace (Utah) via chat*: The threshold has been established by a policy decision at MPOG. That's not from my point of view, that's our threshold, that might not be anybody else's threshold. What to me is the most important thing shown by these histograms is the tremendous variation in care, so I would emphasize that rather than showing a particular threshold.

iii. *Nirav Shah (MPOG Quality Director)*: I think both of those points (excluding non-US institutions and removing the threshold in any data that we share) are both really good points

e. *Alex Abess (Darthmouth) via chat*: Was the vote question just a "pretend" vote? Or is AQI really planning on submitting those 2 as potential measures?

i. *Nirav Shah (MPOG Quality Director)*: This question is for Cathlin. Are you still able to submit those screenshots or will this be for a future submission?

ii. *Cathlin Bowman-Young (ASA)*: We did submit these 2 measures to CMS. The deadline was September 1st, but we will most likely end up going through a negotiation process with CMS, so having that gap information will help us make sure the measures move through the CMS process. If it's easier, even a statement of the variation of care, we know there is based on the data that we have, there is an X percent of variation in care that would be fine too if people are sensitive about sharing screen capture.

iii. *Alex Abess (Darthmouth)*: I just remember that it was quite a bit of debate amongst our group whether that's even a meaningful measure. That was where my question was coming from. Coming from the folks for AQI and ASA side, they were shocked to hear the amount of disagreement amongst the folks in MPOG at whether that's even a meaningful target to chase, and I don't know if sending this example of variation in care is helpful when there's not agreement that it's a meaningful measure

f. *Joseph J McComb (Temple)*: should we vote for the measures individually? Since there seems to be a disagreement in the measures

i. *Nirav Shah (MPOG Quality Director)*: The poll is fully set up for both. If there's any disagreement with the measures, then I think it would be important to get that feedback. Also, we will bring it up with the Executive Board.

g. *Vikram Kumar (Massachusetts General Hospital) via chat*: Could you bring back use cases on an occasional ongoing basis to keep the group informed?

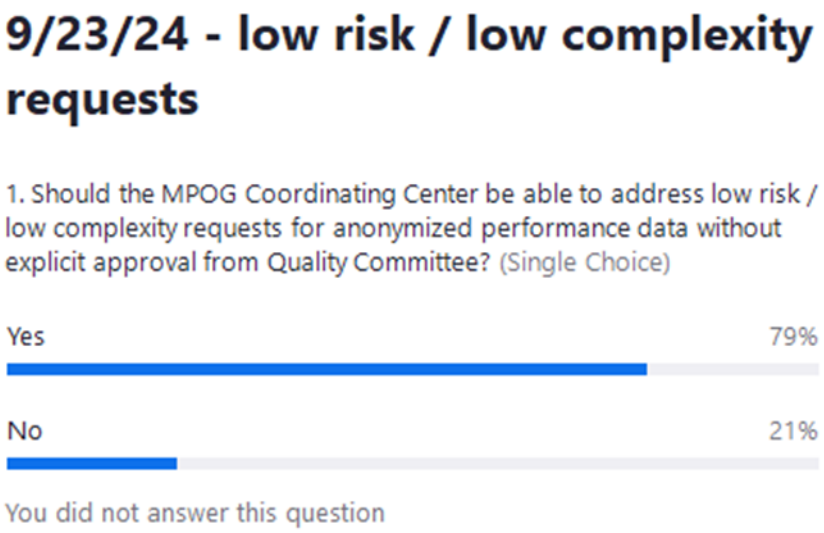
h. *Tariq Esmail (University Health Network - Toronto)* via chat: Can an FYI be included in Quality Committee agenda for any requests that do go through the expedited review so the committee is aware even though express consent will not be needed?

i. *Cathlin Bowman-Young (ASA)* via chat: I appreciate the critical feedback on the antibiotic measure

i. *Kate Buehler (MPOG) via chat*: Hi Cathlin – The critical feedback is regarding the BRAIN-01 (midazolam use) measure...especially replated to the threshold. I am happy to discuss further offline.

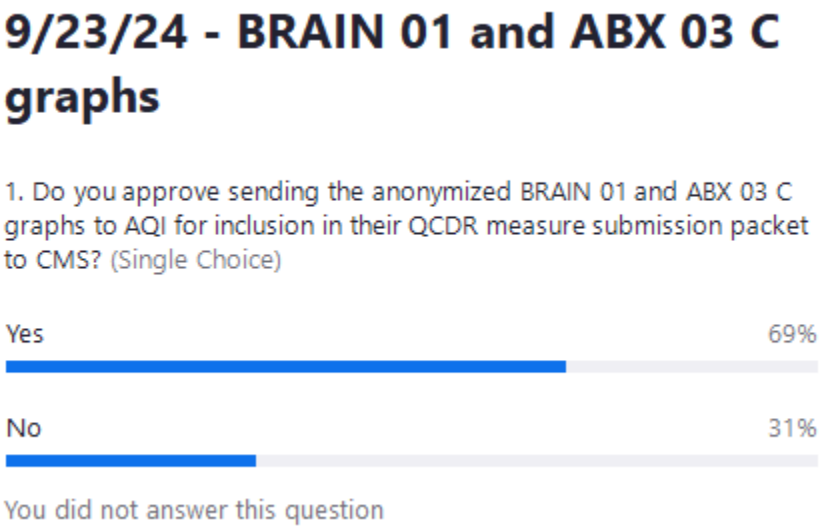
7. Vote:

a. Should the MPOG Coordinating Center be able to address low risk/ low complexity requests for anonymized performance data without explicit approval from Quality Committee? (yes/no)



i) *Nirav Shah (MPOG Quality Director)*: 79% approved of the expedited review. We will be judicious on how we use it. At future Quality Committee meetings, we will provide a pathway for entities that are interested in this area that may be useful.

b. Do you approve sending the anonymized BRAIN-01 and ABX-03-C graphs to AQI for possible inclusion in future QCDR measure submission to CMS? (yes/no)



ii) *Nirav Shah (MPOG Quality Director)*: Two-thirds voted yes, so 25 out of 36 sites, and 11 sites voted no. There are still some concerns either with concept in general or BRAIIN-01. Really good feedback from the group. I'm glad we brought this up. We'll circle back with the Executive Board and make sure there's no other issues.

iii) Next Steps:

a. MPOG Coordinating Center team will draft an expedited review policy and share with the MPOG Executive Board for review and approval.

b. Quality Committee has requested to be notified of any data shared as part of the expedited review process.

c. BRAIN-01 and ABX-03-C anonymized data will be shared with AQI for inclusion in the QCDR measure submission packet

i. Non-US sites to be removed from all graphs.

ii. MPOG measure thresholds will not be included.

iii. Statement about purpose of Brain 01 (informational, built to generate conversation)

8. **Inclusion of "Notable Events" in MPOG extract from sites – interest from sites?**

    1. Background: Notable events is a form in Epic that enables documentation of complications and are **included** part of the medical record
    2. We have received feedback that it may be helpful to enable sites to analyze this data within and across MPOG for QI and research
    3. This information is **not** part of the standard Epic extract to MPOG
    4. Would require IT involvement from sites to query their EHR and generate files to add to the extract
    5. MPOG is trying to understand if there is interest in this type of data, as we refine our roadmap
    6. Interest?
        a. Please let the Coordinating Center know if interested
        b. Is there enough interest across sites
    7. Discussion:

i) *Lucy Everett (Massachusetts General Hospital)*: When Epic introduced this, it took a long time to get through the Epic Steering Board because of concerns about the QA piece. One of the things was that it used to be called complications, and it was changed to notable events. The thought was that anything that should be documented, if the occurrence of the issue was going to be documented in the medical record, then it should be documented in a structured way that would let you report on it and that would let it be found for future anesthetics. I am in favor of doing this, but the biggest risk is that it is underutilized, as it is stated in the chats. If something is in there then it certainly happened, but if it's not in there then it doesn't mean that it didn't happen.

ii) *Mike Mathis (MPOG Research Director)*: I agree with this. I am generally supportive of including this type of information. I am very wary of information bias where self-reporting is very biased. I want to assure the community as the Research Director that if a research project was to be proposed using this, it will be heavily scrutinized. How to mitigate documentation bias is a very challenging issue. I would imagine that Nirav will have similar scrutiny over making sure that we don't come to misguided conclusions about these kinds of measures.

a. *Nirav Shah (MPOG Quality Director)*: That could be an interesting research project to compare Notable Events (self-reported) with the automated physiologic monitor derived data.
b. *Mike Mathis (MPOG Research Director)*: Anshuman Sharma and UCSF are working on an automated algorithm to detect cardiac arrest and it's very interesting to see which ones get automated capture of these events compared to self-reporting of those events. By this indication, documentation bias and information bias would be absolutely something we would scrutinize from a research perspective if a research project was proposed using it.

iii) *Tariq Esmail (University Health Network - Toronto)*: Thank you Lucy and Michael for your perspectives, I think I agree. UHN even before we participated in MPOG, there's a real hesitancy to use notable events, so that context is really helpful. If we do go ahead with this, I wonder if we can think about how it's not really used that well, how we can encourage that use and frame what Lucy just said so that its accepted because the sort of hesitancy of it being in the medical chart versus at some institutions they have separate QA elements. Maybe for an individual institution to compare notable events with their own internal system that captures it might be interesting. I don't know the value of comparing one site with another site based on notable events.

iv) *Jonathan Paul (Columbia)*: At Columbia we are trying to make a push to get people to document more of these. We are selecting a short list and trying to get folks to focus on those in large part to reduce the reliance on automated processes and individual chart reviews by our QA team. I agree with all the potential issues of comparing across sites stemming from self-reporting deficiencies. The potential to maybe explore comparing incidents of self-reporting notable events for sites that do it with machine learning and AI tools that might be able to pick up on these things in a more automated way.

v) *Stephen Gregory (WUSTL) via chat*: Notable Events is very rarely used at Wash U. Almost all major events are documented as quick notes in the intraop EMR. They are not infrequently "signed" by the attending physician as well, which could make them difficult to make anonymous.

vi) *Greg Balfanz (North Carolina) via chat*: We struggle to get people to document here. We have tried to "sell it" as making sure the postop notes are more appropriate as most of our postops are done by a PACU resident. But I fear our compliance with accurate documentation here vs Q notes in the chart is quite bad

vii) *Alex Abess (Darthmouth)* via chat: We don't use notable events feature in Epic at Dartmouth for disclosure reasons – despite the potential benefits

viii) *Lucy Everett (Massachusetts General Hospital) via chat:* I would just say that the same data limitations apply to things like documentation of postoperative vomiting

ix) *Megan Anders (Maryland) via chat*: Positive presence could help complex populations to help study rare events (similar to closed claims) but agree the limitations must be front and center on the data definitions

x) *Nirav Shah (MPOG Quality Director)*: A couple of comments in the chat. Several agree with the fact that it's hard to get providers to document this. Dr. Gregory is saying that some of these are signed, so a provider will put a comment in and then sign it, maybe the anesthesia faculty. Our PHI scrubber should scrub the PHI from it, but sometimes it may not so I think you are correct. There is a risk that names could come across into the Coordinating Center import. As of now, this is something that is not part of the standard Epic extract, so it would require some work. People at your sites would have to generate the queries and add the files to the extract. I am curious to know, for those that didn't put something in the chat, if this would be of interest to a specific site to participate in this. If they think it is worth the work to engage your IT teams to add them to the extract. I am interested in seeing what percentage of sites would be interested in this. Think about it if this is something that we should focus on again in the next year or two.

xi) Next steps:

a. MPOG will not pursue "Notable Events" at this time due to lack of utilization in documentation

Meeting Adjourned: 1102 EST

Next meeting: November 25th, 2024