Obstetric Anesthesia Subcommittee Minutes
December 4th, 2024
1:00-2:00 pm EST - Zoom

Attendees:

Henrietta Addo, MPOG	Kayla Lopacki, Trinity Health
Dieter Adelmann, UCSF	Tiffany Malenfant, MPOG
David Arnolds. Michigan	Christine McKenzie, UNC
Nicole Barrios, MPOG	Mary McKinney, Corewell Health
Kate Buehler, MPOG	Kam Mirizzi, MPOG
Arthur Calimaran, Cleveland Clinic	Melinda Mitchell, Henry Ford
Meilou Calabio, MPOG	Katie O'Conor, Johns Hopkins
Ruth Cassidy, MPOG	Diana O'Dell, MPOG
Johanna Cobb, Dartmouth	Rebecca Pantis, MPOG
Robert Coleman, MPOG	Jack Peace, Temple
Rania Elkhateb, UAMS	Sandy Rozek, MPOG
Kim Finch, Henry Ford	Nirav Shah, MPOG
Jackie Goatley, Michigan	Kristyn Lewandowski, Corewell Health
Josh Goldblatt, Henry Ford	Frances Guida Smiatacz, MPOG
Antonio Gonzalez-Fiol, Yale	Rachel Stumpf, MPOG
Ashraf Habib, Duke	Alexander Taylor, Trinity Health
Jerri Heiter, Trinity Health	Brandon Togioka, OHSU
Jessica Stokinger, Duke	Pam Tyler, Corewell Health
Wandana Joshi, Dartmouth	Meridith Wade, MPOG
John Kowalzcyk, BWH	Allison Lee, Pennsylvania
Heather LaLonde, Trinity Health	

- ## Agenda:
    - Announcements
    - September meeting recap
    - Tranexamic Acid Measure Proposal and Vote
    - 2025 Measure survey results
    - Discussion and voting - future measures
- ## Announcements:
    - Welcome new members:
        - David Arnolds, MD – University of Michigan Medicine
        - Jessica Stockinger, MD – Duke Medical Center
        - Joshua Younger, MD – Northwell Health
    - Future Meeting Dates
        - February 26, 2025, at 1pm EST
        - May 14th, 2025, at 1pm EST
        - September 3, 2025, at 1pm EST
        - December 3, 2025, at 1pm EST
    - OB Transfusion Toolkit now available:
        - OB Transfusion Toolkit Presentation is now available on the Patient Blood Management Toolkit website.
        - Please use as you see fit, the toolkits are available for your use and distribution.
    - Future OB related PCRC Research Proposals
        - The Perioperative Clinical Research Committee (PCRC) helps researchers to coordinate efforts throughout the entire research proposal process from determining feasibility through dissemination of results.
        - For all future PCRC meetings as a member of the OB Subcommittee member you will receive an invitation to attend as an optional attendee.
        - Depending on the presenter schedule, we will also announce all OB research proposals at the OB Subcommittee when possible.
    - September Meeting Recap
        - Azithromycin quality measure for intraoperative cesarean deliveries approved. Will announce when the measure is built and ready to be reviewed on your dashboards.
        - Measure discussion for the 2025 MPOG OB Subcommittee and SOAP Centers of Excellence alignment.
        - Phenotype Discussion: An update of pregnancy phenotype was discussed. Request for volunteers to review cases- if interested in helping, please email Nicole at nicbarri@med.umich.edu

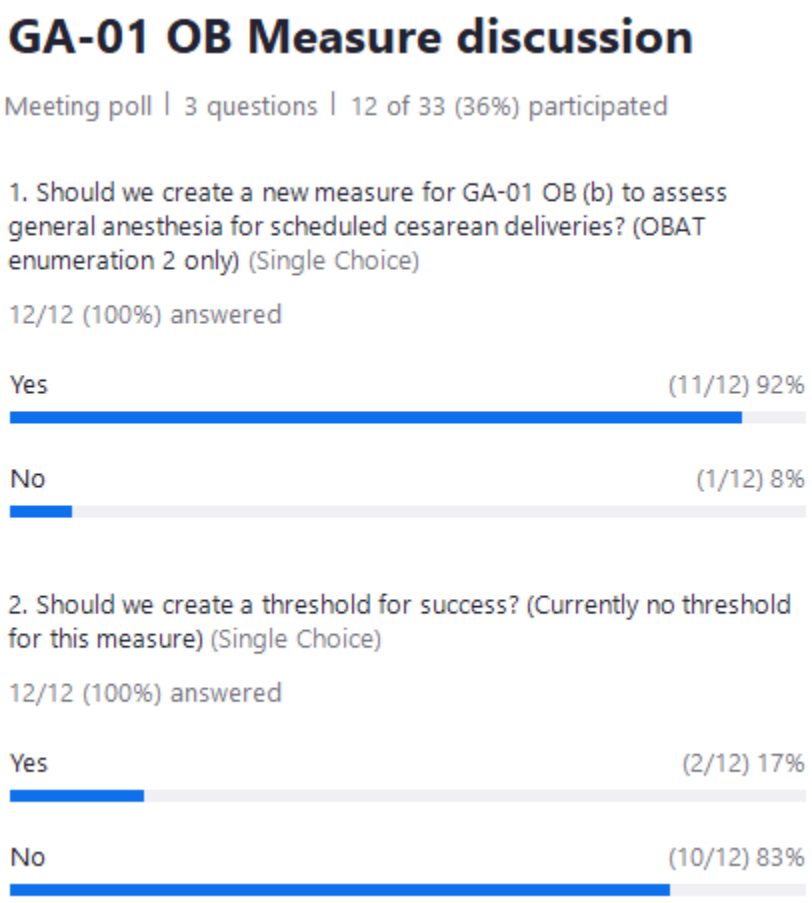
    - Approved Measure: ABX-06-OB
        - Measure Description: ABX-06-OB Percentage of unscheduled cesarean deliveries in which azithromycin was administered in the time period 60 minutes before surgical incision through anesthesia end.
        - Measure Time Period: 120 minutes before surgical incision to Anes End. (Will Flag if given too early).

        - Inclusions:

        - Cesarean delivery patients as determined by: Obstetric Anesthesia Type Phenotype
        - Labor Epidural Converted to Cesarean Delivery (Charted under a single case; obstetric anesthesia type phenotype: value 1)
        - Labor Epidural Converted to Cesarean Delivery (cesarean delivery portion, labor epidural documented as a separate case; obstetric anesthesia type phenotype: value 7)
    - Exclusions:
    - Obstetric Anesthesia Type phenotype:
        - 0 - No
        - 2- Cesarean delivery without a preceding labor epidural
        - 3- Labor Epidural
        - 4- Cesarean Hysterectomy
        - 5- Obstetric Case Unable to Determine
        - 6- Conversion (labor epidural portion)
        - 8- Conversion (cesarean hysterectomy portion)

    - Success Criteria: Non-elective cesarean patients who received azithromycin within the measure time period.

- GA-01-OB: Measure Discussion
    - GA-01-OB: General Anesthesia During Cesarean Deliveries Percentage of cesarean delivery cases where general anesthesia was used.
    - Should we look at Standalone cesarean sections, only OBAT enumeration 2?
    - Should we set a measure of success for GA-01? If so, should it be < 5%.
        - Currently no threshold set for this measure.
    - Vote: Yes/No
    - Should we set a measure of success for GA-01? If so, what should the threshold be?
    - What is your level of interest in creating a quality metric for GA rate for scheduled cesarean deliveries?
    - Discussion:
        - *Josh Goldblatt (Henry Ford Allegiance):* Our site is working on the SOAP COE application now and it recommends a threshold of 2.5-5% but is open to values >5% as long as there is a robust QI process to accompany the score. At our site, with so few c-sections performed each month, a single case converted to general anesthesia can drastically impact our 12-month average score. Measure performance fluctuates greatly for our site which is a community hospital with few cesarean deliveries performed so a set threshold doesn't really make sense for our perspective.
        - *Ashraf Habib (Duke):* Would be reluctant to create a threshold for this but would support building a measure for scheduled deliveries.
        - *Johanna Cobb (Dartmouth):* Would be very helpful to know scheduled vs. unscheduled GA rates. However, do not think we should set a threshold. There are indications for general anesthesia, and we don't want to sway providers from using GA when it really is necessary for their patient.



- **Next Steps:**
    1. Create a new measure to assess GA rate for scheduled cesarean deliveries (OBAT: value 2)
    2. No change to GA-01 – continue measure as informational only. No threshold.

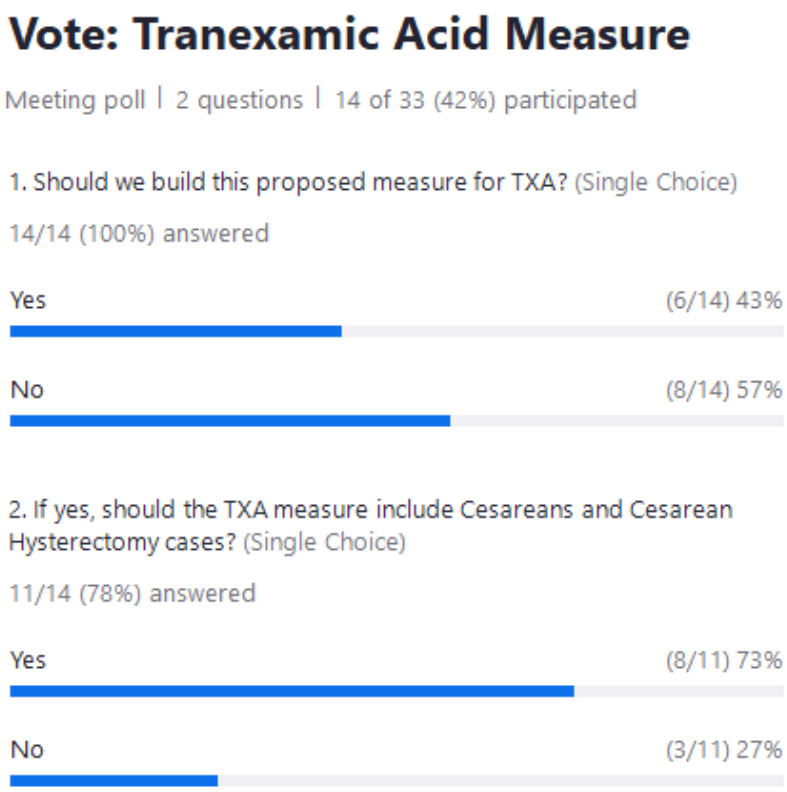
- Tranexamic measure
    - Background: Tranexamic Acid
        - Woman Trail Published 2017
        - **Inclusion criteria**: 193 hospitals in 21 countries. Women 16 yrs or older with dx of PPH after vaginal or cesarean delivery
        - **Design**: International, randomized, double blind, placebo-controlled trial.
        - **Trial Treatment**: 1 GM TXA at a rate of 1 ml per minute vs placebo (2nd dose if bleeding cont'd or started again within 24 hrs). In addition to the usual care.
        - **Primary outcome:** composite of death from all causes or hysterectomy within 42 days of randomization.
    - Expert Review: 2023
        - Saharan Africa and South Asia 1/1000 births a mother dies due to hemorrhage
        - High income countries 1/100,000 births a mother dies due to hemorrhage

        - In low-risk settings (high income countries) there are more thrombotic deaths than bleeding deaths
        - Trials in low-risk settings must be large enough to assess nonfatal thrombosis, as fatal cases are rare. Despite having 11,000 patients, Pacheco et al. study lacked the power to effectively evaluate thrombosis risk.
        - Women Trial -> mortality benefit was primarily seen in Africa where 12,000 pts/20,000 total patients were enrolled. In Europe, where only 1,000 patients were enrolled, there were no deaths.
        - Conclusion: TXA reduced bleeding by 1/3.
    - Background: TXA Acid
        - **TRAAP- Published 2018**
            - Conducted to assess the effect of TXA on blood loss after vaginal delivery.
        - **TRAAP2 –Published 2021**
            - Conducted to assess the effect of TXA on blood loss after cesarean delivery.
        - **Design**: Multicenter, double-blind, randomized controlled trial.
        - **Inclusion Criteria**: Women undergoing CD before or during labor at 34 weeks or more gestational weeks.
        - **Trial Treatment**: Each patient received IV administered prophylactic uterotonic agent and 1GM of TXA.
        - **Primary outcome:** postpartum hemorrhage defined as a calculated estimated blood loss greater than 1000 ml receipt of RBC transfusion within 2 days after delivery.
        - 4551 women were randomized. 4431 underwent CD of whom had primary outcome data available.
        - The results demonstrated that prophylactic uterotonic agent, use of TXA at CD resulted in a calculated estimated blood loss that was significantly lower than those who received the placebo. The difference in blood loss after cesarean delivery was 100 ml which is not clinically significant.
    - **Proposed New Measure: TRAN-05-OB**
        - TRAN-05-OB- Percentage of cesarean deliveries with Tranexamic acid administration for blood loss > 1000 mL
        - Measure Time Period: Anes Start to Anes End
        - Inclusions:
        - Cesarean delivery patients as determined by: Obstetric Anesthesia Type Phenotype
            - 1- Conversion (Labor epidural and cesarean delivery)
            - 2- Cesarean Delivery
            - 4- Cesarean Hysterectomy
            - 7- Conversion (cesarean delivery portion)
            - 8- Conversion (cesarean hysterectomy portion)
        - Exclusions:
        - Obstetric Anesthesia Type phenotype:

- 0 - No
- 3- Labor Epidural
- 5- Obstetric Case Unable to Determine
- 6- Conversion (labor epidural portion)

- Success Criteria: The administration of tranexamic acid in patients with blood loss >1000mL

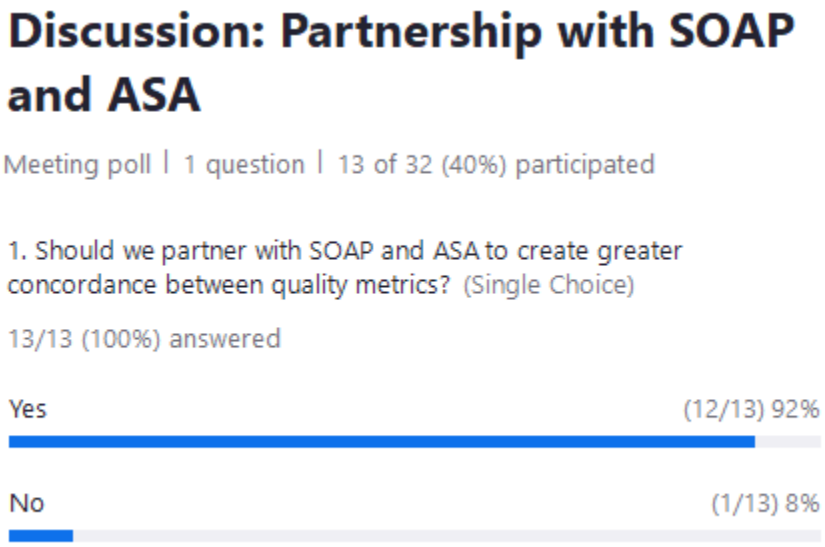
- Discussion:
  - *John Kowalczyk (Brigham & Women's):* Thanks for the detailed review. We have done an evaluation of TXA use at our institution and thought it would be quite high and it was much lower than expected. Not sure what the right answer is here. Barbara Scavone's work in obstetric hemorrhage makes me wonder if TXA is the answer to our issue of PPH. A metric in this space may help us address that question. When a patient has PPH and a second-line uterotonic agent has already been administered, TXA is a low-risk medication. Not sure TXA is a huge game-changer though, at least not in the same way that azithromycin is in addressing SSIs. Very complicated question!
  - *Ashraf Habib (Duke):* We all see this in our practice – we are giving it way too often, even beyond what is probably indicated. Though a benign drug, women feel nauseated after it's administration. There are some side effects. I agree with John – I have mixed feelings building a metric around this. A lot of times it's given per OBGyn request. Seems more like a research question rather than a quality metric.
  - *Brandon Togioka (OHSU):* Returning to the graph that displays EBL fill rates, one of the side effects of looking into this data is that we found many sites have not mapped their QBL variable. We had to update this mapping at our site.
  - *David Arnolds (University of Michigan):* lack of true evidence for what the best role for TXA is. It would be hard to advocate for building this metric. Given the gaps, that we discussed and what we've experienced anecdotally about differing views it would be hard to support this measure.
  - *Kate Buehler (MPOG Coordinating Center):* We can build a new concept for QBL if sites are now starting to capture this data in their MPOG extract. Historically, though it was documented locally, it wasn't included in the standard MPOG Epic extract so creating a concept would not have helped. If sites are seeing this variable, as Josh from Henry Ford has found, we can create a new MPOG Concept for QBL.
  - *Allison Lee (UPenn*): Would agree that this is more of a research question than a quality measure.
  - *Nirav Shah ((MPOG QI Director):* There are other ways for MPOG to follow this without building a measure. We can do a similar analysis in a year and see if practice patterns have changed.
- Vote:



- MPOG OB Subcommittee 2025 Goals and Survey Results
    - MPOG and COE Institutions
    - Feedback from the group:
        - Discussion: Partnership with SOAP Centers of Excellence (COE) to create meaningful measures that our sites can use for quality reporting.
        - Can also help with the application process
    - Discussion:
        - *Ashraf Habib (Duke):* Would support this alignment between the two organizations – MPOG and SOAP would be helpful for both applicants as well as the COE committee. Becomes confusing when there are multiple thresholds or conflicting thresholds across obstetric organizations for similar measures. Aligning with SOAP would be a great step.
        - *John Kowalczyk (Brigham & Women's):* The value to participate with MPOG would be higher, especially as sites attempt to apply for COE. Alignment in this area would make a lot of sense. It would help us, as MPOG sites, to participate with SOAP in an aligned way.
        - *Allison Lee (UPenn):* Only hiccup I could see is who has the final say in these decisions.
        - *Brandon Togioka (OB Subcommittee Chair):* As for who would have the final say – I don't think we know yet. So far, every group has been creating their own

metrics – not sure we know how the alignment will exactly work yet but helpful to know if the group wants to move in that direction.

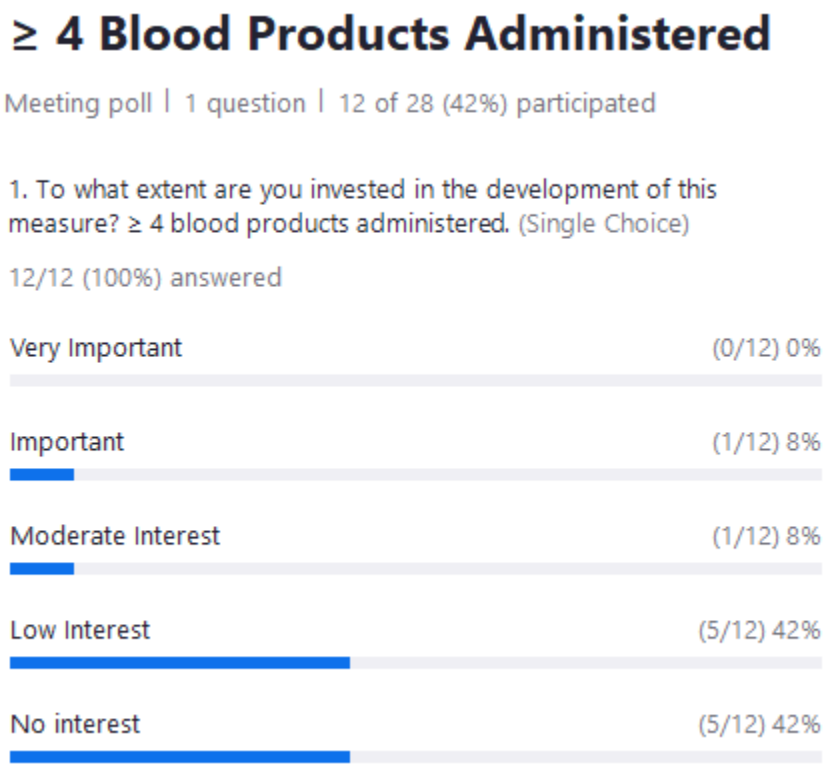
- Vote



- Survey Results
  - Top 4 survey results (11 participants):
    - Proportion of patients (SVD + EPI) with ≥4 blood products transfused
    - Epidural replacement rate
    - Core body temperature monitored during cesarean delivery
    - Multimodal analgesia for cesarean delivery
- Higher volume blood transfusion
  - Is blood transfusion [≥4 units] an indicator of poor anesthesia quality?
  - Is there interest in this measure because of potential to support institutional quality improvement?
  - Is this outcome a proxy for higher risk patients?
    - Overdistended uterus, retained placenta, prolonged labor, placental abruption, placenta previa, chorioamnionitis, higher BMI
  - Are there unintended consequences?
- **Discussion**:
  - *Brandon Togioka (OB Subcommittee Chair):* This was scored very high on the survey by participants however in offline discussions with practitioners around the country, there is some concern that this is not a good quality metric. There is potential of unintended consequences.
  - *John Kowalczyk (Brigham & Women's):* Blood transfusion >4U blood products usually has very little to do with us as anesthesia providers and is more likely related to patient population. Maybe we go after post-transfusion hematocrit levels >32%, to try to assess over transfusion rates. Would rather assess that versus just transfusion rate.

- *Ashraf Habib (Duke):* Agree with what has been stated here. >4U blood products is not a measure of anesthesia quality. Would rather we focus our efforts on an area of anesthesia quality.

- Vote:



Note: Measure survey discussion to continue during the February 2025 meeting.

Meeting concluded: 202pm EST