Partnership for Patients
Safe Deliveries Roadmap
Learning Collaborative Webcast
November 26, 2014

Safe Deliveries Roadmap
Advancing Safety for Mothers and Babies
A Roadmap from Pre-pregnancy to Postpartum

©2014
Today

• Hear about Safe Deliveries Project updates
• Learn about the Safe Deliveries Roadmap process measures
• Engage in a review of cases that will highlight interesting and challenging decision points as they relate to the labor management recommendations

Presented at Washington State Hospital Association Safe Table Webcast Nov. 26, 2014
Safe Deliveries Roadmap Project Coordinator

Mara Zabari, Executive Director of Integration Partnership for Patients
Washington State Hospital Association

206-216-2529
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Presented at Washington State Hospital Association Safe Table Webcast Nov. 26, 2014
Medicaid Quality Incentive

Elective Delivery 37 to less than 39 Weeks Gestational Age

✔ **Numerator:** Patients with elective deliveries >=37 and < 39 weeks gestation

✔ **Denominator:** Patients delivering newborns between >=37 and < 39 weeks of gestation.

*Data collection period:* July 1, 2014 – December 31, 2014

*Reporting deadline:* 45 days following the end of a quarter

*Data collection system:* Data submitted to the Washington State Hospital Association QBS

---

**Elective Delivery Between 37 and 39 Weeks Award Table:**

<table>
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<th>2 – 1.1%</th>
<th>1 – 0.1%</th>
<th>&lt;0.1%</th>
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<tr>
<td>Point Award</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>10</td>
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</table>
Medicaid Quality Incentive

Percent non-medically indicated inductions with unfavorable cervix in nulliparous women

✓ **Numerator:** Number of non-medically indicated inductions with Bishop’s score <9 in nulliparous women
✓ **Denominator:** Total number of deliveries

**Data collection period:** August 1, 2014 - December 31, 2014
**Reporting deadline:** 45 days following the end of the quarter
Data collection system: Washington State Hospital Association Quality Benchmarking System

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Presented at Washington State Hospital Association Safe Table Webcast Nov. 26, 2014
## Medicaid Quality Incentive

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<tr>
<th>Hospital Name</th>
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Presented at Washington State Hospital Association Safe Table Webcast Nov. 26, 2014
Updates

WSHA Maternal Data Center (WSHA-MDC)
Data Submission Guidelines and Specifications
November 12, 2014

To generate perinatal performance metrics for the Washington State Hospital Association (WSHA) quality improvement programs, hospitals may submit data to the WSHA Maternal Data Center (WSHA-MDC), an online data aggregation and quality improvement tool developed by the California Maternal Quality Care Collaborative (CMQCC) and housed at Stanford University School of Medicine.

Changes since October 1, 2014 Version
- Maternal Clinical File: Gestational Age Fields. The original data specifications called for gestational age to be broken down into two distinct fields: "Gestational Age-Weeks" (required) and "Gestational Age-Days" (optional). However, some hospitals clinical systems capture Gestational Age as a "combined" field that includes both completed weeks and days (e.g. 37+4). The MDC now has a new optional field called "Gestational Age_combined". If your hospital wishes to submit in the combined format, please use the column header "gestational_age_combined". If you submit the combined form (e.g. 36+3) in the "gestational_age_weeks" column, you will receive an error message. See pages 15-16.

Changes since July 30, 2014 Version
- Admission Source Coding: Codes D, E, F available options for coding. See Page 7.
- Clarified instructions on selecting cases for clinical files are on pages 13 and 22.
- Information on how to submit Supplemental Files on pages 13 and 22.

Changes since Test Phase Draft of June 24, 2014
- Section A (page 4): Hospitals should not use DRGs or Major Diagnostic Categories (MDCs) to identify maternal and newborn records; use of these codes may inadvertently omit delivery-related cases with severe complications.
- Section A (page 4): Typo corrected in the last ICD-9 code used for identifying maternal records (74.99 replaces 749.9).
- Patient Discharge Data (Pages 7-8): Wording has been clarified around use of Newborn Codes in Source of Referral field.

Questions or Comments
Please contact Anne Castles at 626-639-3044 or safedeliveries@cmqcc.org.

Summary Guidelines and Timelines
- Participating hospitals will submit administrative and clinical data files in CSV file format to the MDC on a monthly basis.
- Submissions should be based on discharge date for all files and are to be made on a calendar month basis, representing discharges from the first day of
Updates

- WSHA-CMDC user group meeting - January 13th 7:00 - 8:30am
Process Measures
Labor Management Bundle Measures

**Outcome:**
- NTSV Cesarean Section (Nulliparous, Term, Singleton, Vertex)
- TSV Primary Cesarean Section (Term, Singleton, Vertex)
- Induced Cesarean Section (Nulliparous and Multiparous)
- Maternal admission to Intensive Care Unit
- Maternal blood transfusions
- Extended maternal length of stay
- Operative vaginal delivery
- Unexpected Newborn Complications measure (UNC)

**Process:**
- Labor induction practices
- First stage labor practices
- Second stage labor practices

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Two Ways to Submit Process Measures

First Way

• OB COAP
  • OB COAP members and LEAPT hospitals
  • Limited data set option

• LEAPT training
  • December 9\textsuperscript{th} 8:30 – 9:30 tentative
  • December 30\textsuperscript{th} 8:30 – 9:30
  • January 5\textsuperscript{th} 2:30 – 3:30

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# OB COAP Limited Data Set

## Process Measure Data Elements

A) Total deliveries for the time period for each month (per OB-COAP, hospitals may need to track this independently).

B) Patient Population for Abortion: Term, Singleton, Vertex presentation (TSV) (>37 weeks gestation) who are laboring and all Primary Cesarean deliveries.

C) Limited data set for each patient in the population:

1. Case ID Number: __________
2. GA at delivery: __________
3. Parity total: __________ (includes both term and preterm; see rcvITalize definition)
4. Date/Time Admission to L&D: __________

If planned primary Cesarean (no labor) go to question #21

5. In Labor at Admission or Induction of Labor? (select) If Induction of labor go to “Labor Induced” section.

6. Cervical Dilation at Admission: __________ (exclude if cervical exam deferred for PROM)

7. Membranes Intact/Ruptured at admission? (select)

8. Concern for fetal status at Admission? (Y/N)

9. Clinical concern for maternal status at Admission? (Y/N)

10. Adequate maternal pain control? (Y/N)

If Labor Induced (Induction of Labor section-questions 11-14):

11. Induction Non-Medically Indicated? (Y/N)

12. If ML Medically indicated, please select medical indication(s) for Induction (check all that apply from list, or “other” option and fill in option).

13. If Induced, Bishop Score: __________

14. Was cervical ripening used? (Y/N)

If Oxytocin used, Date/time Oxytocin started: __________

If Membranes ruptured date/time membranes ruptured: __________

17. Maximum Cervical Dilation Achieved in Stage I: __________

18. Initial Date/Time reached maximum dilation: __________ (date/time at first measurement of maximum dilation)

19. Delivery Type select: Spontaneous Vaginal, Vaginal with Instrument, Cesarean

20. If Cesarean delivery occurred at ≥6 cm to ≤10 cm for labor dystocia and failure to progress uterine activity was:

   * Greater than 200 Minntesvideo units or at least every 5 minutes palpably strong contractions:
     - Yes
     - No

21. If Cesarean delivery what were indications (see OB-COAP choices)

22. Date/Time Delivery: __________

23. Birthweight: __________

24. 5 min Apgar: __________

25. Delivering provider name: __________; Specialty
Two Ways to Submit Process Measures

Second Way

- Washington State Hospital Association
  - No cost
  - Pilot

Interested Hospitals Contact
Mara Zabari, Executive Director of Integration Partnership for Patients
206-216-2529
maraz@wsha.org

by December 19th
**Bundled Process Measures: Case Review of Primary Cesarean Births**

*(draft v1)*

**Inclusions:** >= 37wks, vertex, singleton, and no prior CS

<table>
<thead>
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<th>Core data for all Cesarean birth reviews:</th>
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<tbody>
<tr>
<td>Patient ID: ____________________________</td>
</tr>
<tr>
<td>Parity (prior to delivery): ____________</td>
</tr>
<tr>
<td>Physician ID: __________________________</td>
</tr>
<tr>
<td>Delivery Date: _________________________</td>
</tr>
<tr>
<td>(If IOI form on reverse side filled out skip duplicate information in this Core data section)</td>
</tr>
<tr>
<td>Maximum Cervical dilation at birth ______ cm</td>
</tr>
<tr>
<td>Newborn weight: ____________ gm</td>
</tr>
</tbody>
</table>

**Was cesarean birth planned without labor? Y/N**
- If Yes, Reason for planned cesarean: Patient choice or Medical indication (circle)
- If Medical Indication, what was the indication?
- If planned cesarean Stop Here

- **Delay admission to >= 4cm bundle if spontaneously laboring at admission:**
- Was the cervical dilation >=4cm? Y/N
- If No and admitted at >=4cm dilation, was there:
  - Clinical concern for maternal or fetal status? (Y/N)
  - Ruptured membranes? (Y/N)
  - Inadequate pain control?

**If patient labored, complete one of the 4 bundle categories below which represents the Primary indication for the Cesarean Birth for laboring patients:**

- **Cesarean birth for Labor Dystocia/FTP in 1st Stage of Spontaneous labor (arrest or protraction disorder)**
  1. Was she in the active phase of labor? Y/N (ACOG active phase of labor: Dilation 2-6 cm)
  2. Had ROM occurred or did she have artificially ruptured membranes (before the arrest time started)? Y/N (ACOG)
  3. With adequate uterine activity, did the arrest of cervical dilation last at least 4hrs? Y/N OR

- **Cesarean birth for Labor Dystocia/FTP in 1st Stage with Induction of labor**
  1. Cervical at < 4cm:
     1. What was the Bishop Score? __________
     2. Was cervical ripening used? Y/N
     3. Was oxytocin administered for at least 12 hrs after membrane rupture? Y/N (if maternal and fetal status allow, ACOG)

  OR

  1. Cervical at >= 4cm:
     1. Had ROM occurred or did she have artificially ruptured membranes (before the arrest time started)? Y/N (ACOG)
     2. With adequate uterine activity, did the arrest of cervical dilation last at least 4hrs? Y/N OR

  OR

  1. Cervical birth in 2nd Stage of labor
     1. What was total time of 3rd Stage (time reached 10cm to time of delivery)? _______
     2. For Multip: Was there at least 2 hours in 2nd stage? Y/N (ACOG)
        For Nullip: Was there at least 3 hours in 2nd stage? Y/N (ACOG)
        (ACOG longer durations maybe appropriate on an individualized basis (e.g. with epidural or malposition) as long as progress is being documented and fetal condition allows)

- **Cesarean birth for concern for Fetal or Maternal Status during labor**
  1. Was there concern for fetal status / fetal heart rate tracings? (Y/N) and/or maternal status? (Y/N)

**Comments:**

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Six Labor Bundles for Case Review

Process Measure Pilot

Primary Cesarean (term singleton vertex-TSV) Bundle #s 1-5

★ Bundle #1: Delay admission to dilation >=4cm (spontaneous labor)

★ Bundles #2-5: (One of these Bundles selected per case based on primary indication for Cesarean plus

1) Spontaneous vs Induced labor
2) Maximum cervical dilation achieved:
   <6cm
   6-<10cm
   10cm

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Labor bundles for Case Review (cont):

Primary Cesarean (TSV)  
Process Measure Pilot

★ Bundle #2: 1st Stage-Failure to Progress  
   Spontaneous labor  
   maximum cervical dilation <10cm

★ Bundle #3: 1st Stage-Failure to Progress  
   Induced labor  
   a. maximum cervical dilation < 6cm  
   OR  
   b. maximum cervical dilation 6 to < 10cm

★ Bundle #4: 2nd Stage-Failure to Descend

★ Bundle #5: Fetal or maternal status concern (1st or 2nd Stage)

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Labor bundles for Case Review (cont)
Induction of Labor (term singleton vertex)
Process Measure Pilot

★ Bundle #6: Induction of Labor - Non-Medically Indicated

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Bundle #2 (Process Measure Pilot)

- Cesarean birth for Labor Dystocia/FTP in 1st Stage of Spontaneous labor (arrest or protraction disorder)

1. Did she reach the active phase of labor?  Y / N  
   (ACOG active phase of labor: Dilation ≥6cm)

2. With adequate uterine activity, did the arrest of cervical dilation last >= 4 hrs? Y/N 
   OR 
   With inadequate uterine activity and oxytocin administration 
   did the arrest of cervical dilation last >= 6 hrs? Y/N (ACOG)

3. Had SROM occurred or did she have artificially ruptured membranes (before the arrest time started) ? Y/N (ACOG)
Bundle #3 (Process Measure Pilot)

- Cesarean birth for Labor Dystocia/FTP in 1st Stage with Induction of labor

  A. Cesarean at < 6cm:
  1. What was the Bishop Score? _______
  2. Was cervical ripening used? (if cervix unfavorable) Y / N
  3. Was oxytocin administered for >= 12 hrs after membrane rupture? Y / N (if maternal and fetal status allow, ACOG)

    OR *******************************************

  B. Cesarean at >= 6cm:
  1. With adequate uterine activity, did the arrest of cervical dilation last >= 4hrs? Y / N  OR
  With inadequate uterine activity and oxytocin administration, did the arrest of cervical dilation last >= 6hrs? Y / N  (ACOG)
  2. Had SROM occurred or did she have artificially ruptured membranes (before the arrest time started)? Y / N  (ACOG)
## Importance of Clinical Judgment

<table>
<thead>
<tr>
<th>Early Elective Delivery Measure</th>
<th>Case Reviews/Bundled Process Measures Pilot</th>
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<tbody>
<tr>
<td>Not all medical conditions are on Joint Commission exclusion list</td>
<td>Not all circumstances are reflected in Bundled Process Measure Criteria</td>
</tr>
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</table>
Case Reviews
Primary Term Singleton Vertex C-section
Bundled Process Measures
Case #1: Appropriate use and limitations of Partogram

Spontaneous Labor presenting to Labor and Delivery at 7-8cm
Case #1: Can you use the Partogram if woman presenting to L&D at 7-8 cm dilation?

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Case #2 Example
Bundle #3a: Cesarean birth at < 6cm dilation for Labor Dystocia/FTP in 1st Stage with Induction of Labor

Criteria review:
1. What was the Bishop Score?____
2. Was cervical ripening used (if unfavorable cervix)? Y/N____
3. Was oxytocin administered for >= 12 hours after membrane rupture? Y/N (if maternal and fetal status allow)
Case #2: Induction of Labor and Maximum Cervical Dilation 5cm

**Day 1:** Presented to Triage G1, 37 4/7 weeks with newly diagnosed Diabetes Type 2 this pregnancy, new headache and elevated BP 140/95, Admission for preeclampsia workup BPs to 170/110, Ruled in for Preeclampsia, Magnesium and anti-hypertensives initiated and Induction of Labor consented

**Bishop Score 5:**
- Dilation 3 – 2 pts
- Effacement 50% - 1 pt
- Station -2 - 1 pts
- Consistency Medium – 1 pt
- Position Posterior – 0 pts

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Case #2: (cont)

**Time 0hr:** Induction of Labor initiated with Pitocin; No cervical ripening

**Time 4hr:** AROM, dilation 4cm, effacement 50%

**Time 10hr:** 5cm dilation, 90%, -1

**Time 22 hr:** 5cm, 90%, -1, greater than 18 hrs since AROM, suboptimal cervical change despite up-titration of Pitocin

C-section recommended

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Case #2 Example

Bundle #3a Criteria Review and Results

1. What was the Bishop Score? 6
2. Was cervical ripening used (if unfavorable cervix)? Y/N  No
3. Was oxytocin administered for >= 12 hours after membrane rupture? Y/N (if maternal and fetal status allow) Yes (> 18 hours)

Bundle #3a Result: Failed one of criteria But medically justified

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Case #3 Example

Bundle #2: Cesarean birth for Labor Dystocia/FTP in 1st Stage with Spontaneous Labor

Criteria Review:
1. Did she reach the active phase of labor? Y/N (ACOG active phase of labor: Dilation >=6cm)
2. With adequate uterine activity, did the arrest of cervical dilation last >= 4 hrs? Y/N
   OR
   With inadequate uterine activity and oxytocin administration, did the arrest of cervical dilation last >= 6 hrs? Y/N
3. Had SROM occurred or did she have artificially ruptured membranes (before the arrest time started)? Y/N

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Case #3: Spontaneous Labor and maximum cervical dilation 8cm

G1, cHTN, 41 1/7 wks, presented to Triage in Labor, painful contractions, cervical dilation 1.5cm, 60% effaced

**Time 0 hr:** Admitted to L&D for elevated BPs, with sBP as high as 160, started on Magnesium and anti-hypertensives, initially managed expectantly

**Time 8.5 hrs:** Cervical dilation 2cm, Decision to start Pitocin for augmentation

**Time 28.5 hrs:** Cervix 4cm, Spontaneous Rupture of membranes, BPs 175/95, 160/92

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Case #3: Spontaneous Labor and maximum cervical dilation 8cm

**Time 31 hrs:** Cervix 6cm, 1cm long, -2 station, IUPC placed;, contractions q3-7 min, 40-70 Montevideo units, moderate intensity, Inadequate uterine activity

**Time 34 hrs:** Cervix 7cm

**Time 36 hrs:** Cervix 8cm, 100%, -1, Pitocin increased to 4mu/min, dBPs in 90s, IV antihypertensives, repositioning and resuscitative measures

**Time 39 hrs:** Cervix 8cm, 100%, -1, Minimal cervical change throughout the day, **no cervical change over 3 hours**, Cesarean delivery recommended

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Case #3 Partogram

Active Phase of Labor for ≥37 Weeks GA

Position:

Action Line
Decision Line

Cervical Dilatation (cm) (Plot X)

Descent of Head (Plot O)

Time (hours)

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Normal labor: Expectant management

Off median normal labor curve: Augment labor management

>95th percentile for normal labor curve: Consider safety of continued labor vs delivery

Action Line: "Normal" median labor progress line for active labor (>6 cm), based on the Zhang et al. partograms. When the patient falls off this line, consider interventions to augment labor (AROM, oxytocin), prior to reaching the decision line.

Decision Line: Four hours to the right of the action line. If the patient's labor progress crosses this line, she is outside the 95th percentile of normal labor progress per the Zhang et al. partogram.
Case #3 Example

Bundle #2 Criteria Review and Results:

1. Did she reach the active phase of labor? Y/N (ACOG active phase of labor: Dilation >=6cm) **Yes**

2. With adequate uterine activity, did the arrest of cervical dilation last >=4 hrs? Y/N

**OR**

With *inadequate uterine activity* and oxytocin administration, did the arrest of cervical dilation last >= 6 hrs? Y/N **No** (*arrest with 3 hrs of no cervical change*)

3. Had SROM occurred or did she have artificially ruptured membranes (before the arrest time started)? Y/N **Yes**

**Bundle Result:** Failed one of criteria But justified by clinical judgment

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Safe Deliveries Roadmap Meeting Schedule

2014

- Roadmap Monthly (webcast) 7:00 – 8:00 a.m.
  - December 18

2015

- Roadmap Monthly (webcast) 7:00 – 8:00 a.m

<table>
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<th>August 20</th>
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<td>June 18</td>
<td>December 16</td>
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<td>July 16</td>
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- Safe Tables (in-person) 9:00 a.m. – 2:30 p.m.
  - February 10
  - September 8

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Thank You!

Mara Zabari, Executive Director of Integration Partnership for Patients
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maraz@wsha.org

Safe Deliveries Roadmap Website
http://www.wsha.org/0513.cfm%20

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