Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE)

Quality Committee Meeting Notes – Monday, November 27, 2023

Attendance:

Abess, Alex (Dartmouth)	Lauer, Kathryn (Froedtert)
Abou Nafeh, Nancy (AUB)	Lalonde, Heather (Trinity Health)
Addo, Henrietta (MPOG)	Loyd, Gary (Henry Ford)
Barrios, Nicole (MPOG)	Lewandowski, Kristyn (Corewell)
Bartoszko, Justyna (Toronto)	Lopacki, Kayla (Mercy Health - Muskegon)
Bauza, Diego (Weill Cornell)	Lu-Boettcher, Eva (Wisconsin)
Benitez, Julio (MyMichigan)	Mathis, Mike (MPOG)
Berndt, Brad (Bronson)	Mack, Patricia (Weill Cornell)
Berris, Josh (Corewell - Farmington Hills)	Madoff, Lauren (Boston Children's)
Biggs, Dan (Oklahoma)	Malenfant, Tiffany (MPOG)
Bourget, Marlene (Corewell)	McKinney, Mary (Corewell Dearborn / Taylor)
Boutin, Jim (Henry Ford - Wyandotte)	Mentz, Graciela (MPOG)
Bowman-Young, Cathlin (ASA)	Milliken, Christopher (Sparrow)
Brennan, Alison (Maryland)	Morewood, Gordon (Temple)
Buehler, Kate (MPOG)	Nanamori, Masakatsu (Henry Ford Detroit)
Charette, Kristin (Dartmouth)	O'Conor, Katie (Johns Hopkins)
Cohen, Bryan (Henry Ford - West Bloomfield)	O'Dell, Diana (MPOG)
Coleman, Rob (MPOG)	Owens, Wendy (MyMichigan - Midland)
Collins, Kathleen (St. Mary Mercy)	Pace, Nathan (Utah)
Corpus, Charity (Corewell Royal Oak)	Pantis, Rebecca (MPOG)
Dewhirst, Bill (Dartmouth)	Pardo, Nichole (Corewell)
Domino, Karen (Washington)	Parks, Dale (UAB)
Drennan, Emily (Utah)	Penningon, Bethany (WUSTL)
Edelman, Tony (MPOG)	Perkaj, Megan (Corewell)
Elkhateb, Rania (UAMS)	Pimental, Marc Phillip (B&W)
Esmail, Tariq (Toronto)	Poindexter, Amy (Holland)
Finch, Kim (Henry Ford Detroit)	Qazi, Aisha (Corewell)
Goatley, Jackie (Michigan)	Rozek, Sandy (MPOG)

Goldblatt, Josh (Henry Ford Allegiance)	Saffary, Roya (Stanford)
Gregory, Stephen (WUSTL)	Schwerin, Denise (Bronson)
Hall, Meredith (Bronson Battle Creek)	Shah, Nirav (MPOG)
Harrison, Kelly (UAMS)	Smiatacz, Frances Guida (MPOG)
Harwood, Tim (Wake Forest)	Spanakis, Spiro (UMass)
Heiter, Jerri (St. Joseph A2)	Stam, Benjamin (UMHS West)
Henson, Patrick (Vanderbilt)	Tao, Jing (MSKCC)
Janda, Allison (MPOG)	Toonstra, Rachel (Spectrum Health)
Jiang, Silis (Weill Cornell)	Tyler, Pam (Corewell Farmington Hills)
Johnson, Rebecca (Spectrum & UMHS West)	Vallamkonda, Sushma (MPOG)
Joseph, Tom (U Penn)	VanTreese, PattiAnn (Henry Ford)
Kaper, Jon (Corewell Trenton)	Vaughn, Shelley (MPOG)
Khan, Meraj (Henry Ford)	Vitale, Katherine (Trinity Health)
Kheterpal, Sachin (MPOG)	Wade, Meredith (MPOG)
Kirkham, Kyle (Toronto)	Wedeven, Chris (Holland)
Krauss, Kristin (Temple)	Wissler, Richard (University of Rochester)
Lacca, Tory (MPOG)	Woodbury, Jennifer (UCSF)
LaGorio, John (Trinity Muskegon)	Zittleman, Andrew (MPOG)
Liwo, Amandiy (UAB)	

Meeting Start: 1001

Agenda & Notes

1) **Roll Call**: Via Zoom or contact us
2) **Minutes from October 23, 2023**

3) **Announcements**
   a) **Featured Member– November and December**
      1) Brad M. Taicher, DO, MBA – Duke University School of Medicine

4) **Upcoming Events**
   a) Friday, April 12, 2024: **MSQC/ASPIRE Collaborative Meeting, Schoolcraft College Vistatech Center, Livonia, MI**
   b) Friday, July 12, 2024: **ASPIRE Collaborative Meeting, Henry Executive Center, Lansing, MI**
   c) Friday, September 13, 2024: **ACQR Retreat, Location TBD**
   d) Friday, October 18, 2024: **MPOG Retreat, Philadelphia, Pennsylvania**

5) **New QI Reporting Tool Features Available**
   a) Outpatient Procedures Dashboard
   b) Demographics Filter
      1) Multi-select Functionality
      2) New age group filter for pediatric cases
   c) Certified Anesthesiologist Assistants (CAA)
      1) Previously did not differentiate Certified Anesthesiologist Assistants in QI Reporting Tool (labeled as CRNAs)
      2) As number of CAAs participating in ASPIRE has increased, we need to accurately reflect their care team roles
      3) Will continue to include both CAAs and CRNAs in a single comparison group for Provider Feedback Emails
   d) **Discussion**
      1) *Kathleen Collins (Trinity Health – Livonia):* CRNAs and CAAs are different levels of provider and should not be combined into one category. CRNAs are now doctorate prepared nurses. CAAs are Anesthesia Assistants. This is not an accurate reflection of their training or practice.
      2) *Kate Buehler (MPOG Clinical Program Manager)*: Sites have 10 or 11 CAAs, one site has 90. Most sites don't have a big comparison group, so we group them with the CRNAs. We do the same for fellows and residents.
      3) *Nirav Shah (MPOG Quality Director):* Based on feedback received from some institutions, there is a significant overlap in their practice so think this makes sense, but we can definitely revisit as more CAAs continue to join.
   e) Release Notes can be found on our website

6) **OB Subcommittee Updates**
   a) **Last Meeting:** Wednesday, November 8th, 2023
   b) Meeting Summary
      1) Accepted applications for Vice-Chair position
      2) Reviewed BP-04 – Voted to continue as is
      3) Discussed uterotonic agent use, blood loss and transfusions for cesarean delivery
      4) Minutes posted to the website
   c) **Next Meeting:** Wednesday, February 7, 2024, at 1pm EST.

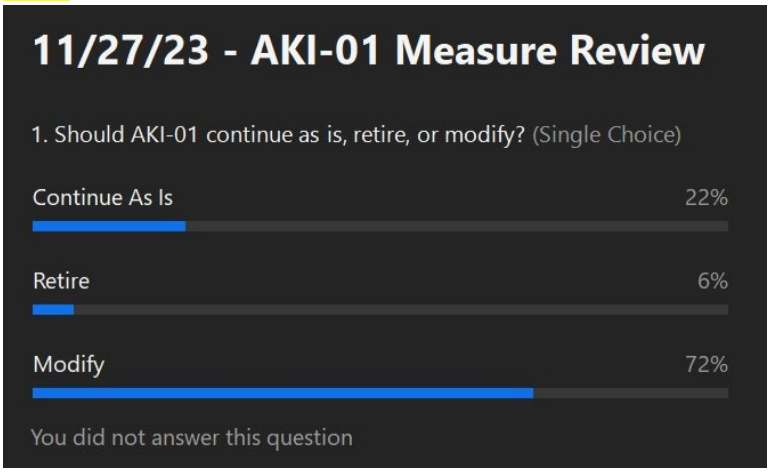
7) **Measure Review: AKI-01 – Dr. Michael Mathis, University of Michigan**
   a) AKI-01 Performance across MPOG
   b) Avoiding Acute Kidney Injury Vote
      1) Vote: 1 vote/ site
      2) Continue as is
      3) Modify
      4) Retire: Need > 50% to retire measure
   c) Coordinating center will review all votes after meeting to ensure no duplication.
   d) **Discussion:**
      1) *Nirav Shah (MPOG Quality Director):* Interesting analysis or perhaps research topic might be

to assess the use of normal saline vs. balanced crystalloid in MPOG data.

2) *Stephen Gregory (WUSTL):* I think that the evidence for one over the other has been extensively studied with no consistent and conclusive evidence, so I would favor deferring a saline vs LR quality metric unless something more conclusive emerges for now.
   (i) *Mike Mathis (MPOG Research Director):* I agree with Gregory. No change to that regard to AKI-01
3) *Josh Goldblatt (Henry Ford Allegiance)*: Given relatively low volume of intraop fluid (as mentioned), what role does Anesthesia play in shifting the generalized care between fluid options?
4) *Justyna Bartoszko (University of Toronto):* Kidney transplant I think there is better quality evidence supporting balanced crystalloids. I suspect there is a lot of heterogeneity across surgical subtypes.
   (i) *Nirav Shah (MPOG Quality Director):* Justyna would you like to elaborate?
   (ii) *Justyna Bartoszko (University of Toronto):* Good proportion of patient population will qualify as being critically ill. Personal feeling that balanced crystalloids does make a lot of sense in the critically ill patient. High risk and multitude of factors for AKI and perioperative outcomes. My center does try to avoid NS and try to use balanced crystalloids, but I don't have strong feelings either way.
5) *Nirav Shah (MPOG Quality Director):* I think there is general agreement to avoid saline at our site but beyond those general guidelines there is nothing more specific
6) *Mike Mathis (MPOG Research Director):* What is the downside or harm in using LR over NS? Harm is just putting too much attention on practice yet to be supported by high quality evidence. From an outcome perspective there is likely not going to be a safety issue. Continue to look at. Looking at variation in practice is a great research project.
7) *Nirav Shah (MPOG Quality Director):* Switch attributable provider. If a case is failed and also failed BP-01, instead update to BP-03 attributable provider. Sounds pretty reasonable to me. Provider who was signed into the case when hypotension happened. Anyone have any thoughts or comments on that?
8) *Mike Mathis (MPOG Research Director/University of Michigan):* Ideal world would measure renal oxygen delivery. AKI is multifactorial and not just hypoperfusion. The benefits of giving providers feedback on cases where there was hypotension outweigh the risks.
9) *Patrick Henson (Vanderbilt University):* If there are multiple instances of BP-03 triggering AKI-01 would they both get attributed?
   (i) *Nirav Shah (MPOG Quality Director):* Yes, all providers flagged for BP-01 *and/or* 03 will be attributed
10) *Nirav Shah (MPOG Quality Director):* Justyna mentioned something about critically ill patients. We should talk about re-introducing risk adjustment for AKI. We have developed a risk adjustment methodology for AKI that we hope will work for other measures as well. Risk adjustment for AKI will be available in 2024.
11) *Josh Goldblatt (Henry Ford Allegiance):* Most metrics are set with thresholds of 90%, but this one is set to inverse. Is there any discussion about standardizing the measures to all be reported the same way? Is high good or high bad can be difficult to remember across measures.

(i) *Nirav Shah (MPOG Quality Director):* Great question. Outcome measures will be inverse. Lower is better. Process of care – high is better. Tends to follow what we are seeing across other QI organizations. Relatively fewer flagged measures. For outcome measures, this is the model that we followed in making the decision of lower is better.

Vote:



Next steps: Modify Provider Attribution

- If case flagged for BP-01 **and/or BP-03**, then attribute provider who was signed into the case when hypotension occurred. Else attribute provider signed in for longest duration of case.

8) **Measure Review: TOC-02 – Dr. Jing Tao, Memorial Sloan Kettering**
   a) TOC-02 Performance across MPOG
   b) Handoff to PACU Vote
      1) Vote: 1 vote/ site
      2) Continue as is
      3) Modify
      4) Retire: Need > 50% to retire measure
   c) Coordinating center will review all votes after meeting to ensure no duplication
   d) **Discussion:**
      1) *Nirav Shah (MPOG Quality Director):* QCDR/MIPS measures. We wanted to align exclusion criteria with some of the national measures. This could be an opportunity to clean it up a bit. Opening the floor to comments and feedback. I know there are a couple of sites heavily involved with the hand off cooperative, so someone who is involved with that on the call could chime in as well.
      2) *Josh Goldblatt (Henry Ford Allegiance) via chat:* There has been a lot of focus on glucose. Did you come across any research on including glucose status in the handoff?
      3) *Kathleen Collins (Trinity Health Livonia):* MPOG lists generic key elements in the specification which allows the individual provider to tailor their handoff to meet the needs for that specific patient. I agree there needs to be a guideline but don't know that it needs to be specific to mandate each element that should be discussed. We did standardize TOC before we went into EPIC but it took feedback and changes from 4 different sites.
         (i) *Jing Tao (Memorial Sloan Kettering):* Not that we want to mandate 25 items but I

wonder if there are there top 5 things we should be specifying that could cause potential issues in PACU?

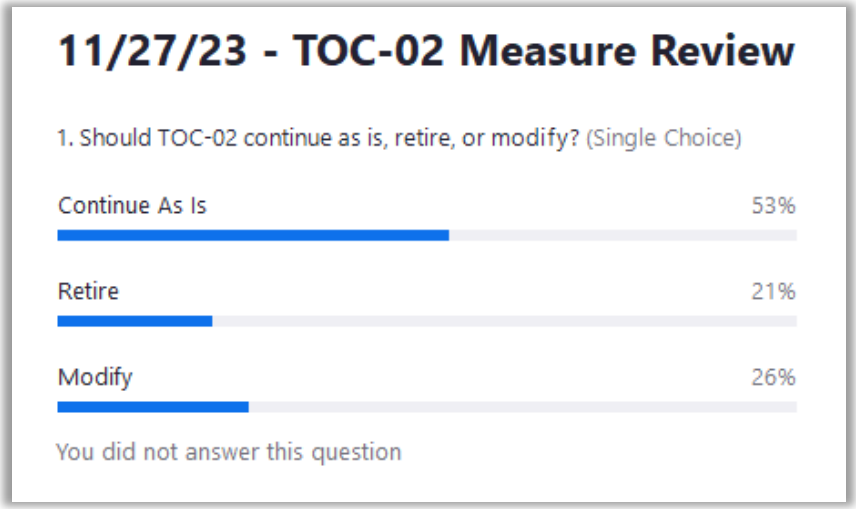
(ii) *Nirav Shah (MPOG Quality Director):* If you are performing really well in this measure may not mean your site is doing a great handoff but that they are doing some sort of handoff.

4) *Xan Abess (Dartmouth) via chat:* Fully recognizing that handoff/communication are important - if the bulk of our institutions are performing at nearly 100%, is there value in continuing this metric at all? (Especially since it's not being used for MIPS/QCDR purposes) Handoffs and communication are clearly important. I just do not know if there is a lot of value in continuing. I am a little hesitant in ad hoc building specifics across multiple institutions.
5) *Jing Tao (Memorial Sloan Kettering):* A checklist improves handoff, but should we standardize things that should be handed off? Should we start defining things that are important such as was Zofran given, hypotension, N/V pain. At this point we are so general and asking if they have a checklist?
6) *Josh Berris (Corewell East – Farmington Hills) via chat:* Do you want to add these elements to the handoff note as discrete data we are going to look for, or are we saying these should just be added and the attestation that we discussed it would be enough?
7) *Alexander Abess (Dartmouth)*: Clearly handoff communications are incredibly important, and I don't know if there is a lot of value in continuing with this measure. Although folks have raised the issue of having a specific handoff element, I am hesitant to ad hoc build those across multi-institutions without solid evidence base. Practice patterns may be quite different from one place to another.

(i) *Jing Tao (Memorial Sloan Kettering)*: It is hard because there is no outcomes data to see if this metric works and cannot change the metric without data. I think we should revise and not take it completely away. It does keep a checklist in mind for places that may not consistently practice this.

(ii) *Alexander Abess (Dartmouth)*: Sometimes it is nice to have prebuilt measure of tracking and having some administrative utilities for that measure.

(iii) *Nirav Shah (MPOG Quality Director*): A few years ago we had a program within the state of MI, we asked our ACQRs to do hand off audits. In addition to the measure, they put their eyes on handovers taking place. There was a form you had to complete to ensure they were covering key elements of a handoff. The most important thing is the high-quality interaction between the anesthesia provider and PACU RN.



8) **Next steps:**
Modify key elements of handoff on measure spec. Exclude the following procedures: radical clavicle or scapula surgery, thoracolumbar sympathectomy, and lumbar chemonucleolysis as exclusions.

Meeting Adjourned: 1100