

Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE)

Quality Committee Meeting Notes – Monday, March 26, 2018

Attendees: P=Present; A=Absent; X=Expected Absence

Abdallah, Arbi 'Ben' (Wash U)	Lacca, Tory (Michigan)
Agarwala, Aalok (MGH)	Ladd, Chris (Michigan)
Angel, Alan (Bronson Battle Creek)	Lins, Steve (Bronson Battle Creek)
Aziz, Michael (Oregon)	Lorzano, Alyssa (OHSU)
Bhavsar, Shreyas (MD Anderson)	Louzon, Kathryn (Beaumont Royal Oak/Troy)
Bornhoft, Katie (Michigan)	Lucier, Michelle (Henry Ford)
Buehler, Katie (Michigan)	Malenfant, Tiffany (Beaumont Trenton/Wayne)
Chiao, Sunny (Virginia)	McKinney, Mary (Beaumont Dearborn/Taylor)
Clark, David (Michigan)	Nachamie, Anna (Weill Cornell)
Coffman, Traci (St. Joseph A2)	Nanamori, Masakatsu (Henry Ford Detroit)
Collins, Kathleen (St. Mary)	Obembe, Samson (Cornell)
Colquhoun, Douglas (Michigan)	Paganelli, William (Vermont)
Coons, Denise (Bronson)	Patel, Ashvin (Beaumont)
Crawford, Joan (Mercy Muskegon)	Pardo, Nichole (Beaumont Grosse Pointe)
Cuff, Germaine (NYU Langone)	Poindexter, Amy (Holland)
DeBoer, Jennifer (Holland)	Poterek, Carol (Beaumont)
Domino, Karen (U of Washington)	Price, Matthew (Beaumont Royal Oak)
Fleisher, Lee (Pennsylvania)	Quinn, Cheryl (St. Joes Oakland)
Gates, Elizabeth (Beaumont)	Schonberger, Robert (Yale)
Goorin, Patricia (Sparrow)	Shah, Nirav (Michigan)
Heiter, Jerri (St. Joseph A2)	Smith, Susan (Beaumont)
Hightower, William (Henry Ford)	Tyler, Pam (Beaumont Farmington Hills)
Horton, Brandy (A4)	Wood, Aaron (Beaumont Farmington Hills)
Kaye, Toni (ASA AQI)	

Agenda & Notes

1. **Minutes from February 26, 2018 meeting approved**- posted on the website for review.
Recording available as well.
2. **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.
3. **Upcoming Events:**
 - a. *April 20th Joint Meeting with Surgical Quality Collaborative – Livonia, MI*
 - i. Welcome ASPIRE and MSQC Membership (30min)
 - ii. Pain Management/Reducing Opioid Use (45min)
 1. Melanie Simpson, PhD, RN-BC, OCN, CHPN, CPE: University of Kansas
 - iii. Medical Cannabis Use for Chronic Pain Patient (30min)
 1. Kevin Boehnke, PhD: Michigan Medicine
 - iv. A Patient's Experience with Enhanced Recovery (30min)
 1. Robert Miller: National Geographic Book Author/Photojournalist.

- v. ASPIRE only breakout session in afternoon (90 min)
 - 1. QI Stories
 - 2. Performance Measure Review
 - 3. ASPIRE Future Direction
 - a. Interested in hearing your thoughts on the future of ASPIRE as well!
 - b. *April 28th IARS. MPOG/ASPIRE – Chicago, IL*
 - c. *July 20 – ASPIRE Collaborative Meeting – Lansing, MI*
 - d. *October 12 – ASA Conference – San Francisco*
- 4. New Sites
 - a. Congratulations to Brigham & Women’s Hospital and Massachusetts General Hospital!
- 5. MPOG Fee Update
 - a. Does not apply to sites funded by BCBSM
 - b. Recommended by MPOG executive board to ensure sustainable funding model
 - c. Ranges from \$10 - \$25K per institution
 - d. Starts 2019
 - e. Communication already initiated with chairs and quality champions
- 6. BCBSM P4P Focus – Transfusion O2 (Applies to Cohorts 1 -3)
 - a. Percentage of cases with a post transfusion hemoglobin or hematocrit value less than or equal to 10 g/dL or 30% (cumulative score through December 2018)
 - b. Performance threshold >85%
 - c. Focus of 2018 Toolkit
- 7. Earning MOCA® 2.0 Part IV Credit
 - a. ~100 anesthesiologists have signed up
 - b. Worked out kinks in the app process
 - c. Fee: \$150, now payable upon application process
 - d. If providers are interested and have not set up ASPIRE account, QI Champion & ACQR can send ASPIRE Activation Email via the Provider Contacts Tool – Katie Buehler to follow up with brief instructions
- 8. QCDR Update
 - a. 2017 Data submitted to CMS
 - b. Contracts for 2018 to be sent out soon
 - c. Questions or Interested – Contact Katie Buehler
- 9. Measure Updates
 - a. Standardized Duration Across Measures where Applicable
 - i. Case Start Algorithm
 - 1. Anesthesia Induction End. If not available, then
 - 2. Anesthesia Induction Begin. If not available, then
 - 3. Procedure Start. If not available, then
 - 4. Patient in Room. If not available, then
 - 5. Anesthesia Start
 - ii. Case End

1. Patient Extubated. If not available, then
2. Procedure end. If not available, then
3. Patient Out of Room. If not available, then
4. Anesthesia End

b. PUL 01 & 02

i. PUL 02

1. Bug fix: Exclude time before intubation and after extubation
2. Change definition of “spontaneous ventilation” to PIP – PEEP \leq 6 and exclude those time periods from calculation of lung protective ventilation
3. For patients less than 5 feet tall, use IBW calculation for 5 feet when calculated lung protective tidal volumes
4. Downside of Devine formula: Becomes inaccurate for very short patients; it was never intended for use in patients less than 5 feet tall

ii. PUL 01

1. Remove outpatient exclusion

10. Measures Updates: TOC 03 & CARD 02 Released!

a. TOC 03

- i. Percentage of patients, regardless of age, who undergo a procedure under anesthesia and are admitted to an ICU directly from the anesthetizing location, who have a documented use of a checklist or protocol for the transfer of care from the responsible anesthesia practitioner to the responsible ICU or team member
- ii. Essential the ICU variant of TOC 02
- iii. On dashboards, not on emails yet. Reach out if you would like it added to Provider Feedback emails

b. CARD 02

- i. Description: Percentage of cases without elevated postoperative Troponin I levels (>0.6) or documentation of perioperative myocardial injury.
 1. Similar to CARD 01, but lowered Troponin I level based on literature showing correlation with mortality levels
- ii. Exclusions: ASA 5 and 6 cases, Outpatient cases, Troponin I \geq 0.01 within 42 days prior to anesthesia start, Pacemaker insertions, Cardiac Ablation, Cardiac surgery without pump, Cardiac surgery with pump and 1-year-old, Cardiac surgery with hypothermic arrest, CABG without pump, CABG with pump, Heart Transplant, Testing of cardioversion or defibrillator functions, Cardiac catheterization
- iii. Success: In cases with a Troponin I value(s) available within 72 hours after anesthesia end, all values must be less than or equal to 0.6 for the case to pass. If no Troponin I values are available within 72 hours after anesthesia end and there is no documentation of perioperative myocardial injury (MPOG Concepts: 90201, 90202), the case will also pass.

- iv. Threshold: 95%. Responsible Provider: Providers assigned to patient longest duration of case unless there are providers who failed BP 01 during case. In that case, BP 01 failure takes precedence over longest duration
- v. Risk adjusted
- vi. Should we retire CARD 01? What should be the process?
 - 1. Quorum approach?
 - 2. Survey Monkey Poll sent to all who participates
 - a. Include information related to ASPIRE Dashboard changes

11. 2018 New Measures

a. PONV 02 (MIPS 463)

- i. Description: Percentage of patients aged 3 through 17 years of age, who undergo a procedure under general anesthesia in which an inhalational anesthetic is used for maintenance AND who have two or more risk factors for post-operative vomiting (POV), who receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively.
- ii. PONV Risk Factors: Age ≥ 3 years, History of Post-Operative Nausea and Vomiting (PONV) in patient, parent or sibling, Strabismus surgery, Surgery ≥ 30 minutes
- iii. Exclusions: Patients < 3 or > 17 years old, Procedures on the Neck, Intrathoracic Procedures, Procedures on the Lower Abdomen, Labor Epidurals, Endoscopy, Obturator neurectomy, Shoulder cast application
- iv. Excluded: Cases in which an inhalation anesthetic is used only for induction

b. TOC 01

- i. Intraoperative handoffs
- ii. Can be supplemented by audit tool
- iii. Only permanent relief (i.e. not lunch/coffee/bio breaks)
- iv. What do we measure?
 - 1. Only anesthesia provider in room to anesthesia provider in room?
 - 2. Include attending anesthesiologist to attending anesthesiologist?
 - i. Discussion: In room handoff preferred (OHSU)
 - ii. Does not differentiate between in room/out of room handoff (Vermont)
 - b. Discussion:
 - i. In room handoff preferred (OHSU)
 - ii. Does not differentiate between in room/out of room handoff (Vermont)
 - 3. Responsible provider
 - 4. Incoming? Outgoing? Both?
 - a. Discussion: Both preferred

Meeting concluded at 10:55am