Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE)

Quality Committee Meeting Notes – Monday, April 27, 2014

Attendees: P=Present; A=Absent; X=Expected Absence

P	Abdallah, Arbi 'Ben' (Wash U)	A	LaGorio, John (Mercy Muskegon)
P	Agarwala, Aalok (MGH)	A	Levesque, Paula (Beaumont)
P	Ajja, Olivia (St. Joesph)	A	Levy, Warren (Pennsylvania)
A	Aziz, Michael (OHSU)	A	Lirk, Philipp (AMC)
P	Becker, Aimee (Wisconsin)	P	Louzon, Kathryn (Beaumont)
P	Bell, Genevieve (Michigan)	A	Mack, Patricia (Weill-Cornell)
A	Berman, Mitch (Columbia)	A	Madden, Lawrence (Mercy Muskegon)
P	Biggs, Daniel (Oklahoma)	P	Maheshwari, Kamal (Cleveland Clinic)
A	Bonifer, Thomas (Allegiance)	A	Marcoe, Greg (Midland)
P	Buehler, Katie (A4)	A	Morey, Timothy (Florida)
P	Coyle, Nina (PhyMed)	A	Naik, Bhiken (Virginia)
P	Cuff, Germaine (NYU Langone)	A	Noles, Michael (OHSU)
P	Coffman, Natalie (Holland)	A	O'Donnell, Steve (Vermont)
A	Coffman, Traci (St. Joseph)	P	Osborne, Jaime (Michigan)
P	Dalton, John (PhyMed)	A	Pasma, Weize (Utrecht)
P	DeSnyder, Kathy (Beaumont)	P	Pace, Nathan (Utah)
P	Dubovoy, Tim (Michigan)	P	Pagenelli, William (Vermont)
P	Eastman, Jaime (OHSU)	A	Price, Matthew (Beaumont)
P	Epps, Jerry, (Tennessee)	A	Quicci, Jennifer (Anes Staffing Consultant)
A	Fleisher, Lee (Pennsylania)	A	Rinehart, Paige (Tennessee)
A	Fleishut, Peter (Weill Cornell)	A	Robinowicz, David (UCSF)
P	Godbold, Michael (Tennessee)	P	Saager, Leif (Cleveland)
A	Haehn, Melissa (UCSF)	A	St. Jacques, Paul (Vanderbilt)
P	Heiter, Jerri (St. Joseph)	P	Schultz, Kelly (Michigan)
P	Harwood, Tim (Wake Forest)	P	Segal, Scott (Tufts)
A	Hausman, Mark (Michigan)	P	Shah, Nirav (Michigan)
A	Ianchulev, Stefan (Tufts)	A	Shanks, Amy (Michigan)
A	Jacobson, Cameron (Utah)	P	Sharma, Anshuman (Wash U)
A	Jameson, Leslie (Colorado)	A	Skolnik, Bruce (Beaumont)
A	Johnson, Rachel (Mercy Muskegon)	A	Smith, Jeffrey (McLaren)
A	Kappen, Teus (Utrecht)	A	Smith, Jori (Sparrow)
P	Kendale, Samir (NYU Langone)	A	Smith, Warner (Utah)
P	Kheterpal, Sachin (Michigan)	A	Sommer, Richard (NYU Langone)
A	Kiers, Gerry (St. Joseph)	A	Soto, Roy (Beaumont)
P	King, Lisa (Oklahoma)	P	Stefanich, Lyle (Oklahoma)
A	Kooij, Fabian (AMC)	A	Tom, Simon (NYU Langone)
P	Kuck, Kai (Utah)	A	Tremper, Keving (Michigan)
A	Kuhl, Mackenzie (Marquette)	P	Wedeven, Chris (Holland Hospital)
P	Lacca, Tory (Michigan)	P	Wilczak, Janet (Oakwood)
P	Lagasse, Robert (Yale)	A	Yasick, Tony (Holland)

Srinivas MD Anderson DeSnyder Beaumont

1. Approve minutes from March 16, 2015
    a. Meeting minutes approved
2. QCDR Update
    a. Sites who have indicated they are a QCDR:
        i. Cleveland Clinic
        ii. Oregon Health Sciences University (OHSU)
        iii. PhyMed - Tennessee
        iv. Stanford
        v. Wake Forest
    b. MPOG will benefit from being a QCDR because we will get better quality data
    c. Individual sites will benefit because it is a straightforward way to report. We will use our existing measures for reporting.
    d. Several ways to submit data
        i. Claims based reporting
        ii. QCDR
    e. CMS deadlines
        i. Test submission due in spring 2015
        ii. Eligible Provider list
            1. Tory has sent out an Excel document to each site who has indicated they want to use ASPIRE to obtain the list of current eligible providers from each institution. The reports due back to Tory mid-May
    f. Developers have started to create a provider enrollment tool so providers can submit their attestations and review their data.
    g. Can a site submit CRNA provider data only? Yes
3. Update on new activity (data diagnostic tool, data submission feedback email, provider feedback email)
    a. It is important to provide timely feedback to sites on the quality of their data.
    b. We are updating our new data diagnostic tool
        i. Allows providers to see if their data meets certain thresholds
        ii. Approximately 75 tests
            1. The person responsible for the upload of data will be responsible to review the data diagnostics
            2. Attestation need to be submitted for each provider
                a. This will include all previous attestations, so providers can see the last time they reviewed their data
            3. The tool is set up so that a provider will review a diagnostic, check the attest and then they will be automatically sent to the next diagnostic. We anticipate it will take 2-hours to complete.
            4. This will be included in the next version of the MPOG Application Suite.
    c. We are testing the provider push e-mail and we anticipate we will be sending a test e-mail to providers in the next couple of months
    d. Each institution QI Champion will be receive a monthly feedback on their data and the chair/head of practice will receive an email each quarter, including the following information:
        i. Case submission progress
        ii. Cases validation
        iii. Data summary progress
4. Galileo feedback tool has already been rolled out to the following institutions:

        a. Medical College of Utrecht
        b. University of Michigan
        c. University of Oklahoma
        d. University of Tennessee
        e. University of Vermont
        f. University of Washington
        g. Weill Cornell

5. Continued discussion on 2015 measures – we reviewed 16 measures we wanted review and currently we have reviewed 5 measures.
    a. Transfusion management vigilance:
        i. Add time frame for hematocrit (preop or intraop)
            1. In some institutions it takes a long time to get lab results back so we have to check if the results times are correct
            2. POC testing can be put in as notes/comments and therefore it may look like labs were not drawn or sent.
            3. We need to document labs in a discretely
        ii. If multiple units are hung, how many times do you check the hematocrit? Still after every units? From a MPOG perspective we need to discuss.
        iii. Exclude criteria:
            1. Duration of surgery < 60 minutes
            2. if the blood transfusion started on the floor
            3. Acute burn patients
        iv. If a Hemoglobin or HCT level is low, do you think it's reasonable to transfuse 2 levels without re-checking? What is that low value? That value will need to be determined by the group.
            1. Perhaps use the time in-between transfusions to determine those type of situations
                a. Maybe two hours because sometimes it takes an hour to get the blood and then an hour to give it