Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE)

OB Subgroup Meeting Minutes – Dec 7, 2022

Attendance:

Monica Servin, University of Michigan	Graciela Mentz, MPOG
Jessica Wren, Henry Ford Health System	Tory Lacca, MPOG
Preet Singh, Washington University	Tiffany Malenfant, MPOG
Ashraf Habib, Duke University	Sandy Rozek, MPOG
Sharon Abramovitz, Weill-Cornell	Rob Coleman, MPOG
Wandana Joshi, Dartmouth-Hitchcock	Meridith Bailey, MPOG
Ron George, UCSF	Nicole Barrios, MPOG
Kim Finch, Henry Ford Health System	Kate Buehler, MPOG
Brandon Togioka, OHSU	Nirav Shah, MPOG
Nicole Zanolli, Duke University	Meridith Bailey, MPOG
Dan Biggs, University of Oklahoma	Ronnie Riggar, MPOG

Announcements

- Meeting dates posted to basecamp. Also see website for 2023 meeting schedule
- July meeting recap:
    - presented data capture rates for cesarean delivery cases in MPOG.
    - Subcommittee voted to move forward with GA03-OB.

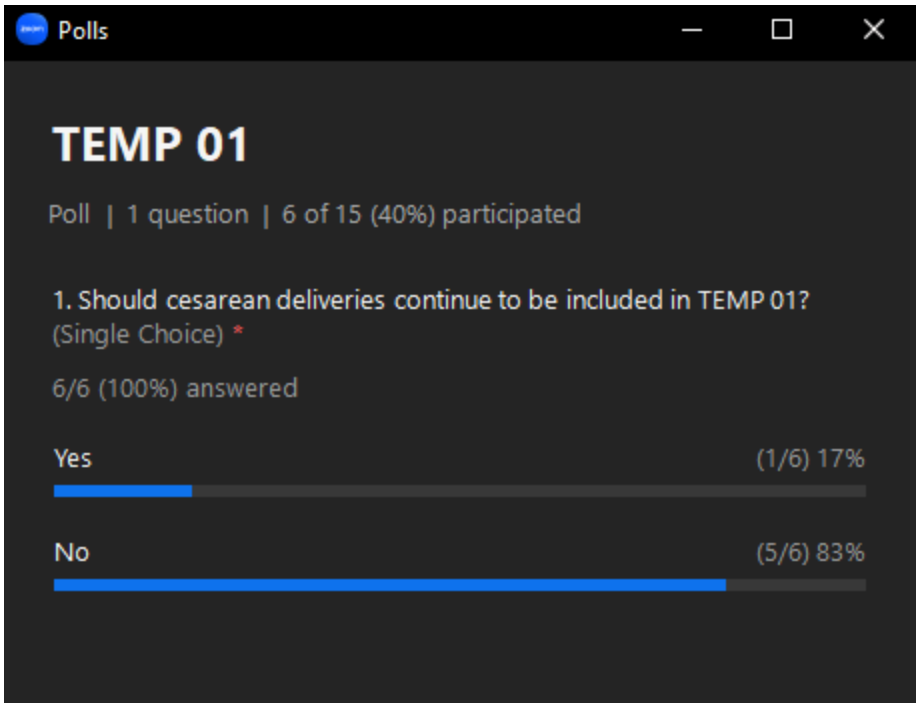
Temp 01- Active warming

- Background- 1st published in Jan 2020
- Every 3 years each ASPIRE measure is reviewed by Quality Committee
- Should TEMP 01 continue to access fluid warming as active warming for this pt population?
- Literature limited to small studies and no single, fluid warming studies were found.

  Warming Literature
    - Butwick, Lipman, Carvalho article- Intraoperative Forced air-warming during cesarean delivery under spinal
    - Sultan, Habib, Cho and Carvalho- The effect of patient warming during cesarean delivery on maternal…
    - Horn, Schroeder, Gottshalk- Active warming during cesarean delivery
    - Meghana, Vasudevaro, Kamath- THe effect of combination of warm IV fluid infusion and FAW vs FAW alone on maternal temperature…
    - Cobb, Cho, Hilton- Active warming utilizing combined IV fluid and FAW decreases hypothermia…

  Discussion:
    - Nirav Shah (MPOG QI Director): What is the practice for cesarean deliveries at each of your institutions?

        - Monica Servin (University of Michigan) We use warm blankets and fluid warmers but do not use forced air. There's a big emphasis here on skin-skin with mom and the forced air warmer can be bulky and there's minimal area between mom and incision. However, we do not routinely assess patient comfort
        - Sharon Abramovitz (Cornell): Using underbody forced air warming and temp sensing foley catheters at Weill Cornell Medicine
        - Ron George (UCSF): No active warming here
        - Wandana Joshi (Dartmouth): haven't been able to convince them to use a bair hugger. Nursing is opposed to it and says it interferes with skin-skin. We do use fluid warmers. Great point on how we don't generally assess the mothers state of comfort.
            - We've been trying to place an underbody but not for elective C-sections.
            - Preet Singh (Wash U): Patients ask us to turn it off in 10-15% of patients as they are uncomfortable with the Bair Hugger on
        - Sharon Abramovitz (Weill Cornell): Doesn't work with patients with a larger BMI so makes it challenging but we use fluid warmers in that situation
    - Jessica Wren (Henry Ford Health System): Do we have any data correlating TEMP 01 and TEMP 05?
    - Nirav Shah (MPOG QI Director): I think it makes sense to focus more on the outcome of hypothermia and exclude Cesarean Sections from TEMP-0. Can re-evaluate when new literature is available.
    - Poll results



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- **Description:** Percentage of cesarean delivery cases converted to general anesthesia after epidural
    - GA-03b-OB: Percentage of cesarean delivery cases converted to general anesthesia after combined spinal epidural
- **Inclusion:** Cesarean delivery cases with epidural anesthesia administered
    - GA-03b-OB: Cesarean delivery cases with combined spinal epidural

- **Exclusion:**
    - Cesarean Hysterectomies as determined by the "Obstetric Anesthesia Type" Phenotype.
    - Non-cesarean delivery cases, including labor epidural only cases
    - Cesarean delivery cases without epidural placement (or CSE for GA-03b)
- Was posted to basecamp for comments/review for those unable to attend the meeting today
- Considerations:
    - Exclusion for cases converted to GA >= 75 min after neonate delivery.
    - Cases converted to GA before neonate delivery and after epidural placement will be included.
    - Documentation is not standardized enough to detect medical reason vs. failed epidural

- Review performance for existing GA measures for cesarean delivery (See slides for GA-01, GA-02, and GA-03 performance across MPOG sites)

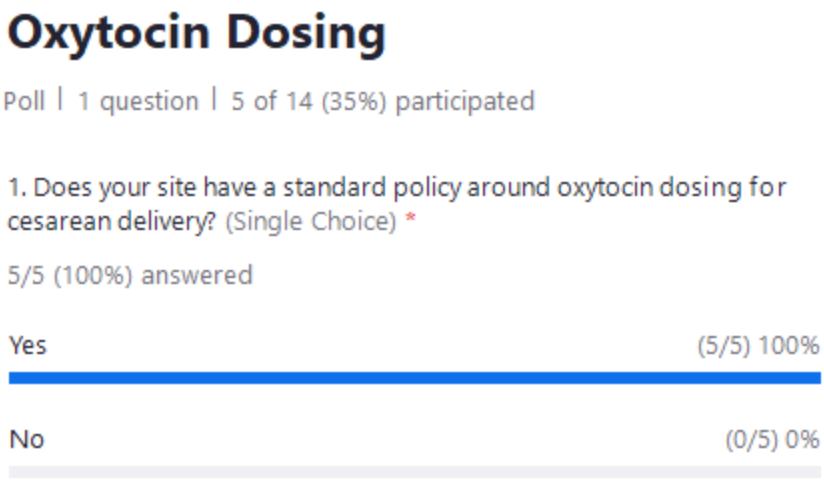
- GA 03-OB next steps- neuraxial and obstetric anesthesia type need some revisions before this is public on dashboards
    - Would the group like to move forward with this measure?
- **Discussion:**
    - Nirav Shah (MPOG QI Director): Lots of variation where half the sites are converting epidural cases to GA. Was that surprising? Are there places where you typically just convert to a GA immediately rather than converting the epidural to be used for the cesarean?
    - Melinda Mitchell (HFHS - Allegiance): Physicians previously were less hands on where CRNAs would start without their presence to get the baby out. We started leading an effort after joining MPOG to change the culture where if the epidural was working that the CRNAs would bolus the epidural and then proceed to GA at that point if needed which has lowered our numbers. I think its driven by the Obstetricians at each sites
        - Monica Servin (University of Michigan): for sites with lower number of C-sections with higher rates of GA conversions. Is that due to anesthesia providers being more comfortable with GA?
        - Kate Buehler (MPOG Clinical Program Manager): I hope some of this variation will improve a little. For example, a site that has 60% conversion with only a few c-section cases included. As our phenotypes are cleaned I'm confident we will improve this capture.
    - Do we want to move forward with building GA-03 measure and push to a dashboard?
        - Melinda Mitchell (HFHS-Allegiance): I think we should leave it in place because this measure had a positive impact on my practice
        - Brandon Togioka (OHSU): I like this measure. I thought our performance would've been higher but it wasn't. This is also a hot topic with SOAP currently.

Oxytocin

- Basecamp discussion July 2022:
    - post regarding oxytocin design at other sites for cesarean delivery.
    - range of practices reported on forum.

- Literature review:
    - Heesen, Carvalho, Duvekot- International consensus statement on the use of uterotonic agents during cesarean section.
    - Duffield, McKenzie, Carvalho- The effect of high rate vs low rate of oxytocin infusion for maintaining uterine contractility during elective cesarean

- MPOG coordinating center review:
    - 238 cesarean cases across 49 sites
    - No standard bolus amount found: 1-6 units found in documentation in MPOG
    - No standard infusion rate was found among sites
    - Does your site have a standard practice around oxytocin dosing for cesarean delivery?
      Poll Results:



Anesthetic Management of Cesarean Hysterectomy for Placenta Accreta Spectrum
Nicole Zanolli and Dr. Ashraf Habib

- Background
- Gaps
- Primary objective of study
- Secondary objective
- Study Design- retrospective cohort study
    - Inclusion criteria-
        - January 1, 2015- December 31, 2021
        - "Cesarean Hysterectomy" in OBAT phenotype
        - MPOG case reviewer to insure will manually reviewed

    - Exclusion criteria-
        - Patients <13 years of age
        - Length of procedure <15 minutes
        - Procedures occurring after cesarean hysterectomy

- Progress
    - completed single center review of PAS at Duke
    - received PCRC approval
    - Planning for individual case review
- **Discussion:**
    - Nirav Shah: You presented a primary and secondary analysis- are you planning to submit the descriptive analysis first as one paper and then a secondary paper based on outcomes based on different techniques?
        - Ashraf Habib: Not sure what we'll get based on the data but we do think we'll end up with two main projects. Will depend on how many instances we find within each group to know how to proceed.
        - Nirav: could narrow it down to the centers who perform the most cesarean hysterectomies first
        - Ashraf: Agree! There are many ways we slice this data- we are excited to see the results and begin our analysis. The benefit of MPOG is the rich intraoperative, minute-to-minute data from many centers.

Meeting End Time: 1354