Obstetric Anesthesia Subcommittee Minutes
September 10th, 2025
1:00-2:00 pm EST - Zoom

Attendees:

Sharon Abramovitz, Weill Cornell	Michael McDonald, University of Chicago
Kate Buehler, MPOG	Christine McKenzie, UNC
Arthur Calimaran, Cleveland Clinic	Mary McKinney, Corewell Health
Ruth Cassidy, MPOG	Christopher Milliken, Sparrow Health
Johanna Cobb, Dartmouth	Kam Mirizzi, MPOG
Rob Coleman, MPOG	Melinda Mitchell, Henry Ford Health
Leanna Delhey, MPOG	Katie O'Conor, Johns Hopkins
Heather Dobbs, Bronson Health	Diana O'Dell, MPOG
Kim Finch, Henry Ford	Rebecca Pantis, MPOG
Jackie Goatley, University of Michigan	Jack Peace, Temple University
Josh Goldblatt, Henry Ford Health	Jillian Printz, Cleveland Clinic
Frances Guida-Smiatacz, MPOG	Sharon Reale, Brigham & Women's
Ashraf Habib, Duke	Laurence Ring, Columbia University
Jerri Heiter, Trinity Health	Rachel Stumpf, MPOG
Patrick Henson, Vanderbilt University	Brian Taussig, NYU Langone
Danish Jaffer, WUSTL	Brandon Togioka, OHSU
Wandana Joshi, Dartmouth	Pam Tyler, Corewell Health
Jeremy Juang, UCSF	Meridith Wade, MPOG
Teshi Kaushik, UAB	Christine Warrick, University of Utah
John Kowalczyk, Brigham & Women's	Jennifer Woodbury, UCSF
Heather LaLonde, Trinity Health	Joshua Younger, Northwell Health
Tiffany Malenfant, MPOG	Amy Zheng, University of Maryland

Obstetric-Anesthesia Quality Subcommittee — Meeting Summary
Date/Time:
Chair: Dr. Brandon Togioka (OHSU) **Vice Chair:** Dr. Wandana Joshi (Dartmouth)
Facilitator: Kate Buehler (MPOG)

1. Announcements

- Next meeting: December 3, 2025 at 1pm EST

- Welcome to new OB Subcommittee members: 24 new members joined since the last meeting held in May.
- OB Subcommittee is open to anyone, if interested in attending, please email Kate Buehler (kjbucrek@med.umich.edu)

2. May Meeting Recap

- Reviewed results of the WOMAN-2 Trial relative to tranexamic acid use
- Voted not to include midazolam as an antiemetic for PONV-05 (Adult PONV Prophylaxis measure)
- **Discussion:**
    - *Patric Henson (Vanderbilt):* Not sure about the history of midazolam and PONV but does that apply to all benzodiazepines? We use more lorazepam than midazolam in our obstetric patients who need anxiolysis.
        - *Wandana Joshi (MPOG OB Subcommittee Vice-Chair)*: We voted not to include midazolam at this time and are waiting for the updated guidelines to be published.
- Discussed and voted on OB Subcommittee measure priorities for 2025. Will focus on the following topics for measure development:
    - Unintended dural puncture
    - Epidural replacement

3. Literature Spotlight (In-the-News)

- Evidence-based clinical practice guidelines on postdural puncture headache: a consensus report from a multi-society international working group (Uppal et al., 2024)
- Reviewed recommendations from recent publication for preventing and treating postdural puncture headache

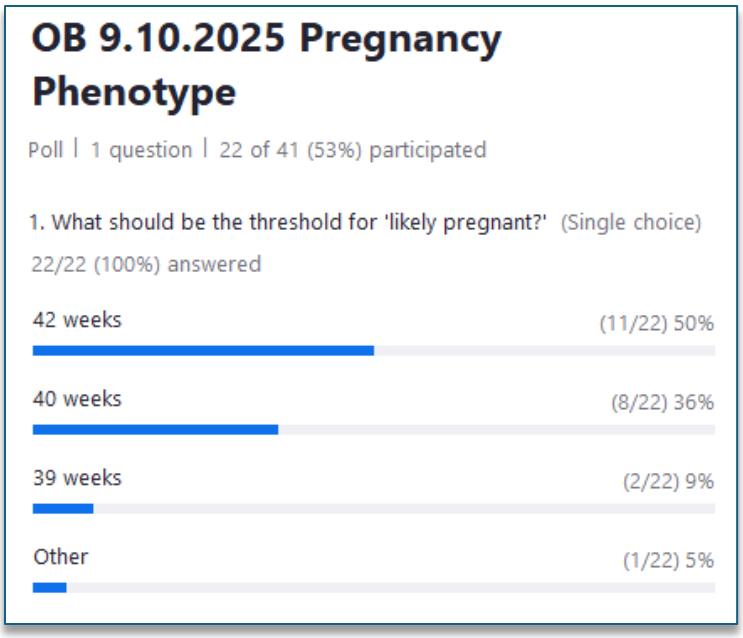
4. Obstetric Phenotypes Update

- Obstetrics Delivery – Date/Time phenotype is now available!
    - Returns date & time of delivery for cesarean or vaginal delivery for cases in MPOG
    - Only considers ages 12-56
    - Limited concepts evaluated – version 2 of this phenotype currently underway. Will post to the OB Subcommittee Forum when updated version is available.
- 'Obstetric – Is Pregnant' phenotype development in progress
    - Proposed updates to primary and secondary results as follows:
        - Primary result: Pregnancy – Likely Pregnant/Not Pregnant/Postpartum/UTD
        - Secondary result: # of days before or after delivery
    - **Discussion:** What is the appropriate threshold for 'likely pregnant?' 39, 40, or 42 weeks
        - *Danish Jaffer (WashU)*: Could she have been pregnant with a prior pregnancy for that chole? A lot of high-risk institutions will have earlier inductions like 34 weeks.

- *Brandon Togioka (MPOG OB Subcommittee Chair)*: If they delivered within an MPOG site yes but if not we wouldn't know. This brings up a good question as to whether we want to optimize sensitivity or specificity for this phenotype?
    - *Laurence Ring (Columbia):* Some places are so busy they may not get to induction before 40+ weeks so limiting it to < 40 may impact some centers
    - *Brandon Togioka (MPOG OB Subcommittee Chair)*: True.

- *Jillian Printz (Cleveland Clinic):* Do D&C's and miscarriages alter this data? I have noticed EPIC warnings stating a patient is pregnant when they present for surgery following a miscarriage. This may be a site-specific issue.
    - *Josh Goldblatt (Henry Ford):* Same thought. This phenotype seems limited by deliveries. While a good start, we might be missing a significant number of pregnancies.
    - *Kate Buehler (MPOG OB Subcommittee Lead):* These will not be considered deliveries in MPOG so will not flag a patient as 'pregnant' prior to the miscarriage or D&C. We can modify to consider these in the future if wanting to identify these pregnancies.
    - *John Kowalczyk (Brigham & Women's):* This may be very tricky to flag D&C vs D&E for AB, missed AB, retained products, and REI purposes, etc.
    - *Brandon Togioka (MPOG OB Subcommittee Chair)*: Jillian, great comment. With our working phenotype we would never know the patient was pregnant because we are only looking at timestamps for delivery. Agree, we also would not be able to determine gestational age at time of D+C, D+E

- **Vote:**



Decision: Maintain phenotype definition of 42 weeks before delivery to determine pregnancy.

5. Antibiotic Measure Updates

- Recently aligned success criteria for ABX-01-OB and ABX-06-OB to assess azithromycin administration 60 minutes prior to surgical incision through surgical incision.
- Also updated ABX-06-OB measure time period to no longer consider uterine incision or neonate delivery. If procedure start or surgical incision are not documented, the case will be flagged for review.
- Score changes were minimal for most sites – sites with significant score changes were notified via email prior to the release of these measure updates.
- **Discussion:**
    - *Danish Jaffer (WashU):* Does it catch start or completion of azithro?
    - *Kate Buehler (MPOG OB Subcommittee Lead):* both are considered - if either are within 60 minutes prior, will pass

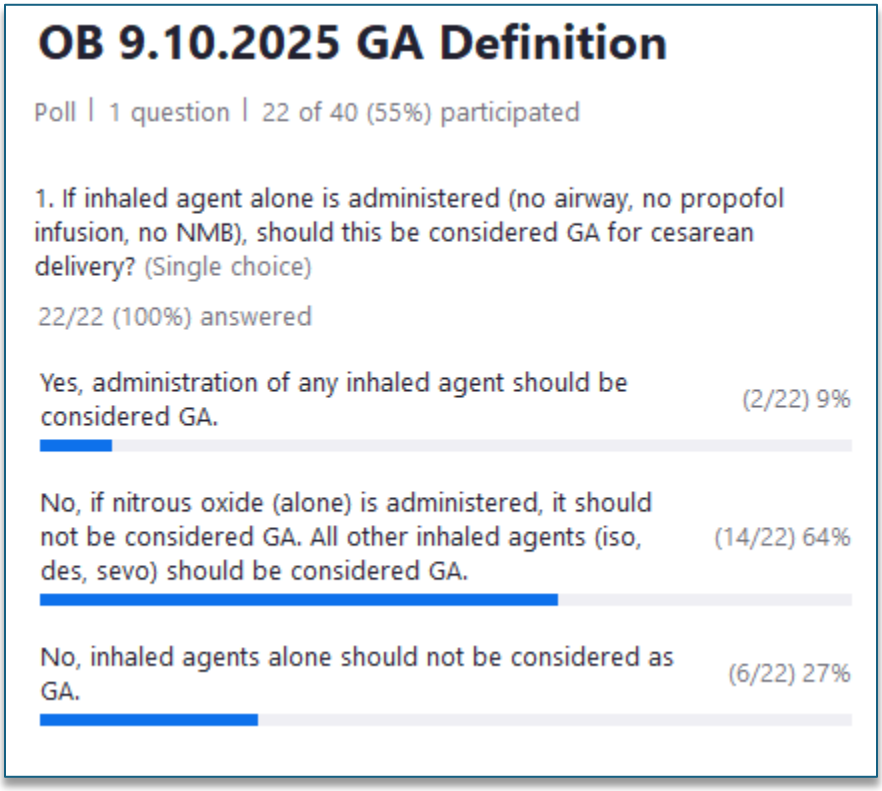
6. General Anesthesia Definition for Obstetrics

- General anesthesia measures for cesarean delivery (GA-01-OB, GA-02-OB, GA-03-OB) are currently defined using the Anesthesia Technique: General phenotype
- All cases resulting in value >0 for the phenotype are considered as 'general anesthesia'
- If inhaled agent alone is administered (no airway placed, no propofol infusion, no NMB), should this be considered GA for cesarean delivery?
- **Discussion:**
    - *Johanna Cobb (Dartmouth):* Curious about nitrous oxide vs. other halogenated agents. Those feel different whether you can be using them with or without an ETT whereas with nitrous you'd be using intermittently as an adjunct so I would move towards not considering that as general anesthesia.
        - *Wandana Joshi (MPOG OB Subcommittee Vice-Chair):* I agree
    - *Josh Younger (Northwell Health)*: Completely agree as well
    - *Danish Jaffer (WashU):* Does the FGF issue remove all of these corner cases?
    - *Kate Buehler (MPOG OB Subcommittee Lead):* Yes, we would add logic to assess for FGF for all other inhaled agents to determine if agent was administered. Nitrous is a separate issue.
    - *Johanna Cobb (Dartmouth)*: Then if there's no FGF then we don't pay attention to the inhaled agents.
        - *Kate Buehler (MPOG OB Subcommittee Lead):* Correct.
    - *Danish Jaffer (WashU):* What's the problem with using an airway procedure note in distinguishing these cases?
    - *Brandon Togioka (MPOG OB Subcommittee Chair)*: Great thought. There are a ton of phenotypes in MPOG, most of them have been created without subcommittee review. The GA phenotypes is being used for all cases, not just OB, so we are starting with this one to see if we can improve the results. The phenotype considers airway placement,

NMB administration, and inhaled agent use most likely because of documentation issues where airway alone cannot determine GA.

- *Christine Warrick (University of Utah)*: We reviewed something similar at our institution and unfortunately airway notes were not a reliable marker of GA - some were missing
- *Danish Jaffer (WashU):* The FGF issue seems like it should be resolved MPOG wide. Pedi ear tubes likely have sevo without ETT but with high FGF
- *Danish Jaffer (WashU)*: So even if they don't get gas, will it still end up flagging as a general anesthetic?
- *Brandon Togioka (MPOG OB Subcommittee Chair)*: There are multiple ways to capture and define a general case.

- **Vote:**



- **Decision: Update GA-OB measures to pass cases if only indication of GA is nitrous oxide administration OR if sevo/iso/des is given without FGF running.**

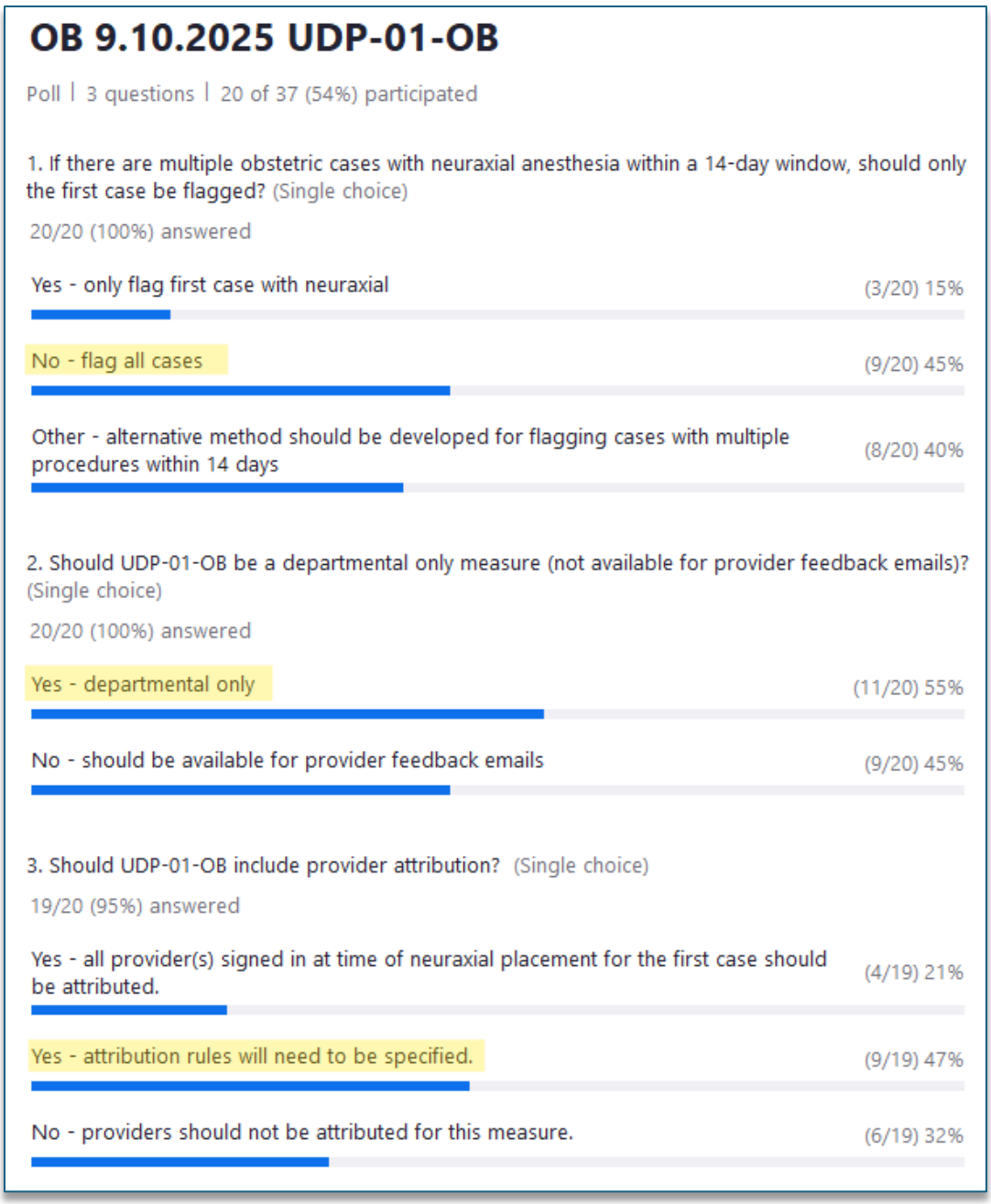
7. New Measure Build Updates

- The subcommittee voted to move forward with measure build for a measure to assess unintended dural puncture and neuraxial catheter replacement at the last meeting in May.
- Measure specification for Unintended Dural Puncture shared with the subcommittee as well as preliminary data.
  - **Discussion:**

- *Josh Goldblatt (Henry Ford):* This shouldn't include intentional dural puncture correct?
- *Wandana Joshi (MPOG OB Subcommittee Vice-Chair):* Correct. We are looking for unintentional
- *Jeremy Juang (UCSF):* We chart DPEs at our institution (separate from CSEs). will this be included?
    - *Kate Buehler (MPOG OB Subcommittee Lead):* We currently don't separate dural punctures from CSEs in MPOG. We would need to add that additional enumeration to the neuraxial phenotype. Currently, most DPEs result as CSE for the neuraxial phenotype.
    - *Ashrab Habib (Duke):* I think the point is that some patients would develop a headache from the spinal component, but I don't see a point we can differentiate which is something we have to deal with. I think it's a limitation we just need to deal with. If we exclude CSE we would be excluding too many patients.
        - *Kate Buehler (MPOG OB Subcommittee Lead):* We are currently under reporting since there are so few flagged cases so I would err on including more cases than not so we would be able to review these and could decide which ones are legitimate UDPs vs. Not based on case review.
    - *Laurence Ring (Columbia):* I do think we will be including extra patients who have a blood patch.
        - *Brian Taussig (NYU Langone):* I completely agree
    - *Jillian Printz (Cleveland Clinic):* CSE or DPEs with just the intended dural puncture, while much less likely, could still result in a spinal headache and eventual blood patch. (As others are saying). But if you compare the rates across anesthesiologists, the data is still significant
- *Danish Jaffer (WashU):* Why not make a PDPH phenotype (rather than UDP phenotype) that is agnostic to neuraxial type?
    - *Laurence Ring (Columbia):* In our procedure notes, we've added a lot of details regarding dural puncture. I worry about unintentionally raising our rates of UDP.
    - *Michael McDonald (UChicago):* I would report all - if a CSE/DPE results in PDPH regardless of if there was an identified dural puncture with the Touhy needle, I think that's data that should be flagged and sent to department/provider
    - *Brandon Togioka (OHSU)*: Do we want to create a measure that's imperfect but provides more data than we currently have? After discussions the current data we have is underreported. The idea is to align with QI metrics that other institutions are using
- *John Kowalczyk (Brigham & Women's):* It seems like, depending on flags and how things are set, that it may be best for all "providers" to receive feedback that the patient developed a PDPH. I would rather know from a personal standpoint to potentially review.

- *Katie O'Conor (Johns Hopkins):* If 45% want it for provider feedback, could we make it available and just let the majority opt to exclude it from provider feedback emails?
- *Jillian Printz (Cleveland Clinic)*: Provider attribution seems confusing if, for example, a different provider from the original replaces an epidural and then the patient is flagged for UDP.

- **Vote:**



OB 9.10.2025 UDP-01-OB

Poll | 3 questions | 20 of 37 (54%) participated

1. If there are multiple obstetric cases with neuraxial anesthesia within a 14-day window, should only the first case be flagged? (Single choice)

20/20 (100%) answered

Yes - only flag first case with neuraxial	(3/20) 15%
No - flag all cases	(9/20) 45%
Other - alternative method should be developed for flagging cases with multiple procedures within 14 days	(8/20) 40%

2. Should UDP-01-OB be a departmental only measure (not available for provider feedback emails)? (Single choice)

20/20 (100%) answered

Yes - departmental only	(11/20) 55%
No - should be available for provider feedback emails	(9/20) 45%

3. Should UDP-01-OB include provider attribution? (Single choice)

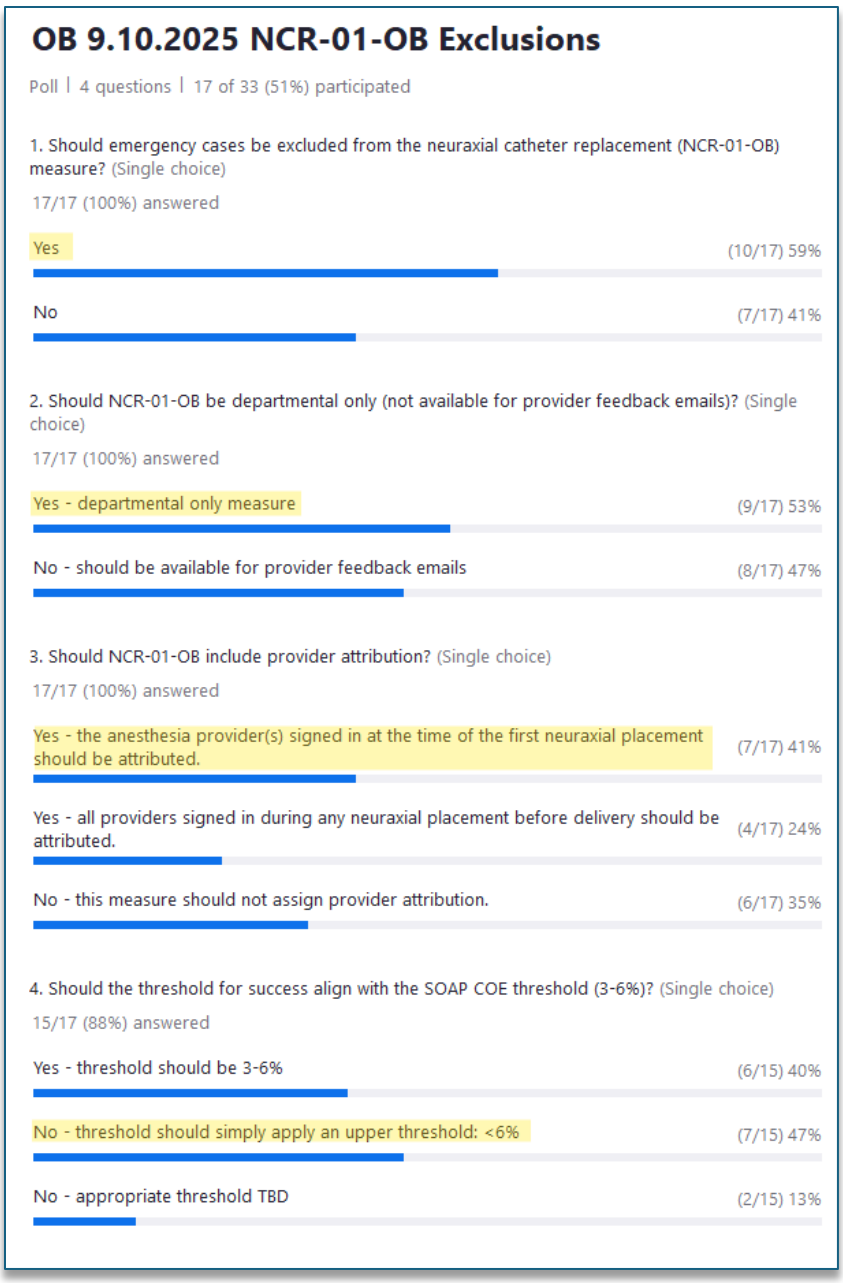
19/20 (95%) answered

Yes - all provider(s) signed in at time of neuraxial placement for the first case should be attributed.	(4/19) 21%
Yes - attribution rules will need to be specified.	(9/19) 47%
No - providers should not be attributed for this measure.	(6/19) 32%

- **Decision:**
  - Flag all cases (not just the first case) for the UDP
  - UDP-01-OB will be released as a departmental only measure initially.
  - Subcommittee would like provider attribution assigned. Will specify logic at the upcoming subcommittee meeting in December.
- Measure specification for Neuraxial Catheter Replacement shared with the subcommittee as well as preliminary data
  - **Discussion:**

- *Danish Jaffer (WashU)*: What is the rationale for excluding C-hyst from this metric?
    - *Brandon Togioka (MPOG OB Subcommittee Chair)*: They are treated a little bit differently clinically with some sites placing thoracic epidurals for these procedures. They potentially could be included, if desired by the subcommittee.
- *Laurence Ring (Columbia):* Epidural catheter replacement for suboptimal analgesia/anesthesia but a repeat procedure might happen for initial IV catheter or for ADP

- **Preliminary Vote:**



OB 9.10.2025 NCR-01-OB Exclusions

Poll | 4 questions | 17 of 33 (51%) participated

1. Should emergency cases be excluded from the neuraxial catheter replacement (NCR-01-OB) measure? (Single choice)

17/17 (100%) answered

Yes	(10/17) 59%
No	(7/17) 41%

2. Should NCR-01-OB be departmental only (not available for provider feedback emails)? (Single choice)

17/17 (100%) answered

Yes - departmental only measure	(9/17) 53%
No - should be available for provider feedback emails	(8/17) 47%

3. Should NCR-01-OB include provider attribution? (Single choice)

17/17 (100%) answered

Yes - the anesthesia provider(s) signed in at the time of the first neuraxial placement should be attributed.	(7/17) 41%
Yes - all providers signed in during any neuraxial placement before delivery should be attributed.	(4/17) 24%
No - this measure should not assign provider attribution.	(6/17) 35%

4. Should the threshold for success align with the SOAP COE threshold (3-6%)? (Single choice)

15/17 (88%) answered

Yes - threshold should be 3-6%	(6/15) 40%
No - threshold should simply apply an upper threshold: <6%	(7/15) 47%
No - appropriate threshold TBD	(2/15) 13%

- **Decision: Re-visit for discussion at the December Meeting**

Action Items

1. **Pregnancy Phenotype:** Maintain phenotype definition of 42 weeks before delivery to determine pregnancy.
2. Update GA-OB measures to pass cases if only indication of GA is nitrous oxide administration OR if sevo/iso/des is given without FGF running.
3. ---
    a. Flag any case associated with the UDP (not just the first case)
    b. Release as a departmental only measure initially.
    c. Specify logic for provider attribution at the upcoming subcommittee meeting in December.
4. Continue to refine logic for neuraxial catheter replacement measure (NCR-01-OB) - discuss at upcoming subcommittee meeting in December.

Next meeting: ***Wednesday, December 3, 2025 — 1 p.m. ET / 10 a.m. PT***