



TOC 02 Review - November 27, 2023

Review TOC 02 Measure Specification by selecting this [link](#)

Feedback from Measure Reviewer(s)

Dr. Jing Tao - MSKCC

Review of new literature (Published 5/2017)

Since miscommunication is a known source of patient harm, developing a standardized method to include a set of key information is a natural next step towards reducing bad outcomes. Prior to the introduction of TOC in 2017, there were a slew of studies demonstrating using a checklist for anesthesia handoff to PACU increased information transferred. Since then, only a small hand full of studies have been published with the majority coming to the same conclusion: using a checklist process increases the quantity and quality of information transferred. One study was able to go a step further and examined rates of hypoxia (O2 sat <90% for >30s), in PACU pre and post checklist implementation.¹ The checklist used in this study included several items that were either not listed or not specified in the MPOG metric (position, airway and fluid management, analgesia, and neuromuscular blockade). Results found patients in the intervention group were significantly less likely to experience hypoxia than the control group (0.8% vs 4.1%). This is the only study I could find examining outcome differences from using a checklist.

¹ Jaulin F, Lopes T, Martin F. Standardised handover process with checklist improves quality and safety of care in the postanaesthesia care unit: the Postanaesthesia Team Handover trial. Br J Anaesth. 2021 Dec;127(6):962-970. doi: 10.1016/j.bja.2021.07.002. Epub 2021 Aug 5. PMID: 34364652.

Appropriateness of rationale

The rationale gives the perception that using a checklist with the required elements for PACU handoff improves outcome. There is currently very little evidence either supporting or denying this claim. With that said, I believe the rationale for TOC 2 remains valid since communication using a standardized form can only help and is known to improve provider satisfaction.

Evaluation of inclusion/ exclusion criteria

I could not find evidence for why radical clavicle or scapula surgery, thoracolumbar sympathectomy, and lumbar chemonucleolysis are excluded from this metric.

Evaluation of definition of success or flagged cases

I have no problem with the definition of success for the metric. I think specification of intraoperative anesthetic management to include analgesia, neuromuscular blockade and reversal, position, etc – variables similar to the ones included in the study I mentioned above could improve outcome on a broader basis, however, I only have one study to back this notion up.

Other feedback

I believe this metric is important and remains relevant but should be taken with a grain of salt for reasons mentioned above. Because minimal evidence exists on the effects of anesthesia PACU handoff on morbidity or mortality, there is ample room for future studies.

Recommendation from Dr. Tao for TOC 02:

	Dr. Tao
Keep as is: no changes at all	<input type="checkbox"/>
Modify: changes to measure specifications (see below)	<input checked="" type="checkbox"/>
Retire: eliminate entirely from dashboard and emails	<input type="checkbox"/>

Summary of recommended modifications (if applicable)

1. Specify intraoperative anesthetic management to include position, analgesia, neuromuscular blockade and reversal, and fluid management.
2. Reconsider removing radical clavicle or scapula surgery, thoracolumbar sympathectomy, and lumbar chemonucleolysis as exclusions



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