Safe Deliveries Roadmap Project Coordinator

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

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maraz@wsha.org

Presented at Washington State Hospital Association Safe Table Webcast, 1/9/13
Today’s Objectives

• Project Overview
• Project Updates
• CMQCC Maternal Data Center (CMDC)

Anne Castles, MPH, MA - CMDC Project Manager
Partnership for Patients

• 40 – Percent reduction in harm

• 20 – Percent reduction in readmissions

• 14 – by 2014

Saving Lives

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10 Targeted Strategies

**Infection Reduction:**
1. Catheter-associated urinary tract infections (CAUTI)
2. Central line-associated blood stream infections (CLABSI)
3. Surgical site infections (SSI)
4. Ventilator-associated pneumonia (VAP)

**Nursing Care:**
5. Injuries from falls and immobility
6. Pressure ulcers

**High Risk:**
7. Adverse drug events
8. Obstetrical adverse events
9. Venous thromboembolism or blood clots (VTE)

**Continuity of Care:**
10. Prevention of readmissions

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OB Adverse Events

- Partnership for Patients: 2012 – 2013
  - Early Elective Delivery Prior to 39 Weeks
  - Episiotomy
  - Safe Deliveries Roadmap

- Partnership for Patients: 2014
  - Early Elective Delivery Prior to 39 Weeks
  - Episiotomy
  - Safe Deliveries Roadmap
  - Pre-eclampsia
  - Hemorrhage

Today’s Focus

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Washington State Hospital Association
Safe Deliveries Evidenced-Based Roadmap

Pre-Pregnancy
- Increased use of preconception care services
- Improved health entering pregnancy
- Reduced risk from complications due to previous pregnancies

First Month
- Healthier mothers and babies

Pregnancy
- Fewer infant abnormalities and disabilities
- Less maternal and fetal complications
- More educated patients

Delivery
- Less maternal morbidity and mortality
- Fewer early deliveries
- Higher Apgar scores
- Fewer NICU admissions

THE VISION
Partners

- American Congress of Obstetricians and Gynecologists
- Association of Women’s Health, Obstetric & Neonatal Nurses
- March of Dimes
- Northwest Organization of Nurse Executives
- Obstetrics Clinical Outcomes Assessment Program
- Rural Healthcare Quality Network
- Washington State Department of Health
- Washington State Health Care Authority
- Washington State Hospital Association – Partnership for Patients
- Washington State Medical Association
- Washington Perinatal Collaborative

More to Come.....

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Safe Deliveries Roadmap
Project Structure

Steering Committee

Pre-conception Advisory Group
Pregnancy Advisory Group
Delivery Advisory Group
Postpartum Advisory Group

Leadership
Measures
LEAPT

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Safe Deliveries Roadmap Steering Committee

- Sharon Beaudoin, MPH, RD - Within Reach
- Tom Benedetti, MD - University of Washington
- Susan Bishop, RNC-OB, MN - Assoc. of Women's Health, Obstetrics and Neonatal Nurses
- Heather Bradford, CNM, ARNP, FACNM - Evergreen Health; WA State Nurses Assoc.
- Kathy Burgoyne, PhD - Comprehensive Health Education Foundation
- Danette Glassy, MD - Mercer Island Pediatrics; BestStart Washington
- Beth Harvey, MD - South Sound Pediatrics
- Maxine Hayes, MD - WA State Dept. of Health
- Patty Hayes, RN, MN - Public Health Seattle King County
- Brian Johnston, MD - UW Harborview
- Ellen Kauffman, MD - Foundation for Health Care Quality
- Judy Kimelman, MD - American College of Obstetricians and Gynecologists
- Mary Looker - WA Association of Community & Migrant Health Centers
- Merry-K. Moos, RN, FNP, MPH - University of North Carolina
- Carolyn Kline, MD - EvergreenHealth
- Gina Legaz, MPH - March of Dimes
- Dan Lessler, MD - WA State Healthcare Authority
- Kathy Lofy, MD - WA State Dept. of Health
- Molly Pessl, BSN, IBCLC – Evergreen Perinatal Education
- Sarah Prager, MD - Multicare Tacoma; UW Dept. of Ob-Gyn
- Dale Reisner, MD - WA State Medical Assoc.
- Roger Rowles, MD - WA Perinatal Collaborative
- Roy Simms, MD - WA Dept. of Social and Health Services
- Bat Sheva Stein, RN, MSN - WA State Dept. of Health
- Tom Strandjord, MD - Overlake Hospital Medical Center; UW Medical Center

A Few More Still to Come!

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Presented at Washington State Hospital Association Safe Table Webcast 1/9/13

Washington State Hospital Association
Safe Deliveries Evidenced-Based Roadmap

Pre-Pregnancy
- Increased use of preconception care services
- Improved health entering pregnancy
- Reduced risk from complications due to previous pregnancies

Pregnancy
- Fewer infant abnormalities and disabilities
- Less maternal and fetal complications
- More educated patients

Delivery
- Less maternal morbidity and mortality
- Fewer early deliveries
- Higher Apgar scores
- Fewer NICU admissions

First Month
- Healthier mothers and babies
Participating Hospitals

- Cascade Valley Hospital and Clinics
- Central Washington Hospital
- Coulee Medical Center
- EvergreenHealth
- Group Health Cooperative
- Harrison Medical Center
- Highline Medical Center
- Island Hospital
- Jefferson Healthcare
- Kittitas Valley Healthcare
- Lake Chelan Community Hospital
- Legacy Salmon Creek Medical Center
- Mid Valley Hospital
- MultiCare Auburn Medical Center
- MultiCare Good Samaritan Hospital
- MultiCare Tacoma General Hospital
- Newport Hospital
- Othello Community Hospital
- Overlake Hospital
- PeaceHealth Southwest Medical Center
- PeaceHealth St. Joseph Medical Center
- PeaceHealth Sacred Heart Medical Center, Oregon
- PMH Medical Center
- Providence Holy Family Hospital
- Providence Mt. Carmel Hospital
- Providence Regional Medical Center Everett
- Providence Sacred Heart Medical Center & Children’s Hospital
- Providence St. Mary Medical Center
- Providence St. Peter Hospital
- Pullman Regional Hospital
- Samaritan Healthcare
- Skagit Valley Hospital
- St. Elizabeth Hospital
- St. Francis Hospital
- St. Joseph Medical Center – Franciscan Health System
- Sunnyside Community Hospital & Clinics
- Swedish/Ballard
- Swedish /First Hill
- Swedish/Edmonds
- Swedish /Issaquah
- Three Rivers Hospital
- UW/University of Washington Medical Center
- UW/Northwest Hospital & Medical Center
- UW/Valley Medical Center
- Valley Hospital/Rockwood Health System
- Walla Walla General Hospital
- Whitman Hospital and Medical Center
- Yakima Valley Memorial Hospital

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Labor Management Bundle

Labor Management Bundle – Draft*

<table>
<thead>
<tr>
<th>Aspect of Care</th>
<th>Decision Point</th>
<th>Practice/Indications</th>
</tr>
</thead>
</table>
| Prenatal       | Assessment of Gestational Age | ✓ Provide documentation on how and when gestational age determined (most recent ACOG criteria or Bundle) – note 17 week dating in most scenarios.
| Labor induction | Pre-procedure | ✓ Consent form discussed with patient and signed for any induction; medical and non-medical (ACOG induction consent or equivalent).
|                | Non-medically indicated | ✓ Not done prior to 39 weeks gestation. |

*additional details and references forthcoming

Between 39 – 40 6/7 weeks gestation must have Bishop score of 8 or greater (no cervical effacement)

Medically indicated

- Does not include medical indications within evidence-based Maternal Association guidelines (ACOG, SMFM, etc.) for definition and most appropriate gestational age for delivery. For indications not on above lists, consultation or advance is recommended.
- Cervical ripening if deemed for unfavorable cervix.

Failed induction (assuming viable mother and fetus) – parameters to test when not causing active labor (≥ 8 cm):

- Failed: failure to achieve uterine contractions every 3 minutes with cervical change after 14 hrs of previous and with AROM (due to contractions), or uterine contractions every 5 mins × 24 hrs without evidence active phase of normal Bishop score was less than 6 or if cervical ripening was used.
- Indications response to a needed, clinically appropriate, second cervical ripening agent.
- Manifestation have been ruptured with inadequate progress (assuming feasible and no contraindications to AROM).
Labor Management Bundle Measures

Safe Deliveries Roadmap – Labor Management Bundle Measures*

Outcome:
- NTSC Cesarean Section (Nulliparous, Term, Singleton, Vertex)
- TTS Primary Cesarean Section (Term, Singleton, Vertex)
- Elective induction of labor
- Maternal admission to Intensive Care Unit
- Maternal blood transfusions
- Maternal length of stay
- Operative vaginal delivery
- Unexpected Newborn Complications measure

Process:
- Compliance with labor induction practices
- Compliance with first stage labor practices
- Compliance with second stage labor practices

*Details, including data source, numerator, denominator and sample requirement will be forthcoming.

For questions, please contact Mara Zabari, Director of Integration - Partnership for Patients, at mzarad@wsba.org or 510) 216-2929.
Roll-out

- On-boarding: (July – December)
  - Readiness assessment
  - Education

- Algorithm and checklist testing: LEAPT group (December – March)

- Data Collection (April)

- Implementation: (April)
Data Sources

CQMCC Maternal Data Center (CMDC)
Obstetrics Clinical Outcomes Assessment Program (OB COAP)
Washington State Health Data System

• Criteria
  • Safe Deliveries Roadmap measures within specified period of time.
  • Data burden on hospitals
  • No duplication of data abstraction
  • Protection from disclosure and discovery – CQIP
  • Ability to drill down to individual cases for quality improvement
  • Hospital and system level reports
  • Costs
  • Capability for health systems that cross state boundaries to allow all of their hospitals to participate.

• Decision - leverage strengths of all three systems
  • CQMCC Maternal Data Center (CMDC) – Safe Deliveries Roadmap outcomes
  • OB COAP – LEAPT project (to be determined)
  • WA State Health Data System – support infrastructure build for future

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Request for Data Submission

Safe Deliveries Roadmap

As a member of the Washington State Hospital Association (WSHA) Safe Deliveries Roadmap initiative, WSHA and the Washington State Perinatal Collaborative are inviting you to participate in a groundbreaking project to collect and analyze data on current OB best practices. Through a partnership with the CMQCC Maternal Data Center (CMDC), this system will use existing data to create Safe Deliveries Roadmap measures benchmark reports for your hospital and system. The benefits to your hospital are:

- Administered by Dr. Elliott Main, one of the nation's leading experts, actively involved in multiple state and national Maternal Quality measurement committees including NQF, ACOG/AMA and the Joint Commission.
- Reduces overall chart abstraction costs by utilizing preexisting data sets such as patient discharge data for multiple high interest and required perinatal measures by CMS, Leapfrog, and the state Medicaid program (e.g. 95% reduction in chart abstracted elements needed for Early Elective Delivery).
- Provides state-of-the-art electronic hospital interface that enables drill down to provider and patient level data.

The CMDC was selected after experts in obstetrics and the state evaluated a number of systems.

Enrollment:

Due by **Friday, February 28, 2014**.

1. Attend the Next Steps Webcast, January 9, 2014, 7:00 - 8:00 a.m. to learn more about the CMDC data system. Connection information below.
2. Print out this form, complete the information below, and send it with your enclosed check made payable to WSHA.

**Cost:**
- Critical access hospitals: $2,500*
- Non-critical access hospitals: $3,500*

*Subsidized by WSHA

**Connection Information:** (Registration is not necessary)
1. Go to: [http://wsa.webex.com](http://wsa.webex.com)
2. Session Password: roadmap (all lower case)
3. Audio connection information: 1-877-668-4400 Session number will appear on the screen. When dialing in, please include your “Attendee ID” code which will appear in the pop-up screen.

For questions, please contact Mara Zabari, Executive Director – Integrated Care Partnership for Patients
706-216-2859 or maraz@wsa.org

☐ YES, I would like to participate in the Safe Deliveries Roadmap Data Collection

☐ Enclosed is a check, payable to WSHA

Please send this form with your check enclosed to: Washington State Hospital Association Attn: Mara Zabari 300 Elliott Avenue West Suite 300 Seattle, WA 98119

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FAQs

• What is the cost to participate?
  • Critical access hospitals: $2,500*/yr
  • Non-critical access hospitals: $8,500*/yr
  * Subsidized by WSHA

• What does subsidized by WSHA mean?

• Is there an opportunity for a reduced fee?

• Can we pay in installments?

• What if we can’t enroll in CDMC at this time but want to continue to participate in the Safe Deliveries Roadmap project?

• Do OB COAP hospitals need to enroll in the CDMC system to participate in the Safe Deliveries Roadmap?

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The CMQCC Maternal Data Center (CMDC)

Anne Castles, MPH, MA  
CMDC Project Manager

Elliott Main, MD  
CMQCC Medical Director

Presented at Washington State Hospital Association Safe Table Webcast, 1/9/13
What is the CMDC? (And how can data help my hospital??)

A one-stop shop to support hospitals’ obstetric quality improvement initiatives and service line management

- Overall hospital performance measures
- Drill-down to the patient level and case review worksheets to identify quality improvement opportunities—for both clinical quality and data quality
- Provider-level statistics—to assess variation within a hospital
- Benchmarking statistics--to compare your hospital to regional, state, and like-hospital peers in WA and CA
- Facilitating reporting to Leapfrog, Roadmap, and HEN
CPQCC and CMQCC

Mission: Improving care for moms and newborns

California Perinatal Quality Care Collaborative (CPQCC)
- Expertise in data capture from hospitals
- Established Perinatal Data Center in 1996: Now 132 Hospital Participants

California Maternal Quality Care Collaborative (CMQCC)
- Statewide collaborative composed of providers, payers, purchasers, public health agencies and consumer groups
- Expertise in maternal data analysis
- Developer of QI toolkits
- Host of collaborative learning sessions
- Established Maternal Data Center in 2011
Why join the Maternal Data Center?

- Support QI activities in a way that is aligned with national and state performance reporting requirements (Joint Commission, Leapfrog, CMS, Medicaid)
- Fingertip access to key perinatal metrics and patient-level drill-down
- Facilitate performance reporting to Leapfrog, Medicaid, CMS Inpatient Quality Reporting Program and HEN
- Improve data quality!
- Reduce data collection, query and reporting burden within clinical, quality & decision support departments by:
  - Combining existing Patient Discharge Data (PDD) with subsets of clinical data
  - Providing user-friendly chart abstraction tools
Low-Burden Data Collection

- **PDD--Discharge Diagnosis File (ICD9 codes)**
- **Birth File (Clinical Data)**

Hospital or State PDD to CMQCC

Hospital or State Vital Records Data to CMQCC

CMQCC Data Center

Calculates all the Measures

**LIMITED CHART REVIEW**
- Roadmap Metrics
  - Optionally:
    - ED<39 Weeks
    - Antenatal Steroids
    - Bilirubin Screen
    - DVT Prophylaxis

**REPORTS**
- Benchmarks against other hospitals
- Sub-measure reports

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Maternal Data Center Demonstration
### Participation Steps

<table>
<thead>
<tr>
<th>What?</th>
<th>Who?</th>
<th>When?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Complete a Participation Agreement with CMQCC and WSHA</td>
<td>Hospital Director-Level/Legal</td>
<td>• Agreement distributed by mid-February</td>
</tr>
</tbody>
</table>
| 2a. Submit a subset of the CHARS Patient Discharge Data (PDD) your hospital already collects and reports | IT staff already making CHARS Data Submissions | • Data specifications distributed by mid-February  
• Aim for first data submission (January 2014 data) in April 2014 |
| 2b. Interim: Submit 7 clinical data elements—either via electronic file submission or manual data entry  
(MRN, DOB, OB Estimate of Gestational Age, Parity, Birthweight, Apgar Score, Delivering Provider)  
Future: Data directly from Vital Records | IT staff create clinical data file from clinical data systems  
OR  
Clinical departments manually enter data for subset of cases  
OR  
Future: Vital Records | Same |

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Value beyond Joint Commission Reporting

- CMDC metrics represent entire population of deliveries
  - Likely to reduce “skew” due to sampling from quarter to quarter

- Easy identification of facility-specific QI opportunities
  - Drill-down patient level information
  - Data quality reports to identify coding issues that impact performance
  - Case review worksheets

- Metrics beyond Joint Commission Perinatal Care set

- Statewide, regional and system-wide benchmarks
CMDC Measures

Labor and Birth Measures
- Elective Delivery <39 Weeks (PC-01)*
- Episiotomy Rate
- OB Trauma (3/4th Laceration)-Cesarean Delivery (AHRQ EXP-2)
- OB Trauma (3/4th Laceration)-Vaginal Delivery w/ Instrument (AHRQ PSI 18)
- OB Trauma (3/4th Laceration)-Vaginal Delivery w/o Instrument (AHRQ PSI 19)
- Cesarean Section—Nulliparous, Term, Singleton, Vertex (PC-02)#
- Cesarean Section—Nulliparous, Term, Singleton, Vertex, Age Adjusted
- Cesarean Section—Term, Singleton, Vertex (AHRQ IQI 21)
- Cesarean Section—Primary (AHRQ IQI 33) #
- Total Cesarean Rate
- Induction Rate
- Failed Induction Rate
- Appropriate DVT Prophylaxis in Women Undergoing C-Section (Leapfrog)*
- Vaginal Birth After Cesarean (VBAC) Rate, All (AHRQ IQI 34)
- Vaginal Birth After Cesarean (VBAC) Rate, Uncomplicated (AHRQ IQI 22)

Newborn Measures
- Newborn Bilirubin Screening Prior to Discharge (Leapfrog)*
- 5 Minute APGAR <7 Among All Deliveries >= 39 weeks
- 5 Minute APGAR <7 in Early Term Newborns
- Birth Trauma - Injury to Neonate (AHRQ PSI 17)
- Unexpected Newborn Complications (Total, Severe, Moderate) (NQF #716) #

Prematurity Measures
- Antenatal Steroids (PC-03)
- Antenatal Steroids-Leapfrog
- VLBW (<1500g) NOT delivered at a Level III NICU

Additional Roadmap Outcome Measures
- Elective Inductions
- Maternal Admission to ICU
- Maternal Blood Transfusions
- Maternal Postpartum Length of Stay (Vaginal vs. Cesarean)
- Operative Vaginal Delivery

*Requires additional limited chart review
#Also a Roadmap Outcome Measure

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Maternal Data Center
Screen Shots
Transforming Maternity Care

Presented at Washington State Hospital Association Safe Table Webcast, 1/9/13
Transforming Maternity Care

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Transforming Maternity Care

Presented at Washington State Hospital Association Safe Table Webcast, 1/9/13
Transforming Maternity Care

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3 Major Drivers of the Primary CS Rate

The Primary CS rate (Denominator=all mothers without a prior CS; Numerator=among those mothers, who had a CS) is comprised of 3 major, mutually exclusive sub-populations. Nulliparous term singleton vertex (NTSV), multiparous term singleton vertex (MTSV) and mothers who have a preterm, multiple, or non-vertex pregnancy. NTSV is the component that has driven the 50% increase in primary CS in the last decade, is typically the largest component, and has the greatest variation among hospitals. This graph helps you determine what drives your primary CS rate. Each component tells you what percentage of your women with no prior CS has a CS for these populations.

### Period: Oct 2012 - Sep 2013 (12 months)

#### What Drives Our Primary CS Rate?

<table>
<thead>
<tr>
<th>Component</th>
<th>NTSV</th>
<th>MTSV</th>
<th>Preterm/Multiples/Breech</th>
<th>Total Primary CS Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sample Hospital</strong></td>
<td>15.9%</td>
<td>2.3%</td>
<td>8.7%</td>
<td>26.8%</td>
</tr>
<tr>
<td>All Community NICUs (2012)</td>
<td>11.4%</td>
<td>3.3%</td>
<td>6.5%</td>
<td>21.2%</td>
</tr>
<tr>
<td>Statewide (2012)</td>
<td>11.5%</td>
<td>3.2%</td>
<td>6.3%</td>
<td>21.1%</td>
</tr>
</tbody>
</table>

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How do Our Hospital’s Primary CS Sub-population Rates Compare?

In contrast to the above bar graph, this figure shows the specific rates for each of the 3 patient sub-populations. For example, what percentage of your NTSV population did you perform a CS on? This allows comparison of hospital performance between hospitals and to benchmarks for a specific indication.

<table>
<thead>
<tr>
<th>Sub-population</th>
<th>Iota Beta Hospital</th>
<th>All Pi-Level NICUs (2012)</th>
<th>Statewide (2012)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nulliparous Term Singleton Vertex</td>
<td>32.7%</td>
<td>27.8%</td>
<td>27.6%</td>
</tr>
<tr>
<td>Multiparous Term Singleton Vertex</td>
<td>6.0%</td>
<td>7.2%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Preterm/Multiples/Breech</td>
<td>68.1%</td>
<td>51.8%</td>
<td>52.2%</td>
</tr>
</tbody>
</table>
3 Major Drivers of the NTSV CS Rate

What Drives Our Nulliparous Term Singleton Vertex (NTSV) CS Rate of 32.1%?

The NTSV CS rate is comprised of 3 major, mutually exclusive sub-populations (Spontaneous labor resulting in CS, Induced Labor Resulting in CS, and CS with no Labor). This breakdown of the NTSV CS rate should help determine where QI efforts can best be applied. The most common issue among most hospitals is a high rate of CS during NTSV spontaneous labor. Some hospitals may also have a high rate during induced labor.

Sample Hospital

<table>
<thead>
<tr>
<th></th>
<th>Spontaneous Labor</th>
<th>Induced Labor</th>
<th>No Labor</th>
<th>Total NTSV CS Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample Hospital</td>
<td>18.0%</td>
<td>6.1%</td>
<td>8.0%</td>
<td>32.1%</td>
</tr>
<tr>
<td>All Community NICUs (2012)</td>
<td>15.3%</td>
<td>7.4%</td>
<td>4.9%</td>
<td>27.6%</td>
</tr>
<tr>
<td>Statewide (2012)</td>
<td>15.6%</td>
<td>7.3%</td>
<td>4.8%</td>
<td>27.6%</td>
</tr>
</tbody>
</table>
How do our hospital’s NTSV CS Sub-population Rates Compare?

In contrast to the above bar graph, these figures show the specific CS rates for each of the 3 NTSV sub-populations with further divisions into CS indications based on ICD9 codes. For example, what proportion of your NTSV Spontaneous Labor population had a CS with the indication of Fetal Distress? A similar approach is taken for Induced Labor. However, for the No Labor sub-population, the denominator is the entire NTSV population. Note: the No labor sub-population often has significant documentation and coding issues.

The comparison to similar facilities and the state as whole may help you identify which area have the most improvement opportunity. Further detail can be obtained by clicking on a label to see trends and other benchmarks. If you continue clicking you can drill down to the individual numerator cases to better understand the findings.

Spontaneous Labor

- FTP / CPD
- Fetal Distress
- Other

Proportion of the NTSV Spontaneous Labor population that had a CS for the specific indication

Induced Labor

- FTP / CPD
- Fetal Distress
- Other

Proportion of the NTSV Induced population that had a CS for the specific indication

No Labor

- Medical Indication
- Macrosomia / Unengaged Head
- Other / Unknown

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Comparison Rates for the 3 Major NTSV Drivers

Spontaneous Labor
- FTP / CPD: 15.3% (Sample Hospital), 15.6% (All Community NICUs 2012), 5.2% (Statewide 2012)
- Fetal Distress: 6.5% (Sample Hospital), 5.4% (All Community NICUs 2012), 5.2% (Statewide 2012)

Proportion of the NTSV Spontaneous Labor population that had a CS for the specific indication.

Induced Labor
- FTP / CPD: 23.4% (Sample Hospital), 24.2% (All Community NICUs 2012), 6% (Statewide 2012)
- Fetal Distress: 7.1% (Sample Hospital), 6.9% (All Community NICUs 2012), 4.7% (Statewide 2012)
- Other: 4.5% (Sample Hospital), 4.7% (All Community NICUs 2012), 4.5% (Statewide 2012)

Proportion of the NTSV Induced population that had a CS for the specific indication.

No Labor
- Medical Indication: 1.4% (Sample Hospital), 1.4% (All Community NICUs 2012), 1.4% (Statewide 2012)
- Macrosomia / Unengaged Head: 2.8% (Sample Hospital), 1.4% (All Community NICUs 2012), 1.4% (Statewide 2012)
- Other / Unknown: 2.1% (Sample Hospital), 2.1% (All Community NICUs 2012), 3.1% (Statewide 2012)

Proportion of the entire NTSV population that had a no labor CS for the specific indication.

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## Provider-Level Cesarean Rates

<table>
<thead>
<tr>
<th>Provider</th>
<th>Total Deliveries</th>
<th>NTSV Cesarean Section</th>
<th>Total CS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rate</td>
<td>D</td>
<td>Rate</td>
</tr>
<tr>
<td>Oct 2012 - Sep 2013 Statewide</td>
<td>27.6%</td>
<td>163090</td>
<td>33.2%</td>
</tr>
<tr>
<td>Sample Hospital</td>
<td>5844</td>
<td>32.2%</td>
<td>2369</td>
</tr>
<tr>
<td>G5xxxx</td>
<td>52</td>
<td>13.6%</td>
<td>22</td>
</tr>
<tr>
<td>G6xxxx</td>
<td>47</td>
<td>36.8%</td>
<td>19</td>
</tr>
<tr>
<td>G7xxxx</td>
<td>68</td>
<td>20.8%</td>
<td>24</td>
</tr>
<tr>
<td>G8xxxx</td>
<td>60</td>
<td>15.4%</td>
<td>26</td>
</tr>
<tr>
<td>A8xxxx</td>
<td>190</td>
<td>42.7%</td>
<td>75</td>
</tr>
<tr>
<td>A6xxxx</td>
<td>52</td>
<td>35.0%</td>
<td>20</td>
</tr>
<tr>
<td>A5xxxx</td>
<td>2</td>
<td>No Cases</td>
<td>0</td>
</tr>
<tr>
<td>A4xxxx</td>
<td>114</td>
<td>35.3%</td>
<td>51</td>
</tr>
<tr>
<td>A8xxxx</td>
<td>214</td>
<td>18.3%</td>
<td>82</td>
</tr>
<tr>
<td>A9xxxx</td>
<td>481</td>
<td>36.2%</td>
<td>163</td>
</tr>
</tbody>
</table>

Presented at Washington State Hospital Association Safe Table Webcast, 1/9/13
Uploading Data Files

- CMQCC receives Birth Data from Hospital (interim) or directly from the Center for Health Statistics (future)
- Hospital uploads Admin Data (Patient Discharge Data) for one or more months
- After both files uploaded, linkage occurs instantaneously.
- If additional record review required, notation “Action Needed” appear

<table>
<thead>
<tr>
<th>DATA STATUS</th>
<th>February ’13</th>
<th>March ’13</th>
<th>April ’13</th>
<th>May ’13</th>
<th>June ’13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Data</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
</tr>
<tr>
<td>Admin Data</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
</tr>
<tr>
<td>Data Linkage</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
</tr>
<tr>
<td>Elective Delivery</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
</tr>
<tr>
<td>Antenatal Steroids</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
</tr>
<tr>
<td>Antenatal Steroids-Leapfrog</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
</tr>
<tr>
<td>Bilirubin Screening</td>
<td>🚨 Action Needed</td>
<td>🚨 Action Needed</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
</tr>
<tr>
<td>DVT Prophylaxis</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
<td>✔ Complete</td>
<td>🚨 Action Needed</td>
<td>✔ Complete</td>
</tr>
</tbody>
</table>
Data Entry for Chart Review

- Once the data linkage is complete, the system performs the preliminary analysis for any chart review measures and identifies the subset of charts to be reviewed.
- A worksheet can be printed for use in review
- Data is entered by clicking into this interactive screen

### CHART REVIEW

**Time Period:** Delivery Discharges from 08/01/2012 to 08/31/2012

Chart review is necessary for 4, or 0.8% of all linked deliveries during this period.

- Uncomplicated Patients (After Joint Commission Algorithm Applied)
- 37/38 weeks gestational age AND
- C/S

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>123456</td>
<td>07/26/2013</td>
<td>07/29/2013</td>
<td>38</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Remaining to complete: 0

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Reporting Center

- Each measure is displayed graphically and as a data table
- Each measure can be downloaded either as an image for use in presentations or as a data file to be used in reports

Select quality measure to display

Select comparison group(s) for your hospital

Download this measure

Click on rate to “Drill Down” to see the numerator cases

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Drill Down Information

- Can drill down to see case-level information
- Hover boxes show definitions for ICD-9 codes

![Drill Down Information Table](image)

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Data Quality Reports

- Identify discrepancies or missing data in Birth Certificate and Discharge data files
- Use to target data performance/quality improvement

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MISSING / INCONSISTENT DELIVERY METHOD

Cases where the BC method of delivery is missing or doesn't match the admin data

Frequency
- Monthly
- Quarterly
- Annually

Download As
- PNG (image)
- CSV (Excel)
Targeting QI Activities

What is driving your *Elective Delivery*<39 Weeks Rate?

---

**Measure Overview**

*Inductions and Cesareans before labor among 37 and 38wk gestations without medical or OB complications (JC, CMS, NQF)*

<table>
<thead>
<tr>
<th>Submeasure</th>
<th>Our Rate</th>
<th>Target</th>
<th>System Average</th>
<th>State Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Delivery Under 39 Weeks</td>
<td>18.5%</td>
<td>5.0%</td>
<td>19.5%</td>
<td>19.5%</td>
</tr>
</tbody>
</table>

**Is our issue with CS or inductions?**

The data below indicates which delivery method—Primary C-section, Repeat C-section or Induction—is driving your hospital’s Elective Delivery < 39 Weeks rate. The delivery methods with the higher numbers are making the greatest impact on your hospital’s overall Elective Delivery rate.

<table>
<thead>
<tr>
<th>Submeasure</th>
<th>Our Rate</th>
<th>System Average</th>
<th>State Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary C-Sections Not in Labor</td>
<td>3.5%</td>
<td>3.5%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Repeat C-Sections Not in Labor</td>
<td>13.9%</td>
<td>13.6%</td>
<td>13.3%</td>
</tr>
<tr>
<td>Inductions</td>
<td>1.2%</td>
<td>2.5%</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

**Are our coding practices comparable?**

**Which providers have the largest impact?**

**Fewer 37-38 week births overall or just “re-labeling”?**

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Comparative Statistics on:

- Demographic Indicators
- Maternal Conditions
- Delivery Methods
- Prematurity Rates
- Length of Stay

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Data Edit Tool: To allow data corrections
Two Security Gates

**MATERNAL DATA CENTER**

<table>
<thead>
<tr>
<th>Email*</th>
<th><a href="mailto:john.doe@example.org">john.doe@example.org</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Login*</td>
<td>john.doe</td>
</tr>
<tr>
<td>First Name*</td>
<td>John</td>
</tr>
<tr>
<td>Last Name*</td>
<td>Doe</td>
</tr>
<tr>
<td>Password*</td>
<td>************</td>
</tr>
</tbody>
</table>

Password Confirmation: ************

Phone numbers*
Each time you log in, you will select one of your listed phone numbers; the Data Center will call (or text) the selected number to transmit a temporary PIN that is also required for accessing the system.

<table>
<thead>
<tr>
<th>Label*</th>
<th>Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type*</td>
<td>Landline</td>
</tr>
<tr>
<td>Number*</td>
<td>(415) 888-1235</td>
</tr>
</tbody>
</table>

Remove this phone number

**MATERIAL DATA CENTER**

<table>
<thead>
<tr>
<th>Cell (626) 260-4532</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home (626) 441-2135</td>
</tr>
<tr>
<td>Office (626) 639-3044</td>
</tr>
</tbody>
</table>

**REQUEST PIN**

<table>
<thead>
<tr>
<th>Call</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call</td>
<td></td>
</tr>
<tr>
<td>Call</td>
<td></td>
</tr>
<tr>
<td>Call</td>
<td></td>
</tr>
</tbody>
</table>
FAQs

• What is the cost to participate?
  • Critical access hospitals: $2,500*/yr
  • Non-critical access hospitals: $8,500*/yr
  * Subsidized by WSHA

• What does subsidized by WSHA mean?

• Is there an opportunity for a reduced fee?

• Can we pay in installments?

• What if we can’t enroll in CDMC at this time but want to continue to participate in the Safe Deliveries Roadmap project?

• Do OB COAP hospitals need to enroll in the CDMC system to participate in the Safe Deliveries Roadmap?
Other Questions?
Next Steps

• Introduction to California Maternal Data Center for:
  • Individuals responsible for obstetric department data capture
  • Individuals responsible for hospital data systems from which Chars data is extracted
  • Individuals responsible for hospital electronic clinical systems (EMR)
• Next presentation **Thursday, January 23\(^{\text{th}}\), noon to 1:00 p.m.**
• Participation agreements distributed mid-February
• Pay fees to Washington State Hospital Association by February 28\(^{\text{th}}\)
• Sign up for training
• Submit data – anticipate April

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Meeting Schedule

2014

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

<table>
<thead>
<tr>
<th>January 9</th>
<th>July 23</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 21</td>
<td>August 19</td>
</tr>
<tr>
<td>March 26</td>
<td>September 18</td>
</tr>
<tr>
<td>April 23</td>
<td>October 21</td>
</tr>
<tr>
<td>May 20</td>
<td>November 26</td>
</tr>
<tr>
<td>June 12</td>
<td>December 18</td>
</tr>
</tbody>
</table>

JUST ADDED!  CQMCC Maternal Data Center - January 23rd, noon – 1:00 p.m.

- Safe Tables (in-person) 9:00 a.m. – 2:30 p.m.
  - April 1
  - July 24
  - November 20

Presented at Washington State Hospital Association Safe Table Webcast, 1/9/13
Thank You!

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

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