Obstetric Anesthesia Subcommittee Minutes
February 11th, 2026
1:00-2:00 pm EST - Zoom
Chair: Brandon Togioka, MD (MPOG OB Subcommittee Chair)
Vice Chair: Sharon Reale, MD (MPOG OB Subcommittee Vice Chair)
MPOG Coordinating Center Facilitator: Kate Buehler, MS, RN (MPOG Clinical Program Manager)

Attendees:

Daniel Berensen, Brigham & Women's	Michael McDonald, UPenn
Kate Buehler, MPOG	Christine McKenzie, UNC
Meilou Calabio, MPOG	Mary McKinney, Corewell Health
Arthur Calimaran, Cleveland Clinic	Chris Milliken, Sparrow Health
Brendan Carvalho, Stanford Health	Melinda Mitchell, Henry Ford
Megan Charette, MPOG	Kam Mirizzi, MPOG
Rob Coleman, MPOG	Michael McDonald, Upenn
Leanna Delhey, MPOG	Katie O'Conor, John Hopkins
Heather Dobbs, Bronson Health	Rebecca Pantis, MPOG
Kim Finch, Henry Ford	Sharon Reale, Brigham & Women's
Cedar Fowler, Stanford Health	Mason Smith, MyMichigan Sault
Josh Goldblatt, Henry Ford	Rachel Stumpf, MPOG
Ashraf Habib, Duke University	Brandon Togioka, OHSU
Jerri Heiter, Trinity Health	Pam Tyler, Corewell Health
Melanie Herren, MPOG	Meridith Wade, MPOG
Zachary Janik, Walter Reed	Christine Warrick, University of Utah
Wandana Joshi, Baystate Health	Aaron Weinberg, Weill Cornell
Jeremy Juang, UCSF	Richard Wissler, University of Rochester
Meraj Khan, Henry Ford	Jennifer Woodbury, UCSF
John Kowalczyk, Brigham & Women's	Josh Younger, Northwell Health
Heather Lalonde, Trinity Health	Amy Zheng, University of Maryland
Allison Lee, UPenn	Andrew Zittleman, MPOG
Tiffany Malenfant, MPOG	

1) Announcements

Vice Chair Appointment

- The committee congratulated Dr. Sharon Reale on accepting the role of OB Subcommittee Vice Chair.
- Leadership thanked all applicants and noted strong interest in the Vice Chair role.

Upcoming Meeting Dates

- June 3, 2026 (1–2 pm ET)
- September 16, 2026 (1–2 pm ET)

Reminder: OB Subcommittee is open to anyone interested; contact Kate Buehler to be added to invites.

---

2) In the News (Research Highlight)

Presenter: Sharon Reale, MD

- Dr. Reale provided a brief overview of a recent study using the MPOG database examining frequency and management of peripartum cardiac arrest, highlighting MPOG's value for evaluating rare outcomes and the granularity available beyond administrative coding.

---

3) December Meeting Recap

The committee reviewed key outcomes from the December meeting:

- Pregnancy trimester phenotype: voted to pause development and investigate alternative approaches for capturing gestational age at time of delivery.
- IONV/PONV (OB-specific) measure direction: voted to move forward with a new obstetric-specific measure; planned updates include:
    - Cesarean delivery removed from PONV-5 (adult measure)
    - Glycopyrrolate considered acceptable prophylaxis
    - Atropine and midazolam not considered appropriate prophylaxis
- Reviewed proposed specs and preliminary data for neuraxial catheter replacement for childbirth.

---

4) NCR-01-OB: Neuraxial Catheter Replacement (Released)

Status: Released to dashboards (departmental only)
Public spec link (shared): https://measures.mpog.org/Measures/Public/102 *(via chat)*

Measure Summary

- Description: Percentage of patients undergoing neuraxial anesthesia for labor or cesarean delivery with evidence of neuraxial catheter replacement.
- Threshold: < 6%
- Measure time period: Obstetric neuraxial anesthesia start → Obstetrics delivery date/time (defaults to anesthesia end if delivery date/time unavailable).
- Success definition: Epidural anesthesia administered without evidence of a second epidural placement procedure for the same obstetric delivery.
- Use/attribution: Departmental only, no provider attribution; not available for feedback emails; emergency cases included; Version 1 with request for iterative feedback.

Exclusions

- Cesarean hysterectomy (Obstetric Anesthesia Type codes 4 & 8).
- Neuraxial anesthesia for procedures other than labor epidural or cesarean delivery.
- Obstetric cases without neuraxial anesthesia (value code 0), with spinal anesthesia (value code 3), or unknown neuraxial type (value code 5), per Anesthesia Technique: Neuraxial.
- Neuraxial start time documented after Obstetrics Delivery Date/Time.

Logic Summary (Epidural Replacement)

A case is flagged if multiple neuraxial procedures are documented for the same delivery, based on:

- Same MPOG Case ID: ≥2 neuraxial procedure notes recorded within the same case ID (Obstetric Anesthesia Type codes 1, 2, 3, or 5).
- Separate MPOG Case IDs for same delivery: ≥2 neuraxial procedure notes under different MPOG case IDs (Obstetric Anesthesia Type codes 6 or 7).

Procedure note assessment (child note logic):

- If any relevant procedure notes contain child notes, restrict assessment to notes with child notes; flag if ≥2 such notes are >20 minutes apart.
- If notes do not contain child notes, assess all relevant procedure notes; flag if ≥2 such notes are >45 minutes apart.

Discussion Highlights

- Ashraf Habib (Duke) noted that both “passed” and “failed” currently indicate “administered more than once” – Coordinating Center to update dashboard verbiage

- Wissler Dick (University of Rochester): Asked if "child notes" is the best term in an OB context *(via chat)*. Kate Buehler clarified this is standard technical terminology ("parent/child notes"), not coined by MPOG.
- Robustness / potential confounding:
    - Cedar Fowler (Stanford) suggested excluding SSS (single-shot spinal) if it is the first technique *(via chat)*, and emphasized a desire for a robust measure *(via chat)*.
    - Christine Warrick (Utah) supported the point *(via chat)* and noted a "sweet spot" concern: very low replacement rates may reflect under-identification of failed epidurals *(via chat)*; Brandon Togioka agreed *(via chat)*.
- Potential enhancements raised during discussion (verbal):
    - Differentiate replacements occurring specifically in the context of intrapartum cesarean conversion (e.g., routine replacement practice) vs. true labor catheter failure.
    - Add case-level fields to support local review (e.g., time between placements / dwell time).

---

5) UDP-01-OB: Unintended Dural Puncture (In Development)

Status: Not yet published; in development (request for feedback).

Measure Summary

- Description: Percentage of patients undergoing neuraxial epidural anesthesia for an obstetric procedure with evidence of an unintended dural puncture.
- Measure time period: Neuraxial anesthesia start → 14 days after neuraxial anesthesia start.
- Success: Neuraxial epidural anesthesia administered without evidence of unintended dural puncture.
- Threshold: ≤ 2%
- Excludes neuraxial techniques for non-obstetric indications.

Inclusion Criteria:

Patients requiring neuraxial anesthesia for:

- Childbirth (labor epidurals and cesarean deliveries; Obstetric Anesthesia Type value codes >0)
- Postpartum tubal ligation (Surgical CPT 58600/58605/58611/58615/58661/58670/58671; Anesthesia CPT 00851)
- External cephalic version (Surgical CPT 59412; Anesthesia CPT 01958)
- Transvaginal cerclage placement (Surgical CPT 59320; Anesthesia CPT 00948)

Included / Excluded Neuraxial Techniques:

Included: CSE, epidural, caudal, and “multiple” (likely includes spinal + epidural or unclear documentation).
Excluded: no neuraxial technique (0), spinal (3), neuraxial-unknown type (5).

Numerator Logic (UDP Evidence)

UDP is identified by any of the following within the defined window:

- Inadvertent dural puncture concept documented on the case (ID: 50291)
- Epidural blood patch concept documented on a subsequent case within 14 days (ID: 50507)
- Epidural blood patch CPT (62273) found within 336 hours (14 days) of neuraxial procedure start
- ICD codes consistent with CSF leak / dural puncture / neuraxial headache (e.g., G96.0, G97.0, G97.41, O74.5, O89.4; ICD-9 349.31)

Denominator Discussion

- Neuraxial procedures (#)
- Obstetric procedures (#)
- Deliveries (#)
- 14-day “obstetric encounter”

UDP-01-OB Discussion Summary:

- Multiple participants raised concern about attribution when multiple neuraxial procedures occur close together and how that could inflate numerator/denominator inconsistently.
- Wandana Joshi (Baystate Medical) asked what SOAP uses as the COE denominator
- Daniel Berenson (BWH) suggested NCR and UDP should use the same denominator
- Cedar Fowler (Stanford) asked how two blood patches would be handled *(via chat)* – Dr. Togioka expressed that only 1 UDP would be counted even if two EBPs were required
- Cedar Fowler (Stanford) noted that nitrous oxide may generate an anesthesia record at some institutions *(via chat)*, which could affect denominator interpretation unless restricted to deliveries with neuraxial. Dr. Togioka confirmed the denominator would be limited to only deliveries with neuraxial.

Case Flagging and Attribution

Slides recap prior committee votes (September 2025) and the current proposed approach:

- Prior vote: flag all associated cases; proposal now is to flag only the first neuraxial case per delivery.
- Maintain UDP as department-only (no provider feedback emails).
- Despite prior vote to add provider attribution, current proposal is no provider attribution due to attribution limitations.

---

6) 2026 Planning Discussion

Planned workstreams listed:

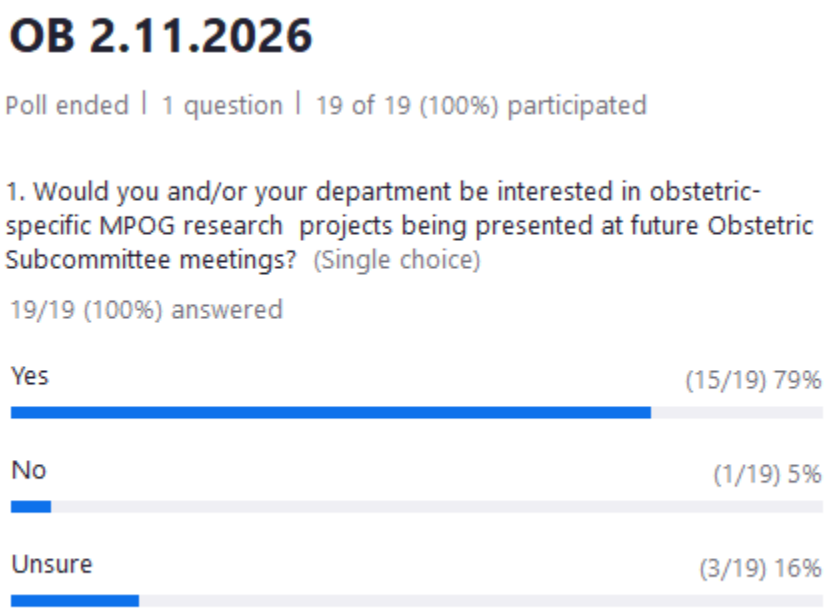
- UDP-01-OB: Unintended dural puncture (priority)
- PONV-06-OB: IONV/PONV prophylaxis for cesarean deliveries
- New phenotypes: neuraxial anesthesia start time; gestational age at time of delivery

Additional ideas raised *(via chat)*:

- GA for cesarean – these measures already exist (GA-01-OB, GA-02-OB, and GA-03-OB)
- Transfusion rate

Poll Result

- Poll topic: incorporating brief (~5 minute) research presentations in routine meetings.
- Result: majority in favor (as summarized verbally at close of meeting).



Decisions

- NCR-01-OB is released as a departmental-only measure (no provider attribution; emergency cases included) and will be refined iteratively based on feedback.
- UDP-01-OB remains in development; current direction supports department-level reporting and avoiding provider attribution until capture/attribution improves.
- Committee will add short research highlights to future meetings based on poll support (verbal consensus).

Action Items

1. Continue to investigate if ICD-10 codes (Z39.83) may be used for determining gestational age for future obstetric research projects.
2. MPOG team to update dashboard language for NCR-01-OB where both "passed" and "failed" cases display "administered more than once."
3. MPOG team: Consider refinements to improve NCR-01-OB robustness including:
    1. Creating a separate (new) measure to assess spinal placement after epidural for labor epidurals converted to c-section.
    2. Adding measure build detail column for time between epidural placement and replacement catheter placement
4. MPOG team + committee: Continue UDP-01-OB denominator/numerator refinement, including modification to only include childbirth procedures (labor epidurals and c-sections).
5. Committee members: Submit additional measure/phenotype suggestions for future work

Contact Information for Questions:

- Kate Buehler, MS, RN – MPOG Clinical Program Manager (kjbucrek@med.umich.edu)
- Brandon Togioka, MD – Chair (togioka@ohsu.edu)
- Sharon Reale, MD – Vice Chair (screale@bwh.harvard.edu)

Meeting Adjourned: 1402

Next meeting: ***Wednesday, June 3, 2026 — 1 p.m. ET / 10 a.m. PT***

Appendix A – Full Transcript

Opening and Welcome

00:05:43 — Brandon Togioka (OB Subcommittee Chair):
Welcome, everybody. Thank you for joining. This is the MPOG OB Anesthesia Subcommittee meeting, our first meeting of 2026. We have two additional meetings later this year, and we'll review those dates shortly.

Leadership Announcement

00:07:08 — Brandon Togioka (OB Subcommittee Chair):
First, I'd like to congratulate Dr. Sharon Reale on becoming our new Vice Chair. We're excited to have her in this role. Dr. Reale serves at Harvard and Brigham and Women's Hospital as the Obstetric Anesthesia Fellowship Program Director and has published impactful obstetric anesthesia research using MPOG data.

Thank you to everyone who applied for the Vice Chair position. The level of interest reflects the impact and relevance of this subcommittee's work in improving obstetric anesthesia quality. Congratulations again, Dr. Reale.

Upcoming Meeting Dates

00:08:16 — Brandon Togioka (OB Subcommittee Chair):
We are returning to three meetings per year to align with other MPOG quality committees.

- June 3, 2026 — 10:00 am PT / 1:00 pm ET
- September 16, 2026 — 10:00 am PT / 1:00 pm ET

The OB Subcommittee is open to anyone interested. For voting, only one vote per contributing MPOG institution is allowed, but all feedback is welcome.

In the News — MPOG Research Highlight

00:09:07 — Sharon Reale (OB Subcommittee Vice Chair):
We recently published a study using MPOG data examining peripartum cardiac arrest. We identified 87 arrests among 778,000 deliveries, approximately 1 in 9,000 (11.2 per 100,000), consistent with prior literature.

Hemorrhage and amniotic fluid embolism were leading contributors. Ten cases were associated with anesthetic complications. Approximately 20% demonstrated potential guideline deviations, including medication timing or perimortem cesarean decisions.

ROSC was achieved in about 80% of cases, with approximately 70% 30-day survival. Risk factors strongly associated with arrest included maternal age >40, elevated BMI, placenta accreta spectrum, and ischemic heart disease.

The manuscript is published in Anesthesiology, with an editorial and podcast forthcoming.

00:11:32 — Brandon Togioka (OB Subcommittee Chair):
This is a great example of the power and granularity of the MPOG database compared to registry-only or ICD-based analyses. Congratulations on excellent work.

December 2025 Meeting Recap

00:12:18 — Brandon Togioka (OB Subcommittee Chair):

- Development of the pregnancy trimester phenotype was paused due to challenges accurately capturing gestational age at delivery.
- ICD-10 Z3A codes (gestational age by week) are being explored as a potential solution.
- The committee voted to create a new obstetric-specific IONV/PONV measure.
    - Cesarean delivery will be removed from the adult PONV-5 measure.
    - Glycopyrrolate will be accepted as prophylaxis.
    - Atropine and midazolam will not be included as prophylaxis.

NCR-01-OB: Neuraxial Catheter Replacement

Measure Release

00:14:18 — Brandon Togioka (OB Subcommittee Chair):
NCR-01-OB has been released on OB dashboards.

Key characteristics:

- Departmental only
- No provider attribution
- Emergency cases included
- Version 1 (logic subject to refinement)

Measure Description

Percentage of patients undergoing neuraxial anesthesia for labor or cesarean delivery with evidence of neuraxial catheter replacement.

- Threshold: <6%
- Timeframe: Neuraxial start → Delivery (or anesthesia end if delivery time unavailable)
- Success: Epidural placed without evidence of second placement

Exclusions

- Cesarean hysterectomy
- Non-OB neuraxial cases
- Spinal-only anesthesia
- Unknown neuraxial type
- Neuraxial start after delivery

Documentation Logic Discussion

00:20:11 — Brandon Togioka (OB Subcommittee Chair):
Institutions vary in documentation structure. Some include detailed "child notes" attached to procedure notes.

Logic:

- If child notes exist → assess only those; flag if ≥2 notes >20 minutes apart
- If no child notes → assess all notes; flag if ≥2 >45 minutes apart

This timing is subjective and will be refined iteratively.

Discussion — NCR Measure

Cedar Fowler (Stanford):
Could replacement rates be elevated by patient-requested replacement prior to cesarean, even if catheter is functioning?

Brandon Togioka (OB Subcommittee Chair):
We cannot reliably determine reason for replacement in current logic.

Kate Buehler (MPOG Coordinating Center):
We could add case report elements (e.g., filter for cesarean-associated replacements).

John Kowalczyk (BWH):
Some institutions routinely replace epidurals with spinal or CSE for cesarean delivery.

Christine Warrick (University of Utah):
Academic institutions sometimes perform spinal followed by epidural placement to increase procedural numbers—this may appear as two procedures.

Josh Goldblatt (Henry Ford):
Clarified alignment with SOAP COE standards. Pure spinals are excluded.

Daniel Berenson (BWH):
Suggested adding catheter dwell time to better understand failure timing.

Kate Buehler (MPOG Coordinating Center):
Agreed to add time-between-placements to case report.

Ashraf Habib (Duke):
Asked whether epidural replaced with spinal is captured.

Kate Buehler (MPOG Coordinating Center):
Not currently. This is a pure catheter-to-catheter replacement measure. A separate measure could evaluate conversion to spinal.

UDP-01-OB: Unintended Dural Puncture (Draft Measure)

Description

Percentage of patients undergoing neuraxial epidural anesthesia for obstetric procedures with evidence of unintended dural puncture (UDP).

- Threshold: ≤2%
- Timeframe: Neuraxial start → 14 days post-procedure
- Departmental only
- No provider attribution (proposed revision)

Included Procedures

- Labor epidural
- Cesarean delivery
- Postpartum tubal ligation
- External cephalic version
- Transvaginal cerclage

Included Neuraxial Techniques

- Epidural
- Combined spinal-epidural
- Caudal
- Multiple/unclear documentation

Excluded:

- Pure spinal
- No neuraxial
- Unknown type

Numerator Identification

UDP evidence includes:

- Discrete UDP documentation
- Epidural blood patch documentation
- CPT 62273 within 14 days
- ICD-10/ICD-9 codes for CSF leak, dural puncture, or neuraxial headache

Underreporting remains likely despite multiple capture strategies.

Denominator Discussion

Options discussed:

- Number of neuraxial procedures
- Number of obstetric procedures requiring neuraxial
- Number of deliveries
- 14-day obstetric encounter

Brandon Togioka (OB Subcommittee Chair):
“Obstetric encounter” was proposed to avoid double-counting when multiple neuraxial procedures occur in a short timeframe.

Ashraf Habib (Duke):
Clarified that obstetric encounter counts once per 14-day window.

Brendan Carvalho (Stanford):
Suggested simplifying denominator to deliveries only, to reduce complexity.

Daniel Berenson (BWH):
Suggested proportional attribution but agreed delivery-based denominator aligns better with NCR logic.

Cedar Fowler (Stanford):
Clarified denominator should be deliveries with neuraxial, not all deliveries (nitrous-only cases could otherwise inflate denominator).

Consensus Direction:
Use delivery-based denominator (deliveries with neuraxial anesthesia).
Flag only the first neuraxial-associated case within delivery episode.

Preliminary UDP Data

Rates ranged from near 0% to approximately 4% across institutions. Lower rates likely reflect incomplete data mapping.

Kate Buehler (MPOG Coordinating Center):
Outreach doubled the number of sites mapping a discrete UDP variable. Several sites are working on building discrete documentation fields.

2026 Planning Discussion

Priorities:

- Finalize UDP-01-OB
- Develop PONV-06-OB (combined IONV/PONV prophylaxis for cesarean delivery)
- Continue gestational age phenotype development
- Expand neuraxial start time phenotype

Poll — Research Presentation Segment

The committee was polled regarding adding brief (~5 minute) MPOG research presentations to meetings.

Result: Majority in favor.

Brandon Togioka (OB Subcommittee Chair):
We will begin inviting authors of recent MPOG publications to provide short highlights at future meetings.

Adjournment

01:04:39 — Brandon Togioka (OB Subcommittee Chair):
Thank you all for your time and thoughtful discussion. We look forward to seeing you at the next meeting.