ASPIRE Measure Survey Results

Names

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Institutions

University of Michigan	University of Utah
NYU Langone Medical Center	Oakwood Hospital Dearborn Michigan
OHSU	University of Washington
University Medical Center Utrecht	University of Tennessee Medical Center
Holland Hospital	Mercy Health Muskegon
University of Pennsylvania	Henry Ford Hospital
University of Vermont	University of Oklahoma
University of Michigan Health System	University of Oklahoma
Weill Cornell Medical College	Tufts Medical Center
University of Virginia	Beaumont Health
UMHS	UWSMPH
AMC, Amsterdam	University of Colorado
University of Florida	Vanderbilt
Academic Medical Center, University of Amsterdam, The Netherlands	Marquette General Hospital
	Washington University School of Medicine

Performance Measure Survey - SCIP

	Mean Score	Standard Deviation	Min Score	Max Score
SCIP 1 (Abx)	6.93	2.80	1	10
SCIP 2 (Temp)	7.00	2.85	1	10
SCIP 3 (beta blockade)	6.38	2.80	1	10

Neuromuscular Blockade

	Mean Score	Standard Deviation	Min Score	Max Score
NMB - TOF	7.52	1.82	4	10
NMB - Neostigmine	7.28	2.19	2	10

Monitoring Vigilance

	Mean Score	Standard Deviation	Min Score	Max Score
No 10 min gap	6.83	2.66	1	10

Transfusion Management

	Mean Score	Standard Deviation	Min Score	Max Score
Receiving PRBC	6.41	2.46	1	10
Documented Hct	7.28	2.10	1	10
PACU Hct	7.45	1.94	1	10
Hct nadir	6.21	2.23	1	10

Glucose Management

	Mean Score	Standard Deviation	Min Score	Max Score
Insulin or recheck	8.17	1.26	6	10
Recheck after insulin	7.59	2.04	1	10
Dextrose or recheck	7.17	1.98	3	10

Ventilator Management

	Mean Score	Standard Deviation	Min Score	Med Score
< 10 mins at 10cc/kg	6.83	2.54	1	10
< 20 mins at 10cc/kg	7.59	2.06	1	10

Colloid Management

	Mean Score	Standard Deviation	Min Score	Max Score
Albumin	5.03	2.37	1	8
Hetastarch/ Pentastarch/	4.55	2.05	1	8

PONV

	Mean Score	Standard Deviation	Min Score	Max Score
2 classes anti-emetics	7.21	1.93	1	10

Overdose

	Mean Score	Standard Deviation	Min Score	Max Score
Naloxone	6.72	2.43	1	10
Flumazenil	5.93	2.72	1	10

End Organ Failure

	Mean Score	Standard Deviation	Min Score	Max Score
Reintubation	8.28	1.65	4	10
Troponin	7.45	2.28	1	10
AKI	7.48	2.20	1	10

Pain Management

	Mean Score	Standard Deviation	Min Score	Max Score
Pain Score	7.55	1.97	4	10

Some of the thing (like albumin) are not common in our Country

@22/23: cannot deliver... don't have labs after 24 hours

The direction of benefit (high number or low number best) should be standardized for all quality measures. I favor making a small number (zero) be the best possible response

The language describing quality measures should be standardized to avoid ambiguity.

In particular, #2 is ambiguous. Is the quality measure the use of warming devices, the avoidance of hypothermia or both?

Examples of rewriting the quality measures:
#24: Proportion of patients with peak pain score > 8 in PACU.
#1: Proportion of patients not receiving antibiotics within the SCIP recommended time window.
#!5: Proportion of patients receiving sustained intraoperative mechanical ventilation with tidal volumes >= 10 ml/Kg IBW for 20 or more minutes.

I am very interested in the role that residual NMblockade plays in prolonged intubation or reintubation. However, from the cases that I have reviewed in our data base the reversal and monitoring appear to have been done. The sensitivity of the monitor being used and variability in monitoring site could play a significant role. Also the time between the last NM blocker dose and the reversal dose may have an effect. Not sure what we will capture with documenting reversal alone.

With regard to the troponin level and creatinine levels I hesitate to correlate a care time interval of 4 to 7 post operative days directly with anesthesia care. How do you plan to separate the care of the intraoperative physicain from the post operative care team?

temperature normothermic (maybe above 36.5) at end of the case should be used rather than warming per se to drive change. My preference is to focus on the AQI measures for pay for performance as those that are of highest priority.

I am conflicted. Some of these are statisics I would like to know, but I don't necessarily think they are quality indicators--or are quality indicators for certain types of cases, but not all. Additionally, some of the data will be difficult to get depending on the EMR combinations that practices have. Call me if you would like to discuss this in greater detail. Respectfully, Lyle Stefanich

#4 and 5 - if patient is extubated. Not if left intubated.
#14, 15, 16 and 17 - "without"? Should it be "with"?
#18 All patients or those with risk factors receive prophylaxis

SCIP and other upcoming CMS measures should be prioritized.
I would consider capturing PACU pain scores < or =5 and those > or = 8.
Most commonly postanesthesia check of the patient occurs within 48 hrs. Not all institutions may have ways of documenting troponin and creatinin in periods greater than that. This however would be a great measure to apply when AIMS becomes part of a bigger, integrated documentation system i.e. Epic.
I would consider capturing patients who receive volume expanders instead of those who do not...
Every PRBC administered intraoperatively or in the PACU/ICU should be tied to a documented Hct within +/- 60 min of administration.

In general, SCIP measures are so closely monitored in-house that these aren't very important-- pretty much everybody already knows they do well.

The tidal volume is too high. Most of the current stuff says 6 range and it is calculated on height or ideal body weight not actual body weight. I think the overdose is a rare event so might pass but glucose management is a big deal.

Many of these are very dependent on exclusion criteria which are not included in the text. Ex troponin except in cardiac surgery. As is frequently the case those details are the difference between a good indicator or not.

Mean Survey Score by Category