MPOG QI - Quality Committee Meeting Notes – Monday, September 22nd, 2025

Attendance:

Balfanz, Greg (North Carolina)	Krauss, Kristin (Temple)
Bauza, Diego (Weill Cornell)	Lacca, Tory (MPOG)
Berndt, Brad (Bronson)	LaGorio, John (Trinity Health)
Bollini, Mara (WUSTL)	Lalonde, Heather (Trinity Health)
Bowman-Young, Cathlin (ASA)	Lewandowski, Kristyn (Corewell Troy)
Brennan, Alison (Maryland)	Lopacki, Kayla (Mercy Health - Muskegon)
Brown, Morgan (Boston Children's)	Lozon, Tim (Henry Ford - Wyandotte)
Brown, Sheree (Trinity Health)	Mathis, Mike (MPOG)
Buehler, Kate (MPOG)	Malenfant, Tiffany (MPOG)
Cain, James (University of Florida)	McKinney, Mary (Corewell Dearborn / Taylor)
Calabio, Mei (MPOG)	Milliken, Christopher (Sparrow)
Cassidy, Ruth (MPOG)	O'Conor, Katie (Johns Hopkins)
Chopra, Ketan (Henry Ford - Detroit)	Ohlendorf, Brian (Duke)
Clark, David (MPOG)	Owens, Wendy (MyMichigan - Midland)
Cohen, Bryan (Henry Ford - West Bloomfield)	Pardo, Nichole (Corewell Grosse Pointel)
Coleman, Rob (MPOG)	Paul, Jonathan (Columbia)
Colquhoun, Douglas (MPOG)	Pennington, Bethany (WUSTL)
Corpus, Charity (Corewell Royal Oak)	Pimentel, Marc Phillip (B&W)
Denchev, Krassimir (St Joseph Oakland)	Poindexter, Amy (Holland)
Dewhirst, Bill (Dartmouth)	Premo, Alison (Corewell Dearborn)
Doney, Allison (MGH)	Schonberger, Rob (Yale)
Dutton, Richard (US Anes Partners)	Schwerin, Denise (Bronson)
Edelman, Tony (MPOG)	Scranton, Kathy (Trinity Health St. Mary's)
Esmail, Tariq (Toronto)	Shah, Nirav (MPOG)
Everett, Lucy (MGH)	Shettar, Shashank (OUHSC)
Finch, Kim (Henry Ford Detroit)	Stam, Benjamin (UMHS West)
Ganesan, Rajarajan (Chandigarh, India)	Steadman, Randolph (Houston Methodist)
Goatley, Jackie (Michigan)	Stierer, Tracey (Johns Hopkins)
Goldblatt, Josh (Henry Ford Allegiance)	Stumpf, Rachel (MPOG)
Gonzalez, Marbella (Dartmouth)	Toonstra, Rachel (UMHS West)
Hall, Meredith (Bronson Battle Creek)	Tyler, Pam (Corewell Farmington Hills)
Henson, Patrick (Vanderbilt)	Vaughn, Shelley (MPOG)
Huntington, Michelle (Corewell Health West)	Vishneski, Susan (Wake Forest)
Jewell, Elizabeth (MPOG)	Vitale, Katherine (Trinity Health)
Johnson, Rebecca (UMHS West)	Wedeven, Chris (Holland)
Kaper, Jon (Corewell Trenton)	Wildes, Troy (Nebraska)
Karamchandani, Kunal (UT Southwestern)	Woody, Nathan (UNC)
Kheterpal, Sachin (MPOG)	Yee, Branden (Wash U)
Kirke, Sarah (Nebraska)	Zittleman, Andrew (MPOG)

Meeting Start: 1002

Meeting start, roll call, and prior minutes

- Dr. Nirav Shah opened the meeting, confirmed a packed agenda, and reiterated roll-call via Zoom participants (attendees using phone only were asked to notify the Coordinating Center). July 2025 QC minutes were posted; with no objections, they were considered approved.

Announcements

- **Summer 2025 Application Suite Upgrade:** Link available on the website; **Content Sync will not work until the upgrade is applied**—sites were urged to upgrade promptly.
- **QI Reporting Tool dashboard:** Some scores may be inaccurate; an update will be posted to the Basecamp QC forum when corrected.
- **Featured Member:** Xan Abess, MD (Dartmouth) highlighted for Sept–Oct; Dr. Shah noted his recent MPOG delirium-screening publication and long-standing quality leadership.
- **Upcoming events: MPOG Retreat —** Fri, Oct 10, 2025 (San Antonio, TX) – Registration Open; 2026 in-person dates set (East Lansing, Ann Arbor, San Diego).

New Measure Discussion — Glycemic Management (Outpatients)

- Existing MPOG hyperglycemia measures **exclude outpatients** with anesthesia duration <4h. Sites asked to start assessing ambulatory workflows and compliance. Recent SAMBA 2024 guidance suggests a target 180–250 mg/dL for diabetics; evidence is limited for non-diabetics in ambulatory settings.

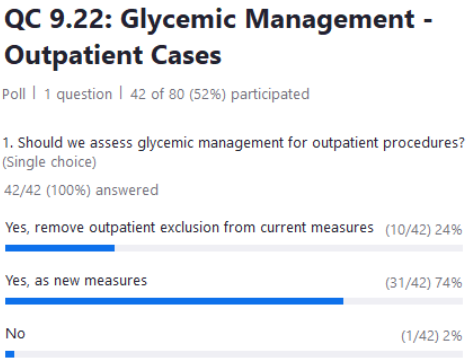
Options on the table:

1. **Create new outpatient-specific measures** (keep existing GLU-09/10/11/12/13 unchanged for inpatients).
2. **Remove outpatient exclusion** from current measures.
3. **Leave measures as-is** (no ambulatory expansion).

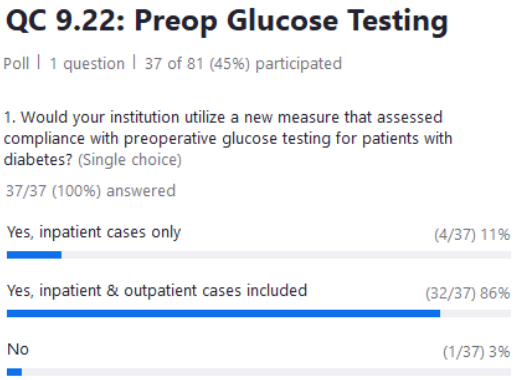
- **Companion idea:** A Pre-op Glucose Evaluation measure for adult diabetics (Pre-op Start → Patient In Room; success = glucose documented within 4 hours). Proposed denominator/exclusions were reviewed (age <18, ASA 5–6, emergencies, non-diabetics).
- **Discussion:**
  - Desire to avoid discouraging glucose checks, noting that 15–18% of non-diabetics may be undiagnosed; interest in denominators that don't penalize reasonable testing.
  - 120-minute recheck window (when using subcutaneous insulin) cited in chat as a practical threshold at one site.
  - Example site workflows: "all surgical patients get a pre-op check," and light insulin scales in some programs (e.g., treat >180 mg/dL minimally), with plans to expand to outpatients.

Voting Results

- **Outpatient glycemic management measure: 31/42 (74%)** in favor of **building a new measure**; 10 selected "remove" (i.e., not pursue).



- **Pre-op glucose testing measure: 32/37** would use a measure for both inpatients and outpatients (smaller share for inpatient-only).



Next Steps:

- Broad interest in moving forward with outpatient assessments
- a workgroup will develop specifications (thresholds 180 vs 250 mg/dL for diabetics, recheck/treatment timing, hypoglycemia countermeasure, and pre-op metric details).
- **Volunteers:** Henson (Vanderbilt), Bollini (WashU), Abess (Dartmouth), Gonzalez (Dartmouth), Esmail (UHN), Wildes (Nebraska).

Measure Reviews — Decisions, Rationale, and Implementation Notes

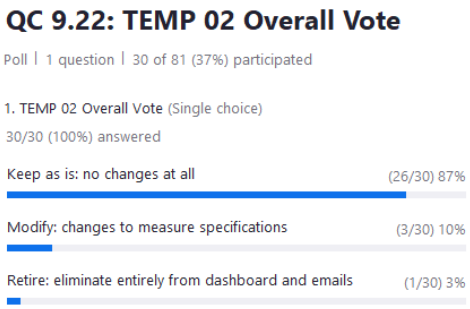
TEMP-02: Core temperature monitoring

Reviewer: Jon Kaper (Corewell Trenton).

Discussion:

- No new literature to change the rationale or inclusion/exclusion.
- Measure logic emphasizes at least one documentation that the temperature site is "core", acknowledging EHR variation; zero-flux thermometers were added previously.

Recommendation & vote: **Keep as-is** (**26/30** sites).



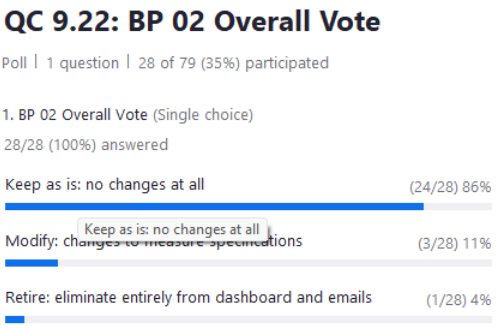
BP-02: Avoiding BP gaps > 10 minutes

Reviewer: Marc Pimentel (MGB).

Discussion:

- PACU hold cases when patients remain in OR: Some sites hit Anesthesia End upon a "true PACU hold," but most do not; consensus that if anesthesia time continues, then anesthesia-level monitoring (q5–10 min) should continue (don't adopt PACU q15 standards while anesthesia is still active).

Recommendation & vote: **Keep as-is** (poll **24/28** to keep; **3/28** modify).



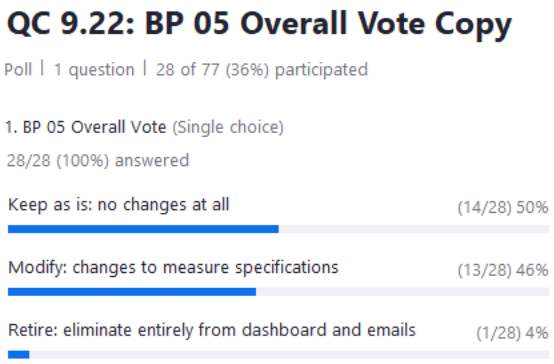
BP-05: Hypotension during induction

Reviewer: Rob Schonberger (Yale).

Discussion:

- Since 2016, literature (often from Sessler's group) shows pre-incision hypotension is common and preventable; a yes/no threshold remains more practical than AUC due to measurement-method dependence (NIBP vs A-line).
- Live remarks reinforced: keep criteria, include references, and proceed with the ASA filter to target sicker cohorts in QIRT without changing the denominator.

Decision: **Keep as-is** (binary success at MAP <55 before incision), add updated references, and add ASA status as a filter in QIRT (for analysis, not as an exclusion).



QI for Learners — Update

- **Progress to date:** SRNAs can now receive provider feedback emails when they sign into cases.
- **Roadmap:**
    - **Downloadable case logs** (CSV/Excel) for residents.
    - **Learner-focused dashboards**, with site champions selecting measures.
    - Ability to include a **subset of measures** in learner feedback emails.
    - **New phenotypes** to track resident experience (e.g., high-value cases).
    - **Provider-role filter** in QIRT (resident/SRNA/other).

Action items

Coordinating Center & volunteers: Convene **Outpatient Glycemic Management** workgroup; draft specifications for thresholds (180 vs 250 mg/dL), inclusion/denominator details (diabetics focus), **recheck/treatment windows** (e.g., 90–120 min), and a **hypoglycemia countermeasure**; scope the **Pre-op Glucose Evaluation** measure.

- **Measure governance:**
    - **TEMP-02:** Maintain as-is.
    - **BP-02:** Maintain as-is; draft **FAQ** guidance for PACU holds (monitor per anesthesia standards if anesthesia time is ongoing).
    - **BP-05:** Maintain as-is; **add references** and **ASA filter** in QIRT.

Meeting Adjourned: 11:01am EST

Next meeting: Monday, November 24, 2025 10am EST via Zoom

Full Transcript

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00:15:30 — *Nirav J Shah (MPOG)*: Thank you all, for joining this, September edition of the Quality Committee. We got a packed agenda, as always. Just a couple of notes, meeting minutes for the last, for the last meeting are, posted. That was in July, so if anyone has any additions or comments on those, please let us know. Otherwise, we'll consider those meeting minutes approved. And then, of course, roll call, we usually do via the Zoom participant list. If for some reason you've signed in, just using your phone, without logging into the Zoom account, please let us know you've attended so, we can, mark your participation. Kate, I'm going to just make a request. Rob Schonberger just texted me, saying he's looking for the Zoom link. If you don't mind sending him the… thank you so much. Oh. Okay, so as I mentioned, we have a packed agenda for today. We're going to start by talking a little bit about glycemic management. We need some feedback from the group, and then we have 3 measure reviews. By Doctors, Kaper, Pimentel, and Dr. Rob Schoenberger. And then, time permitting, we do have a brief update regarding our QI for Learners, work group. And so we, we, put that on the, back burner on the last meeting as well. We ran out of time. If we don't… we are not able to, update the group this time, we'll just send something out via… via the forum. Couple of announcements. The most recent, AppSuite, upgrade happened over the last couple months. Some of you may still be, upgrading. The link is available on our website, as well as the release notes. And, just a reminder from the team, Content sync will not work until you apply the upgrade, so please apply the upgrade as soon as possible. Our featured member, for, September, October, super thrilled that, Xan, Dr. Xan Abess, is our featured member. Of course, long-standing quality champion and involved in, in, in many parts of, of MPOG, including his recently published paper on delirium screening, screening within MPOG. So, Xan's a super interesting guy. Check out the website to learn more about Xan and what he's been up to. And upcoming events, of course, we are looking forward to seeing many of you at the annual retreat next month. It's just a few weeks away now, three weeks, two and a half, three weeks away. If you are planning on coming and haven't registered yet, please register. It'll give us a good idea of who all is going to be there. Looks like many of you already have registered, so super excited to see many of you, many of you in person. And looking forward to a great, great conference and a great agenda as well. And then for next year, we do have our deeds finalized for next year as well for our in-person meetings. our, March meeting in collaboration with MSQC, the Michigan Surgical Quality Collaborative.

> *Marbelia Gonzalez (Dartmouth) [chat]*: Xan is the floor runner today. I will make sure to tell him you recognized him. Thanks ☺

> *Michael Mathis (MPOG) [chat]*: Link to MPOG retreat registration: MPOG Retreat 2025 – MPOG.

New Measure Discussion — Glycemic Management (Outpatient Focus) **[back to the top]**

00:19:39 — *Nirav J Shah (MPOG)*: Okay, so just wanted to dive right in, and talk a little bit about glycemic management, actually hyperglycemic management, to be more… to be more specific.

So, we have gotten some feedback, over the last few months, even before that, but probably more in the last few months, about starting to think about assessing hyperglycemic management for outpatient cases. And so, as many of the existing MPOG measures related to hyperglycemic management exclude outpatient procedures with an anesthesia duration of less than 4 hours, and this is a decision we made many, many years ago. Excuse me. Given that, hyperglycemic management protocols for outpatient

cases were… were limited, and in many cases, most of the hyperglycemic management protocols related to inpatient or admin-after, cases or patients. More and more, it seems like these protocols are starting to include outpatient cases, and that, includes protocols here that we have, at the University of Michigan as well. And so, and there's been some recent, guidelines released by our colleagues at Samba as well, Society of Ambulatory Anesthesia, kind of starting to comment on hyperglycemic management in the, for, for ambulatory anesthesia for outpatient cases.

Given that recent interest, given the recent feedback, given the recent guidelines from Samba, we just wanted to throw out a few options, a couple of options for folks to discuss, maybe comment on, I want to thank our colleagues at Vanderbilt and WashU and some other places around the country that have kind of brought this up and helped us tailor, some of these options or discussion points, really, to talk about today. And so it includes, a couple of different potential areas that MPOG can go into. One is… to create new outpatient-specific measures to assess hyperglycemic management, and so we kind of leave glucose 9, 10, and 11 our existing hyperglycemic management measures as is. We continue to exclude outpatient cases from those measures, but we create these new outpatient-specific measures to assess management of hyperglycemia. So that's… that's kind of one option. Another option is we just take our existing measures as is, blood sugar at 180 milligrams per deciliter, and just remove the outpatient case exclusions for those measures, that would mean that, what we're stating at MPOG is that the protocols are essentially the same between inpatient or admit after, and outpatient cases. And then, of course, the third option, or third option, is that we could just kind of leave everything as is, and kind of leave the… those outpatient cases, as excluded from, the assessment of, of hyperglycemia management, here within, at least within MPOG, and continue to learn a little bit more about where the evidence is going, and what our, our, our society recommendations are. So a couple of just additional discussion points, and then I'd kind of like to open it up to see if folks have any, any additional comments. One is, SAMBA, again, most recently, in 2024, recommended a target range of 180 to 250 milligrams per deciliter. I think they focused on the diabetic patient population.

> *Josh Goldblatt (Henry Ford Allegiance) [chat]*: If adding outpatients to existing metrics, how does that change scores?
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> *Kunal Karamchandani (UT Southwestern) [chat]*: I don't work in an ambulatory setting, but I think there should be a separate metric rather than merging with the existing one.
>
> - *Patrick Henson (Vanderbilt) [chat]*: Reacted 👍. 100%.
> - *Bethany Pennington (WUSTL) [chat]*: I agree.
> - *Troy Wildes (Nebraska) [chat]*: Reacted 👍.
>
> *Aaron Wood (Corewell) [chat]*: Need to only include diabetics. Need to only include cases that have an incision. 120 time interval. 180 threshold value.
>
> *Anthony Edelman (MPOG) [chat]*: glycemic management is low hanging fruit for quality of periop care. we should be checking and treating, independent of output v input
>
> *Ketan Chopra (Henry Ford – Detroit) [chat]*: Separate metric. Only include general cases? Can't imagine holding off a busy cataract day for 60–90 min to recheck. Is it treat/wait then proceed? or treat then proceed? I work in ambulatory settings as well, holding an ortho surgeon back isn't

going to go that well compared to a hospital setting where things can be shuffled around. Happy to be part of the work group

Troy Wildes (Nebraska) [chat]: Concerns and thoughts on outpatient population:

- The biggest problem that I see in outpatients is failing to reliably check glucose values in patients with diabetes and I'd be concerned that a metric based on detected hyperglycemia might discourage checking
- I am concerned about stacking subcutaneous insulin treatments in outpatient and the risk of hypoglycemia
- As opposed to the inpatient population, patients with elevated glucoses in the outpatient setting will more specifically be patients with diabetes as non-diabetes hyperglycemia will be much more rare

Kim Finch (Henry Ford Detroit) [chat]: About 15–18% of our non-diabetic patients are undiagnosed diabetics

Aaron Wood (Corewell) [chat]: Yes 120 minute time threshold is based on use of subcutaneous insulin

Josh Goldblatt (Henry Ford Allegiance) [chat]: We have one protocol for all surgical patients, and all should get a check in pre-op.

Marc Philip Pimentel (Mass General Brigham): Yeah, so at NMTB, we're kind of halfway there as well, but we haven't really gone into the outpatient space, so our overall goal for glucose control is… It's 110 to 150 in all patients, but as far as, kind of, enforcement and rules and measures, it's really just being done for inpatients with an incision sting overnight, and all of them get a glucose check in the PACU. And a really light insulin sliding scale, like, getting, like, one unit if you're over, I think, 180, which is, like, almost nothing. But, it's our start, and it's going to get more, more robust and comprehensive, and I could see this going to the outpatient space in some way.

Nirav J Shah (MPOG): Definitely seeing, some consensus around at least assessing in the outpatient space, what our workflow is, and whether or not we're checking glucose measures for our diabetic patients, and, and maybe, are we treating it or not? And maybe this is one of those measures that we, kind of mark without a specific threshold to begin with, if we end up building this, and then we kind of see where folks are landing. Several more comments in the chat, again, regarding separate measures, regarding, forming a small work group, to iron out the details, and then some concerns from Dr. wild in Nebraska, failing to reliably check glucose values in patients with diabetes, and so, I'll just skip to the next slide here. And there has been some thoughts around, and some feedback, just, yeah, around, like, are we… Checking… pre-op, glucose in patients with, with or without, with diabetes, and with diabetes in this case. And so, yeah, so I think there is, maybe some appetite to understand, as Dr. Gonzalez mentioned, to expand the denominator and, see if, are we actually, and also to make sure that we're not discouraging the checking of blood glucose for any reason. So… Kim, about 15–18% of our non-diabetic patients are undiagnosed diabetics, okay? And yeah, iPhone users is Aaron Wood from… Corewell, thanks for… Responding to that. Josh, we have our own protocol for CERF for 1 surgical patients. So, lots of comments on this, and I know I do want to get to the measure reviews.

Seems like there is interest in moving forward, at least this is a space where people want to learn more. I'm going to throw two polls out there, one regarding, kind of, overall glycemic management for outpatients, and then one regarding, the pre-op glucose measurement, and kind of get the overall temperature feedback from the group. See if I can launch this… All right, first of all, glycemic management. So, everyone, anyone can vote on this one. It's not a measure review, I just want to see what folks think. Alright, going to end the poll, share results… Yeah, so it looks like there is, some support to… I hope folks can see this, 31 out of 42, 74%. Building a new measure, and another 10, say, remove. So the vast majority are looking for more information for glycemic management in the outpatient space, so that's good information for us. And several of you have, in the, chat have mentioned that you're willing to be part of a work group, so thank you. We'll notate that as well.

- *Patrick Henson (Vanderbilt) [chat]*: Would ask to be included in a workgroup
- *Troy Wildes (Nebraska) [chat]*: I'm also interested in being involved in a workgroup.
- *Mara Bollini (WUSTL) [chat]*: I would also love to help.
- *Tariq Esmail (Toronto) [chat]*: Yes to the working group idea. Need to spend some time thinking of it for our sites. Thanks for the conversation.
- *Marbella Gonzalez (Dartmouth) [chat]*: We, Dartmouth, Xan, or I will also be interested in joining the working group. Thanks [back to the top]

Measure Reviews — TEMP-02, BP-02, BP-05

00:41:26 — *Nirav J Shah (MPOG)*: We will move on to our first measured review. From Dr. Kaper, from Corwell Health East, going to be talking a little bit about TEMP-02, John, if you just give me one second, I will bring up your review.

TEMP-02 Measure Review *[back to the top]*

Jonathan Kaper, MD, MHSA (Corewell Trenton): Okay, so good morning, everyone. So, since I presented this last in July of 2022, there's not been a lot of new literature. On the topic, especially none that really, brings, any new… any new initiatives, to the forefront. In terms of the appropriateness for the rationale. You know, unplanned, hypothermia, impaired wound healing, adverse, cardiac events. Altered drug metabolism and coagulopathies. So, no changes in the past 3 years would call into question the appropriateness of the rationale for intraoperative measuring of the core temperature. In looking at the, inclusion and exclusion criteria.

Again, I didn't really find that any, changes would be recommended. When I did present this 3 years ago, we did discuss If it would be appropriate to measure core temperatures in patients having their axial procedures. But obviously, core temperatures in patients, just undergoing sedation, Poses some challenges, but maybe, perhaps, potential in the future, if there's better… better modalities available for measuring core temperature. In terms of the flag cases. Currently, it's just one temperature documented from anesthesia start to patient out of the room. You know, perhaps there'd be, an opportunity, to expand that to more than one measurement. With that said, though, if you're doing core temperature measurements, it's probably going to be a continuous measurement, so I would anticipate there being one… more than one, regardless during the course of the case. In terms of, other feedback on this measure, it's a well-established measure, really unequivocal benefit to the patients.

So, based, on the literature review, new studies from the last 3 years, no further feedback, or recommendations, seem, to be necessary. So, my recommendation would just be **to keep it as is**, with no recommended changes. So, Yeah, again, I think a pretty straightforward and uncontroversial topic.

Nirav J Shah (MPOG): Yeah, thank you. I agree, it seems relatively uncontroversial. You know, regarding the measurement, question, I think, you know, if I remember correctly, the way that we, built this measure is that we want at least one… documented, label that there is a core temperature measure… a core temperature measured, and so… or that the location of the temperature measurement was… was in a… in a core temperature location. And so, so not necessarily that we don't just want one temperature measurement, but we want at least one documentation that it was, a core temperature location. And I think that's kind of how we… we thought about it when we built it. And that's… was due to some, like, variation in how this was documented across different electronic health records, where for some, it was just part of, like, a regular assessment, a few 15-minute assessment, and for others, it was, like, a one-time documentation that the location of the… of the temperature probe was in a… was in a core location. Any, any other thoughts? Any other… Comments on, on the core… core temperature measure. We did add the zero-flux thermometer a few years ago to this. We have made a couple of modifications. Time. And I… I understand that this… my screen looks like it's annotated with a couple of green lines. I don't know if everyone can see that. I can see that. I don't know how to remove it. trying to, like, figure that out, but if anyone knows how to remove those annotations easily up from the Zoom controls, let me know, and I'll go ahead and do that. Any other, any other comments or thoughts before we move to a vote here? Okay. Oh. Book 2… Alright, and this member, one vote per site for this one, because we're making decisions on whether to keep, modify, or remove. One… one vote per active site. You're doing that, I'll just show… Kind of variation in performance. Across MPOG, still, still some variation.

Nirav J Shah (MPOG): All right, looks like, 26 out of 30 agreed that we should keep it as is, so we will go ahead and do that. Dr. Kaper, thank you so much for you. I know you have a super busy schedule, so I really, really appreciate taking the time and effort to do this. Thank you. [back to the top]

BP-02 Measure Review *[back to the top]*

00:48:38 — *Nirav J Shah (MPOG)*: Okay, next we will move to Dr. Pimentel. you have BP-02, and let me scroll to the beginning.

Marc Philip Pimentel (B&W): BP-02 Hasn't been changed in several years. This one is making sure that we have a blood pressure, with no gaps longer than 10 minutes. Your vision article, that support this measure is the Kruger paper that showed that there was, extra increase in undissected transition into relative hypertension or absolute hypertension, or a decrease in 40% from baseline. If we didn't measure, in this time period. So nothing answering this question, has been kind of put forth in the interval. But, you know, this does, jive with the ASC monitoring standards, which also have been updated, but were firm back in 2020, five years ago. If you could kind of scroll down. And so, here are the inclusion and exclusion criteria. We include all the adult patients having Anesthesia, and we exclude ASA5s and 6s. Patients having block-only labor epidurals and MRI, I think, because of the difficulties in getting BPs and MRI sometimes. So, success criteria, kind of are as stated, make sure there's a 10 minute or less gap. So, the measure goes from the first blood pressure until anesthesia end time. So, one of the questions I had about this particular measure is, regarding what happens when you're on a PACU hold. I don't know if any of you have ever been on a PACU hold before. I'm assuming some of you at least have,

waiting for a bed to go into, in the PACU or upstairs the floor, if they have to. And during this time, the period, the patient, may just recover, and it would normally have been transition to PACU standards for, measuring blood pressure, which, at least at my hospital, is, Q15 minutes and not Q… 5 or 10. So… if the patient is clinically appropriate for kind of an extended interval for a BP measurement, you know, what should we be doing? In terms of this measure. I think we're most stringent now because we are measuring this CNN, so officially, you know, we are still in charge of the patient's care, and so we're usually trying to apply the ASA standards. But I just wanted to kind of open that question up to the group, you know. how do we do for… for practical? Do we still really, be on a measuring, that often? Because some of these packet holds, you know, some of them are just 5, you know, just, like, maybe 15 minutes or so, but others, I've heard, can be 40 minutes. Sometimes an hour or more at a time, and so… You know, so, what do we do? Do we want to do anything to… To adjust for these, these cases or not. Okay, and then, you know, finally, in terms of a measure. metrics, you know, there's… we are doing very well as a group on this measure, only maybe about an eighth of the sites are below the 90% benchmark that we've set, so there's actually quite very little variation in terms of the measure between different sites. So, as far as an improvement goal, there may not be much for individual sites to do, except for maybe the bottom, bottom view. But for individuals who are getting the emails, you know, every, every… every month, you know, it might be something that… I want to make sure at the individual level, at least, that people are still… make sure there are no gaps in the blood pressure. So… For that reason, I was going to… I recommend **to keep it as is,** for now.

> *Greg Balfanz (North Carolina) [chat]*: Not sure if it's right or wrong, but when we go on true pacu hold we hit anesthesia end. So I assume that would close this case for this metrics purposes

00:53:25 — *Nirav J Shah (MPOG)*: Thank you, Mark. Yeah, and the other thing, that we've heard, As for new learners, it's like a nice… Measure for new residents, you know, as, like, an introduction to. performance movement and practice feedback, and I know, at least here at the university, you know, Lara Zisplat and others have mentioned that this is something that they mention when they're kind of dipping their toes, the residents' toes, into performance feedback. Tariq?

> *Tariq Esmail (Toronto)*: Thanks, Nirav, and thanks… thanks for the review. I think that's a really interesting question. I hadn't thought about the PACU hold situation, and that ebbs and flows at our institution in frequency. I guess, on first thought, a reflection of that, I think in the chat somebody said they do click anesthesia end. I think so that must be variable at different institutions, because we would have to stop our data capture, and then we end anesthesia, so that wouldn't happen for us, so we would definitely be sort of dinged in this measure. But I think, given that the goal is not to have PACU holds, and that they hopefully are infrequent, or not consistent. My first impression would be to keep the measure as is. And this is all for information anyway, so since everyone's doing so well, if you do get a future review, and you end up seeing that, oh, this was as due to a pack you hold. I mean, that's fine. You are now aware that that was the case, and it no longer needs to matter, to you, but I guess that's taking a more conservative, you know, safety-first approach than extending the duration, but that's sort of my first impression. But I do know that I would have staff that would criticize us slash me for, you know, a measure that's still continuing to be applied when standards of monitoring have shifted. But I think that's the best of both worlds, or at least that's my opinion.

Marc Philip Pimentel (B&W): Yes, I agree. I've also had to deal with this feedback from my staff about the feedback, so… Yeah, that's just why I bring it up. Thank you.

Nirav J Shah (MPOG): Dr. Gonzalez? I agree, and my… every time I get that from the people that have failed the metric. When there is, and we have a lot of packet holes, is just, you know, continue monitoring every 5 or 10 minutes, but just start counting when you are riding your packing holes, so you can leave the room 30 minutes later and still be, you know. compliant with all the Phase 1, you know, post-op areas. But it is something that I hadn't thanked until a couple of people sent me an email saying, hey, I failed this metric, how come I did that? Yeah. Yeah, it's interesting. I think we… our… our perspective here at the U is that if you're in the operating room and you're with the patient continuously monitoring them, then, then you should be monitoring for, you know. And really, it's being counted as anesthesia time. You should be monitoring, with, you know, usual, typical anesthesia standards, but… Interesting that, you know, Trebell Fonda mentioned that when they go on a true PACU hold, they hit anesthesia end. I would think, you know, that process is probably the exception, not the rule. It's very, very interesting that you guys do that. Any other comments? Okay, alright, let me launch the poll.

Okay. Looks like we have a quorum in the poll. Share results, 24 out of 28 to keep as is, and 3 out of 28 to modify. Okay, so I think we have our direction there. Dr. Pimentel, thank you so much for your review. Really, really appreciate it. Stop sharing this… And then… We'll move to the final review for today. BP05, Rob, just give me one second. Sure. That up, and then scroll to the top. Okay, the floor is yours. Thank you. [back to the top]

BP-05 Measure Review [back to the top]

00:59:07 — *Rob Schonberger (Yale)*: I really appreciate and look forward to folks giving some feedback on this informational measure. Just as a reminder, BP-05 is the pre-incision hypotension informational, ASPIRE metric that, that we added a couple of years ago now. The success is that it includes patients who've had at least 5 minutes between anesthesia induction start and incision. It excludes patients who arrive with a blood pressure map less than 60. And success is maintaining blood pressure so that it does not, fall below 55 MAP before incision. There… the previous description of the measure, had literature, only through, 2016, and there have been several articles, I'd say the majority of them by Dr. Sessler, since that time that, that I've put up there on the, Google Doc. One, looked at the association of hypotension during non-cardiac surgery before and after skin incision with, AKI and a retrospective analysis, essentially found That between a quarter and a third of, of, of all hypotensive episodes were occurring prior to incision, and that the association with AKI was significant, in both of those periods when looked at as an area under the curve. And that was a, a threshold of, less than MAP of 65. Second, new reference I put in here was a bundle to prevent post-induction hypotension, which I thought was important to have. Because the question, also a Sessler article, a question of, you know, can you do anything about this? Are these patients somehow just going to, by nature of… their condition going to be hypotensive prior to incision, there's nothing you can do about it. So again, Sessler's group had a bundle to prevent MAP less than 65 prior to incision, and they succeeded in decreasing the rates of hypotension prior to incision. And then the third one, again, early use of norepinephrine in high-risk patients undergoing major abdominal surgery. A randomized controlled trial looked at norepinephrine infusions versus ephedrine boluses, and sure enough, the norepinephrine infusion group had fewer hypotensive episodes to less than 65. And there is a Jack article out literally this week, during the American College of Cardiology, again from Dr. Sessler, with a, a multi-center randomized trial from

China. Looking at major cardiac adverse events in patients with a higher blood pressure goal versus a lower blood pressure goal of 65 versus 80 MAP, and did not find a difference in the primary outcome of cardiac complications. So, our measure is not an AUC, not an area under the curve measure, it's a yes-no measure. And so, I'd love to hear folks' feedback. It's kind of… Because of that, you know, observational data implicate MAP less than 65 prior to skin incision is potentially an important determinant of post-operative morbidity when looked at an AUC. It's complicated to look at area under the curve. It's very dependent on, on, method of measurement. Are you using an A-line, or are you using intermittent non-invasive blood pressures? And so, kind of looking at a yes-no metric, we chose map less than 55, because there's also data for that, and it seemed like a more severe kind of cutoff. If you hit that, regardless of the time that you were there, it's probably not a good thing. We did a MPOG study looking at older adults, it was funded by NIAA, so we're looking at older adults, I'm sorry, NIA, National Institute on Aging, and showed that there was indeed, in terms of the yes-no metric. In association with AKI, pre-incision. In older adults. So, my, suggestion, pending your vote and your comments, is that the MAP55 yes-no metric is reasonable, certainly not written in stone, as more data may emerge. perhaps most meaningful in older adults, but given the uncertainties and the observational data suggesting MAP65 as a threshold for AUC being significant, I thought it was reasonable, given that we're sticking with the yes-no metric. For now. My suggestion was to modify it to include some of the more recent data. To give folks some background if they look this up. And I'm encouraged by the fact that there is significant data out there showing that MAP less than 55 is both reasonably common and preventable, because I don't think that those data were out there when we first were making this metric. We knew it was common, we weren't sure that bundles would actually, in a randomized, rigorous fashion, cause it to be preventable. I'll stop there.

> *Tariq Esmail (Toronto) [chat]*: We haven't spent any time with this measure yet, so I apologize I don't have any practical input from our sites yet.

Nirav J Shah (MPOG): Excellent, thank you, thank you so much. Comments from the group, thoughts from the group? As you kind of alluded to, This measure as a bundle of measures looking at, you know, blood pressure management, in the operating room, I think… I think serves an important role, and it, you know, the one thing, I think, you know, that we were talking about, you know, during, the NIA project is that, you know, this This time period is one that typically you can, you know, attribute to the anesthesia provider, you know, solely, mostly, I would say. And so, from that… from that perspective, it's a good proxy for, you know, anesthesia provider workflow versus what's happening, you know, on the other side of the drapes. We did have one additional comment from the Corning Center, and Dr. Schoenberg, I'd be curious to hear your thoughts on it. In the QI reporting tool, There's, you know, multiple ways in which you can slice and dice the measure performance, including by age. In this case. Yeah, for this measure, it seemed in particular, would be interesting, and maybe for some of the other blood pressure measures as well, to include a filter by ASA status as well, so that if you're looking, trying to target to a more, you know, a sicker population, it would allow you within the QI reporting tool to do that. I'm just curious to hear your thoughts on that.

> *Josh Goldblatt (Henry Ford Allegiance) [chat]*: Can you clarify what the modification recommendation is? Is it just references?
>
> *Nirav J Shah (MPOG) [chat]*: yes

01:06:27 — *Rob Schonberger (Yale)*: Thanks for… I… I had meant to comment on that. Thank you for the reminder. I think that that… one of the… probably one of the most referenced MPOG articles ever is the Mathis article that perioperative hypotension and its association with post-operative bad outcomes is, very dependent on preoperative risk. And, I think that having had that, it would be very useful for folks to be able to filter based on ASA status. whether we would limit it by ASA status, I'm not sure I would go that far, but I'm curious what others think.

> *Marbella Gonzalez (Dartmouth) [chat]*: 92 yo female for lap chole ASA 2., healthy and only HTN. BP still very relevant and we will miss that is ASA status is filtered

Nirav J Shah (MPOG): Yeah, that was our thought as well, is that it wouldn't be necessarily an exclusion criteria for the measure, but just a way you could slice and dice within the, Within the reporting tool. Any other comments? Alright, launch the poll. Again, please remember, one… one vote per site.

While folks are, putting their response, and I did want to mention, some of you may have noticed, those of you that may have looked on the dashboard, excuse me, this morning, there is, a current issue for some sites with, scores reporting on the dashboard. Team is working through that Right now, should be fixed, be fixed ASAP. We'll send a message out on the forum once, once the all clear has been given from our, from our technical team. I wanted to make sure folks knew about that. I'll probably also send a message across the forum as well, if we think it's going to be off. The scores are going to be off for any extended period of time on the dashboard.

Okay, so yeah, I think the overwhelming is to, you know, **keep the criteria as is.** I think, obviously, modifying to include the references, we have direction to keep the criteria as is, and to stick with the yes-no versus the AUC, which I think, is an important consideration, and certainly makes a… I think Rob makes a lot of sense, to stick with the single at 55. Dr. Schonberger, thank you so much. I really, really appreciate, your feedback here. Thank you. [back to the top]

QI for Learners Update **[back to the top]**

01:10:22 - *Nirav J Shah (MPOG)*: Okay, great. I think just enough time to talk about the last topic, which is an update on the QI for Learners group, so… first I want to thank the QI for Learners work group, for their work this past spring and early summer to talk about how we can make MPOG more relevant, for our residents and other learners across MPOG, and so the group met a couple of different times to talk about some potential opportunities, and we did make a couple of changes, and so the major change that I wanted to mention is that**, SRNAs can now be included in provider feedback emails**, so if your SRNAs are signing in and signing out to their cases, then, within the provider contacts tool, we could now mark them, to receive, the feedback emails, and so I think some of you have already taken advantage of this. I know others may be interested as well. If you have any questions on that, let us know, but it should be pretty straightforward to do.

We did have some additional feedback that we wanted to talk about that is part of MPOG product planning, and that includes creating files or reports for residents and their program directors to view ACGME case logs. And this has been, a long-standing area of feedback. We've started to work on that in a couple of different ways. We know that some folks have done that locally, including here at the University of Michigan with MPOG data, and so we're trying to make that something that all sites can use. We wanted to add some functionality for, residency program directors and site champions to pick,

a subset of measures that could be sent to residents, or other learners, or other groups. And so a plan is to… to build that functionality in. Not just, at a dashboard level, but also at a provider feedback level.

We've gotten some feedback around creating additional phenotypes to track the resident experience. Dr. Caldwell is leading some efforts in this area, and we'll talk more about that in upcoming meetings, but the plan is to… and if a patient… if a case, for example, has had a massive hemorrhage or massive resuscitation, like, how do we, you know, pluck those experiences and those phenotypes and make sure we can track them, and make sure that residents are… we're putting our residents in positions to be able to receive that kind of experience throughout their residency training. And then finally, adding a provider role filter to the QI reporting tool, so that you can filter performance by, by residents, or by SRNAs or other provider types, so that, can start to target the analysis and the QI work, to, to specific, provider roles. So, I mean, all exciting stuff.

I know several of you have already reached out to us about being included in further updates and further discussions, and we've marked all of your information down, so we will make sure we include you. If someone hasn't done it, but is interested in, definitely let us know. And, you know, super excited to, to make progress in this area as well. So, any final thoughts or comments on this? Before we wrap it up for today.

Okay, I think we are at time. Thank you so much. A huge thank you to our measure reviewers and the sites that, you know, helped us bring the glycemic management topic up for discussion as well. So, thank you guys so much, and we'll see, hopefully, many of you in a couple weeks in San Antonio. Thanks, everyone. [back to the top]