Obstetric Anesthesia Subcommittee Minutes

February 3, 2021

1:00-2:00pm EST - Zoom

	First Name	Last Name	Institution
X	Sharon	Abramovitz	Weill-Cornell
X	Aymen	Alian	Yale
	Ami	Attali	Henry Ford-Detroit
X	Dan	Biggs	University of Oklahoma
	Traci	Coffman	St. Joseph Ann Arbor
	Eric	Davies	Henry Ford- Allegiance
	Carlos	Delgado Upegui	University of Washington
	Ghislaine	Echevarria	NYU
X	Ronald	George	UCSF
X	Antonio	Gonzalez-Fiol	Yale
	Ashraf	Habib	Duke
	Jenifer	Henderson	St. Joseph Oakland
X	Wandana	Joshi	Dartmouth
X	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
	Marie-Louise	Meng	Duke
	Arvind	Palanisamy	WashU
	Carlo	Pancaro	University of Michigan
X	Monica	Servin	University of Michigan
	David	Swastek	St. Joseph Ann Arbor
	Mohamed	Tiouririne	UVa
X	Brandon	Togioka	OHSU
	Christine	Warrick	University of Utah
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	Brooke	Szymanski-Bogart	MPOG QI Coordinator (OB program lead)

1. **Announcements**
    a. 2021 Meeting Dates
        i. May 5, 20201 1-2pm EST
        ii. August 4, 2021 1-2pm EST
        iii. November 3, 2021 1-2pm EST
    b. Obstetric Anesthesia Type phenotype completed!
        i. Is able to identify scheduled cesarean delivery cases vs. labor epidural vs. conversion cases
2. **October 2020 Meeting Recap and Follow-up**
    a. BP 04 Prolonged hypotension measure update and discussion
    b. GA 01 General Anesthesia for Cesarean Delivery Measure
        i. Unable to capture reason for GA in MPOG Data
        ii. Will require review at the local level
        iii. Number of cases per month is small for review
    c. OB Dashboard released: Please reach out with feedback
        i. Steps to access OB Departmental Dashboard
            1. Change entity in upper left corner to your own institution
            2. Choose 'Dashboards' then 'Obstetric' from banner along the top
        ii. *Wandana Joshi (Dartmouth):* What OB specific measures are included on the dashboard currently? Is it just ABX 01 currently or is the blood pressure measure also available?
            1. *Brooke Szymanski-Bogart (MPOG):* Just ABX 01 currently but BP04 should be available in the next couple of weeks after we finish validating
3. **ABX 01 Provider Attribution Discussion**
    a. ABX 01: Percentage of cesarean deliveries with documentation of antibiotic administration initiated within one hour before surgical incision
    b. Currently does not have provider attribution
    c. Which providers should be notified/listed in association with the case (if any)?
        i. *Angel Martino-Horrall (Beaumont Health System)*: Think it would be nice to add provider attribution to this existing measure as long as we can also still see departmental performance
            1. *Nirav Shah (MPOG Quality Director)*: Yes, will still be able to see departmental performance for this measure on the dashboard in addition to individual provide performance
        ii. *Wandana Joshi (Dartmouth)*: Our institution used to get data by provider for P4P measures and it reminds providers where they are on the spectrum in practice/performance. Really only valuable at the provider level.
        iii. *Aymen Alian (Yale)*: Should add provider attribution; in our institution, we share this information with providers to motivate them to improve to be in line with their peers
        iv. *Brandon Togioka (OHSU)*: Agree with adding provider attribution
        v. *Monica Servin (Michigan Medicine)*: Does ABX 01 account for emergency cases?
            1. Kate Buehler (MPOG): Yes- looks for an antibiotic to be administered within one hour before incision through anesthesia end for emergency cases
4. **BP 04 Prelim Data Review**
    a. Final validation in progress
    b. Current performance shows little variance in scores with all sites performing between 90-100%.

i. Subcommittee Discussion: Wonder if this is accurate- score seem too high
ii. *Brandon Togioka (OHSU)*: Is this measure looking at 5 minutes of hypotension as the thresold?
    1. *Brooke Szymanski-Bogart (MPOG)*: That's correct.
iii. *Brandon Togioka (OHSU)*: What is the average time before neuraxial start? These scores look too high to me
    1. *Brooke Szymanski-Bogart (MPOG)*: I will look into it with my next round of case review and post to the forum
iv. *Wandana Yoshi (Dartmouth)*: I wonder how many centers are using prophylactic phenylephrine infusion after the spinal
    1. *Sharon Abramovitz (Weill-Cornell)*: All elective cases are hanging prophylactic phenylephrine infusion at our institution
v. *Aymen Alian (Yale)*: Consider monitoring gaps in blood pressure or duration of minutes of continuous hypotension. We sometimes just do BP measurements manually
    1. *Nirav Shah (MPOG Quality Director):* If you do BP manually do you put it into Epic?
    2. *Aymen Alian (Yale):* Yes, we manually put it into EPIC and note that it is manual because of 'shivering issue'

c. BP 04 will be available on departmental level OB Dashboards soon!

5. GA 01 Measure spec discussion

a. Description: Percentage of cesarean delivery cases where general anesthesia was used
b. Measure Time Period: Anesthesia Start to Anesthesia End
c. Inclusions: All cesarean delivery cases (scheduled or conversion)
d. Exclusions:
    i. Cesarean hysterectomies – Keep exclusion?
    ii. Non-cesarean delivery cases
    iii. Add any more exclusions?
    iv. *Brandon Togioka (OHSU):* Any coagulopathy exclusions yet based on platelet count?
        1. *Nirav Shah (MPOG Quality Director)*: Not currently but we could add this. Could add platelet count to the measure case report details to allow review
        2. *Ron George (UCSF):* Wouldn't exclude those patients but would want to know which patients had coagulopathies: neuraxial anesthesia was contraindicated and therefore defaulted to general
        3. *Nirav Shah (MPOG Quality Director):* Could standardize approach for documenting reason for conversion to GA if this group is interested in drafting those recommendations. Cycle time to get these changes implemented could take some time but in the end, could help with allowing MPOG to capture and measure the reason for conversion to GA
            a. *Ron George (UCSF)*: Our IT team is working on this now. Could share with this group when finalized. A lot of it stems from institutions where you're using the same LD encounter for cesarean delivery and that the anesthesia type isn't clarified. Putting a stop in the record to ensure you've documented the anesthetic type would help with capturing this data.
            b. *Angel Martino-Horrall (Beaumont Health System)*: Agree would be really interesting because under that you would have to choose anesthesia types. I'm very interested in that if you could share data on how you did that with your IT team. Converting to

an epidural to GA due to failed epidural would be helpful. I thought that was our original goal with this measure?

c. *Nirav Shah (MPOG Director)*: We cannot tease that out from the MPOG data currently. We can determine if a GA was performed but figuring out WHY is harder. It's not documented in a standardized way currently which is why we can't create this measure yet.

4. *Wandana Joshi (Dartmouth):* Looking at this topic came from my interest in SOAP centers of OB excellence. They differentiate between primary cesarean deliveries and those converted to general. What we should capture is those as a result of failed epidural. What I'm hearing is that we need to standardize this with Epic or the anesthesia record at sites to be able to capture this reason.
    a. *Nirav Shah (MPOG Director):* That is correct. Sounds like the work at UCSF may be able to help us here.
5. *Ron George (UCSF):* That will be part of the data that we capture. The reminder that if you do change anesthetic types that will pop up to identify that. Part of an ongoing process so patients can see 1 hr within the epidural what the primary reason was for failure and ongoing assessment tool. Just rolled out this month. Cesarean hysterectomies would be excluded but what about those that do not get a hysterectomy? Occasionally we all have imaging that points in the wrong direction, administer general anesthesia and the placenta ends up falling out and patient keeps their uterus
    a. *Nirav Shah (MPOG Quality Director):* We may be able to figure that out with billing codes
6. *Kate Buehler (MPOG)*: This measure will filter down to those that were converted to a general (scheduled or conversion). Up to sites to do manual review of those cases and decide what areas to focus on for improvement. Agree- somewhat of a clunky, manual process right now because we don't have standardized documentation across sites but is a good place to start until we can create a more refined measure in the future

v. *Wandana Yoshi (Dartmouth):* How do you tease out if the case was a GA?
vi. *Brooke Szymanski-Bogart (MPOG):* Identified using our GA phenotype which specifically looks at airway placement + inhalational gas administered + paralytics.

e. Success: Cesarean delivery completed without use of general anesthesia
f. Responsible Provider: Which providers should be notified/listed in association with the case?
g. Threshold: Should a success threshold be added to this measure?

6. 2021 Planning Survey Results and Next Steps

a. 9 responses – Thank you!
b. Interest from the committee for measures on these topics:
    i. PONV in PACU following cesarean delivery (67% very important)
    ii. PONV Prevention (antiemetics administered)
    iii. First temp in PACU following cesarean delivery (56% very important)
    iv. Non-opioid adjunct for cesarean delivery (44% very important; 33% extremely important)
    v. Several write-in measures also added (See slide 12 for topics suggested)

c. Several suggested measure topics align well with SOAP ERAC elements:
    i. PONV (Prevention or in PACU)
        1. *Sharon Abramovitz (Weill-Cornell)*: We have an ERAC protocol but I don't think it mentions in there when to give an antiemetic in relation to when the baby is born. Do most sites wait until delivery to administer ondansetron or given at the beginning of the surgery? When do other centers administer ondansetron and dexamethasone?
            a. *Wandana Yoshi (Dartmouth)*: We give at the beginning of surgery
            b. *Monica Servin (Michigan Medicine)*: We give both ondansetron and dexamethasone at the beginning of the case at Michigan Medicine
            c. *Brandon Togioka (OHSU)*: Not standardized- do give two agents but just depends on when provider decides to administer
            d. *Dan Biggs (University of Oklahoma)*: Give ondansetron in preop with azithromycin
            e. *Ron George (UCSF)*: Give metoclopramide preop and ondansetron after the case
    ii. First temp in PACU following cesarean delivery: Could be modification of TEMP 03 (Existing adult MPOG measure) or could create a new TEMP 05 (OB) measure that includes cesarean delivery; current measure excludes cases less than 60 minutes in length
    iii. Non-opioid adjunct for cesarean delivery
d. **Existing related MPOG measures include:**
    i. TEMP 01: Percentage of cases that active warming was administered by the anesthesia provider
        1. Cesarean deliveries are included
        2. Labor epidurals are excluded
        3. Success: documentation of an active warming device (including fluid warmer for CD) OR temp ≥ 36.0 within 30 minutes before case end
    ii. TEMP 02: Percentage of cases with at least one core temp documented intraoperatively for any patient receiving a general anesthetic
        1. Cesarean deliveries included, but this measure is limited to only those that received general anesthesia
        2. Cases <= 30 minutes are excluded
        3. *Ayman Alian (Yale)*: What kind of temp probe are you using: bladder, cutaneous, axillary, in epidural/spinal CD cases?
            a. *Brandon Togioka (OHSU)*: All labor epidurals and cesarean deliveries are going to start using foley catheter probes moving forward – should improve our temp outcomes
            b. *Angel Martino-Horrall (Beaumont Health System)*: Are skin temps excluded or do they fail for TEMP 03?
            c. *Nirav Shah (MPOG Quality Director)*: Will need to check measure spec again but I don't believe skin temps are included for the current temperature outcome measure
            d. *Correction*: Skin temps are reviewed for TEMP 03 and if the temperature is >36.0 degrees Celsius during the measure time period, the case will pass. Spec is available here.

iii. TEMP 03: The percentage of cases with hypothermia (< 36) within 30 minutes before or 15 minutes after anesthesia end
    1. Limited to cases >60 minutes in duration
    2. Excludes labor epidurals and labor epidurals converted to cesarean deliveries
iv. PONV 01- The percentage of cases with appropriate antiemetic administration for postoperative nausea and vomiting prophylaxis
    1. Inclusions: patients receiving inhalational general anesthesia with three or more risk factors for PONV
    2. Include cesarean deliveries, but is limited to only those that received inhalational general anesthesia
v. PONV 03- Percentage of patients who undergo a procedure and have a documented nausea/emesis occurrence OR receive a rescue antiemetic in the immediate postoperative period.
    1. Includes cesarean deliveries
    2. Excludes labor epidurals
    3. Modifications for OB?
vi. Which measure is the top priority for development in 2021?
    1. "PONV 04- OB" PONV in PACU
        a. Include antiemetic administration as criteria for flag?
        b. Merge into PONV 03?
vii. "PAIN 02 – OB" Multimodal analgesia for cesarean deliveries

Meeting adjourned at 1406