Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE)

Quality Committee Meeting Notes – Monday, July 22nd, 2024

Attendance:

Benjamin Stam	Laurence Ring
Bethany Pennington	Linda Liu
Bill Dewhirst	Lorile Greenblatt
Bradford Berndt	Mara Bollini
Brian Reon	Marc Philip Pimentel
Bryan Cohen	Mary McKinney
C.Bowman-Young	Megan Perkaj
Charity Corpus	Mellany Stanislaus
Chris Bourgeois	Merajuddin khan
Chris Wedeven	Meredith Hall
Claire Ostarello	Meridith Wade
Dale Parks	Michael Mathis
Denise Schwerin	Michele Narens
Diana O'Dell	nancy abou nafeh
Diego Bauza	Nicole Barrios
Dieter Adelmann	Nikki Pardo
Douglas Colquhoun	Nirav J Shah
Elizabeth Jewell	Pam Tyler
Eva Lu-Boettcher	Rania Elkhateb
Germaine Cuff	Rebecca Johnson
Hanna Van Pelt	Rebecca Pantis
Heather LaLonde	Ronnie Riggar
Hedi Schroeck	Roya Saffary
Henrietta Addo	Ruth Cassidy

Jacquelyn Goatley	Sachin Kheterpal
Jason Sheffield	Sandra Becker Rozek
Jing Tao	Sarah Kirke
Joe Tandoc	Shu Zhu
Jonathan Kaper	Spiro Spanakis
Jonathan Paul	Stephen Gregory
Joseph J McComb	Tiffany Malenfant
Josh Goldblatt	Tim Harwood
Karen Domino	Tom Joseph
Kate Buehler	Troy Wildes
Kate Hubbert	Victoria A Lacca
Katherine Vitale	Vikram Kumar
Kathleen Collins	Wendy Owens
Kathy Lee Scranton	Yuan Yuan
Katie O'Conor	Yuliana Salamanca

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 May 20th, 2024, Quality Committee Meeting

1. *Nirav Shah (MPOG Quality Director)*: Before we get started, I wanted to give a shoutout and acknowledge the great work of Dr. Dan Biggs from Oklahoma. He retired last month and was one of the original MPOG QI Champions and PIs that has worked with MPOG for a long time. He has been a big part of what MPOG has been over the last decade or so. Best wishes to Dan as he starts his next phase of life. Thank you, Dan!

(4) Announcements

1. Precision Feedback Trial Launched
    a. Full scale launching Wednesday May 22, 2024!
    b. All eligible sites (46) opted in. Thank you!
    c. 23 to receive the same email. 23 sites to receive updated "precisionized email"
    d. Thank you in advance for meeting your upload deadlines, especially during the next 6 months. Please let the coordinating center know of any potential delays.
2. Featured Member – July and August
    a. Roya Saffary, MD – MyMichigan Health – Stanford University

(5) 2024 Meetings

1. Friday, September 13, 2024: ACQR Retreat, Henry Executive Center, Lansing, MI
2. Friday, October 18, 2024: MPOG Retreat, Philadelphia, Pennsylvania
3. **Upcoming Events**

(6) Provider Feedback: Student Registered Nurse Anesthetists

a. Provider Feedback Email Groups:

1. Provider feedback emails currently include the following comparison groups: Attendings, Residents, Fellows, CRNAs, AAs
2. Participating site (Cleveland Clinic) has requested that an additional comparison group be added for SRNAs
3. Would other sites be interested in this additional comparison group for SRNAs?
4. Do other sites have SRNA sign in and sign out data?
5. Discussion:
    (i) *Hedi Schroeck (Dartmouth Hitchcock Medical Center) via chat*: Dartmouth. Yes, interested. Yes, we have sign-in and sign-out data.
    (ii) *Alvin Steward (UAMS) via chat*:
    UAMS would be interested. Yes, they sign in and out of the case.
    (iii) *Josh Goldblatt (Henry Ford Health System) via chat*: Yes, and Yes for Henry Ford
    (iv) *Troy Wildes (Nebraska Medicine) via chat*:
    Interested too. Yes, they sign in here (U of Nebraska)
    (v) *Marc Pimentel (Brigham & Women's Hospital) via chat*: Yes, SRNAs sign in at BWH
    (vi) *Mary McKinney (Corewell Dearborn/Taylor) via chat*: The SRNA's that I have seen on cases at Dearborn do sign and out.
    (vii) *Joseph Tandoc (Henry Ford Health System Macomb) via chat*: Yes, and Yes Henry Ford Macomb
    (viii) *Bradford Berndt (Bronson Kalamazoo) via chat*: Yes, we would be interested at Bronson Methodist. They sign in here too
    (ix) *Charity Corpus (Corewell Royal Oak) via chat*: Both yes for RO Corewell
    (x) *Tom Joseph (UPenn) via chat*: Interested. They sign in sometimes, but we would standardize 100% sign in
    (xi) *Stephen Gregory (WashU) via chat*: Yes, for Wash U

(xii) *Katie O'Connor (Johns Hopkins) via chat*: JHM interested

(7) QI Reporting Tool Updates

a. Site Selected Dashboard – Updated
   1. View measures on emails alongside other measures of interest
   2. "**Star**" measures of departmental interests are not on emails

b. Updated Result Reasons

c. Updated Breakdown by location graph

d. Release nots not available on our website.

e. Discussion:

i) *Mary McKinney (Corewell Dearborn/Taylor) via chat*: Really like the new functionality! Great work!

ii) *Marc Pimentel (Brigham & Women's Hospital)*: I think this is great. It's always good having to look back and see which measures we are tracking, but I didn't want to send emails to everyone just because I was looking at it. These are very welcome changes. Thank you.

iii) *Nirav Shah (MPOG Quality Director):* Thank you, Marc. As you're starting to navigate the QI Reporting tool, now that we've hopefully gotten some underlying performance issues resolved, please let us know if there are any other features that you think will be helpful. If you are still having performance issues for the standard display, anytime you click on the query buttons or if you're filtering for more than 2 years of data, then essentially, we need to re-query the database. If you're within 2 years and still having significant performance issues, let us know so we can address it.

(8) Measure Review: PAIN-02: Dr. Roya Saffary, Stanford University

1. Description: Percentage of adult patients receiving at least one non-opioid adjunct preoperatively or intraoperatively.
2. Exclusion criteria:
   a. Age < 18 years
   b. ASA 5 & 6
   c. Patients who remained intubated postoperatively
   d. Procedures such as open cardiac, obstetric procedures, ECT, TEE/Cardioversion, Endoscopy, Bronchoscopy, Intubation only cases, Diagnostic imaging, non-operative procedures, central line placement, lumbar puncture, otoscopy, eye procedures
3. Success criteria: At least one non-opioid adjunct (medication, regional block, or local injection) was administered to the patient during the measure time period.
4. Other Measure Details
   a. Dexamethasone given alone is not considered a non-opioid adjunct to prevent multiple false positives that may skew measure performance.

b. Opioid Sparing Medications must be administered between Preop Start and Anesthesia End via a valid route. Lidocaine given IV is not considered.
c. Local Anesthetic Considerations: Documentation must occur between Preop Start and Anesthesia End
d. Regional/Neuraxial Block is determined by the Peripheral Nerve Block and Neuraxial phenotypes respectively. Documentation considered from Preop Start through PACU end.

5. Discussion:

(i) *Roya Saffary (Stanford University)*: I was concerned about local injection and how well that is documented. I personally find it difficult to find where it is documented and how to obtain the data.

(ii) *Nirav Shah (MPOG Quality Director):* As long local injection is documented in the MAR; we will get the local information that is administered by the local team. Assuming the circulating nurses documented it. There may be a couple sites where the anesthesia team documented, but the data we receive shows it is being documented by circulating nurses, and we are including that in.

(iii) *Roya Saffary (Stanford University)*: For other feedback, we have a lot of patients to that get blocks and catheters placed outside of the OR. So, either in the ER or on the floors and they may come to the OR with them in and I do not know if they are being properly captured. From personal experience, when I have patients that I care for in the OR who come in with a catheter, I do not document that the catheter is running. I assume it's the nursing report and nursing chart, but unsure if that crosses over to the MPOG data. To avoid false positives, we must figure out how to capture that data, but not include patients that simply get a block without an operative procedure.

(iv) *Nirav Shah (MPOG Quality Director):* Not just at Stanford, but I know there are other hospitals where those blocks are being pushed as early as possible. If the local anesthetic that is being administered through that block, if it's a catheter, if that was documented by the anesthesia tea or the circulating nurse team as being administered or being infused during the procedure, then we will likely get it, but we are not looking at the procedure documentation that's happening in the emergency room. If it happens to fall within the period in which we are pulling block information, then we may be getting the data. I am leery of extending and including the procedure notes obtained in the emergency room. We may include blocks that we did not intend to. So, I think we can investigate this and see if we can be better at capturing what we need and see if we are missing a lot of blocks that should be included as well.

(v) *Roya Saffary (Stanford University):* Will it be possible to link cases that are in the OR to previous blocks. If they had a block, they include those blocks, versus patients who had a block but with no operative procedures afterwards. I do not know how feasible it will be.

(vi) *Nirav Shah (MPOG Quality Director):* We could extend the period between when the block was performed and the procedure. For example, 4, 12, or 24 hours and potentially include many of those. If we did that, we would have to see if there are a lot of blocks that we are including that we do not intend to. We can at least extend the look back period for procedure notes.

(vii) *Rania Elkhateb (UAMS) via chat*: Can there be a separate quality metric for cardiac cases?

a. *Nirav Shah (MPOG Quality Director)*: This is a valid perspective. We plan to share this feedback with the Cardiac Subcommittee, Dr. Janda and others, to bring it up at the next meeting and see what their approach could be. Should they try and include it in this measure or create a new cardiac measure? Assuming there is more variation in administration in non-opioid adjuncts and cardiac cases, they could skew or change overall performance for PAIN-02. The Cardiac Subcommittee needs to figure out how they would like to implement it and if the rules of implementation are a little bit different.

(viii) *Josh Goldblatt (Henry Ford Health System)*: Most EMRs that I have seen do include and administration mode of "Rate Verify." If anyone in the periop team documents this on a pain catheter, this should be captured by MPOG. The places I have worked at consider it policy anytime there is a handoff that the receiving nurse would document it. I am unsure of the individual practices at other sites. It may be worth visiting to ensure that data is captured and that those procedures are captured.

a. *Nirav Shah (MPOG Quality Director)*: I am not 100% sure if the rate and verify crosses into MPOG extract.

6. **PAIN-02 Exclusion**:

a. Current exclusion for patients transported to ICU intubated. However, more liver transplant cases with OR extubations. Received feedback from sites that adjuncts (acetaminophen, regional, etc) may not always be appropriate for these patients.

1. **Consider adding Procedure Type: Liver Transplant as exclusion**.

b. Current exclusion for endoscopy cases, but ERCPs are not part of these exclusions. We are adding ERCP as part of the endoscopy case type exclusion for PAIN-02.

c. Discussion:

(i) *Ketan Chopra (Henry Ford Health System) via chat*: We have a lot of patients with popliteal catheters who come down for repeat procedures, is there anything we can do to document this now or just hold off until it is investigated?

a. *Nirav Shah (MPOG Quality Director):* We need to see if those are being included right now, or if we are not capturing those, let us

know. We can investigate further to see why they are not being captured. If it is the time window or some other reason.

(ii) *Rania Elkhateb (UAMS)*: Are repeated procedures not excluded from the metrics? If the same patient has 2 surgeries, will they both be captured?

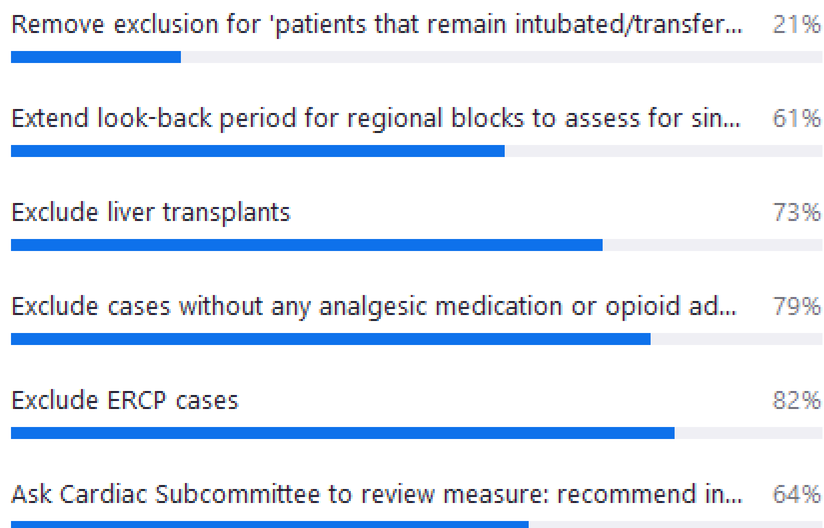
a. *Nirav Shah (MPOG Quality Director):* Both are being captured and both are being looked at individually. The thought behind this measure was that if a patient has an index procedure, then returned a couple of days later for a re-operation, then the re-operation should still get an opioid sparing adjunct unless it met one of the exclusion criteria.

d. MPOG Coordinating Center Comments on PAIN-02:

1. Consider additional exclusion for cases without any analgesia (opioids or opioid sparing agents) administered between preop start and anesthesia end.
2. Consider additional exclusion for anesthesia block only cases
3. Update organization of exclusion list to be similar to PAIN-01
4. Performance across MPOG – June 2023 – May 2024
    a. Performance range: 46% - 100%

e. PAIN-02: Vote

1. Remove exclusion for patients that remain intubated/transferred to ICU
2. Extend look-back period for regional blocks to assess for single-shot blocks performed on floor or ED before transfer to OR
3. Exclude liver transplants
4. Exclude cases without any analgesic medication or opioid administered
5. Exclude ERCP cases
6. Ask Cardiac Subcommittee to review measure: recommend including cardiac cases
7. Coordinating center will review all votes after the meeting to ensure no duplication across sites



7. Measure Updates

a. SMOK-02: Provider Attribution

1. Description: Percentage of adult patients who are documented as current tobacco smokers and also receive an approved smoking cessation intervention from an anesthesia provider.
2. Updated measure to attribute only those providers signed in at anesthesia start rather than all providers signed into case (as originally specified)
3. No change to departmental performance
4. Minimal performance changes overall for individual providers

b. Glucose Measures: Provider Attribution

1. Provider Attribution Overview:
2. Measures are assigned a result (passed/flagged/excluded) at the case level
3. Each provider signed into the case is also assigned a result – may differ from case level result
4. Provider attribution criteria is developed by the Quality Committee when the measure initially developed, and is specific to each measure
5. Not all measures assign provider attribution – some measures provide departmental results only (MORT-01)
6. Provider Attribution – Glucose Measures

   (a) Current Logic:

      (i) For glucose measures looking for treatment or/rechecking within 90 minutes: Provider(s) who administered insulin or rechecked glucose within 90 minutes will PASS.

(ii) If no insulin administered or if no recheck occurred: Providers signed in exactly 90 minutes after the glucose result are flagged (Not *within* 90 minutes, *at* 90 minutes)

(iii) Issue:

1. If transfer of care occurred during the 90 minutes after the high (or low) glucose value, the measure will attribute a relief provider rather than the primary provider. Is this appropriate? We are assuming that the handoff happened appropriately.

(iv) Example:

8. 1100: Provider A signed in
9. 1200: Glucose – 350 mg/dL
10. 1230: Glucose treated with insulin (Provider A - PASS)
11. 1300: Glucose – 300 mg/dL
12. 1330: Provider A signed out
13. 1330: Provider B (relief provider) signed in
14. 1430: Glucose not treated or rechecked (Case – Flagged; Provider B – Flagged)
15. 1435: Provider B (relief provider signed out)
16. 1435: Provider A signed in
17. Should both providers be flagged? Only Provider B (signed in at 90 mins)? Or Provider A as well (within 90 minutes)
18. If the 2nd high glucose was re-checked or treated, should both providers PASS, or just Provider B?

7. Discussion:

(i) *Josh Goldblatt (Henry Ford Health System)*: I have been working with Kim Finch to investigate our glucose processes across Henry Ford. We recently audited 200 glucose cases, to see what step happened. We did not concentrate on provider attribution but noticed treatment issues through handoff in different phases of care from preop to intraop and then into PACU. While auditing for quality, we laid out a 15-minute hand over window. So, if a provider leaves preop and the recheck is due within 15 minutes, the departing provider or team should take care of that, so the receiving team is not left with a 15-minute window. We are also considering reminder BPAs that remind providers to intervene. So, we are using a 30-minute window for that. Part of our conversation has been around avoiding over testing. In the example given, is a handoff that occurred 30 minutes after a high glucose way too early to consider? I think it is too early. It is less than half of the allocated 90-minute time frame. Personally, I like the idea of attributing to both providers, positive and negative.

(ii) *Kathleen Collins (Trinity Health Livonia)*: I am in favor of both providers being attributed. We had a CRNA who gave a 15-minute break and the 90-minutes happened during that time. The person who gave the break was attributed, but then the CRNA that was there before and after the break was not attributed. If it is a

problem with process and handoff, then both providers should be attributed in this circumstance.

a. *Nirav Shah (MPOG Quality Director)*: The counter point of that could be that there's already transfer of care measures that are meant to address that.

(iii) *Troy Wildes (Nebraska Medicine) via chat*: I do think it is unfair to attribute someone who signs in right before the glucose/insulin due time (e.g. 10-10 min) as there is no sufficient time to intervene and would suggest excluding receiving physician in this scenario (not attributing both) *(Seconded by Katie O'Connor (Johns Hopkins))*

8. Vote:

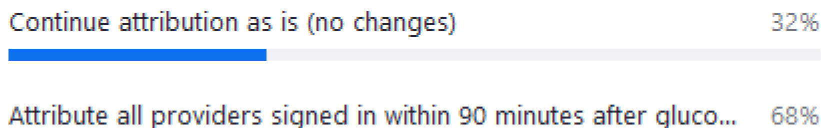
a. 1 vote/site – Coordinating Center will review all votes after the meeting to ensure no duplication

b. Continue as is – no changes

c. Modify – Attribute all providers signed in within 90 minutes after glucose

7/22/24 - Glucose Measures

1. Glucose Measures (Single Choice)



8. New Measures

a. **NMB-04: Variation in Sugammadex Administration**

1. Description: Percentage of adult and pediatric (> 3 years) cases with sugammadex administration where cumulative sugammadex dose $\leq$ 200 mg OR $\leq$ 3 mg/kg
2. Threshold: 90%
3. Measure Time Period: Anesthesia Start to Earliest Extubation
4. Exclusions:
    a. Age $\leq$ 2 years
    b. ASA 5 & 6
    c. Cases < 30 minutes
    d. Patients that were not extubated in the immediate postoperative period
5. Success: Cases where cumulative sugammadex dose was $\leq$ 200 mg OR $\leq$ 3 mg/kg
6. NMB-04 Performance across MPOG
    a. June 2023 – May 2024 Performance range 51% – 100%

b. **NMB-05: Quantitative Monitoring**

1. Description: Percentage of cases with documentation of train-of-four count or ratio provided by a quantitative monitor (acceleromyography, electromyography, kinemyography, or mechanomyography)
2. *No threshold – informational only measure*
3. Measure Time Period: Patient in Room to Patient Out of Room
4. Exclusions:
    i. ASA 5 & 6 including Organ Procurement
    ii. Patients not receiving neuromuscular blockade
5. Success: Documentation of train-of-four count, or ratio provided by a quantitative monitor (acceleromyography, electromyography, kinemyography, or mechanomyography)
6. NMB-05 Performance across MPOG
    iii. June 2023 – May2024 Performance range 0% – 99%
7. **Discussion:**
    (i) *Troy Wildes (Nebraska Medicine) via chat*: We are finding NMB-05 very useful in supporting quantitative expansion. Any way to start thinking about provider attribution for this one so we can look at this data at our sites?
        a. *Nirav Shah (MPOG Quality Director)*: We can. Once we have more confidence in the data quality across all sites and we have interest, we can think about provider attribution as well.
    (ii) *Joseph McComb (Temple Health) via chat*: Would like to see recovery percentage with Quantitative monitoring > 90%.
        a. *Nirav Shah (MPOG Quality Director)*: Yes, great point. Maybe another measure related to neuromuscular dosing as well.

c. **BRAIN-01: Benzodiazepine use**
1. Description: Percentage of patients ≥ 70 years old who received a benzodiazepine perioperatively.
2. *No threshold - Informational only measure*
3. Measure Time Period: Pre-op Start to PACU End
4. Exclusions:
    a. Age < 70 years
    b. ASA 5 & 6
    c. Floor/ICU emergent intubation only cases
    d. ICU transfer postoperatively
5. Success: Avoiding administration of benzodiazepines for patients ≥ 70 years
6. BRAIN-01 Performance across MPOG (Inverse)
    a. June 2023 – May 2024 Performance Range 0% - 86%

Meeting Adjourned: 1102 EST

Next meeting: September 23rd, 2024