Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE)

Quality Committee Meeting Notes – Monday, February 25, 2019

Applefield, Daniel (St. Joseph Oakland)	Lacca, Tory (MPOG)
Angel, Alan (Bronson Battle Creek)	Lins, Steve (Bronson Battle Creek)
Bailey, Meridith (MPOG)	Louzon, Kathryn (Beaumont Royal Oak/Troy)
Berris, Josh (Beaumont Farmington Hills)	Lucier, Michelle (Henry Ford)
Biggs, Dan (Oklahoma)	Mack, Patricia (Weill Cornell)
Bledsoe, Amber (Utah)	Mathis, Mike (Michigan)
Bodas, Alina (Cleveland Clinic)	Malenfant, Tiffany (Beaumont Trenton/Wayne)
Buehler, Katie (MPOG)	McKinney, Mary (Beaumont Dearborn/Taylor)
Clark, David (MPOG)	Milliken, Chris (Sparrow)
Collins, Kathleen (St. Mary)	Nachamie, Anna (Weill Cornell)
Coons, Denise (Bronson)	Naik, Bhiken (Virginia)
Crawford, Joan (Mercy Muskegon)	Nanamori, Masakatsu (Henry Ford Detroit)
Cuff, Germaine (NYU Langone)	Quinn, Cheryl (St. Joseph Oakland)
Domino, Karen (U of Washington)	Pardo, Nichole (Beaumont Grosse Pointe)
Dubovoy, Tim (Michigan)	Poindexter, Amy (Holland)
Jameson, Leslie (Colorado)	Poterek, Carol (Beaumont)
Johnson, Ray (Beaumont Wayne)	Rensch, Robert (Beaumont Kalamazoo)
Haus, Jason (Beaumont Troy)	Rosario, Lisa (Beaumont)
Heiter, Jerri (St. Joseph A2)	Schmidt, Carol (Beaumont)
Hightower, William (Henry Ford W. Bloomfield)	Shannon, Lori (Beaumont)
Hitti, Nicole (Weill Cornell)	Shah, Nirav (MPOG)
Horton, Brandy (A4)	Studt, Lindsay (Beaumont)
Kaye, Toni (ASA)	Tyler, Pam (Beaumont Farmington Hills)
LaGorio, John (Mercy Muskegon)	

Agenda & Notes

1. **Minutes from January 28, 2019 meeting approved**- posted on the website for review. Recording available as well.
2. **Roll Call**: Will contact QI Champions and ACQRs directly to inquire about participation status if missing. Other participants can review meeting minutes and contact Coordinating Center if missing from attendance record.
3. **Upcoming Events**:
   a. *April 5, 2019 – MSQC/ASPIRE Collaborative Meeting*
      i. Schoolcraft VistaTech Center- Livonia
      ii. Keynote Speaker: Dr. Rob Schonberger (Yale)
      iii. Dr. Sachin Kheterpal giving an update on PROSPER
   b. *July 26, 2019 – ASPIRE Collaborative Meeting*
      i. Lansing, MI
      ii. Performance review component will be ASPIRE sites only
      iii. Un-blinding to see what we can learn from each other and what areas we need to improve in. Will plan to do this on an annual basis.
   c. *October 18, 2019 – MPOG Retreat*
      i. Orlando, Florida

d. Mark your calendars! Remaining Quality Committee meetings in 2019:
    i. Monday, April 22, 2019 at 10:00 a.m. Eastern
    ii. Monday, June 24, 2019 at 10:00 a.m. Eastern
    iii. Monday, September 23, 2019 at 10:00 a.m. Eastern
    iv. Monday, November 25, 2019 at 10:00 a.m. Eastern

4. **Import Manager Conversion**
    a. Several sites live!
        i. New data extract and prerequisite to get Preop and PACU data.
        ii. If your site is interested in conversion, begin to think of a time frame to start and contact coordinating center.
    b. A few sites very close to full conversion.
    c. New conversions dependent on FileChecker app – developed by technical team to ensure that files contain all needed data before engaging MPOG coordinating center
    d. Will pilot with several sites, then available to all this summer

5. **MQUARK Analytics**
    a. Audit results now available
    b. https://mquark.mpog.org/Forms/ProjectReports.aspx
    c. Any QC colleagues interested in handovers?
        i. Let us know if you're interested in helping define a cohesive handover improvement program. Looking to form a group to form a quality improvement program specifically on handovers.
        ii. Carol Schmitt (Beaumont Royal Oak) Created a handover badge card for providers at their institution that is working well. Posted to forum.

6. **Measure Updates**
    a. **QCDR Farewell!!**
        i. After data is submitted this month, we can complete QCDR measures updates in March/April!
        ii. PONV – add propofol infusion and metoclopramide
        iii. TRAN 02 – changes discussed last meeting
            1. Extend the measure period to 18 hours after surgery to take the lowest hgb/hct in that time period
            2. Evaluate the hgb/hct at the time of transfusion (within 90 mins) – if less than or equal to 8/24, will pass measure
    b. **Update to Pulmonary Measures**
        i. PUL 01, 02, 03
        ii. No longer require that data "tagged" as machine captured – this label was not coming from machine anyway, was assigned by technical team.
        iii. Already implemented - no significant impact. Does not impact scores.

iv. Add measure bounds for Case Start to Case End (no boundaries currently) - need them for IM sites

c. **NMB 02 – Appropriate Reversal**
   i. Measuring patients that receive a reversal agent after you have given a non-depolarizing neuromuscular blocker.
   ii. To account for cases where a dose of muscle relaxant was given early in the case, and then not re-dosed, this measure does not require that neostigmine be administered if a non-depolarizer was not administered for 3 hours before extubation for adults and 2 hours for pediatric patients.
   iii. An acceleromyography ratio of ≥ 0.9 documented after last dose of NMB and before earliest extubation is also included as a measure of success.
   iv. **Discussion**
      1. Numerous studies have documented that it is not possible to determine if neuromuscular function has recovered to more than a train-of-four ratio > 0.4 using clinical evaluation (head lift, hand grip) or tactile or visual evaluation with a qualitative neuromuscular function monitor.
      2. It is, therefore, likely that the clinicians who did not reverse NDNMB were relying on one of these techniques to evaluate neuromuscular recovery
      3. What is the real impact of time alone? Is 3 hours sufficient or should we increase back to 4 hours? Variation in patient response to non-depolarizers? Should all patients receive reversal?
      4. Conclusion – No changes yet. Consider removing 3 hour criteria for not requiring reversal.
      5. If we completely removed the criteria to give reversal, we see that there are providers that are not using reversal and are depending on the duration of action for NMB to be limited to 3 hours. Based on recent literature, our spec may be incongruous with best practice which may suggest reversal on all patients unless acceleromyography of >/=0.9 is achieved.
      6. Input
         a. *Kathleen Collins, CRNA (Trinity - St. Mary's Livonia)* – Site has been more proactive in reversing patients over the past year and have seen positive results. **In support of requiring reversal.**
         b. *Dr. Josh Berris (Beaumont Farmington Hills)* – Sugammadex has highlighted how well patients do when they are reversed properly before extubation. Historically, providers relied on subjective measurements or extended time period since last dose of NMB to determine if reversal was needed. Since using Sugammadex, providers enlightened as to what reversal really looks like. **In support of requiring reversal.**

c. *Dr. Leslie Jameson (University of Colorado)* – Seeing less respiratory complications after giving reversal more often and agrees that the 3-hour time frame set for the NMB measures is not enough. Conducted an economic analysis in favor of Sugammadex - will post to Basecamp. **In support of requiring reversal.**
d. *Dr. Jason Haus (Beaumont Troy)* – Asked how University of Colorado handles giving Sugammadex to pregnant patients? – Recommendation from the group: if patient is scheduled to have any anesthesia, team will discuss risk of contraceptive failure in preop or PACU.
e. *Dr. Nirav Shah (University of Michigan)* – added Sugammadex to PACU discharge order set. Ask the PACU nurse to give patient description/teaching plan to patient. If patient is admitted, it is a part of the hospital discharge packet.

7. **HS Troponin T**
    a. Sites are now using HS Troponin T as a marker for myocardial injury
    b. MPOG now has concepts for Troponin T
    c. MPOG Coordinating Center is unclear on how to incorporate into CARD 02 measure that currently looks at a Troponin I increase greater than 0.6
    d. Looking for guidance from Quality Committee- particularly sites who are using Troponin T
    e. Discussion:
        i. Dr. Mike Mathis (University of Michigan) – most of the perioperative literature around Troponin T suggests that a value as low as 14 ng/L as a predictor for MI/poor outcomes. However, this may lead to several cases failing that never progress to MI. In addition, literature suggests that the absolute value alone is not necessarily a predictor but the change over time must also be considered.
        ii. No feedback from the group during the meeting. Contact Coordinating Center with recommendations/experience regarding HS Troponin T interpretation.

Meeting concluded at 10:50am