Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE)

Quality Committee Meeting Notes – Monday, November 28, 2022

Attendance:

Abess, Alex (Dartmouth)	Johnson, Rebecca (Spectrum & Metro)
Agerson, Ashley (Spectrum)	Kaper, Jon (Beaumont Trenton)
Andreae, Michael (Utah)	Katta, Gaurav (Henry Ford)
Bailey, Meridith (MPOG)	Koltun, Ksenia (Corewell)
Barnes, Conrad (Texas Southwestern)	Lacca, Tory (MPOG)
Barrios, Nicole (MPOG)	LaGorio, John (Trinity Muskegon)
Bauza, Diego (Weill Cornell)	Lewandowski, Kristyn (Beaumont)
Berndt, Brad (Bronson)	Liu, Linda (UCSF)
Bollini, Mara (WUSTL)	Lopacki, Kayla (Mercy Health - Muskegon)
Biggs, Dan (Oklahoma)	Ma, Xiaolu (Maryland)
Bouwhuis, Alex (Holland Hospital)	Malenfant, Tiffany (MPOG)
Brennan, Alison (Maryland)	Mango, Scott (MyMichigan)
Brydges, Garry (MD Anderson)	Mathis, Mike (MPOG)
Buehler, Kate (MPOG)	McKinney, Mary (Beaumont Dearborn / Taylor)
Charette, Kristin (Dartmouth)	Mentz, Graciela (MPOG)
Clark, David (MPOG)	Milliken, Christopher (Sparrow)
Coleman, Rob (MPOG)	Moody, Rebecca (Beaumont)
Collins, Kathleen (St. Mary Mercy)	Nurani, Shafeena (Beaumont Troy)
Corpus, Charity (Beaumont Royal Oak)	O'Dell, Diana (MPOG)
Denchev, Krassimir (St Joseph Oakland)	O'Reilly-Shah, Vikas (Seattle)
Dewhirst, Bill (Dartmouth)	Owens, Wendy (MyMichigan - Midland)
Domino, Karen (Washington)	Pace, Nathan (Utah)
Drennan, Emily (Utah)	Pardo, Nichole (Beaumont)
Dutton, Richard (US Anesthesia Partners)	Pimental, Marc Phillip (Brigham and Women's Hospital)
Everett, Lucy (MGH)	Ping Yu, Shao (Weill Cornell)
Finch, Kim (Henry Ford Detroit)	Poindexter, Amy (Holland)
Fisher, Clark (Yale)	Quinn, Cheryl (St. Joseph Oakland)
Gall, Glenn (St. Mary Mercy Livonia)	Riggar, Ronnie (MPOG)
Goatley, Jackie (Michigan)	Rozek, Sandy (MPOG)
Gibbons, Miranda (Maryland)	Schonberger, Rob (Yale)
Hall, Meredith (Bronson Battle Creek)	Shah, Nirav (MPOG)

Harwood, Tim (Wake Forest)	Stewart, Alvin (UAMS)
Heiter, Jerri (St. Joseph A2)	Toonstra, Rachel (Spectrum Health)
Henson, Patrick (Vanderbilt)	Tyler, Pam (Beaumont Farmington Hills)
Hubbert, Kate (Holland Hospital)	Veach, Kristine (Trinity Ann Arbor, Chelsea, Livingston)
	Vaughn, Shelley (MPOG)
	Woody, Nathan (UNC)
	Wren, Jessica (Henry Ford Wyandotte/Macomb)
	Andrew Zittleman (MPOG)

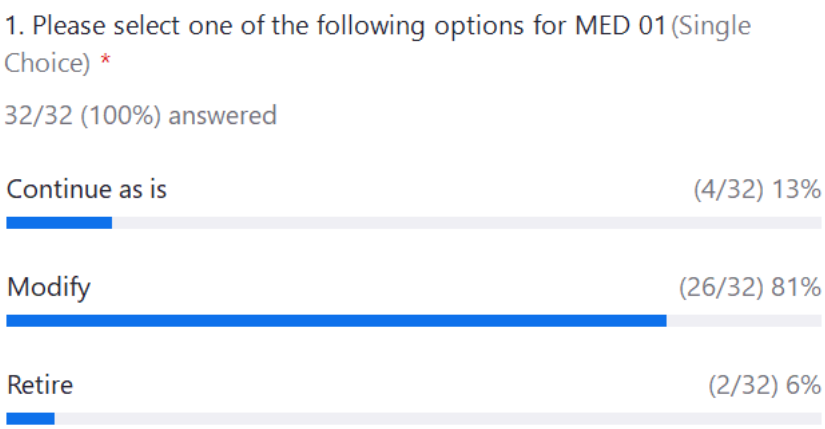
Agenda & Notes

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 the Coordinating Center if they are missing from the attendance record.
2. **Minutes from September 26, 2022 meeting approved**- minutes and recording posted on the website for review
3. **Announcements**
    - MPOG Featured Member (November- December 2022): Meredith Hall, MD - Bronson Battle Creek
    - Upcoming Meetings:
        - MSQC/ASPIRE Collaborative Meeting: April 21, 2023 @Michigan Union, Ann Arbor
        - ASPIRE Collaborative Meeting: July 14, 2023, Henry Center, Lansing, MI
        - ACQR Retreat: September 15, 2023, DoubleTree Hotel, Ann Arbor
        - MPOG Retreat: October 13, 2023, San Francisco
    - TEMP-07 Released!

4. **Measure Review: MED-01, Karen Domino, MD, MPH - University of Washington**
    - **DISCUSSION:**
        - See presentation slides for additional literature included as part of Dr. Domino's review.
        - Recommendations per Karen Domino's review:
            - Modify parameter to include PACU
            - Reduce threshold to lower amount
            - Consider elimination of flumazenil pending MPOG assessment of use
        - Patrick Henson (Vanderbilt) via chat: Agree with extending into PACU and agree that flumazenil use is probably not worth tracking
        - Marc Pimentel (BWH): Agree with extending into PACU; should methadone be considered by this measure also?
            - Dr. Karen Domino (UWashington): Would agree with including methadone
        - Nirav Shah (MPOG Quality Director): How should we update the measure to include the PACU time period, specifically in regards to attribution?

- Karen Domino (UWashington): Incidence is low…do we need a responsible provider?
- Gaurav Katta (Henry Ford):I think we should have everyone as the responsible provider. The rate is so low I think it's wise to make everyone aware.
- Alvin Stewart (University of Arkansas) via chat: But the pacu provider is not documented on a timeline. So that person will not be notified. The department quality officers would like an overall measure.
    - Nirav Shah: Only intraop providers would be made aware given the MPOG infrastructure (not all PACU providers are submitted as part of the extract)
- Marc Pimentel (BWH) via chat: Agree - the outcome is serious enough that all providers should be listed as responsible providers. Maybe administration of naloxone in the PACU can be called out separately
- Emily: Is Nalbuphine included?
    - Guarav Katta: Not currently included in the measure.
- Patrick Henson (Vanderbilt): Honestly use in PACU is likely more clinically significant, don't we think?
- Mike Mathis (MPOG Research Director): If studying PACU administration, would be interesting to break down by time... for example (1) first 30 minutes of PACU stay, (2) 30-60 minutes in PACU, (3) after 60 minutes into PACU stay
    - Gaurav Katta (Henry Ford) via chat: If we make PACU a separate measure we may as well eliminate the intraop measure completely since the rate of intraop use will be extremely low
- Shafeena Nurani (Corewell Health-East Troy) via chat: I like the idea of making PACU use a separate measure
- Karen Domino (University of Washington): Not sure we need to break out PACU separately- more important that people look at the measure since incidence is so low.
- Michael Andreae (UUtah) via chat: Is Naloxone at low dose given for itching when no IV opioids are in play? Epidural with fentanyl and local, itching prophylaxis with low dose Naloxone?
- Mike Mathis (MPOG Research Director): Do any QI champions have stories where providers would avoid treatment for opioid overdose to pass the measure?
    - Kate Buehler (MPOG Coordinating Center): To avoid this I think it makes sense to make this measure departmental only
    - Nirav Shah (MPOG Quality Director): I agree with the measure being departmental only but still think all providers involved should be listed in the dashboard to facilitate case review
    - John LaGorio (Mercy Muskegon): When educating providers about this measure I was very clear that when Narcan is needed it should be given and that this measure isn't punitive
        - Mike Mathis (MPOG Research Director) via chat: Really enlightening insights John -- agree with that approach, being transparent about goal... avoid the "Narcan necessary situation" rather than avoid giving narcan

- **MED 01 VOTE:**



Conclusion: Make the following revisions to MED 01

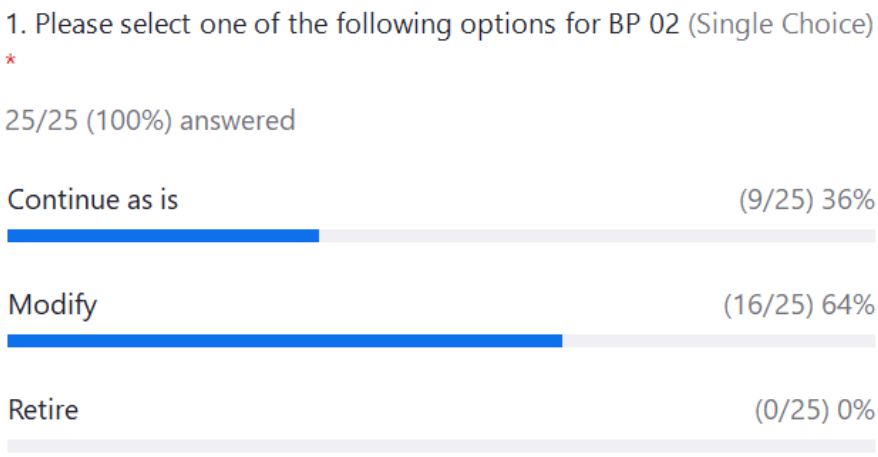
- **Reduce or eliminate threshold**
- **Focus on naloxone and remove flumazenil (but review flumazenil data first)**
- **Add methadone**
- **Departmental only measure but extend attribution to all providers signed into the case**
- **Include PACU time frame in the measure**

5. **Measure Review:** [BP-02, Marc Pimentel, MD - Brigham and Women's Hospital]
    - **DISCUSSION:**
        - **Marc Pimentel's recommendation to QC:**
            - Modify measure to account for PACU hold scenarios where there aren't BPs recorded while waiting for PACU bed
        - Patrick Henson (Vanderbilt): Should be charting "Anesthesia end" if on PACU hold, correct? I do like the idea of PACU hold event tho
        - Nirav Shah (MPOG Quality Director): If on hold for PACU bed, should we still be monitoring the patient? Maybe not every 5 minutes but is there some criteria we should apply to support some monitoring while 'on hold?'
        - Gaurav Katta (Henry Ford): If you are billing for anesthesia time (have a provider continuously available) during the PACU hold, I feel like you probably shouldn't be charting "anesthesia end". We don't chart anesthesia end here during PACU holds, but I'll admit our holds aren't that long.
            - Marc Pimentel (BWH): Only document 'anes end' when the patient is actually dropped off in PACU
            - Mike Mathis (MPOG Research Director) via chat: I only chart anesthesia end, once the handover team has assumed continuous care of the patient
            - Diego Bauza (Cornell): Do we have any indication of how many cases 'PACU hold' would apply to? If we are still billing for anesthesia time during PACU hold, would it be appropriate to change the timing of VS?
                - Dan BIggs (UOklahoma): We at our institution treat it just as a regular timing because of the billing, but I'm not opposed to loosening the requirements for other institutions who aren't billing for anesthesia time during those PACU holds which is

what I think the group was asking. But since we explicitly bill for anesthesia time we will likely continue monitoring BP at our regular intervals.

- Nirav Shah (MPOG Quality Director): Coordinating Center can assess if PACU hold events are submitted to MPOG consistently- if so, can account for the % of flagged cases during PACU hold time period vs. other time periods during case

- **BP-02 VOTE:**



Conclusion: Update BP 02 to break out PACU Hold cases - still include in the measure but report the number of cases flagged due to PACU Hold gaps vs. gaps during other portions of the case

6. **Hyperglycemia Measure Update**

- GLU 01:
  - Adding 'pass' criteria to consider cases that were administered insulin SQ within 120 minutes before the high glucose value (this change was already applied to GLU 03/05)
  - Adding exclusion for cases with case duration ≤ 30 minutes
- GLU 03 & GLU 05:
  - Adding exclusion for cases with case duration ≤ 30 minutes
  - Updated definition of preop start to default to 60 minutes before anesthesia start when preop start is not documented

7. **PONV 05 Measure Update**

- Per previous Quality Committee recommendations:
  - Added exclusion for TEE
  - Added exclusion for endoscopy
  - Includes all c-section patients, regardless of age
  - Includes amisulpride as antiemetic
  - Increases time period to 4 hours before c-section start time for cases that convert from labor epidural
- Additional recommendations:
  - Exclude cases with duration ≤ 30 minutes
  - Exclude MRI cases
- *Performance scores minimally impacted by these changes: +/- 2.5%

Meeting concluded at 1101.