Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE)

Pediatric Subcommittee Meeting Minutes – November 4, 2024

Attendance:

Henrietta Addo, MPOG	*Meredith Kato, OHSU*
*Peggy Allen, Akron Children's**	*Sachin Kheterpal, MPOG*
Benjamin Andrew, Duke	*Rahul Koka, Johns Hopkins*
Nicole Barrios, MPOG	*Heather LaLonde, Trinity Health*
Morgan Brown, Boston Children's	*Thomas Long, Vanderbilt*
Robert Brustowicz Boston Children's	*Eva Lu-Boettcher, University of Wisconsin*
Kate Buehler, MPOG	*Tiffany Malenfent MPOG*
Mei Calabio, MPOG	*Graciela Mentz, MPOG*
Ruth Cassidy, MPOG	*Kam Mirizzi, MPOG*
Ellen Choi, University of Chicago	*Viviane Nasr, Boston Children's*
Julianna Clark-Wronski, University of Chicago	*Ali Nye, OHSU*
Robert Coleman, MPOG	*Diana O'Dell, MPOG*
Tony Edelman, MPOG	*Vikas O'Reilly-Shah, Seattle Children's*
Lucy Everett, Mass General	*Rebecca Pantis, MPOG*
Olga Eydlin, NYU Langone	*RJ Ramamurthi, Stanford*
Amber Franz, University of Washington	*Chuck Schrock, WUSTL*
Jackie Goatley, University of Michigan	*Nirav Shah, MPOG*
Kirsten Groody University of Michigan	*Ruchika Sharma, University of Virginia*
Ruchika Gupta, University of Michigan	*Frances Guida Smiatacz, MPOG*
Bishr Haydar, University of Michigan	*Margaret Stewart, University of Michigan*
Jerri Heiter, Trinity Health	*Rachel Stumpf, MPOG*
*Ahmar Husain, Phoenix Children's**	*Meridith Wade, MPOG*
Cathie Jones, Boston Children's	*Lindsey Weidmann, CHOP**

**Denotes participant from non-active MPOG Institution*

Start: 1602

Minutes from May 13,2024 meeting approved - minutes and recording posted on the MPOG website for review

Announcements

- Pediatric case data across MPOG sites have increased from 2.6 million to 3.2 million cases, enhancing potential for QI analysis and research.
- At the Spring meeting, Seattle Children's reported significant improvement in Train-of-Four documentation for the NMB-01 measure, increasing from an 18% baseline to over 80% following department engagement and an EMR update.
- The research committee (PCRC) approved three new pediatric studies: Blood pressure management in pediatric surgery (PCRC 254), Post-induction hemodynamic reference values (PCRC 192), and Neonatal airway management practice (PCRC 257).
- In 2025, the subcommittee will review four QI measures across three domains of care, with thanks to volunteer contributors: NMB initial dosing, transfusion practices, and nitrous oxide use.

Measure Review: PONV-04-Peds (Review Document)

- Dr. Ben Andrew and Dr. Meredith Kato provided an in-depth analysis of the postoperative nausea and vomiting (PONV) quality metric for pediatric patients. The current guideline from 2020 is being updated, with the 2025 guideline in submission. This metric focuses on providing antiemetic prophylaxis based on assessed patient risk.
- Ondansetron and dexamethasone have strong supporting data as effective agents, whereas other potential regimens lack sufficient randomized trial data. Continued debate on the role of dexmedetomidine, which lacks robust PONV-specific data.
- **Data Availability and Risk Calibration**: questioned the comprehensiveness of underlying model data for more precise scoring adjustments.
    - The existing models, POVOC (2004) and VPOP (2014), are the primary tools for predicting pediatric PONV risk. However, these models are somewhat outdated and lack recent robust evidence. Both models were built using data without antiemetic intervention and have limitations regarding their applicability to current practices.
- **Opioid Use and Risk Definition**: Discussions indicated differences in how opioid administration relates to PONV risk. Evidence suggests that *any multiple* use of intraoperative opioids increases the risk for postoperative nausea or vomiting
    - Current measure logic considers opioids a risk factor if ≥ 1 long-acting opioid is administered between Induction End and PACU End
        - Morphine, Meperidine, Methadone, Oxycodone, Hydrocodone
    - Consider broadening this list to any opioids administered between Induction End and PACU End. Update risk factor to only count if > 1 opioid is administered during that timeframe.
- **Preoperative Anxiety as a Risk Factor**: Suggestions to include preoperative anxiety as a risk factor were considered but ultimately not recommended due to insufficient robust data and practical challenges in measurement.
- **Expansion of age range to include patients ≥ 28 days:** Patients one month up to 2 years have shown over 20% PONV with placebo. This shows vomiting risk reduced by ondansetron, but further data are lacking. https://pubmed.ncbi.nlm.nih.gov/16037143/

- **Proposed Modifications**
    - Update success criteria to at least a single agent for all patients (0 risk factors), with combination therapy of two agents for those at higher risk (≥ 1 risk factor).
    - Modify definition of opioid risk factor → Multiple doses of any opioid between induction and PACU end.
    - Update age inclusion of Infants *(*pending MPOG central data analysis)*
    - Consider Hydrocortisone IV as an antiemetic
    - Add Anticholinesterase administration intraop as risk factor

- **Next Steps**
    - Begin preparatory work for changes in the MPOG Dev environment
    - Wait for the release of the 2025 updated guidelines before publishing measure changes.
    - Review MPOG Central data and summarize findings for PONV process/outcomes for patients < 3yrs old.
    - Send summary and voting link to MPOG Pediatric champions after 2025 guidelines are published

Future QI Measure Development:

- Discussion on potential metrics for pediatric anesthesiology, focusing on the process of measure development and the types of metrics—both process and outcome—that could add value. Ideas for new metrics include discharge readiness, antibiotic appropriateness, PACU pain scores, and pediatric cardiac measures.
- Morgan Brown (Boston Children's) highlighted ongoing efforts to develop cardiopulmonary bypass measures, with further updates expected early next year.
- Suggestions included aligning metrics with NSQIP, although challenges exist with manual data abstraction. Additionally, neonatal video laryngoscopy as a potential metric was noted, aligning with ongoing PCRC studies

Meeting Concluded: 1702

Full Transcript

Announcements

Vikas O'Reilly-Shah (Seattle Children's): Thanks, everybody, for joining our November meeting of the Pediatric MPOG Committee. Although we have a thin agenda, I hope we can spend a good bit of time discussing some measure development at the end of the meeting. I'm pleased to report the continued growth of pediatric cases across various sites. We're now up to 3.2 million cases, compared to 2.6 million at the last check-in. It's a really nice growth in the cases available for various analyses that we are contemplating for both quality and research purposes.

A quick recap on the spring meeting: we discussed the development and dissemination of quality feedback at Seattle Children's, specifically highlighting our documentation of Train-of-Four for our NMB-01 measure. We had a baseline rate of 18%, and after chatting with the department in just one morning meeting and implementing one measure in our electronic medical record, I'm happy to report that our performance is now over 80%. Nirav also went over some sustainability and quantitative monitoring measures, highlighting variability in performance across institutions.

Our research update is a new standing agenda item. Recently, there were two approved PCRCs: one is a large team effort with myself, Wes Templeton, and a sizeable group of others looking at interventions on blood pressures using vasopressor and colloid in pediatric non-cardiac surgery. Another is PCRC 192, focusing on reference values for post-induction hemodynamic measures in pediatric patients undergoing general anesthesia for non-cardiac procedures. Both studies examine hemodynamics in slightly different ways. Then there's PCRC 257, which looks at neonatal airway management practices. If you're at an MPOG institution, you're welcome to join these meetings as a non-voting member.

We have a cadence of meetings three times a year; our next one will be in March. We are always open to agenda items from anyone on the call, so feel free to email myself, Morgan, or Meredith Wade if you have anything you'd like to discuss. Over the course of 2025, we will be reviewing three measures: NMB initial dosing, transfusion vigilance and over-transfusion, and avoiding nitrous at induction. We appreciate those who have volunteered to review these measures. Ensuring that the measures stay relevant and current with the latest literature is crucial, and we thank you for your time and effort. You, too, could have your name up in lights if you'd like.

PONV-04-Peds Measure Review

Ben Andrew (Duke University): Dr. Kato and I were tasked with reviewing the PONV, or postoperative nausea and vomiting, quality metric. This is a process measure for prophylaxis against postoperative nausea and vomiting in pediatric patients. This is the second iteration of this process metric, which was updated after the last consensus guidelines for PONV management were released back in 2020. The metric asks clinicians to provide antiemetic prophylaxis based on the assessed risk of each patient developing PONV. You create a risk score sum from a list of risk factors, and then administer antiemetic agents accordingly: one agent for one risk factor, two agents for two risk factors, and three or more agents for three or more risk factors, ensuring these agents come from different pharmacologic classes. I will say that the consensus guidelines group for PONV in adults and children just met last year, and I

was part of the pediatrics team. The updated 2025 guidelines are in the completion or submission phase and should be published in the next several months with some minor changes that may influence how this measure changes in the future.

A large portion of this document focuses on evidence review for risk prediction and intervention against PONV in children, much of which comes from our review for the guidelines update. To summarize, past guidelines have recommended a risk-based prophylaxis approach. To implement this, we need robust evidence for predicting PONV risk accurately in our current anesthetic landscape. Risk tools should provide a sense of the probability of PONV for a patient without intervention, which should generally match actual incidence rates. We must also clearly understand the effects of our interventions from randomized trials, such as the odds ratio effect of a single agent chemoprophylaxis with ondansetron on PONV probability. Understanding when to step up therapy based on a patient's risk is also essential, considering system, patient-level priorities, and resources. There is a dearth of evidence in pediatric patients for these commitments.

Starting on this page with risk prediction in children, there's significantly less evidence compared to adult literature. Only two robust, multivariable prediction models exist for pediatric PONV. These models, actually developed to predict postoperative vomiting rather than both nausea and vomiting, were built in 2004 and 2014. They used prospective studies that gave children no antiemetics, and they looked at risk factors for postoperative vomiting. These models are somewhat outdated, focusing on volatile maintenance agents like Halothane to Isoflurane, received by patients. There's also an oversimplification in risk profiles, trying to condense risk scores into memorable 1-2-3-4 point scales. Despite this, they are our best tools so far.

For example, the POVOC score from 2004 includes factors like surgery duration over 30 minutes, patient age over 3 years, strabismus surgery, and family history of PONV. The VPOP score from 2014 uses three age categories, family history, surgery duration over 45 minutes, high-risk procedures, and multiple opioid doses. These tools were validated in smaller studies, but no newer risk prediction models have been developed. Importantly, both studies found similar PONV risks in patients with no or one risk factor: 5-6% and 9-10%, respectively.

Regarding interventions, there isn't a large amount of randomized data outside of 5-HT3 antagonists like ondansetron and dexamethasone. Both drugs show robust randomized trial data, with ondansetron effective down to one month of age per FDA labeling; they are also the only agents with reliable combination therapy data. Beyond these, evidence is scarce, particularly for suggesting two, three, or four-agent regimens. During our Duke study before implementing guidelines, we found that meeting antiemetic thresholds based on risk showed benefits, particularly for low-risk patients, with one or two risk factors. However, for patients with higher risk or recommended three agents, the benefit vanished. This reflects the need for further evidence validating multi-agent regimens' efficacy, particularly in pediatric patients.

In summary, evidence for predicting PONV risk and intervention effects in pediatric patients is lacking. The current metrics of one agent per risk factor need revision as newer guidelines get published, and further research is necessary to provide definitive recommendations.

Meredith Kato (OHSU): Thank you, Ben. That was a thorough presentation. I also conducted a literature review and found no data substantially changing our risk profile or how we define it, validating your points. Two topics arose in my review. First, hydrocortisone isn't on the list although methylprednisolone and dexamethasone are; to administer a small dose of dexamethasone atop a stress steroid dose seems unnecessary. I searched for evidence to support treating hydrocortisone equivalently to dexamethasone, examining studies on severe COVID and refractory asthma that discussed steroid equivalents. It's reasonable to add hydrocortisone to the qualifying list if it helps ensure measure success.

The second point is about dexmedetomidine. While some studies associate it with reduced PONV, the effect causality is unclear. There are no primary PONV-focused studies or robust randomized trials like those for ondansetron and dexamethasone. Thus, I don't support dexmedetomidine as a qualifying agent against PONV. Its apparent benefit likely comes from reduced opioid use rather than an inherent PONV reduction capability.

Summarizing, the data for dexamethasone, dexmedetomidine, and hydrocortisone compliance against PONV measures doesn't strongly support precedex's efficacy alone. Rather, dexmedetomidine probably helps through overall opioid reduction. Therefore, adding hydrocortisone reasonably aligns with measure success. With that, we should open the floor to comments or questions.

Discussion

Vikas O'Reilly-Shah (Seattle Children's): Are the underlying betas available, such that we could, essentially tune the scoring approach to hew closer to the underlying data.

- *Ben Andrew (Duke University):* Both the POVOC score (2004) and the VPOP score have some limited model coefficients available, but they are not comprehensive in assessing risk factors for postoperative nausea and vomiting (PONV). These studies and previous guidelines simply combine the risk factors from both scores, assigning each a point. This approach is currently our best tool but is far from ideal as it does not provide a calibrated risk prediction for patients. Without this calibrated tool, it's difficult to determine at which point additional antiemetic agents should be introduced. Evidence shows that patients with no risk factors often have similar PONV risk to those with one risk factor. Therefore, the group strongly recommends that all children, even without risk factors, receive at least one agent for antiemetic prophylaxis, unless contraindicated, and a second agent, ideally ondansetron and dexamethasone, for those with any risk factors. Beyond dual-agent prophylaxis, there is insufficient evidence to support the inclusion of additional agents like diphenhydramine or to endorse total intravenous anesthesia (TIVA) for this purpose. As such, the group recommends focusing on risk mitigation techniques tailored to the individual child, rather than adding more antiemetic agents. These techniques might include adjuvant therapies like dexmedetomidine, opioid reduction through

regional anesthesia, fluid loading therapy, or acupuncture, which have supporting evidence but are not considered chemoprophylaxis. This approach aims to adhere to the evidence base without encouraging non-evidence-based practices

- *Vikas O'Reilly-Shah (Seattle Children's)*: Risk mitigation techniques you mention are also those that are very difficult for us to capture.
- *Ben Andrew (Duke University)*: When we met and discussed this previously, **we considered simplifying the measure to focus solely on chemoprophylaxis for PONV using familiar agents instead of creating a comprehensive metric for patient risk and clinician approach**. Incorporating risk reduction techniques that are not robustly available or well-understood is challenging. The guidelines will ultimately recommend providing chemoprophylaxis at a reasonable rate and in combination when necessary for children at increased risk: one agent for everyone, two if at risk, and beyond that, appropriate risk mitigation.

Vikas O'Reilly-Shah (Seattle Children's): I'll pull up the slide of the **proposed modifications** to help prompt discussion:

- Inclusion Criteria: All patients ≥ 28 days and < 18 years old
- Exclusion Criteria:
  - MAC Cases → use Anesthesia Technique: Sedation phenotype
  - MRI Cases without an Airway
- Success Criteria:
  - Patients at **low risk** for PONV (0 Risk Factors) receive at least one prophylactic pharmacologic antiemetic.
  - Patients at **moderate - high risk** for PONV (≥ 1 Risk Factor) receive combination therapy consisting of at least two prophylactic pharmacologic antiemetic agents from different classes.
- Antiemetic List
  - Add Hydrocortisone via IV route

Ben Andrew (Duke University): I think there's one thing worth mentioning. Reviewing the risk scores, particularly the one using opioid exposure, I noticed our implementation limits this to long-acting opioids expected to last until the PACU period. Evidence suggests that any multiple use of intraoperative opioids increases the risk for postoperative nausea or vomiting. I'm unsure if this aligns with adult metrics.

- *Kate Buehler (MPOG):* Yeah, I think what happened is, we recently on the adult side adopted the pediatric method for opioid use or determining opioid use for postoperative pain. It says includes use of opioids given intraoperatively and extends into the post-anesthesia care unit or postoperative period or opioids given in PACU. Is that the same as what you have here for peds?
- *Meridith Wade (MPOG):* Yeah, ours is any long-acting opioids administered after induction and before PACU end.
- *Kate Buehler (MPOG):* Yeah, I think that's what we moved to, too.
- *Ben Andrew (Duke University)*: Yeah. So I just don't know how that jives with the evidence in the adult side, but in peds, as far as I know, the only study that looked at risk prediction is the Vpop

study. They used sufentanil, any dose at induction and in PACU counted. Induction and later on in the procedure counted; 3 doses intraop counted; but not a single dose. We're not currently using things like sufentanil in that metric. But it may be the adult evidence makes it reasonable.

- *Vikas O'Reilly-Shah (Seattle Children's)*: This does highlight an interesting question Because I'm not sure why, for something like methadone, we would do it after induction and or anesthesia ready. It's such a rapid onset that if I'm planning to give it, I'll just give it with induction.
- *Ben Andrew (Duke University)*: I also just don't know if there is a differential effect of opioid classes in terms of their emetogenic properties**. Does multiple fentanyl doses intraop not change your risk for postoperative nausea and vomiting the same way that 2 morphine doses do?** I don't know. In children, that's not been looked at, and I don't know if adults have clarified that as well.

Lucy Everett (Mass General): Does 3 to 17 remain a risk factor?

- *Meredith Kato (OHSU):* We did not discuss changing that, so yes.

RJ Ramamurthi (Stanford): Is there a value to redefining the risk factors, adding preop anxiety as an additional risk?

- *Meredith Kato (OHSU):* That did not come up in my lit review. I don't think we should change that. Ben, do you concur?
- *Ben Andrew (Duke University)*: Yeah, there's a smattering of evidence about pre-medications and their differential effects on PONV and the like, but I don't know that it's strong enough to say pre-op anxiety should be a risk factor. The biggest problem is there's lots of factors associated with PONV in some study, but how they interact with each other when added to this list is unclear. I would **argue in favor of keeping it as close to the original risk scores as we can, with exceptions like anticholinesterases, which change risk**. Adding other factors changes the calculus of what a risk score of 2, 3, or 4 means.
- *Vikas O'Reilly-Shah (Seattle Children's)*: Even if we were to know that, I'm not sure we could discreetly understand from our data whether pre-op anxiety was present in a patient.
- *Meredith Kato (OHSU):* Everything I know about pre-op anxiety was prospectively collected. It's not mass scale data.
- *Vikas O'Reilly-Shah (Seattle Children's)*: I would imagine many places document some sort of indicator about the degree of anxiety.
- *Meredith Kato (OHSU):* There's the induction instrument in Epic. Its evidence based but doesn't generate numbers.

Meredith Kato (OHSU): We discussed waiting to implement these changes until the new guidelines come out, which is coming soon. Ben, do you want to speak to that? The paper is in the submission phase, and we thought we should align with that, to avoid confusion.

- *Ben Andrew (Duke University):* Yeah, I think it would be appropriate to wait, and they should be submitting within the next few weeks. We discussed building this in the background for the new recommendations. The biggest changes are the success criteria, shifting from 3+ agents to a universal one-agent recommendation, and changing the age cutoff. Previously, the metric only

included patients 3 or older, following the POVOC score. However, evidence shows ondansetron benefits even in children as young as one month, leading to its FDA labeling. So, we considered extending the age range below 3 years.

- *Vikas O'Reilly-Shah (Seattle Children's)*: I don't have concerns about it. I'd just be curious to see data for under-3 population as it's not routine practice to give antiemetics to neonatal infants.
- *Ben Andrew (Duke University):* This is an interesting point. Practices often emanate from studies setting age thresholds, leading to a dogmatic belief that children younger than 3 don't have PONV. However, there's evidence of children one month old benefiting from prophylactic ondansetron. This may change practice and promote discussion on prophylaxis appropriateness.
- *Vikas O'Reilly-Shah (Seattle Children's)*: It could change practice. If we say this is what we're gonna do, it will change practice.
- *Meredith Kato (OHSU):* It doesn't have to be zofran. For infants, you can give decadron, which also reduces airway swelling.

Meredith Kato (OHSU): Any more data from MPOG to help find a suitable cutoff, or thoughts on how young we should consider not needing antiemetics?

- *Cathie Jones (Boston Children's):* More data is needed because PONV numbers for kids needing treatment under one are very low. Including treatment numbers will help see if we're failing young kids.
- *Ben Andrew (Duke University):* I'll review the trial of one month up to 2 years showing over 20% postoperative vomiting with placebo. This shows vomiting risk reduced by ondansetron, but further data are lacking. https://pubmed.ncbi.nlm.nih.gov/16037143/
    - *Ruchika Gupta (University of Michigan):* George Politis uses this same study as evidence (that you mention Ben Andrew), and does give zofran for infants, not neonates.
- *Ben Andrew (Duke University):* Original studies unfortunately didn't report continuous risk associated with age, making us uncertain about the true risk threshold. We may need to extend below 3 without going to one month if that's what most agree on.
- *Morgan Brown (Boston Children's):* I use dexamethasone frequently in the small kids for all sorts of reasons including PONV
- *Cathie Jones (Boston Children's):* I would be wary of using 1mo+, most of our MOR team starts giving at 1yr+ unless there is a significant risk factor
- *Lucy Everett (Mass General):* We will have results from the two PCRCs related to pedi PONV hopefully in the next few months but not clear that it will really add to the recommendation here.
- *Meredith Kato (OHSU):* Is there MPOG data on kids aged 28 days to 1 year? Looking at outcomes with different prophylaxis could help.
    - *Vikas O'Reilly-Shah (Seattle Children's)*: Yes, reviewing similar data could help answer the question.
    - *Cathie Jones (Boston Children's)*: It might help, knowing formal studies are confounded.

Next Steps

- To help inform voting, query MPOG database and present a data summary of

    - PONV in ages 28 days – 3yrs
- Make the proposed updates to the measure code in DEV.
- Wait for 2025 consensus guidelines to be published
- Send data summary and link to vote on each proposed modification separately.

QI Measure Development

Vikas O'Reilly-Shah (Seattle Children's): The other item on the agenda today is to discuss future measures. Essentially, what else do we want to build out as a pediatric anesthesiology community? We already have several pediatric-specific measures built out, and you can review these on the MPOG website for detailed definitions.

To summarize the process of building a measure, we start with an idea and discuss it, create the specification, approve it, and then the MPOG team builds, tests, and refines it. Once published, we periodically revisit it for revisions. We have both process and outcome metrics. Outcome metrics are more challenging to obtain, but process metrics are easier to implement since we know what we did, even if we don't always know patient outcomes.

When thinking about future focus areas, considering care domains and other areas like efficiency and operational cost metrics can be a reasonable place to start. This slide shows how to conceptualize a new metric, considering the reliability of underlying data and the effort required to determine what's available or to implement the metric.

We have a set of criteria for potential metrics, annotated by color to indicate ease of access to the data. At our recent MPOG retreat before the ASA meeting, a small group discussed metrics of interest for future exploration, including discharge readiness, antibiotic appropriateness, pacu pain scores, and pediatric cardiac measures.

Morgan Brown (Boston Children's): We're exploring important metrics for cardiopulmonary bypass cases. We're looking at adult measures, existing literature, and what would be supported for pediatrics. Potential measures include use of adjuncts, extubation practices, and renal outcomes. More details will be shared after further discussions in January or February.

Discussion:

Vikas O'Reilly-Shah (Seattle Children's): Any thoughts about these or other metrics of interest for your institutions, or suggestions for concepts that could support future metrics?

- *Morgan Brown (Boston Children's):* We've been discussing antibiotic appropriateness locally and have shifted to using Linezolid instead of Vancomycin after a thorough analysis.

Meredith Wade (MPOG): We haven't focused much on operational metrics, costs, or efficiency. Is there interest in these areas for enhancing OR efficiency?

- *Vikas O'Reilly-Shah (Seattle Children's)*: Discussion at the meeting was mixed about operational metrics. Many institutions already focus on these locally, so MPOG might not add much value

here. Institutions might feel exposed by benchmarks on efficiency. There was also talk about Pacu pain scores, but concerns about reliability and consistency of data remain.

Eva Lu-Boettcher (University of Wisconsin): Any thoughts about aligning some of our future metrics with NSQIP? Some institutions spend a lot of time and effort having NSQIP support staff to query QI measures important to establish the hospital as a level 1 surgery center, surgeons have approached me about how to make their lives easier etc.

- *Vikas O'Reilly-Shah (Seattle Children's)*: Aligning metrics with Nisqip poses challenges due to the need for manual data abstraction. There's interest in exploring NLP-based approaches to identify outcomes from postoperative notes.

Ruchika Gupta (University of Michigan): Would something like the use of video laryngoscopy for neonate intubation be a useful metric?

- *Vikas O'Reilly-Shah (Seattle Children's)*: Yes, it could be. There's already a PCRC for neonatal airway management, and it might be useful to track how often video laryngoscopy is used compared to direct laryngoscopy.

Wrap Up:

Vikas O'Reilly-Shah (Seattle Children's): if you have specific areas of interest for metric development, please email meridith@med.umich.edu. We will also send out a poll to gauge preferences among the group for new metrics. Thanks, appreciate your time.

Meeting Concluded @ 1702