

MPOG Pediatric Subcommittee Meeting

December 4, 2023



Agenda

Announcements

Dr. Brad Taicher, MPOG Pediatric Subcommittee Chair

Measure Review: Multimodal Analgesia (PAIN-01-Peds)

Dr. Lisa Einhorn, Duke University

Provider Feedback: Using MPOG for Pediatric QI

Dr. Lauren Madoff, Boston Children's

MPOG Peds Research: Current Projects & Process

Dr. Vikas O'Reilly-Shah, Seattle Children's

Dr. Michael Mathis, MPOG Research Director

2024 Meetings

- **Pediatric Subcommittee Meetings**
 - March
 - July
 - December
- **MPOG Updates at SPA Q&S**
 - April & October
- **MPOG Annual Retreat 2024**
 - October (Philadelphia, PA)



Pediatric Subcommittee Leadership

MPOG is pleased to announce Drs. Vikas O'Reilly-Shah (Seattle Children's) and Morgan Brown (Boston Children's) as the new pediatric subcommittee leadership team.

Chair



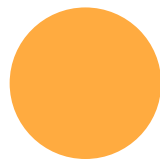
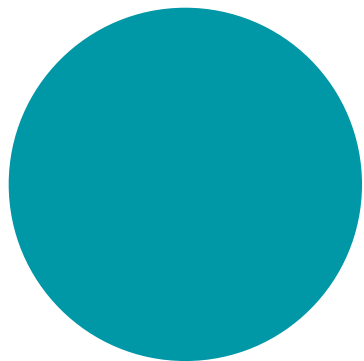
Vice Chair



Membership Update

- 28 Pediatric Hospitals
- Welcome to our newest site - Johns Hopkins!
- Onboarding In Progress
 - Indiana University Health, Riley Children's Hospital
 - Lucile Packard Children's 





Measure Updates



NMB-04: Variation in Sugammadex Dosing

Description: Percentage of cases with sugammadex administration that had a cumulative dose $\leq 200\text{mg}$ OR $\leq 3\text{mg/kg}$.

Background:

- Measure proposed by Dr. Megan Anders (Univ. Maryland). Strategies for cost-containment are an area of interest.
- A timely measure – groups may be engaging in discussion of loosening formulary restrictions given ASA guideline

Limitations:

- Pediatric dosing (allows high dosing for peds)
- Measure may become obsolete when sugammadex comes off patent (January 2026)
- May incentivize underdosing
- Focus on vial vs mg/kg dosing



Measure Details

Rationale

- Fixed cost of 200mg vial
- Acknowledges dose rounding given small injection volumes
- Encourages judicious use of NMBD to end with at least TOF = 2
- Compliant with FDA approved dosing and ASA 2023 guideline

Exclusions

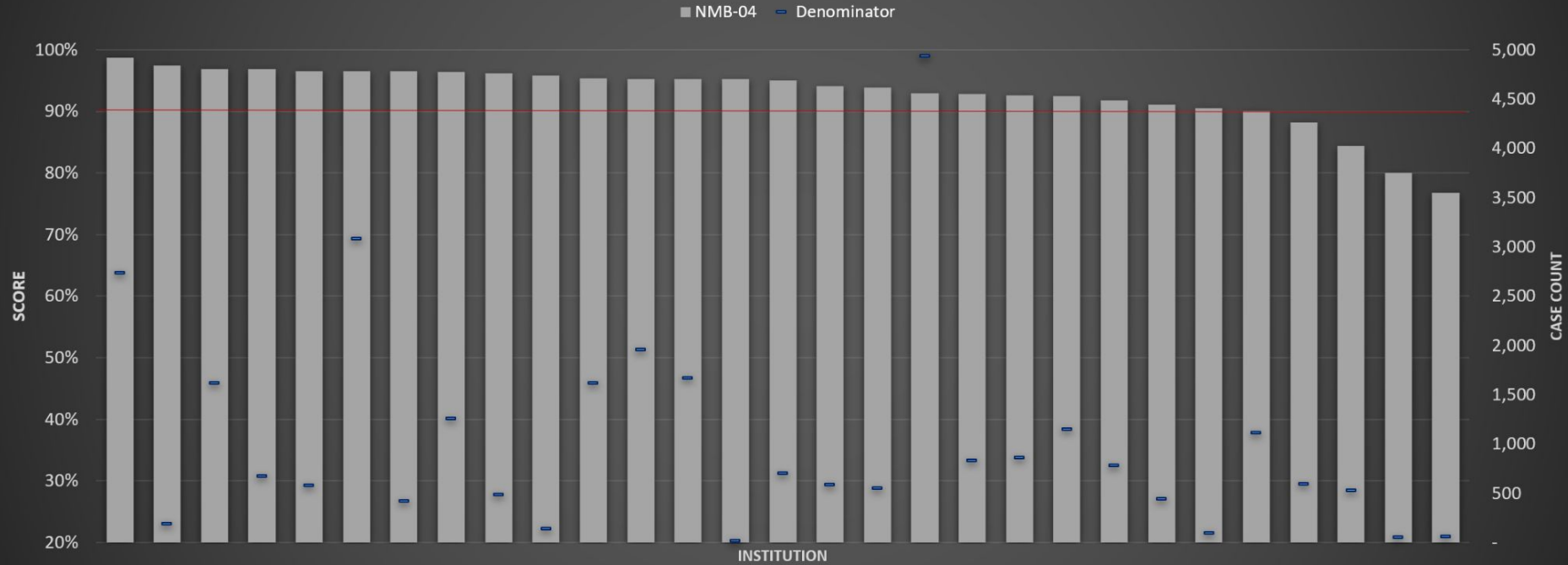
- Age $\leq$ 2yrs
- ASA 5 and 6 cases including Organ Procurement (CPT: 01990)
- Cases <30 min
- Patients that were not extubated in the immediate postoperative period

Threshold – 90%

- Acknowledges CICV, unexpected discontinuation of surgery, safety margin for individualized dosing

Sugammadex Dosing $\leq 200\text{mg}$ or $\leq 3\text{mg/kg}$

Past 12 months: Patients 3 - 18y

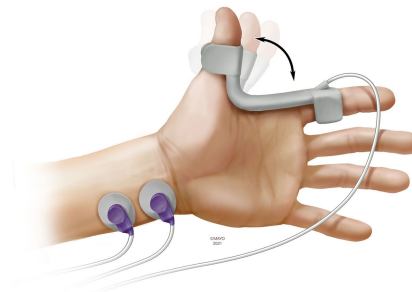


NMB-05: Quantitative NMB Monitoring

Coming Soon!

Description: Percentage of cases with documentation of train-of-four count or ratio provided by a quantitative monitor

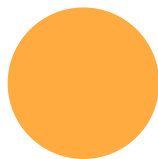
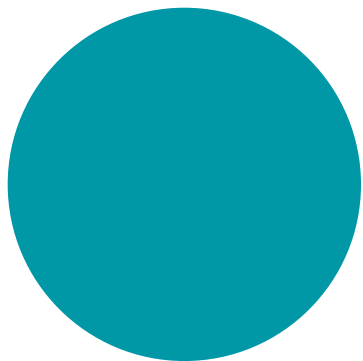
- Acceleromyography
- Electromyography
- Kinemyography
- Mechanomyography



Success Criteria: Documentation of train-of-four count **or** ratio provided by a quantitative monitor between patient in room and patient out of room.

All MPOG institutions contributing subjective data while only half of contribute data from quantitative monitoring.

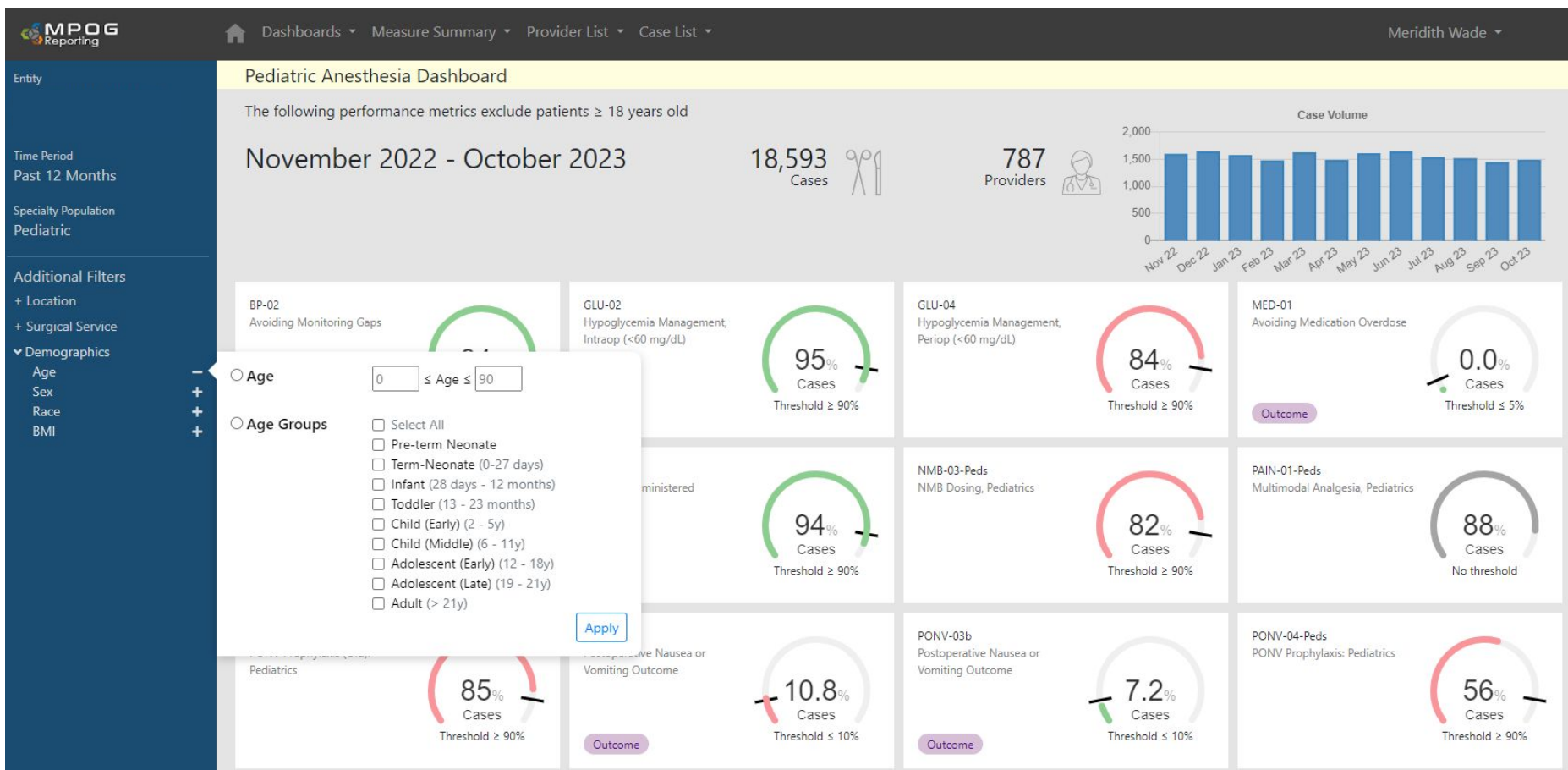
Concept ID	New MPOG Concept Name	Example Values	# institutions	# of occurrences
3330	Train-of-four Qualitative (Subjective, Clinician Reported) Count	TOF Count: (0,1,2,3,4, ST)	65	62,052,001
3485	Train-of-four Quantitative (Objective) Ratio	TOF Ratio: decimals or % Values between 4 - 100	35	11,318,093
3033	Train-of-four Quantitative (Objective, From Device) Count	TOF Count (0, 1, 2, 3, 4)	24	7,167,485
3486	Train-of-four Quantitative (Objective) Count and Ratio combined	TOF Count + ratio: 4/4 55%	8	3,032,509
3487	Subjective Clinical Neuromuscular Monitoring Assessment (head lift, hand grasp)	0-4 and sustained tetany	3	183
3488	Train-of-four Post Tetanic Count (PTC)		0	-



QI Dashboard Updates



New Demographics filter with multiselect options



Provider tab links directly to provider specific case list

Entity
Duke - University Hospitals

Time Period
Past 12 Months

Additional Filters
+ Location
+ Surgical Service
+ Demographics

NMB-03-Peds: NMB Dosing, Pediatrics Providers [More Info](#)

Percentage of pediatric patients ≤ 5 years old who receive appropriate initial dosing of non-depolarizing neuromuscular blocking drugs (NMB) intraoperatively.

Summary

Case List

Show entries

Provider	Resident	CRNA	Attending
BRAD, TAICHER	AA		
JONES, JOHN	CR		
SMITH, JANE	Re		
DAVIES, JAMES	Re		
BROWN, JAMES	At		
WILLIAMS, JANE	CR		
JONES, JANE	At		
SMITH, JANE	At		
DAVIES, JANE	Re		
BROWN, JANE	Re		
WILLIAMS, JANE	CR		
JONES, JANE	Reside		
SMITH, JANE			
DAVIES, JANE	AA		
BROWN, JANE	CRNA		
WILLIAMS, JANE	Resident		
JONES, JANE	Attending		
SMITH, JANE	Resident		
DAVIES, JANE	CRNA		

Case Report Download

Show entries

View Case	Measure Result	Date of Service	Operating Room	Surgical Service	Procedure	Primary Anesthesia CPT	Measure Result Reason
View Case	Flagged		DNOR PED01	Pediatric Surgery	(Actual)REPAIR INITIAL INGUINAL HERNIA, AGE 6 MONTHS TO YOUNGER THAN 5 YEARS, WITH OR WITHOUT HYDROCELECTOMY; REDUCIBLE (Right Groin); LAPAROSCOPY, SURGICAL; ABDOMEN, PERITONEUM, AND OMENTUM, DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR WASHING (SEPARATE PROCEDURE) (Abdomen)	00840	NMB Dose: Rocuronium - 1.1 MG/KG
View Case	Flagged		DNOR 07	Plastics	(Actual)PALATOPLASTY FOR CLEFT PALATE, SOFT AND/OR HARD PALATE ONLY (Bilateral: Mouth); TYMPANOSTOMY (REQUIRING INSERTION OF VENTILATING TUBE), GENERAL ANESTHESIA (Bilateral: Ear)	00172	NMB Dose: Rocuronium - 1.3 MG/KG

Showing 1 to 2 of 2 records

TAICHER, BRAD

1POG

Easily navigates to MPOG case viewer with measure details

Case Search
Chart
Record Search
Administrative
H & P
Outcomes
Labs

Case ID
Institution
Time
Procedure

Age/Sex/Race
Height/Weight
ASA Class

Surgical Service
Admission
Room Name

Main Chart

EKG Pulse Rate
 SpO2 Pulse Rate
 BP Sys Cuff
 BP Dias Cuff
 End Tidal CO2(mmHg)

Time	07:40	07:45	07:50	07:55	08:00	08:05	08:10	08:15	08:20	08:25	08:30	08:35
BP Dias Cuff	40	42	44	44	47	46	50	44	50	47	48	55
BP Mean Cuff	52	59	60	63	62	58	64	58	67	60	62	67
BP Sys Cuff	73	81	86	91	93	81	86	81	91	83	84	88
Cardiac Rhythm	NSR											
EKG Pulse Rate	0	34	45	26	16	14	16	16	16	16	16	16
Respiratory Rate - Unspecified	99	100	100	100	100	100	100	100	100	99	99	99
Respiratory Rate by EKG Biomap	96	151	76	115	137	148	150	143	138	133	128	127
SpO2 %	97.5	97.7	97.5	97.5	97.5	97.3	97.3	96.8	96.8	96.8	96.8	96.8
SpO2 Pulse Rate	0	0	0	0	0	0	0	0	0	0	0	0
Temp 1 - Unspecified Site	0	0	0	0	0	0	0	0	0	0	0	0
Temperature Route	0	0	0	0	0	0	0	0	0	0	0	0
Train-of-four Qualitative (Subject)	0	0	0	0	0	0	0	0	0	0	0	0

All Staff

Meds-IV

ACETAMINOPHEN

CEFAZOLIN

FENTANYL

KETOROLAC

ROCURONIUM

SUGAMMADEX

Meds-SQ

BUPIVACAINE 0.25%

Inputs Infusion

LACTATED RINGERS

Flowsheet

Physio

Time	07:40	07:45	07:50	07:55	08:00	08:05	08:10	08:15	08:20	08:25	08:30	08:35
Respiratory Rate - Unspecified	0	34	45	26	16	14	16	16	16	16	16	16
Respiratory Rate by EKG Biomap	99	100	100	100	100	100	100	100	100	99	99	99
SpO2 %	97.5	97.7	97.5	97.5	97.5	97.3	97.3	96.8	96.8	96.8	96.8	96.8
SpO2 Pulse Rate	0	0	0	0	0	0	0	0	0	0	0	0
Temp 1 - Unspecified Site	0	0	0	0	0	0	0	0	0	0	0	0
Temperature Route	0	0	0	0	0	0	0	0	0	0	0	0
Train-of-four Qualitative (Subject)	0	0	0	0	0	0	0	0	0	0	0	0

Physio Misc

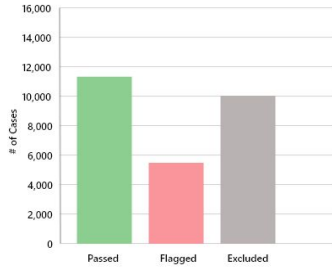
Ventilator

Time	07:40	07:45	07:50	07:55	08:00	08:05	08:10	08:15	08:20	08:25	08:30	08:35
End Tidal CO2 (mmHg)	1.0	1.3	1.2	1.4	2.5	3.4	3.4	2.8	2.7	2.7	2.6	2.4
Minute ventilation	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Nitrous Exp %	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Nitrous Insp %	32	97	88	90	47	44	43	43	43	43	23	23
Oxygen Exp %	32	91	91	94	49	47	47	47	48	48	28	28
Oxygen Insp %	0	13	18	2	17	16	16	14	14	14	13	13
Peak inspiratory pressure	0	13	1	1	5	5	5	5	5	5	5	5
Positive End Expiratory Pressur...	6.7	7.7	7.7	4.3	4.4	3.9	3.9	3.4	3.3	2.8	2.8	2.7
Sevoflurane Exp %	8.1	7.5	7.6	4.6	4.7	4.2	4.1	3.5	3.1	2.8	2.8	2.7
Sevoflurane Insp %	50	34	74									

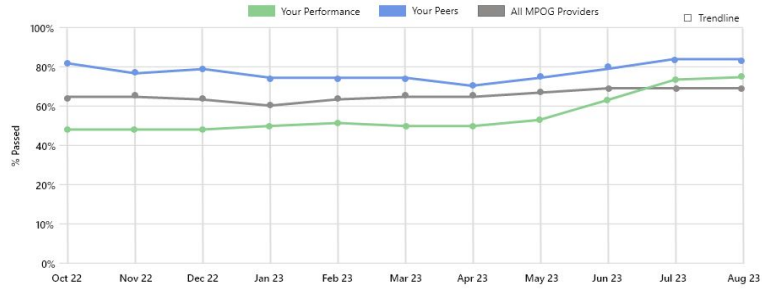
Overall Score



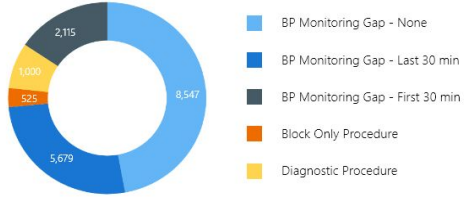
Result Counts



Performance Trend



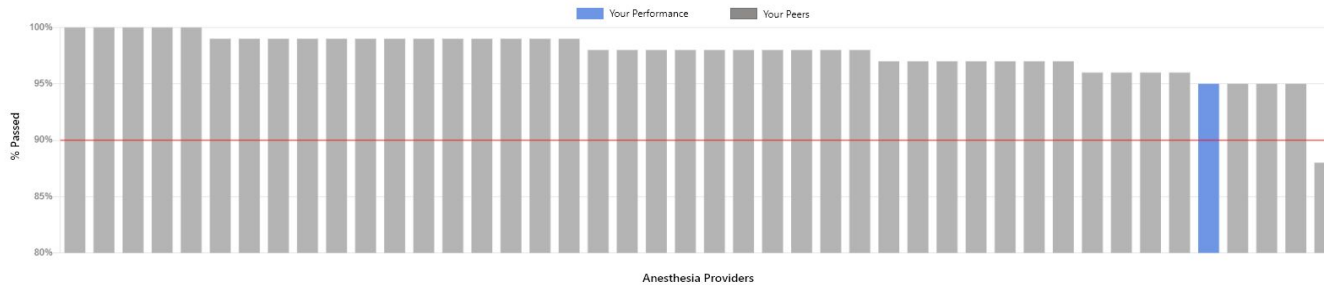
Result Reasons



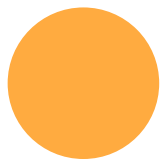
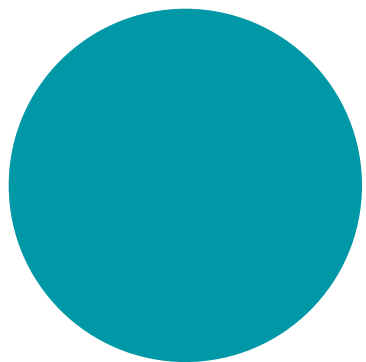
Flagged Cases

	Anes Attending	CRNA/Resident	Case Date	Procedure	Result Reason
View Case	Sample Text	Sample Text	Sample Text	Sample Text	Sample Text
View Case	Sample Text	Sample Text	Sample Text	Sample Text	Sample Text
View Case	Sample Text	Sample Text	Sample Text	Sample Text	Sample Text
View Case	Sample Text	Sample Text	Sample Text	Sample Text	Sample Text
View Case	Sample Text	Sample Text	Sample Text	Sample Text	Sample Text
View Case	Sample Text	Sample Text	Sample Text	Sample Text	Sample Text

Provider Comparison



Coming Soon!
Improved Provider
Dashboard



Peds Cardiac Workgroup



Peds Cardiac Workgroup

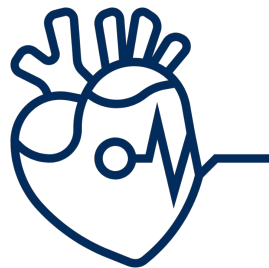
Background:

- MPOG formed an adult cardiac subcommittee and has built a number of cardiac specific QI measures.
- Current cardiac procedure phenotype does not accurately categorize all peds cases

Proposal: Form a pediatric cardiac workgroup to

- Define a cardiac phenotype specific to congenital cardiac procedures
- Build QI process and outcome measures
- Increase multicenter research with MPOG platform
- Future CCAS-STS/MPOG data merge

First Interest Meeting: Early February 2024



PAIN-01-Peds

Measure Review

Dr. Lisa Einhorn
Duke University



MPOG Pediatric Subcommittee PAIN-01 PEDS Measure Review

**Lisa Einhorn, MD, FAAP
Duke University**

Rationale

- Multimodal pain management in children during the perioperative period can decrease postoperative pain, improve clinical outcomes, and increase patient satisfaction after surgery.
- Opioids remain an important analgesic strategy in acute pain management yet carry significant risk of perioperative complications including postoperative nausea and vomiting (PONV) and dose-dependent respiratory depression.
- The American Society of Anesthesiologists (ASA) and Society for Pediatric Anesthesia (SPA) have published guidelines and recommendations which endorse the routine use of multimodal analgesia when appropriate to reduce opioid exposure and opioid-related side effects.
- Current evidence supports the use of opioid sparing analgesics in pediatric surgical populations that act through different mechanisms. This list includes (but is not limited to) acetaminophen, NSAIDs, dexamethasone, ketamine, clonidine, and dexmedetomidine.

Rationale Evaluation

- Rationale is appropriate and based on Clinical Practice Guidelines from ASA and SPA.
- No new CPGs have been published for pediatrics in the time period since the last review.
- Changes: Multiple modifications in language in the rationale for clarity and flow.
- Suggest removing the words indicating that opioids carry a significant perioperative risk of “increased recovery time after surgery.” This remains controversial in the literature and is not supported by a recent article published in JAMA Surgery in adult patients (PMID: 37314800) which concludes that “reduced opioid administration during surgery may have the unintended outcome of increasing postoperative pain and opioid consumption.”

Review of New Literature

- **PMID: 37300350. Paediatr Anaesth. 2023 Sep;33(9):699-709. doi: 10.1111/pan.14705.**

Recent report of a single-center QI project reviewing 41260 patients who underwent intraoperative opioid free anesthesia using multimodal analgesia and regional anesthesia. Showed decreased opioid rescue rates and PONV treatment in PACU and stable in-hospital pain scores and length of stay.

- **Supports Rationale of PAIN-01 PEDS measure**

Current Inclusion/Exclusion Criteria

- **Inclusions:**
- Pediatric patients requiring anesthesia
- **Exclusions:**
- Patients ≥ 18 years of age
- ASA 5 and 6
- Procedure Types
 - [TEE/Cardioversions](#)
 - [Endoscopy](#)
 - [Bronchoscopy](#)
 - [Obstetric Procedures](#)
 - [ECT](#)
 - [Diagnostic Imaging Procedures](#)
 - Open Cardiac and 'other' cardiac procedures as determined by [Procedure Type: Cardiac Surgery](#)
- [Intubation Only](#) cases
- [Block Only](#) cases - **Proposed addition**
- Myringotomy and Tube cases - **Proposed addition**
- Otoscopy (00124)
- Central Line Placement (00532)
- Lumbar Puncture (00635)
- Other (01990, 01991, 01992, 01999)
 - Rooms tagged as 'Other - offsite anesthesia'
 - Cases with procedure text 'ABR Testing' (without any additional procedures listed)
- Patients who remained intubated postoperatively (see 'other measure build details')
- Cases with a Spinal, Combined Spinal/Epidural or Unknown [Anesthesia Technique: Neuraxial](#)

Evaluation of Inclusion/Exclusion Criteria

- **Inclusion criteria:** Propose the addition of open cardiac cases that are extubated in the operating room.
- **Exclusion criteria:** Propose the addition of Block Only cases and Myringotomy and PE tubes. Continue to exclude cases with spinal/CSE/Epidural or Unknown Anesthesia Neuraxial Technique due to high likelihood of misclassification following a review of a large sample of these cases.
- Will discuss patients who receive no analgesic medications in the next slide

Evaluation of Definition of Success or Flagged Cases

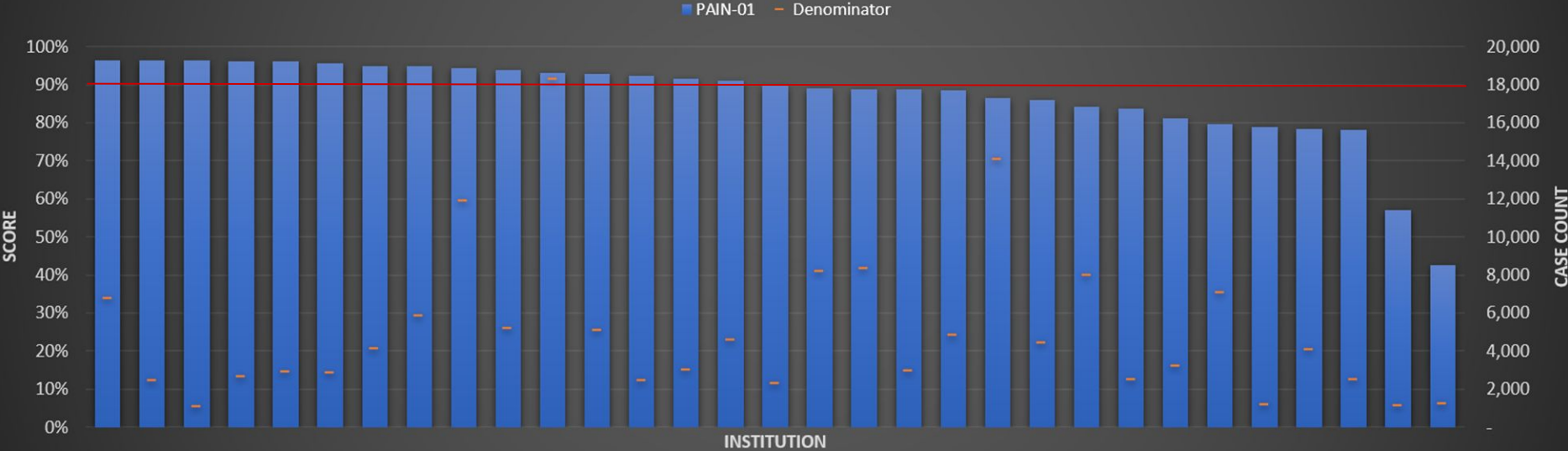
- There were a total of 201,667 cases in the PAIN-01 (PEDS) measure. 34 institutions included. Of 100,000 pulled in the data extraction, **11,217 were flagged** (11.2%).
- Of the flagged cases, **5,507 (49%) received no analgesic medications (no opioids, no multimodal)**. Common procedures in this category are listed below:
 - BAER with Sedation; ABR testing; Biopsy (kidney, liver, skin etc); Radiotherapy treatment; Bilateral Myringotomy/Tympanostomy Tubes; Lumbar Puncture/Bone Marrow Aspiration; Botox Injection; Arthrocentesis; Eye exam under anesthesia; EGD/Colonoscopy; CT/MRI needle biopsy; Cystoscopy removal of stent/Cystogram; Dental restorations/extractions; Laser tx; Echo; Spica Cast change
- Some of these procedures are already listed in the exclusion criteria (ie: ABR, LP) but require improved logic beyond CPT codes to increase accuracy.
- Other common procedures on this list may be appropriate to add to the exclusion criteria.
- **As the goal of this measure is to reduce opioid exposure using non-opioid analgesics, it may be worth considering whether it is appropriate to exclude all patients who received no analgesics during a procedure (no opioids and no multimodal therapies).**

Additional Discussion Points

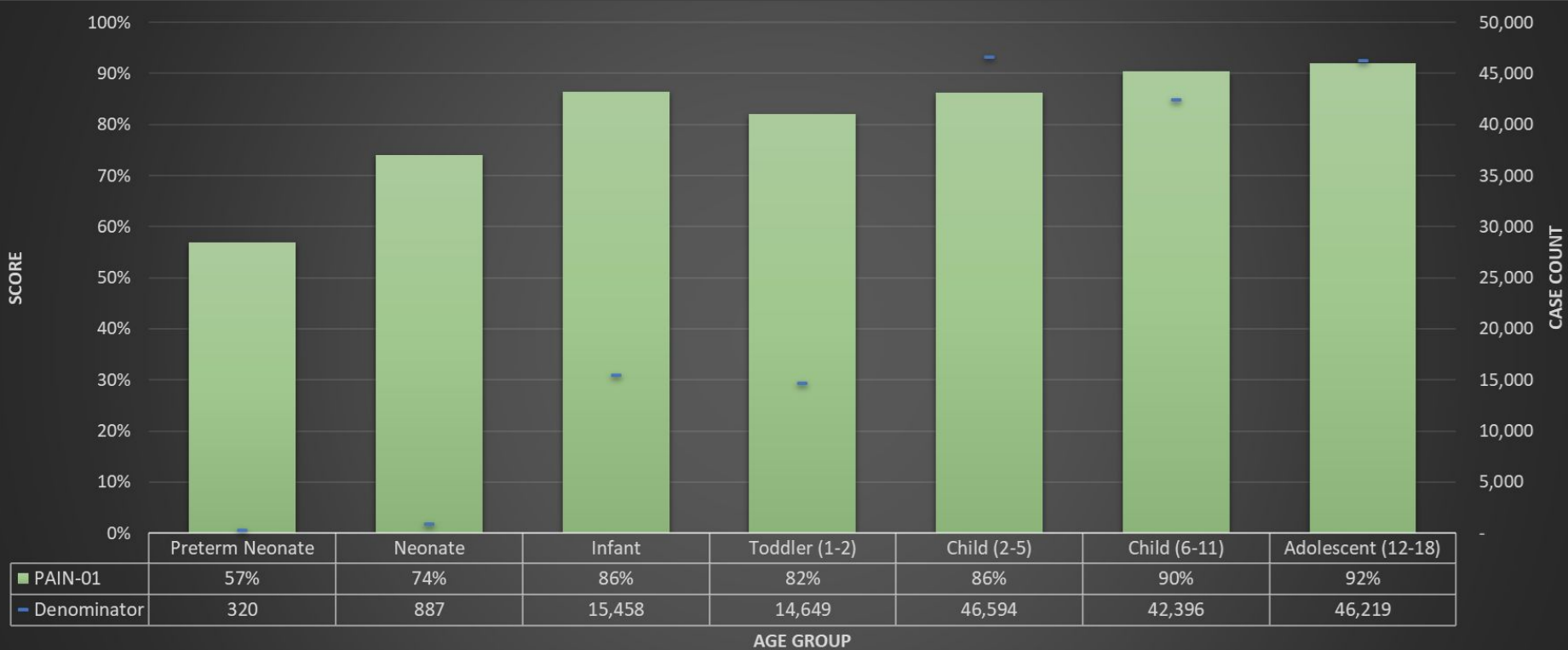
- **Threshold:** currently none set. Would recommend setting to 90%, this seems imminently feasible and appropriate based on current numbers
- **Responsible Provider:** Continue any provider signed into the case? Other options include: provider who has signed in longest, provider at the end of the case.
- **Success Criteria:** Discrepancy between MIPS measure definition which requires 2 multimodal analgesics excluding opioids vs PAIN-01-PEDS which currently requires 1 multimodal analgesic.
 - Adding the requirement for a second multi-modal will likely result in significantly more flagged cases and may/may not be feasible for all included procedures.
- **Exclusion Criteria:** Exclude those who received no analgesia?
- **Questions or other concerns?**

Multimodal Analgesia Compliance Across MPOG Pediatric Hospitals

Past 12 months



PAIN-01 Performance by Age Group



Summary of Recommended Modifications

PAIN-01-Peds



- Add threshold of 90%
- Include Cardiac procedures that were extubated intraop
- Exclude Block Only cases
- Exclude Myringotomy & Tube cases
- Exclude cases that receive no analgesia
- Improve accuracy of ABR and Lumbar Puncture exclusions
- Modify language in Rationale

PAIN-01-Peds

1 vote per site

Continue as is / modify / retire

Need > 50% to retire measure

Coordinating center will review all votes after meeting to ensure no duplication



Using MPOG for Pediatric QI

Dr. Lauren Madoff
Boston Children's

Goals

Individual

- Review personal metrics
- Compare to others within the department

Institutional

- Target department-wide areas for improvement
- QI measures at multi-institutional level

Timeline

- June 2023: Announced the initiation of MPOG dashboard at department-wide staff meeting
- August 2023: Second announcement about individual MPOG dashboards
- September 2023: Individual MPOG dashboards go live
- Staff encouraged to review dashboards



Entity

lauren madoff
(Boston Children's Hospital)

Time Period

Past 12 Months

Additional Filters

+ Location

+ Surgical Service

▼ Demographics

Age

Sex

Race

BMI

My Measure Performance

The following measures have been selected as focus areas for your institution.

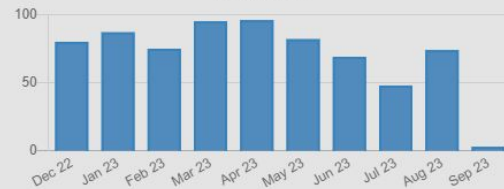
December 2022 - November 2023

709

Cases



Case Volume



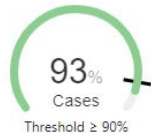
BP-02

Avoiding Monitoring Gaps



NMB-02

Reversal Administered



TEMP-03

Perioperative Hypothermia



Outcome

Departmental MPOG QI Committee

- Volunteer committee
 - 10 volunteers
- Monthly meetings
 - 1 metric reviewed at each meeting
 - Is the information being recorded correct?
 - Mapping errors?
 - Is the data relevant to our practice?
 - Can the data be improved?

Future Directions

- Provide feedback on existing metrics
- Develop new metrics
 - Cardiac
 - Pain
 - Blocks
 - Multi-modal analgesia
- Email Lauren.Madoff@childrens.harvard.edu



Research Update

Pediatric Research Update

Two multicenter pediatric research proposals recently accepted by the MPOG Perioperative Clinical Research Committee (PCRC)

- **PCRC 0145:** Prophylaxis Practice in Pediatric PONV: A Retrospective Observational Study
- **PCRC 0180:** The Association of Guideline Directed Prophylaxis with the Incidence of Postoperative Nausea and Vomiting in Pediatric Patients.

Primary Collaborators: *Lucy Everett, Ben Andrew, Wes Templeton, Vikas O'Reilly-Shah, Lisa Vitale, Brad Taicher, Meridith Wade*

Recent MPOG Peds Publications

Congratulations to Dr. Wes Templeton and team on their publication in Anesthesiology!

> [Anesthesiology](#). 2023 Sep 22. doi: 10.1097/ALN.0000000000004781. Online ahead of print.

Hypoxemia in School Age Children Undergoing One-Lung Ventilation: A Retrospective Cohort Study from the Multicenter Perioperative Outcomes Group (MPOG)

T Wesley Templeton¹, Bridget Krol², Scott Miller¹, Lisa K Lee³, Mike Mathis⁴, Susan R Vishneski¹, Debnath Chatterjee, Ruchika Gupta⁴, Rebecca A Shroeder⁵, Amit K Saha¹; Multicenter Perioperative Outcomes Group Investigators

Congratulations to Dr. Sydney Brown and team on their publication in BJA!

Observational Study > [Br J Anaesth](#). 2023 Oct;131(4):e117-e120. doi: 10.1016/j.bja.2023.07.013.

Epub 2023 Aug 11.

A retrospective observational cross-sectional study of intraoperative neuromuscular blocking agent choice and dosing in a US paediatric referral hospital before and after introduction of sugammadex[☆]

Sydney E S Brown¹, Kevin Spellman², Ruth Cassidy³, Rebecca Nause-Osthoﬀ³, Meridith Bailey³, Graciela Mentz³, Deborah Wagner³, Bishr Haydar³, Wilson Chimbara³, Sachin Kheterpal³, Douglas Colquhoun³

Other Projects

PCRC-0128	03/14/2022	Weill Cornell	Pryor/Tangel	Accepted
PCRC-0127	08/09/2021	Washington	Lele	Accepted
PCRC-0092	03/09/2020	Mass General	Rosenbloom	Accepted

Pediatric Phenotypes In Progress - PCRC 241/Nasr

Gestational Age at Birth

Current State

- AIMS data sites have mapped to MPOG concepts is very limited and highly variable.
- MPOG Concepts Available
 - Pediatrics-Premature Birth
 - Pediatrics-Gestational Age at Birth

Some value examples include:

Text

- *28 - 31 weeks (2)*
- *< 28 weeks (3)*
- *24.57142857*
- *Twin at 32 weeks EGA*
- *Premature newborn (BW ... lb ... oz: NICU x 100 days)*
- *22 5/7 wks*
- *Less than 37 weeks*
- *Yes*

Numeric

- *0.156*
- *1*
- *0*

Gestational Age Phenotype

Description: determines if a case was performed on a patient that was born prematurely.

Limitation: Results dependent on submission and accuracy of ICD codes

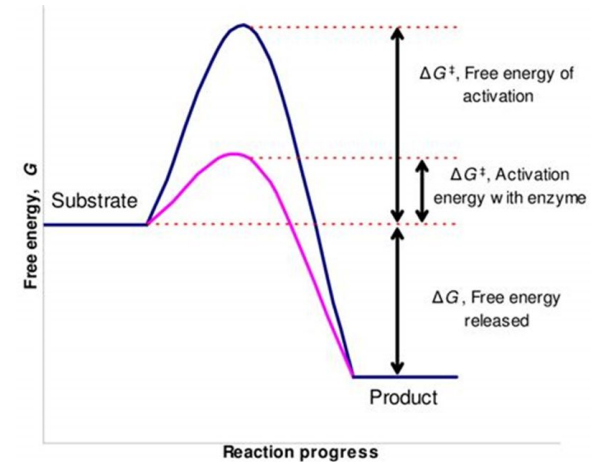
Future Goal: Refine phenotype with additional data submitted to increase accuracy and fill rates for projects on neonates

- Encourage sites to review/update their current variable mappings
- Share current and best documentation practices.

Value	Code	Definition
Extremely Preterm	1	Gestational age < 28 weeks
Preterm, Unspecified	2	Unspecified weeks of gestation
Very Preterm	3	Gestational age 28 - 31 6/7 weeks
Moderately Preterm	4	Gestational age 32 - 33 6/7 weeks
Late Preterm	5	Gestational age 34 - 36 6/7 weeks

PCRC proposals and “rightsizing” the paper

- Typically, one “proposal” -> one manuscript
- Diffuse proposals and hypotheses lead to unfocused manuscripts
- Paper must be “big” enough to warrant reading it, the “energy of activation”
- More messages, more complexity increase the energy of activation
- Novelty, focus, and “buzz” decrease energy of activation
- Paper must be “small” enough to be consumable and have a clear message (or two)



Reporting

- Pick an EQUATOR checklist
 - <https://www.equator-network.org/> & <https://www.goodreports.org/>
 - Use it when designing the protocol
- If there is a better checklist for a novel methodology (machine learning, etc), use it
 - <https://www.ahajournals.org/doi/10.1161/CIRCOUTCOMES.120.006556>
- STROBE is not enough anymore
 - RECORD, SQUIRE, etc

MPOG-specific guidance

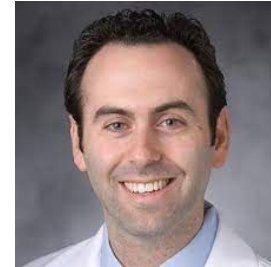
- When reporting a paper, sample size is your enemy, not your friend
- Do ***NOT*** highlight how many cases are in MPOG that you “started” with
 - readers question generalizability after excluding so many cases
- Statistical significance is a burden that must be explained
- Effect sizes are the key
- Consider a priori minimal clinically important difference in protocol
- MPOG data is no longer restricted to “academic medical centers”
- Model parsimony builds upon hypothesis focus
- Use supplemental digital content freely for model reporting

Wrap Up

Next Meeting: March 2024

If interested in joining email Meridith@med.umich.edu

THANK YOU Dr. Taicher for your many contributions over the past few years as subcommittee Chair and for your continued participation as a member of the MPOG pediatric subcommittee!





Thank You!