MSQC 2021 Hysterectomy QI Project: Kickoff Webinar
Q&A from January 20, 2021 Session

<table>
<tr><th>Question</th><th>Answer</th></tr>
<tr><td>When does the fasting blood sugar or HgbA1C need to be performed?</td><td>
Preoperative lab values obtained within 90 days prior to the operation date will count toward the measure. This includes point of care/finger stick (POC) testing values (e.g., pre-op holding, inpatient unit). Remember that to meet the Glycemic Control measure for non-diabetic patients, the blood sugar values need to be from a fasting specimen.

Abstract the Blood Glucose field as you always have in the past with any blood sugar value performed closest to surgery time; specimen can be fasting or non-fasting.
Abstract the Fasting Blood Glucose field only if you have at least one fasting specimen. In other words, if most recent value is an FBS, that value will be entered into both the Fasting Blood Glucose and the Blood Glucose fields. MSQC has created a document with abstraction tips for the blood glucose variables, available in the Workstation Resources.
<table>
<tr><th colspan="3">Preoperative Blood Glucose Values* – BG** vs. Fasting (FBG) ***
Abstraction Rules for Lab Values</th></tr>
<tr><th>What Lab value is in patient's record?</th><th>Enter value in BG field in Workstation</th><th>Enter value in FBG field in Workstation</th></tr>
<tr><td>FBG</td><td>FBG</td><td>FBG</td></tr>
<tr><td>BG (non-fasting)</td><td>BG</td><td></td></tr>
<tr><td>Both FBG and another BG</td><td>BG/FBG*</td><td>FBG</td></tr>
</table>
*Preoperative Blood Glucose Values = value closest to and prior to Patient In Room Time
**BG = the Blood Glucose value closest to Patient In Room Time (could be fasting, non-fasting/random, POC) – no change to this
***FBG = specifically the Fasting Blood Glucose value closest to Patient In Room Time – new

Tips:

FBG should only be reported when labeled as "fasting" or when patient is known to be fasting, otherwise this would be considered BG

Patients who were fasting from midnight before surgery (or within 8 hours before surgery) and had BG obtained before surgery, this would be considered FBG
Patients who drank clear liquids (other than sugar free items) or carb drinks after midnight (or within 8 hours before surgery), this would be considered BG (it is not fasting)
If FBG is the only value, it would be reported in both BG and FBG because it the BG closest to surgery

Since a lot of the labs come in through Data Integration, the DI process will need to be updated to accept FBG field if you wish to integrate this. If you are used to your labs integrating, this will be easy to skip over, so ensure it is filled out when available until your DI process includes this lab.

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For the glycemic control requirement, do we report the lab values, or do we need to capture any follow-up required for elevated values?	The requirement is to only report the lab values. These values get abstracted into the preop lab tab in the workstation.
Does the preoperative teaching on pain management need to address multimodal pain management? If so, what type of evidence do we need to count it? If the documentation does not specify multimodal pain management but we know that the education content always includes multimodal, is that adequate?	If the SCQR has verified that preop education process: 1) addresses the specific elements required, 2) delivers the content in written and verbal format, and 3) is consistently provided to the patient procedure population being reviewed, you can count it as meeting the requirement. For example, it is documented in the chart that the patient completed the preop teaching class, and you have examples of the education documents showing the program covers pain management.
Is there a time limit on the date the preoperative uterine imaging closest to hysterectomy was performed? Sometimes the most recent result might be 12 months old, and the patient has been receiving alternative therapies in the interim.	There is no time limit for when the preop imaging was performed. Just collect the measurements closest to the surgery if there is more than one.
For the uterine size measure, do we use the imaging performed preoperatively or do we use the intraoperative/pathology findings?	There are two different variables related to uterine size: 1. Preoperative Uterine Size (Preop Tab) Definition: The uterine size findings from the radiology study or surgeon-reported uterine size closest to the hysterectomy procedure. 2. Specimen Weight (Postop Tab) Definition: The uterine weight as documented within the pathology report
If the pathology report lists the uterine weight separate from the adnexa specimen, do I report just the uterine weight, or the combined weight of uterus plus adnexa?	Provide the complete weight of the specimen(s) removed. If any part of adnexa is removed (one ovary, one fallopian tube, or both), select "Uterine + adnexa" as the Specimen Weight Type and provide the total weight(s). If the specimens are received by pathology separated, as in uterus separate from tubes and/or ovaries and/or mass and weighed separately, then add the weights together, select uterus + adnexa, and report the total weight.
If an anti-emetic medication is administered in the preop holding area, does it count for the intraoperative PONV measure?	Anti-emetic medications for this measure can be administered in the preoperative holding area or intraoperatively.
If propofol injection is administered for anesthesia induction, does this count as PONV prophylaxis as well?	No. If the propofol is delivered via injection for anesthesia induction, it does not count toward the PONV prophylaxis measure. For PONV prophylaxis, it must be administered as an infusion per the Program Manual measure definition.

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If a medication that appears in the both the intraoperative PONV prophylaxis definition and the intraoperative multimodal pain management definition, does it count for both measures? For example, dexamethasone?	Acknowledging that there may be an 'overlap' of a medication between the PONV variable and the Intraoperative MMPM variable, it will be necessary to determine that the time of administration, route, dose, and any other qualifiers of the medication are applicable to both of the variable definitions. If the medication administered meets all the qualifiers for both measures, then yes it can be counted.
Can you elaborate on the timing of Toradol and when it does/does not count toward intraop/postop multimodal pain management?	As part of our Professional/Clinical/QI review, we did consider the timing of administration of several medications, and more specifically, Toradol/ketorolac and the intent to aid in managing the patient's immediate postop pain. Our intent is not to minimize the importance of Toradol's administration, but to encompass the orders occurring after surgery for the 24 hours once the patient leaves the OR. The primary purpose of the Postop Multimodal Order/Use variable is to ensure that a patient receives orders for at least two non-opioid pain management agents during the time period starting after they leave the OR. When administered as a single dose ('1x') in the late Intraop period, Toradol and other NSAIDs will provide pain relief only for the first few hours after a patient leaves the OR. The MM Pain management definitions are consistent with the intent of the 2021 QI project, which is to control the patient's pain during and after surgery while also reducing the use of opioids. A one-time dose of Toradol at the end of surgery will not meet this intent. Therefore, Toradol ordered/administered late in the intraoperative period does not count as a postoperative multimodal pain management agent. If it is ordered/administered in the early intraoperative period it can be counted as an intraoperative agent, but not as postoperative. We hope this clarifies why MSQC does not include Toradol at the end of the case for postoperative pain management for the QI variable even though the administration of Toradol at the end of the case is clinically a good option for initial postop pain management.
Can you give more information on the Benign Surgical Specimen Review process and what we need to provide to MSQC?	Sites will need to describe their process for reviewing and monitoring uterine surgical specimens without pathology findings supporting the need for hysterectomy. (Guidance note: These cases are those with pathology findings (e.g. normal, unremarkable, physiologic, reactive, or of minor importance) amenable to medical or surgical treatment less invasive than hysterectomy. In general, these changes would rarely require hysterectomy to relieve a patient of symptoms.) There is no requirement that you have a such a process; rather, that you share any process you may have in your final QI report submission to MSQC.
Will there be paper data collection worksheets updated for 2021 cases?	Paper data collection worksheets are currently being updated with 2021 abstraction requirements, and will be posted in the Workstation when completed.

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<tr><td>What is the SCQR meeting attendance requirement for 2021? There is a 2-day SCQR conference that we may not be able to attend. If we cannot attend this conference, do we still get full credit for attending 2 other conferences during the year? How do we earn meeting credits?</td><td>The 2021meeting schedule for SCQRs is listed below. The April meeting will be virtual. The format of the remaining 3 meetings (June, September, and December) are TBD.
SCQR Meetings for 2021:
April 23 MSQC-ASPIRE Meeting – virtual
June 4 SCQR Training Day, tentatively at the H Hotel, Midland
Sept 23-24 MSQC Meeting, tentatively at the Double Tree, Bay City
Dec 10 MSQC Meeting, tentatively at Schoolcraft College
Four meetings are scheduled in 2021 for SCQRs, and at least 3 require attendance in order to earn the full 8 points available on the P4P scorecard.

With the virtual conferences, we have been able to use the CME submission process to track attendance. The sessions have been recorded and posted for viewing at a later time for those unable to attend the original broadcast. This has allowed us to offer a several-week window post-conference to allow SCQRs to view the content, process your CME credits, and obtain P4P attendance credit.

<table><tr><th colspan="4">2021 Michigan Surgical Quality Collaborative</th></tr><tr><th colspan="4">Performance Index Scorecard</th></tr><tr><th colspan="4">Project Time Period: 1/1/2021 – 12/31/2021</th></tr><tr><th>Measure</th><th>Weight</th><th>Measure Description</th><th>Points</th></tr><tr><td rowspan="4">1</td><td rowspan="4">8</td><td colspan="2">Collaborative Meetings (4) – Surgical Clinical Quality Reviewer (SCQR)</td></tr><tr><td>3 or more meetings</td><td>8</td></tr><tr><td>2 meetings</td><td>4</td></tr><tr><td>1 meeting</td><td>0</td></tr></table></td></tr>
<tr><td>Is the new 2021 manual out yet?</td><td>The 2021 Program Manual is available in the Resources section of the Workstation.</td></tr>
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