# Obstetric Anesthesia Subcommittee Minutes

**October 20, 2020**

**1:00-2:00pm EST**

**Zoom**

| | | | |
|---|---|---|---|
| X | Sharon Abramovitz, Weill Cornell | | Arvind Palanisamy, Washington University |
| | Ami Attali, Henry Ford- Detroit | | Carlo Pancaro, Michigan Medicine |
| X | Dan Biggs, University of Oklahoma | | Mohamed Tiouririne, University of Virginia |
| | David Swastek, St. Joseph Mercy Ann Arbor | X | Brandon Togioka, Oregon Health Science University |
| | Eric Davies, St. Joseph Mercy Oakland | X | Joshua Younger, Henry Ford, Detroit |
| X | Ghislaine Echevarria, NYU Langone | | Marie-Louise Meng, Duke |
| X | Ronald George, University of California- San Francisco | X | Christine Warrick, University of Utah |
| | Jenifer Henderson, St. Joseph Oakland | | Ashraf Habib, Duke |
| X | Rachel Kacmar, University of Colorado | X | Tom Klumpner, Michigan Medicine |
| | Joanna Kountanis, Michigan Medicine | X | Nirav Shah, ASPIRE Director |
| X | Carlos Delgado Upegui, University of Washington | X | Kate Buehler, MPOG Clinical Program Manager |
| | Stephanie Lim, University of California- San Francisco | X | Meridith Bailey, MPOG QI Coordinator |
| X | Wandana Joshi, Dartmouth University | X | Brooke Szymanski, MPOG QI Coordinator |
| X | Angel Martino, Sparrow Health System | | |
| X | Antonio Gonzalez, Yale | | |

1. **Announcements**
    a. Please update Zoom name with your name so others can get to know you
    b. 2021 Meeting Dates
        i. February 3, 2021 1-2pm EST
        ii. May 5, 20201 1-2pm EST
        iii. August 4, 2021 1-2pm EST
        iv. November 3, 2021 1-2pm EST
    c. Basecamp Forum: please email coordinating center if you are no on the OB Basecamp Forum
2. **OB Specialty Dashboard (see slides for screenshots)**
    a. Available via 'Dashboard Beta' link on mpog.org
    b. Replaces existing QI Dashboard and allows us the opportunity to build subspecialty dashboards to support the subcommittee efforts; supported fully by MPOG- no longer supported by an outside vendor
    c. Obstetric subspecialty dashboard: Auto-filtered to obstetric cases and includes OB-specific measures
    d. Additional filters available for location, age, gender, race/ethnicity, time period

e. Data reflects performance for only the OB population on the subspecialty OB dashboard

3. **July 2020 Meeting Recap and Follow-up**
   a. AKI 01: Postoperative AKI
      i. Interest in tracking patients with severe pre-eclampsia
      ii. Added a new column on the measure case report tool and a new row to the web case viewer to identify patients with severe pre-eclampsia
      iii. Let us know if there are any issues with false flagging cases with pre-eclampsia or any cases that may have been missed with the diagnosis code
   b. BP 04 Hypotension during Cesarean Delivery measure discussed
      i. Include pre-eclampsia and HELLP syndrome patients in the measure
      ii. Flag cases with SBP<90mmHg for >5 minutes for all patients (pre-eclampsia, HELLP included)
      iii. Include scheduled and conversion cases
      iv. Include urgent and emergent cesarean deliveries
      v. Use oxytocin administration start time (bolus or infusion) if neonate delivery time is not available
4. **BP 04: Prolonged Hypotension Measure Update**
   a. Still in development
      i. Complex phenotype development that will support future OB measure development:
         1. OB Anesthesia Start
         2. Neuraxial start Time
         3. Cesarean Delivery start time
      ii. Please provide any feedback regarding the measure not performing as expected once it is released. This feedback is used to refine the phenotypes further for improved accuracy.
   b. See slides for preliminary performance scores by site (anonymized)
   c. BP 04 Exclusions:
      i. Cesarean delivery patients undergoing general anesthesia- determined using Anesthesia Technique- neuraxial phenotype
      ii. Patients undergoing cesarean section with hysterectomy (CPT: 01969)
      iii. Emergency cesarean delivery with diagnosis of placental abruption (ICD-10: O45*)
      iv. Rupture of uterus (spontaneous) before onset of labor (ICD-10: O71.0)
      v. Newborn affected by intrauterine blood loss from ruptured cord (ICD-10: P50.1)
      vi. **Abnormal uterine or vaginal bleeding, unspecified (ICD-10: N93.9)**
         1. Should we keep this exclusion? Measure examines codes with a date 30 days before day of surgery to 7 days after
      vii. Placenta previa with hemorrhage, third trimester (ICD-10: O44.13)
      viii. Hemorrhage from placenta previa, antepartum condition or complication (ICD-10: 641.13)
      ix. Hemorrhage from placenta previa, delivered, with or without mention of antepartum condition (ICD-10: 641.11)
   d. BP 04 Exclusion Discussion:
      i. *Josh Younger (Henry Ford-Detroit)*: Is placenta percreta or placenta accreta included in the exclusion criteria? Those should be excluded.
      ii. *Christine Warrick (University of Utah)*: Typically, hypotension occurs after delivery with those conditions. I would feel comfortable including them as we can control blood pressure during the case itself.
      iii. *Tom Klumpner (Michigan Medicine)*: Would agree- those are usually an issue after delivery.

        iv. *Nirav Shah (ASPIRE Director)*: Not currently excluded but we can examine those CPT codes and exclude those later if the subcommittee determines that to be appropriate.
        v. *Angel Martino Horral (Sparrow):* Is there a code for rupture of uterus after the onset of labor, or only before onset of labor as listed?
        vi. *Nirav Shah (ASPIRE Director):* We will need to look through the code and see if there is a more applicable code
    e. Will post to forum if more questions arise during the measure validation process
    f. Plan is to release in the next month- will post to forum when available for review
    g. Discussion:
        i. *Brandon Togioka (OHSU)*: Would be nice to see breakdown by number of minutes of hypotension as well as the time from neuraxial placement to delivery
            1. *Kate Buehler (MPOG)*: Case list does show number of minutes of hypotension currently so reviewers will be able to filter on that column to review cases with longer time periods of hypotension compared to shorter periods
        ii. *Sharon Abramovitz (Weill Cornell)*: Has anyone else had to change their practice due to Joint Commission policies to not hang phenylephrine before the case in preparation for emergencies?
        iii. *Brandon Togioka (OHSU)*: Also had issues with that in the past- moved to pre-filled syringes of phenylephrine
        iv. *Rachel Kacmar (University of Colorado)*: Same at Colorado, we've move to using pre-made syringes of 10mL of phenylephrine which is enough to treat initial hypotension before getting a drip started
        v. *Nirav Shah (ASPIRE Director)*: Once this measure is released, the dashboard scores will allow us to review historical data (at least 12 months) to identify practice changes due to Joint Commission recommendation to not hang phenylephrine in advance of the case

5. **GA 01 General Anesthesia for Cesarean Delivery Measure**
    a. High interest in this measure topic with the call for measures survey that was sent out in December 2019
    b. Should this be the next measure the OB Subcommittee creates?
    c. Around 7% of cesarean deliveries in MPOG have general anesthesia
        i. According to SOAP, <5% of cesarean deliveries in US use general anesthesia
        ii. Hand review of cases have around 18% with a discernable reason for GA in a free text note- would need to standardize documentation in order to capture reason for GA consistently in MPOG
        iii. Most sites in MPOG show 0-10 GA cases for cesarean delivery per month over the last year- individual case review of the few cases/month could help identify trends for reason for conversion to GA
        iv. See slides for preliminary data for GA conversion rates across MPOG sites (anonymized)
    d. Discussion:
        i. *Josh Younger (Henry Ford-Detroit)*: Not a good clinical explanation but one reason for GA conversion may simply be that there isn't enough time to get neuraxial placed
        ii. *Angel Martino-Horrall (Sparrow)*: Are we aiming to look at the variation across sites and compare scores of general anesthesia rates or are we focusing on the reason for conversion?

            1. *Nirav Shah (ASPIRE Director):* I think sites are interested in identifying the reason for GA at their institution and seeing if there are any interventions to reduce conversion rate
    iii. *Ron George (UCSF)*: We have been working on this for a while at UCSF as our rate is approximately 12%. We created three different buckets for reasons for conversion to GA so we can track this better. The reasons we developed for documenting these conversion reasons in Epic are:
        1. Patient comorbidities
        2. Failure of regional technique
        3. Failure to use regional technique due to timing
    iv. *Wandana Joshi (Dartmouth*): We are interested in this measure too. Are other sites looking at DPE rates?
    v. *Angel Martino-Horrall (Sparrow)*: We trialed the DPE technique at our institution for a while and it did not make a difference in failure rate or quality of the block. We are not a training institution though, so the majority of our providers are experienced providers
    vi. *Ron George (UCSF):* We use a fair amount of CSE (60%) and DPE (40%) and they all fail ☺
    vii. *Christine Warrick (University of Utah)*: A recent abstract presented at ASA by the University of Chicago showed a 15% decrease in c-section conversion rate to GA in morbidly obese patients when using DPE compared to CSE.
    viii. *Nirav Shah (MPOG Director)*: We have a need for standardization of documentation around reasons for conversion to GA. If others can share screenshots of their build, we can work with Epic to share the code and try to standardize the documentation
    ix. *Joshua Younger (Henry Ford Detroit):* Some of the issues may be coming from not enough frequent rounding on the floor to assess the epidural. If you have a method of documenting that you checked in with the patient and checked the level, you may be able to better find epidurals that stopped working a few hours prior. I would like to see some sort of measure to see how often we are checking in on the labor floor
    x. *Ron George (UCSF):* Trying to implement assessment of epidural within the first hour of placement to determine efficacy of block; looking to document: pain with contraction, Dermatome block right/left, an original bromage scale right and left
    xi. *Antonio Gonzalez (Yale):* When we look at failed epidural catheters for c-sections, looking at how many boluses the patient got and how comfortable the patient was after block was placed. If the patient got more than 3 or 4 boluses, we assess the record to see if we missed something with the patient care. The epidural likely should have been replaced. For GA, another benchmark should be looking at elective c-sections (which should have a much lower rate) compared to general anesthesia for urgent or emergent cases.
    xii. *Carlos Delgado (University of Washington):* At UW, we have stipulated q2h rounding for epidurals – gets tough if you have a busy floor, but it's doable; and catheter replacement if >2 boluses
  e. Will post to the ASPIRE forum as we continue to develop this measure. Some questions we have currently:
    i. Exclude cesarean deliveries with hysterectomy?
    ii. Exclude cesarean deliveries with other procedures list
    iii. Which providers should be notified/listed in associated with the case?

6. **Plans for 2021**
  a. General subcommittee feedback
  b. Call for measures survey 2021

**Meeting adjourned at 1400**