ASPIRE Collaborative Meeting
Afternoon Session
April 23, 2021, 12:15-1:15pm

I. Welcome to New Sites!
   A. Spectrum
   B. Borgess
   C. MidMichigan
   D. Metro
II. CME and meeting notes available on the MPOG website under Events/News
III. ASPIRE Virtual Collaborative Meeting: July 16, 2021 9a-noon
IV. Matters Arising/Questions from the Group
V. Performance Review Session
   A. Process:
      1. Pick measures that have some variability
      2. Pick measures of timely interest
      3. Describe measure to refresh memory
      4. Ask sites to describe their workflow
      5. What can the collaborative learn from you?
      6. What can you learn from the collaborative?
      7. What can we learn from each other?
   B. SUS 01- Fresh gas flow < 3 l/min when using inhalational anesthetic agent
      1. Description: Percentage of cases with mean fresh gas flow (FGF) ≤ 3L/min, during administration of halogenated hydrocarbons and/or nitrous oxide
      2. Inclusion Criteria: Patients administered halogenated hydrocarbons and/or nitrous oxide, for greater than or equal to 30 minutes from placement of the airway device to removal of the airway device.
      3. Exclusions:
         a) Cases in which halogenated hydrocarbons and nitrous oxide are NOT used
         b) Cases with maintenance period < 30 minutes
         c) Cases with >20% of Fresh Gas Flow values manually entered during the case (automated capture of FGF required)
      4. Success: Mean FGF ≤ 3L/minute during the maintenance period of anesthesia, when administering inhalational agents
      5. Performance scores shared with group; Feedback:
         a) Alex Bouwhuis (Holland): Small hospital with a small group of providers who have practiced this way for a long time. Could be that there is also a focus on reducing cost
         b) Traci Coffman (St. Joseph Mercy Health System): Culture and initiative last year was to be ‘greener’ prompted by the ASPIRE meeting last year. Instituted no use of desflurane and reduced gas flows.
            (1) Nirav Shah (ASPIRE Director): How did you structure this education?
            (2) Traci Coffman (SJMHS): We have an educational lecture that we distribute to everyone with questions following the lecture to ensure competence; Removed desflurane from

the ORs. Providers needed to go retrieve it before they could use it.

(3) Joel Kileny (SJMHS): Use CRNA morning measures to reinforce this metric on a weekly basis

(4) Nirav Shah (ASPIRE Director): Any pushback?

(a) Joel Kileny (SJMHS): Not really. We live in Ann Arbor so the culture is pretty environmentally conscious already.

(5) Ksenia Koltun (Royal Oak): Some confusion at Royal Oak with implementing this measure. Cases where this is an issue are those requiring jet-ventilation or the desire is to perform deep extubation where high flows are turned up.

(6) Bryan Cohen (Henry Ford West Bloomfield): Issue with not recording the inspired gas at the end of the case, only pulling over the expired gas.

(a) Nirav Shah: Recommended working with Biomed teams to pull this data over from ventilator to EHR.

C. BP 03- Low MAP prevention (MAP < 65 for 15 minutes cumulative duration)

1. Inclusions - All adult patients regardless of anesthetic technique
2. Exclusions - Baseline MAP < 65 mmHg, OB , Cardiac, Lung/Liver Transplant
3. Success: MAP < 65 mmHg that does not exceed cumulative time of 15 minutes
4. Performance scores shared with group; Feedback:
   a) Kathleen Collins (St. Mary's Livonia): Liberal with phenylephrine and pressors- jump on it quickly and monitor the blood pressure closely. Just a culture thing but our population tends to be older but less sick overall. Not doing open hearts or big vascular cases like some other centers. What we do, we do well but we don't do every case type.
   b) Aaron Wood (Beaumont FH): Vigilance, education, phenylephrine administration
   c) Joel Kileny (SJ Ann Arbor): Have made this an education focus for 2021 with sending literature updates via email
   d) Alex Bouwhuis (Holland): Wonder how many sites really push/promote clear liquids until 2 hours before surgery. We're pretty good about it (often a headache when we want to start a case early), and perhaps our patient's are a little less dehydrated than others.
      (1) Kathleen Collins (St. Mary Livonia): Wed do the same
   e) Eric Davies (HF Allegiance): Any particular thoughts on the recent A&A article by Sessler et al on the relationship between providers, MAP, and outcomes and accompanying editorial?
      (1) Nirav Shah (ASPIRE Director): As a single center study from Cleveland Clinic, it was pretty remarkable how little variation there was between providers. Still think looking at hypotension at an institutional level does still make sense and maybe even at a provider level depending on the institution

D. TEMP 02- Core temperature monitoring

1. Description: Percentage of cases with risk of hypothermia that the anesthesia provider measured core (or near core) temperature intraoperatively
2. Inclusions - All surgical patients receiving general anesthesia
3. Exclusions - ASA 5 and 6 cases, neuraxial or regional technique only, labor epidural, MRI procedures, cases less than 30 mins
4. Success - Cases with at least one core (ie not skin) temperature documented between Anesthesia Start and Patient out of Room
5. Performance scores shared with group; Feedback:
    a) Masakatsu Nanamori (Henry Ford Detroit): This was a focus area for our site in past years- have worked on making it easier to document within Epic; sent monthly education and reminder emails to assist providers in documenting core routes.
        (1) Nirav Shah (ASPIRE Director): DId you remove skin temp probes?
            (a) No, we didn't need to remove the skin probes from the ORs. Just needed to correct documentation
    b) Kathleen Collins (St. Mary's Livonia): No way to document with Epic transition; has since been added to Epic documentation but that's why we dipped in performance for a period of time. When we are sharing the airway we use the skin temp probe and place it in the nasopharynx until we get a core temp. Are other sites doing this as well?
        (1) Eric Davies (HF Allegiance): Yes we use nasopharyngeal probes
        (2) Bradford Berndt (Bronson): We are using skin probes in a similar matter for many types of cases at Bronson Methodist
        (3) Sachin Kheterpal (Michigan Medicine): That's what we used to do at UM, but had some safety events with the "sharp" part of the probe. removed for those reasons, side benefit was getting rid of the skin temp ability
        (4) Aaron Wood (Beaumont FH): There is a nasopharyngeal probe made
6. PONV 03- PACU nausea/vomiting rates
    a) PONV 03 Description: Percentage of patients, regardless of age, who undergo a procedure and have a documented nausea/emesis occurrence OR receive a rescue antiemetic in the immediate postoperative period.
    b) PONV 03b Description: Percentage of patients, regardless of age who undergo a procedure and have a documented nausea/emesis occurrence
    c) PONV 03b doesn't take into account if patient received antiemetic in the immediate postoperative period
    d) Exclusions - Patients transferred directly to the ICU, liver transplant, labor epidural
    e) Success: Patient does not report nausea, have an emesis event or receive an antiemetic during the immediate postoperative period.
    f) Performance Scores shared with group; Feedback:

(1) A lot of variation across sites with PONV 03 scores.
(2) Brad Berndt (Bronson Kalamazoo): We have been working on PONV 01/02 over the past year and encouraging providers to administer 2 antiemetics consistently for high-risk patients and are encouraged to see this PONV 03 score.
(3) Nirav Shah (ASPIRE Director): New PONV Guidelines released in 2020 that we plan to incorporate into PONV 01 as there is come concern at the coordinating center that improvement on PONV 01 does not necessarily correlate with improved PONV 03 scores. Interested to hear from sites if they are finding this to be true in their own practice.
    (a) Amy Poindexter (Holland): Found that there were very few people that failed the process measure and also failed the outcome measure.
(4) Eric Davies (Henry Ford Allegiance): Is there still a concern over this data not accurately reflecting PACU nurse practices based on documentation concerns?
    (a) Kate Buehler (ASPIRE Coordinating Center): Over the past year, sites have been working on improving this data capture so we believe this is more accurate now. PONV 03 could be higher than PONV 03b if nurses routinely administer antiemetics immediately upon PACU admission vs. actual documentation of nausea or vomiting in PACU (PONV 03b).

E. MORT 01- 30 day in hospital mortality
    1. Description: Percentage of patients with in hospital death reported within 30 days after procedure.
    2. Measure Time Period - Anesthesia Start to 30 days after Anesthesia End
    3. Inclusions - All patients undergoing anesthesia
    4. Exclusions - ASA 6
    5. Performance Scores shared with group; Feedback:
        a) Nirav Shah (ASPIRE Director): Is this useful? Have you started looking into flagged cases? How are sites using this or not using this measure?
        b) Eric Davies (Henry Ford Allegiance): We aren't the only site that hasn't looked at this measure, mortality after surgery is a pretty complex thing. Still trying to drill down on simpler process measures like temperature and sustainability. I want to applaud ASPIRE for getting this data and creating this measure - its a major achievement! We all need this data as a long term goal to drill down on this data to help….opposed to reporting individual provider performance. Focus should be more on systematic performance.
        c) John Lagorio (Mercy Muskegon): Mortality is something the hospital tracks and something that is reported to CMS, part of VBP. Most hospitals are looking at this. Working with hospital administrators and letting them know we are looking at this metric and trying to improve in this area is very helpful.

d) Davies (Henry Ford Allegiance): How valid is this data? Have sites compared this data with their actual hospital mortality data
e) Lagorio (Mercy Muskegon): As an anesthesia provider, no we are not reviewing this data but as a medical director we are reviewing the hospital mortality data. We have not compared ASPIRE mortality data vs. our own hospital mortality data.
f) Nirav Shah (ASPIRE Director): This data does come from administrative data from your hospitals EHR