Obstetric Anesthesia Subcommittee Minutes

November 3, 2021

1:00-2:00 pm EST - Zoom

	First Name	Last Name	Institution
X	Sharon	Abramovitz	Weill-Cornell
	Aymen	Alian	Yale
	Ami	Attali	Henry Ford-Detroit
X	Dan	Biggs	University of Oklahoma
X	Brendan	Carvalho	Stanford
	Traci	Coffman	St. Joseph Ann Arbor
X	Eric	Davies	Henry Ford- Allegiance
X	Carlos	Delgado Upegui	University of Washington
	Ghislaine	Echevarria	NYU
X	Kim	Finch	Henry Ford
X	Ronald	George	UCSF
X	Jackie	Goatley	University of Michigan ACQR
X	Antonio	Gonzalez-Fiol	Yale
X	Ashraf	Habib	Duke
	Jerri	Heiter	St. Joseph Ann Arbor, Chelsea, Livingston
	Jenifer	Henderson	St. Joseph Oakland
X	Wandana	Joshi	Dartmouth
	Rachel	Kacmar	University of Colorado
	Tom	Klumpner	University of Michigan
	Joanna	Kountanis	University of Michigan
	Stephanie	Lim	UCSF
X	Angel	Martino-Horrall	Beaumont Health System
X	Philip	McClarty	Metro Health
	Marie-Louise	Meng	Duke
	Rebecca	Minehart	MGH
	Melinda	Mitchell	Henry Ford - Allegiance
	Arvind	Palanisamy	WashU
X	Denise	Schwerin	Bronson ACQR

X	Monica	Servin	University of Michigan
	David	Swastek	St. Joseph Ann Arbor
X	Mohamed	Tiouririne	UVa
X	Brandon	Togioka	OHSU
	Christine	Warrick	University of Utah
X	Jessica	Wren	Henry Ford
X	James	Xie	Stanford
X	Joshua	Younger	Henry Ford-Detroit
X	Nirav	Shah	MPOG Quality Director
X	Kate	Buehler	MPOG Clinical Program Manager
X	Meridith	Bailey	MPOG QI Coordinator
X	Tiffany	Malenfant	MPOG Clinical Informatics Specialist
X	Andrew	Zittleman	MPOG Clinical Informatics Specialist
	Victoria	Lacca	MPOG Administrative Manager

A. **Announcements**:
   a. 2022 Meeting Dates
      i. February 2, 1pm EST
      ii. August 3, 1pm EST
      iii. December 7, 1pm EST
   b. GA 02-OB and TEMP 05-OB are now released to your OB dashboards

B. August 2021 Meeting Recap
   a. BP 04 filtering by neuraxial anesthesia type is available through the "Measure Case Report Tool". Please reach out to the coordinating center if you do not have access to this tool and would like access or if you have any questions about how to download the reports
   b. Subcommittee confirmed interest in a review of unblinded institutional data at a future meeting
   c. Please continue to share your practices around standardization of documentation for reason to convert to general anesthesia for cesarean delivery cases
   d. Provider attribution for GA 01 was discussed- consensus to continue without attribution
   e. For TEMP 05 (hypothermia at the end of the case or in PACU), cases will be flagged if there are not temperatures taken during that time frame per the recommendation of the subcommittee

C. Glucose Monitoring Measures
   a. Background: Sites document labor epidural cases that are converted to cesarean deliveries two ways:
      i. The labor epidural and cesarean delivery are documented as one case. MPOG labels these as "Conversion (Combined)" Cases
      ii. The labor epidural and cesarean delivery are documented as separate cases. MPOG labels these as "Conversion (Labor epidural portion)" Cases and "Conversion (Cesarean Delivery portion)" Cases

b. Perioperative glucose measure (GLU 03/04/05) start time for conversion cases discussion
    i. *Ron George (UCSF)* via chat - continue to exclude labor epidural cases from GLU measures
    ii. *Josh Younger (Henry Ford, Detroit)*- workflow in LD is scheduled and conversions to cesarean. Patients who are severely premature on betamethasone will be out of glucose control. Do we differentiate between these different cohorts?
    iii. *Sharon Abramovitz/Ashraf Habib/Carlos delgado/Mohamed Tiourirhine/Antonio Gonzalez/Dan Biggs* - agree. Exclude OB patients from GLU measures
    iv. For those measures only measuring intraop glucose (GLU 01 and 02). Do we exclude cesarean deliveries for those cases as well?
        1. *Josh Younger (Henry Ford, Detroit)* - average C-section is 2 hours….so your surgery is over before you have time to treat or recheck.
        2. *Wandana Joshi (Dartmouth)* - I agree as well. We have limited time with the patients for the cesarean delivery. The nurses are more involved with the glucose management than we are involved.
        3. *Josh Younger (Henry Ford, Detroit)* - should also consider the baby outcomes as well, not just the mom.
        4. *Ron George (UCSF)* - If we open this door in the future it will need to be very specific to the OB population as a separate series of measures.

c. Conclusion: Consensus from the group to exclude cesarean delivery patients from all glucose measures (GLU 01-05); can revisit glucose management in the future and will create OB-specific glycemic management measures if needed

D. Unblinded Data Review: Performance for GA 01 and 02 was shared with the subcommittee- this was a confidential session; unblinded data was removed from the presentation before posting. General discussion topics are noted below- any comments specific to a sites performance were omitted from the minutes.
    a. GA 01/GA 02 Review
        i. *Ron George (UCSF)* - Are we able to separate scheduled vs. non-scheduled C-sections?
        ii. *Kate Buehler (MPOG)* - GA02 gives a glimpse of that but we can look into this more
        iii. *Wandana Joshi (Dartmouth)* - SOAPs Center of Excellence recommends an overall GA rate of 5% or less for cesarean deliveries, whether they are scheduled or not.
        iv. *Ron George (UCSF)* - The UK world college uses 5% for scheduled and 10% for non-scheduled/emergent c-sections
        v. *Mohamed Tiouririne (U.Virginia)* via chat - I believe the standard is between 5-11% all comers (scheduled and urgent/emergent)
        vi. *General Discussion Topics:*
            1. Evening/weekend coverage being staffed by the general pool- not OB anesthesiologists. Could this contribute to higher GA rates? One site reports this was not the case, instead, about half were cases that fit into high acuity/fetal tracing.
            2. Surgeons not wanting to wait for epidural to take effect. This could lead to higher GA rates
            3. *Brandon Togioka (OHSU):* There have been some patient reports of dissatisfaction if GA was not used: could be some liability with patient

satisfaction; with the use of glidescopes and C-MAC now, it may be safer and okay to use GA in these circumstances

4. All GA cases should be reviewed at an institution level each month by a committee to determine appropriateness of GA
    a. Is there a standard review criterion from SOAP for which providers can base their review of the GA cases to determine if they were 'appropriate?' Just wondering if the review is similar at every site...
5. UCSF is now reviewing all GA 02 cases to determine if failed spinals were the reason for conversion. This review is identifying opportunities to improve epidurals/spinal placement and dosing to avoid the need to convert to GA
6. Cornell is working on standardizing re-dose management of epidurals and replacing catheters that don't seem to be working
7. *Josh Younger (HF)* – Interesting to see if a dedicated OB Anesthesiologist team makes a difference with GA Rates. (Ron George – 50% call by non-core OB anesthesiologists at UCSF)

Meeting concluded at 2:01pm