Obstetric Anesthesia Subcommittee Minutes
February 26th, 2025
1:00-2:00 pm EST - Zoom

Attendees:

Sharon Abramovitz, Weill Cornell	Tiffany Malenfant, MPOG
Henrietta Addo, MPOG	Christine McKenzie, UNC
Nicole Barrios, MPOG	Mary McKinney, Corewell Health
Kate Buehler, MPOG	Chris Milliken, Sparrow
Meilou Calabio, MPOG	Kam Mirizzi, MPOG
Arthur Calimaran, Cleveland Clinic	Melinda Mitchell, Henry Ford
Johanna Cobb, Dartmouth	Katie O'Conor, Johns Hopkins
Laura Cohen, Massachusetts	Diana O'Dell, MPOG
Robert Coleman, MPOG	Rebecca Pantis, MPOG
Charity Corpus, Corewell Health	Jack Peace, Temple
Leanna Delhey, MPOG	Nirav Shah, MPOG
Kim Finch, Henry Ford	Shashank Shettar, Oklahoma
Jackie Goatley, Michigan	Frances Guida Smiatacz, MPOG
Ronald George, Sinai Health	Rachel Stumpf, MPOG
Josh Goldblatt, Henry Ford	Alexander Taylor, Trinity Health
Ashraf Habib, Duke	Brandon Togioka, OHSU
Jerri Heiter, Trinity Health	Pam Tyler, Corewell Health
Wandana Joshi, Dartmouth	Meridith Wade, MPOG
Jeremy Juang, UCSF	Jennifer Woodbury, UCSF
John Kowalczyk, Brigham & Women's	Joshua Younger, Health

- **Agenda:**
    - Announcements
    - December meeting recap
    - Days Before Delivery Phenotype update
    - OB Champion role discussion
    - ABX-06 measure released.
    - 2025 Goals

- **Announcements:**
  Future Meeting Dates
    - May 14th, 2025, at 1pm EST
    - September 3, 2025, at 1pm EST
    - December 3, 2025, at 1pm EST

- **In the News**
  - Reported incidence of pain during cesarean delivery is approximately 15-23%.
  - Adverse outcomes:
    - PPD
    - PTSD
    - Chronic pain

- **December Meeting Recap**
    - **OB Patient Blood Management Toolkit** now available! Adapt as needed to share this educational resource with your department.
    - **OB PCRC update:** All OB Subcommittee members from active MPOG sites will be invited to Perioperative Clinical Research Committee (PCRC) meetings when obstetric anesthesia research projects are proposed. Attendance is optional.
    - **GA-01-OB:** General Anesthesia During Cesarean Delivery will remain an informational measure with no threshold to define 'success.'
    - **SOAP/OB Subcommittee**: Support overall alignment with SOAP Centers of Excellence (COE)
    - **TXA measure**- Subcommittee voted against building TXA measure – percentage of cases with TXA administered with EBL > 1000 ml.
    - **Transfusion ≥ 4 units blood products measure**- Subcommittee voted against building measure to assess percentage of cases with transfusion of ≥ 4 units of any blood products.

- **Pregnancy Phenotype: Days Before Delivery Update**
    - **Description-** the Days Before Delivery phenotype will be used to determine the days before delivery using our Obstetric Anesthesia Type (OBAT) Phenotype to determine if a patient had a delivery in MPOG within 42 weeks of an OBAT procedure.
    - **Phase I**- Once this is developed, we will develop phase II which will be more sensitive for pregnant patients.
    - **Enumerations**:
        - 0= No delivery found in MPOG
        - 1= Delivery found in MPOG within 42 weeks of procedure
        - 2= Delivery found in MPOG more than 43 weeks before procedure
        - 3= Delivery found in MPOG after 42 weeks

- **Limitation**
    - *This phenotype relies on the MPOG Obstetric Anesthesia Type Phenotype which has limitations due to predicted or actual CPT codes and accurate procedure text documentation. Additionally, if a delivery is performed outside an MPOG institution, or if that delivery is a vaginal delivery with no labor epidural that information will not be available.*
- **Discussion**: Group shared that a new enumeration would help best identify labor epidural/delivery cases. Workgroup will meet one last time before moving this phenotype to prod.
    - Nicole will schedule follow up meeting with phenotype work group before this goes to PROD.

- **OB Champion Role Description**

  Role Summary
    - Each participating site that provides obstetric anesthesia care is encouraged to select an Obstetrics (OB) Champion to participate on the MPOG OB Subcommittee.
    - The primary role of an OB Champion is to understand and use MPOG tools and data to improve anesthesia care for laboring mothers.
    - The OB Champion can work alongside their MPOG Quality Champion to implement local QI initiatives supported by MPOG data.

- **OB Subcommittee Member vs. Champion**

MPOG OB Anesthesia Champion	MPOG OB Subcommittee Member
Obstetric anesthesiologist (Does not need to be OB fellowship trained)	OB anesthesia provider, administrator, or QI leader interested in participating in MPOG OB Subcommittee
Votes on behalf of site at OB Subcommittee meetings	Serves as backup to champion for OB Subcommittee votes
Attends MPOG OB Subcommittee meetings	
Conducts measure reviews	

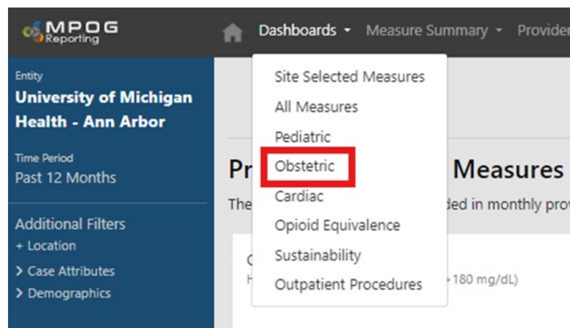
- **Sites without a named MPOG OB Champion:**
    - American University of Beirut Medical Center
    - Atrium Health (Wake Forest)
    - Columbia University
    - Corewell Health: all except Butterworth
    - Holland Hospital
    - University of Maryland
    - Massachusetts General Hospital
    - Michigan Medicine
    - MyMichigan - all sites

- Nebraska
- NYU Langone Medical Center
- Temple University Hospital
- University of Alabama
- University of Arkansas
- UCLA
- University of Chicago
- University of Florida
- University of Wisconsin
- University of Tennessee
- UT Southwestern
- Vanderbilt University

- **Departmental Dashboard Access**
    - Subspecialty dashboard access (Obstetrics, Pediatrics and Cardiac) was removed in December 2024.
    - Many OB Champions and ACQRs have full departmental dashboard access and may not have noticed a change in access.
    - If you have noticed a change in access, please reach out to your Quality Champion and Nicole and we can help get access re-established.

- **OB Champion Key Responsibilities**

- **Review Performance Data**
    - MPOG reviews/provides ongoing measure performance data via reports, dashboards, and collaborative meetings.
    - OB Champions can review case data using several different tools:
        - QI Reporting Tool
        - Measure Case Report
        - DataDirect
    - If interested, please contact Nicole to learn more.



- ABX-06-OB -**Azithromycin Administration for Non-Elective Cesarean Deliveries**
    - **Description**: Percentage of standalone cesarean deliveries in which azithromycin was administered 60 minutes before surgical incision
    - **Inclusion**: Enumerations 1 and 7 using OBAT (Non-elective cesarean cases.)
        1- Conversion (Labor epidural and cesarean delivery charted under one case ID)

7- Conversion (cesarean delivery portion, labor epidural documented on another case ID)

- **Exclusion**: 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)
- Cases with Chorioamnionitis ICD codes: O41.12-O41.1299

- **MPOG OB Subcommittee 2025 Goals**
  - **GA rate for all cesarean deliveries**
    - Available as MPOG metric: GA-01-General Anesthesia During Cesarean Deliveries
  - **GA rate for unscheduled cesarean deliveries**
    - Can be estimated from MPOG metric GA-02
    - MPOG metric GA-02 (% of CD cases where GA was administered after neuraxial labor analgesia)
    - Would miss unscheduled CD not proceed by NA
  - **GA rate for scheduled cesarean deliveries**
    - Can be estimated from MPOG metric GA-01 – OBAT enumeration #2
    - OBAT enumeration #2 (CD without preceding NA)
  - **Epidural replacement rate**
    - MPOG measure does not exist
    - We could review the data, may be possible to create
  - **Percentage of laboring patients receiving neuraxial labor analgesia**
    - Unable to estimate due to lack of data on patients that deliver without neuraxial labor analgesia.
  - **PDPH rate & Epidural blood patch rate for PDPH**
    - Difficult to estimate due to lack of data on conservatively treated PDPH.
  - **Accidental dural puncture rate**
    - MPOG measure does not exist.
    - Measure would always underestimate true rate.
  - Discussion-*Brandon Togioka (OHSU, Chair):* Looking at the GA measures, I have a question for the group. We could try to create a different measure to assess the rate of GA for scheduled and unscheduled cesarean deliveries by including a time component. It is not perfect, but most scheduled extend delivers will occur between 7 A.M 5 PM, we could potentially do that -is that of interest to the group?
  - *Ashraf Habib (Duke)*: Just a question related to scheduled vs unscheduled cesareans. It is a designation, at least in my institution for the C-section, whether it is scheduled or unscheduled- I wonder whether this would be available in the Epic chart to indicate the leveling or the nature of this of this cesarean that we can use for measure.
  - *Brandon Togioka (OHSU, Chair):* That is a great idea. Could just send us a screenshot of how that is coded in your system, perhaps we can look and see if we can find something similar to other institutions.

- **New Measure Development Discussion**
  1. **Epidural replacement measure**: Proportion of patients that require a second neuraxial procedure prior to delivery.
  2. **Temp measure**: Proportion of patients undergoing cesarean delivery with at least one core body temperature measured.
  3. **Pain Measure**: Two options for pain measures.
     a. **Multimodal**: PAIN- Proportion of patients administered at least two non-opioid adjuncts preoperatively or intraoperatively (multimodal)
     b. **Inadequate pain control**: Proportion of patients undergoing cesarean delivery with inadequate anesthesia (supplemental analgesia)
  4. **Accidental dural puncture measure**: Proportion of patients receiving neuraxial labor analgesia with an unintentional dural puncture.

- **Epidural Replacement Rate**
  - SOAP COE core metric for neuraxial labor analgesia
  - Longstanding interest in this measure on the OB subcommittee
  - Methods to capture replacement:
    - Two neuraxial procedure notes in a single record or admission
    - Two timestamps for "neuraxial procedure start" or "end"
    - Medications administered?
    - Free text search, challenging
    - Other ideas?
  - Questions:
    - How do you document neuraxial procedures?
    - For a CSE or DPE, do you document two procedure notes?
    - Should there be a time threshold?

  Discussion:

  - *Brandon Togioka (OHSU, Chair):* We thought of a few methods to capture the replacement rate. We could look for several things like more than one neuraxial procedure note in a single record, time stamps for numerical procedure, start or end. We could look for certain medications, such as a test dose. Free text is challenging, that perhaps could be like a fourth or fifth option. If we cannot find the other ones, and then perhaps other ideas that we have not thought of. All of you are very bright, and we will think of things that we did not. question here for the group? How do you all document neuraxial procedures? How feasible do you all think this is?
    - *Wandana Joshi (Dartmouth, Vice Chair):* The one comment I wanted to make is and I welcome feedback from everybody, but most people tend to write a second note. If you see two notes for labor analgesia within one encounter that that probably means that that patient had an epidural replacement rate. As opposed to someone who may have had a repeat like went to cesarean delivery and had a repeat.
    - *Ashraf Habib (Duke):* We use two neuraxial procedure notes. We have the neuraxial procedure. Note for every, for every interaction procedure. So, this is the way we are doing it at Duke we are finding two procedure notes w/in the same record.
    - *John Kowalczyk (Brigham and Women's):* Looking at procedure notes would be a really great way to capture it. Most people are probably doing new

procedure notes for all of the procedures. That is certainly what we do here. Typically, what I have done at other places as well. I would imagine that would be in a great way to capture it as a high reliability high fidelity way.

- *Brandon (OHSU, Chair):* Christine and Laura had great comments in the chat. Christine is also looking at procedure notes. Laura says, they have, something great that is built on their institution, which we do not have that asks if it is a replacement epidural, and perhaps it's and probably easier to identify if there is a second note. Another question for the group- we built a CSE note and it took years to then build a DPE note, and we have people putting in dual spinal notes without any medication administered with an epidural. I am wondering how others document procedure notes.
- *Ashraf Habib (Duke):* We have two types of procedure notes- an epidural note and a CSE/DPE note. Within the CSE/DPE note we have a mandatory field to indicate whether this was a CSE or a DPE. We can tease out which technique was used between the two.
- *John Kowalczyk (Brigham and Women's):* We have a similar thing. We have an epidural note that splits epidural and DPE, and then a separate CSE note, slight variation on the same theme.
- *Ron George (Mt. Sinai, Toronto via Chat):* Will we capture replacements in the OR?
  - *Brandon (OHSU, Chair)*: We could possibly capture any replacements, what about 20 minutes after the first placement?
  - *John Kowalczyk (Brigham and Women's)*: I think that is very reasonable time frame.
- *Christine McKenzie (UNC):* Just a quick point if we were looking at the entire hospitalization, could we set the delivery time as the end time so that you are only looking for procedures before that. Just in case, you know, people are doing another neuraxial for, DNC, or a tubal?
  - *Brandon Togioka (OHSU, Chair):* Excellent point. Thank you. Okay, any other thoughts? We will go on to the next slide then.

- **Core Body Temperature**
  - Proportion of patients undergoing cesarean delivery with at least one core body temperature measured.
    - SOAP COE measure
    - TEMP-02: Percentage of patients receiving GA that have at least one core body temperature documented.
      - Measure time period: "anesthesia start" to "out of room"
      - Excludes cases < 30 minutes
      - Threshold for success, > 90%
  - Questions:
    - Modify to include all CD patients (NA+GA)?
    - Does this impact patient outcomes?
    - How do you measure temperature?

  - Discussion:
  - *Brandon Togioka (OHSU, Chair)*: Core Body Temperature- percentage of patients that have at least one core body temperature documented. We know that hypothermia is

associated with multiple issues, including impaired wound healing, adverse cardiac events impaired drug metabolism and at the extremes it can prolong length of stay and increased cost of hospitalization. The question here is -is this something of interest to the group? Should we create a specific measure for interoperative temperature?
  - *Wandana Joshi (Dartmouth, Vice-Chair*): I am not overly enthusiastic about this measure, but I think it is worth looking into. Temperature is not routinely measured during neuraxial anesthesia due lack of equipment or cost.
- *Brandon Togioka (OHSU, Chair)*: Great comment. I will say, the skin and temporal artery measurements do not count in Temp-02, which is the current Core monitoring MPOG measure. We do not measure this either on admission to PACU and we would do poorly on this measure. Does anyone feel strongly that this is important?
  - *Josh Younger (Northwell):* Do we know how impactful this is, in this population? Not knowing the literature off hand here, but I know that we're presuming that infection rates are increased with this, but do we know how much we expect the temperature to decrease in a surgery that takes anywhere from, you know, one to two hours on average in this this population
  - *Ashraf Habib (Duke):* It is potentially very important, there was a study from South African group a few years ago and they measured the temperature over eight hours, and the results were striking. Many of the patients' temperatures remained low for quite some time after surgery. Active warming was not incorporated routinely in this study it suggesting it is important and probably impactful.
  - *Brandon Togioka (OHSU, Chair)*: Thank you for that comment. Did anyone else have other thoughts on this were nearing the end. We have a few more measures to go through, and we will start within our next meeting. To get good feedback. The most important part of this meeting is to have these collaborative discussions because there's so much shared knowledge. Nicole, just briefly skip to the very end where we have the measure, build reliability, effort, graph just to give a preview of what we will vote on next time.
- *Brandon Togioka (OHSU, Chair)*: We will go through these last comments before we end. I want to be considerate of everyone's time. In terms of when we think about building these measures, there is obviously measures that people are excited about because it makes a big difference, but some of these are difficult to build. Some are easy to build with high reliability, but maybe not as interesting. So, we tried to chart them based on effort.
- *Brandon Togioka (OHSU, Chair)*: Thank you all very much for being here. I really appreciate you all. It is very exciting to see so much interest in OB quality.

Meeting concluded: 2:01pm