Obstetric Anesthesia Subcommittee Minutes

February 2, 2022

1:00-2:00 pm EST - Zoom

	First Name	Last Name	Institution
x	Ami	Attali	Henry Ford-Detroit
X	Dan	Biggs	University of Oklahoma
x	Laurie	Chalifoux	Spectrum
X	Kathleen	Collins	St. Mary Mercy Livonia
x	Carlos	Delgado Upegui	University of Washington
x	Kim	Finch	Henry Ford
x	Daniel	Grutter	St. Joseph Mercy Ann Arbor
x	Ashraf	Habib	Duke
X	Meridith	Bailey	MPOG QI Coordinator
X	Kate	Buehler	MPOG Clinical Program Manager
X	Jerri	Heiter	St. Joseph Ann Arbor, Chelsea, Livingston
X	Rebecca	Johnson	Anesthesia Practice Consultants
x	Wandana	Joshi	Dartmouth
X	Rachel	Kacmar	University of Colorado
x	Tom	Klumpner	University of Michigan
X	Victoria	Lacca	MPOG Administrative Manager
X	Tiffany	Malenfant	MPOG Clinical Informatics Specialist
x	Angel	Martino-Horrall	Beaumont Health System
x	Rebecca	Minehart	MGH
X	Melinda	Mitchell	Henry Ford - Allegiance
X	Ronnie	Riggar	MPOG Admin Assistant
X	Denise	Schwerin	Bronson ACQR
x	Monica	Servin	University of Michigan
X	Nirav	Shah	MPOG Quality Director
X	Preet	Singh	Washington University
X	Jessica	Wren	Henry Ford
X	Joshua	Younger	Henry Ford-Detroit
X	Andrew	Zittleman	MPOG Clinical Informatics Specialist

A. **Announcements**:
   a. 2022 OB Subcommittee Meeting Dates
      i. August 3, 1pm EST
      ii. December 7, 1pm EST
   b. MPOG Retreat in New Orleans, LA: October 21, 2022

B. **November 2021 Meeting Recap**
   a. Reviewed unblinded site performance for 'general anesthesia in cesarean delivery' measures (GA 01/02)
      i. Subcommittee expressed interest in separating elective vs. non-elective cesarean cases
      ii. MPOG can separate ASA 'E' cases but not necessarily indicative of elective vs. non-elective
      iii. Many non-elective c-sections do not have an 'E' assigned
      iv. SOAP Centers of Excellence recommends reviewing cases that converted to general anesthesia at an institutional level
      v. **Follow-up question:** Would there be interest in developing a list of considerations for reviewing these cases at your sites?
         1. **Conclusion:**
            a. Dr. Habib mentioned that Duke has a standard list of criterion they use and he would be willing to share with the Coordinating Center
   b. Subcommittee discussed applicability of existing ASPIRE glycemic management measures for the OB population
      i. Subcommittee recommended excluding cesarean deliveries from all glucose measures (GLU 01-05)
      ii. After reviewing cases, Coordinating Center proceeded with excluding cesarean deliveries from hyperglycemia measures (GLU 01/03/05) as this is typically managed outside of the OR by obstetrician and nursing
      iii. However, we opted to continue to include cesarean deliveries for hypoglycemia measures (GLU 02/04) at this time due to potential opportunity to improve health system processes (outside of OB).
      iv. Plan to revisit with Quality Committee & see if attribution might be removed for obstetric anesthesiologists in the future

C. **PONV 05: Obstetric Considerations**
   a. New Proposed Adult Prophylaxis Measure- PONV 05: Percentage of patients, aged 18 years and older undergoing a procedure with appropriate prophylaxis for postoperative nausea and vomiting, as defined by:
      i. At least two prophylactic pharmacologic antiemetic agents of different classes administered preoperatively or intraoperatively for patients with one or two risk factors
      ii. At least three or more prophylactic pharmacologic antiemetic agents from different classes preoperatively or intraoperatively for patients with three or more risk factors
      iii. **For cesarean delivery cases only: At least two prophylactic pharmacologic antiemetic agents from different classes preoperatively or intraoperatively. (per SOAP ERAS 2021 guidelines)**

iv. Excludes: Labor epidurals
v. Risk factors not considered for cesarean delivery patients
vi. Measure time period: C-section start time for cesarean conversion cases; preop start for scheduled c-sections

b. PONV 05 discussion:
i. Antiemetic administration data: most common medication(s) for cesarean delivery cases in MPOG shared with subcommittee: Ondansetron and Dexamethasone seem to be most common - see slide 10
ii. Agree on the inclusion criteria for cesarean delivery patients, ignoring risk factors?
iii. Agree with measure time period for administration: Preop start - PACU Start?
iv. Agree with giving any 2 antiemetics from separate classes? Specify which classes must be given (or not given)? For example, propofol infusion would be included as an acceptable antiemetic
v. Exclusions apply?
- ASA 5 or 6
- Patients <18 years old.
- Patients transferred directly to the ICU

vi. Shared blinded performance for PONV 05 for cesarean delivery patients only - see slide 12
vii. **Conclusions**:
1. Modify exclusion criteria to include all cesarean delivery patients regardless of age
2. Modify start time to include 30 minutes before cesarean delivery start for conversion cases to ensure capture of antiemetics given by nursing on the unit before OR
3. Antiemetics from 2 different classes is appropriate - no change to success criteria

D. Unblinded Data Review: PONV 03/03b

a. Unblinded Data Review: Performance for PONV 03/03b was shared with the subcommittee- this was a confidential session; unblinded data was removed from the presentation before posting. General discussion topics are noted below- any comments specific to a site's performance were omitted from the minutes.
b. Current Measure: PONV 03 - Percentage of patients, regardless of age, who undergo a procedure and have a documented nausea/emesis occurrence OR receive a rescue antiemetic in the immediate postoperative period
i. Time period: Recovery room in through 6 hours after Anesthesia End
ii. Inclusion: Cesarean Deliveries
iii. Exclusion: Labor Epidurals
iv. Discussion:
1. Ashraf Habib (Duke): Proper timing of dexamethasone is 2 hours before delivery unless cord blood donor. If cord blood donor- hold and give after delivery
2. Carlos Delgado (UWashington): U of Washington in Seattle - intraop admin of antiemetics (ondansetron+dex) is the practice.

3. Wandana Joshi (Dartmouth): We don't send all our CD patients to PACU. Most patients will recover in their labor room. Will this affect data collection?
4. Rebecca Minehart (MGH): Is anyone using pain dosing for dexamethasone (>0.1mg/kg)? I have been toying with this idea, especially since the higher PDPH risk reported with dex hasn't borne out in subsequent studies. Also, We've been reprimanded for raising blood glucoses in DM with dex
5. Angel Martino-Horrall (Beaumont Health System): Wonder how much PONV can be attributed to azithromycin administration. Can this be examined?
    a. Nirav Shah (MPOG): Yes
6. Ashraf Habib (Duke): Many other factors impact antiemetic selection. We are at the top of 'discrepancy'. Many of the patients who experience PONV is out of our control.
7. Preet Singh (WashU): two time frames that are consistent 1)BP is low and 2) when baby is delivered?
8. Monica Servin (Michigan Medicine): PONV03 looks through PACU; Measure looks 6 hours after Anesthesia End. However, some sites are only contributing data through PACU end only.
9. Ashraf Habib (Duke): Sites could have more PONV rates if they are sending data post-PACU. Can we look at measure performance for 2 hours after anesthesia end vs. 6 hours?
    a. Kate Buehler: How should we define PACU end?
    b. Ashraf Habib (Duke): Most patients go to PACU but there are some that recover in their rooms. If we are able to use 2 hours as a cutoff it will standardize a timeframe we are looking at across all sites
    c. Monica Servin (Michigan Medicine): I agree. Nurses at our institution consider 2 hours that 'PACU' window.
    d. Angel Martino-Horrall (Beaumont Health System): Is there a way to see which sites have scored well for PONV03 and what antiemetics they have used? I'm wondering if there is something specific to the PACU timeframe if there is a specific 'cocktail' sites are finding effective.
        i. Nirav Shah (MPOG): Yes. We do this collaboration within the state of Michigan with unblinded data reviews once a year as well.

c. PONV 03b: Percentage of patients, regardless of age who undergo a procedure and have a documented nausea/emesis occurrence with or without receiving an antiemetic in the immediate postoperative period.
    i. Time period: Recovery room in through 6 hours after Anesthesia End
    ii. Inclusion: Cesarean Deliveries
    iii. Exclusion: Labor Epidurals
d. PONV 03/03b Discussion: Both are already available on the OB Dashboard
e. Recommended modifications to PONV 03/03b for the OB population?
    i. Modify measure for OB to include patient out of room to 2 hours after surgery rather than 6 hours postop in order to standardize data capture across sites

ii. Assess whether data from OB units is coming into MPOG before and after cesarean delivery cases - if so, what is the time window on either side of the case that MOST sites are able to contribute? - MPOG Coordinating Center to investigate

E. 2022 Planning

a. Progress in 2021
   i. Created new postop temperature measure for cesarean deliveries: TEMP-05-OB
   ii. Created measures focused on general anesthesia rates for cesarean deliveries
      1. GA 01: Percentage of cesarean delivery cases where general anesthesia was used
      2. GA 02: Percentage of cesarean delivery cases where general anesthesia was administered after neuraxial anesthesia
   iii. Added consideration for cesarean deliveries in new PONV prophylaxis measure: PONV 05

b. Recap of 2021 Plans
   i. Sent out survey in late 2020: 9 responses
      1. PONV in PACU following cesarean delivery: Complete!
      2. First temperature in PACU following cesarean delivery: Complete!
      3. Non-opioid adjunct used for post cesarean delivery pain: Still priority?
   ii. Reviewed survey 'write-in' topics that were rated as 'Extremely Important' or 'Very Important'
   iii. Discussion:
      1. Sharon Abramovitz (Cornell) - Should also consider looking at patients with spinals on phenylephrine infusions.
   iv. Next Steps:
      1. Modifications to PONV process measure (PONV 05) for the obstetric population:
         a. Modify exclusion criteria to include all cesarean delivery patients regardless of age
         b. Modify start time to include 30 minutes before cesarean delivery start for conversion cases to ensure capture of antiemetics given by nursing on the unit before OR
         c. Antiemetics from 2 different classes is appropriate - no change to success criteria
      2. Modifications to PONV outcome measure for obstetric population:
         a. Modify measure for OB to include patient out of room to 2 hours after surgery rather than 6 hours postop in order to standardize data capture across sites
         b. Assess whether data from OB units is coming into MPOG before and after cesarean delivery cases - if so, what is the time window on either side of the case that MOST sites are able to contribute? - MPOG Coordinating Center to investigate
      3. Will send out survey to OB Subcommittee members to assess potential topic areas for new measures: please complete survey and committee will reconvene in August to determine future measure build priorities
      4. Potential focus areas based on 2020 survey results:
         a. Multimodal analgesia for cesarean deliveries
         b. Azithromycin use

c. Phenylephrine infusion use
d. ERAS area of focus

Meeting concluded at: 1402