Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE)

Quality Committee Meeting Notes – Monday, June 22, 2020

Abess, Alex (Dartmouth)	Horton, Brandy (St. Joes Oakland)
Angel, Alan (Bronson)	Janda, Allison (MPOG)
Andrawes, Michael (MGH)	Khan, Meraj (Henry Ford)
Applefield, Daniel (St. Joseph Oakland)	Kheterpal, Sachin (MPOG)
Bailey, Meridith (MPOG)	Koning-Randall, Kim (St. Joseph Ann Arbor)
Berndt, Bradford (Bronson)	Kurz, Andrea (Cleveland Clinic)
Berris, Josh (Beaumont)	Lacca, Tory (MPOG)
Biggs, Dan (Oklahoma)	LaGorio, John (Mercy Muskegon)
Bollini, Mara (Washington University)	Lewandowski, Kristyn (Beaumont Royal Oak)
Boutin, Jimmy (Henry Ford)	Lucier, Michelle (Henry Ford)
Bouwhuis, Alex (Holland)	Pack, Patricia (Weill Cornell)
Buehler, Kate (MPOG)	Malenfant, Tiffany (Beaumont Trenton/Wayne)
Charette, Kristin (Dartmouth)	Malvia, Shobha (Michigan Medicine)
Chen, Lee-Lynn (UCSF)	McKinney, Mary (Beaumont Dearborn / Taylor)
Collins, Kathleen (St. Mary Livonia)	Nanamori, Masakatsu (Henry Ford Detroit)
Coons, Denise (Bronson)	Overmyer, Colleen (University of Chicago)
Davis, Quinten (Mercy Muskegon)	Pace, Nathan (Utah)
Dewhirst, William (Dartmouth)	Pardo, Nichole (Beaumont)
Domino, Karen (Washington)	Poindexter, Amy (Holland)
Everett, Lucy (MGH)	Quinn, Cheryl (St. Joseph Oakland)
Forro, Jason (St. Joseph)	Ruiz, Joseph (MD Anderson CC)
Gall, Glenn (St. Mary Livonia)	Rutherford, Renee (Borgess)
Goorin, Patricia (Sparrow)	Saffary, Roya (Stanford)
Grandinetti, Amanda (ASA)	Shah, Nirav (MPOG)
Hall, Kathleen (Borgess)	Szymanski, Brooke (MPOG)
Heiter, Jerri (St. Joseph A2)	Tyler, Pam (Beaumont Farmington Hills)
Hightower, William (Henry Ford)	Wren, Jessica (Henry Ford Wyandotte/Macomb)

Agenda & Notes

1. **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.
2. **Minutes from April 27, 2020 meeting approved**- minutes and recording posted on the website for review.
3. **Upcoming Events**
    - 2020 Quality Committee Meetings
        - August 24, 2020 @ 10am EST
        - October 26, 2020 @ 10am EST
    - ASPIRE Quality Committee Virtual Meeting – July 17, 2020
        - Dr. Gary Loyd from Henry Ford to speak about COVID-19 Ramp-up
        - Dr. Matt Wixson, Associate Chair for Diversity, Michigan Medicine Department of Anesthesiology to speak about Social Determinants of Health / Disparities of Care
    - MPOG Retreat – Friday, October 2, 2020
        - The meeting will be virtual and the length condensed. More details to follow.

4. **Announcements**
    - Featured Members: Dr. Leslie Jameson from the University of Colorado for May and June
    - Cardiac Subcommittee: Thank you for your interest!
    - Welcome three MPOG Executive Board members: Dr. Michael Avidan from Washington University in St. Louis, Dr. Michael Gropper from UCSF and Dr. George Mashour from Michigan Medicine
    - Dr. Julie Huffmyer from the University of Virginia received Research in Education Grant using ASPIRE data.
5. **What's happening across MPOG during COVID-19?**
    - Review of case volumes (see slides to view data)
        - All MPOG Sites
        - Michigan Sites
        - Neuraxial Labor Epidural
            - People left the city to go elsewhere to avoid COVID
            - More home births?
            - No change in labor epidural volume at Cornell- Dr. Patricia Mack
        - Total Hip Arthroplasty
        - Emergent Status
6. **Measure Updates:**
        - In-Hospital Mortality (MORT 01): Measurement of in-hospital 30-day mortality rate
        - Exclusions developed after literature review & discussion at the coordinating center. Intended to exclude cases where inpatient mortality is highly unlikely due to procedural or anesthetic care. Proposed Exclusions:
            - ASA 6
            - Central Line Placement (CPT 00532)
            - Diagnostic Imaging/Radiology (CPT 01922)
            - Gastrointestinal Endoscopy (CPT 00731, 00740, 00810, 00811, 00812, 00813)
            - ECT (CPT 00104)
            - Electrophysiologic Procedures (CPT 00537)
            - Lithotripsy (CPT 00872, 00873)
            - External Cephalic Procedure (CPT 01958)
            - Pain procedures (CPT 01991, 01992, 01995, 01996)
            - Bronchoscopy (CPT 00520)
            - Cardioversion (CPT 00410)

Webex Poll: Do you agree with the following exclusions?
RESULTS: 37 responses
Yes: 18/65 (28%); **No: 19/65 (29%); No response: 28/65 (43%)**
If no, what modifications do you suggest?

- No exclusions
- Only exclude ASA 6
- Exclude ASA 6 and organ procurement
- No exclusions of any type. Death is death. All deaths should be counted
- Report both with and without the exclusions
- Would consider inclusion of advanced endoscopy procedures such as ERCP/EUS/etc
- No exclusions at first and then evaluate the data
- Would recommend to include all cases in measure.
- Do not exclude bronchoscopies and GI endoscopies.
- I would cast the broadest possible net to start. Maybe exclude ASA 6 only. Go from that data to refine.
- We may be more likely to pick up anesthesia related mortality in those areas in which it is not expected.
- I agree with removing ASA 6 and if the primary anesthesia CPT was for a central line placement only, but I would favor leaving in more cases.
- Include all deaths. Bronchs and endo cases can be very high acuity
- Agree with the idea of no exclusions or very limited exclusions.
- Agree with no exclusions
- Wondering if it would be better to have no exclusions.
- I tend to agree that there should be no exclusions (besides ASA 6) if the goal is to increase visibility and notify providers when their patients suffer mortality within the first 30 days.
- If the goal is every death visible, the endo deaths (for example) need to be there - if anything, that's especially important. Maybe this needs to not be called a "measure" since that immediately evokes emotions and desire for exclusions. Maybe a portal or window or dashboard.
- Should cast a wider net, possibly a way to separate endo and OR cases? Endo mortality is an area that needs a deep dive to help inform the patient/family as to risk of the proposed procedure.

NOTES:
MGH: Is there a reason you are excluding central line placement? This will exclude a lot of patients.
Dr. Nirav Shah (ASPIRE Director): This exclusion would only exclude cases with the central line placement as the primary CPT code for the case (isolated central line placements) and should not eliminate a large number of cases.

Eric Davies, Henry Ford Allegiance: Recommends not have any exclusion and include all procedures to see what the data shows us.

Dr. Nirav Shah (ASPIRE Director): The intent is to inform individual providers to review their own cases that resulted in mortality. Risk adjustment and institution comparison is a future goal for this data but currently, we just want providers to be aware of their own patient outcomes.

Nathan Pace via Chat: Mortality is mortality, do not exclude anything. Make all deaths visible.

Sachin via chat: If the goal is to describe the mortality, can include all non-organ procurement cases; if the goal is to compare, do want to exclude "low incidence/outlier cases" like these listed. I would say remove ASA 6 and organ procurement and just "flag" for follow up

MORT 01 Calculation Poll

- Post-operative mortality ratio literature supports calculation where each patient who died counts only once in the numerator, but each procedure counts individually in the denominator
- Example: A patient has a Whipple procedure, had multiple bring backs for anastomotic leaks, and then died of sepsis. The patient would count once in the numerator, but all cases would be counted in the denominator.
- Represents the risk associated with each case
    1. $\frac{\#\ of\ patient\ who\ died}{\#\ of\ total\ procedures}$

Webex Poll: Do you agree with the following calculation for determining inpatient morality?

RESULTS: 35 responses

Yes; 34/62 (55%); No: 1/62 (2%); No response: 27/62 (44%)

If no, what modifications do you suggest?

- Should be death count by hospital admission count. It artificially lowers the mortality to use death count by procedure count.
- Via Chat: Re: calculation - we calculating anesthetic mortality, not surgical encounter mortality so I support the proposed numerator/denominator
- Via Chat: Consider only including cases where a majority of participating sites perform the procedure. It would allow us to compare against one another at a glance.

Webex Poll: Please vote to accept, accept with revisions, or reject the MORT 01 inpatient mortality measure.

RESULTS: 44 responses

Accept: 16

Accept w/Revisions: 25

Reject: 3

- Glycemic Management Survey Results:
    - Thank you to everyone who participated – 35 responses!
    - Measure update plan
    - Will keep hyperglycemia threshold at 200mg/dL for glucose measures as opposed to lowering to 180mg/dL (60% vs. 34%)
    - Will keep timeframe for treatment of hyperglycemia at 90 minutes as opposed to shortening to 60 minutes (63% vs. 34%)
    - Will develop treatment measure (54% support)
        1. Will require two *escalating* glucose measurements before requiring treatment, instead of only one high glucose measurement (61 vs. 39%)
        2. Will include Preop through PACU in the measure (81%)
    - Will maintain institution level attribution only for hyperglycemia in preop and PACU for GLU 03

7. **Measure Review Process**

Background:

- MPOG QI measures need to be reviewed to stay current and relevant.
- MPOG QI measures may be "topped out" or no longer relevant for QI, and should be retired
- Should reflect latest evidence and consensus of the MPOG Quality Committee
- MPOG Quality Champions have tremendous experience and expertise that should be leveraged
- All MPOG measures should be reviewed every three years
- Coordinating Center will create a review schedule for all measures
- Coordinating Center will request MPOG Quality Champions and other MPOG members to sign up for measure review

Plan:

- Coordinating Center may also assign/ request specific members to review measures in their area of expertise.
- Reviewers will make one of the following recommendations (with supporting information)
- Continue measure as is
- Modify measure
- Retire measure

Considerations:

- Coordinating Center will not assign more than 1-2 measures per year/ per Quality Champion
- Coordinating Center may assign multiple members for a single measure or group of measures

- Reviewers will be de facto members of MPOG Quality Improvement Measure Workgroup
- Coordinating Center team will assist reviewers as necessary to complete review process

NOTES: You should see a sign-up sheet coming out soon. We only have a few measures for consideration in 2020. If there is a specific area of interest, please reach out to both Nirav Shah and Kate Buehler.

8. **Microbiology Concepts**
    - New Microbiology Category with prefix 'Micro'
        - Culture type (aerobic, anaerobic, AFB etc.)
        - Specimen type (wound, CSF, fluid etc.)
        - Immunology – Antibody tests
    - **COVID-19 Related Concepts available**
        - Micro – Virology – Novel Coronavirus (COVID-19)
        - Immunology – Antibody – COVID19 - IgG

Meeting concluded at 10:55am