Safe Deliveries Roadmap
Learning Collaborative Webcast
June 18, 2015

Safe Deliveries Roadmap
Advancing Safety for Mothers and Babies
A Roadmap from Pre-pregnancy to Postpartum
Mara Zabari, Executive Director of Integration
Washington State Hospital Association

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maraz@wsha.org

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015
Hear Dr. Loren Molina, from Tacoma General Hospital - MultiCare Health System, discuss the challenges of managing the bariatric pregnant patient.

Learn how they are developing processes to address the unique needs of this population and steps to take at your own hospital to provide safe and effective care.

Learn how to determine your best practices for the antepartum, intrapartum and postpartum periods.

Get updates on the Safe Deliveries Roadmap project.
Medicaid Quality Incentive
2015
OB Measures

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015
Timeline

**July 1, 2015 through December 31, 2015**
- Hospitals collect performance data

**March 2016**
- Chief Financial Officer attestation

**April 2016**
- HCA determines which hospitals qualify for payment

**July 2016 (state fiscal year 2017)**
- Hospitals receive incentive payment and new year begins
Safe Deliveries

- Non medically indicated inductions with unfavorable cervix in nulliparous women

- Elective deliveries in 37 to less than 39 weeks gestational age (PC – 01)

- Cesarean section rate for low risk first born (NTSV) (PC-02)
Percent non-medically indicated inductions with unfavorable cervix in nulliparous women

✓ **Numerator:** Number of non-medically indicated inductions with Bishop’s score <9, prior to cervical ripening, in nulliparous women

✓ **Denominator:** Total number of deliveries

**Data collection period:** July 1, 2015 - December 31, 2015  
**Reporting deadline:** 45 days following the end of the quarter  
**Data collection system:** Washington State Hospital Association Quality Benchmarking System

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**Obstetrical Inductions Award Tables:**

For hospitals with ≤100 deliveries/6 months (July-December 2015)

<table>
<thead>
<tr>
<th>Threshold</th>
<th>&gt; 3 cases</th>
<th>3 cases</th>
<th>2 cases</th>
<th>0-1 case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point Award</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

For hospitals with >100 deliveries/6 months (July-December 2015)

<table>
<thead>
<tr>
<th>Threshold</th>
<th>&gt; 3%</th>
<th>2.1 - 3%</th>
<th>1.1 - 2%</th>
<th>0 – 1%</th>
</tr>
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<tbody>
<tr>
<td>Point Award</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

This measure is used in the quality incentive for acute care hospitals with obstetrical units.
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.

*Review Process Available*

_Data collection period:_ July 1, 2015 – December 31, 2015  
_Reporting deadline:_ Monthly data submitted by 75 days following the end of a quarter  
_Data collection system:_ Data submitted to the Washington State Hospital Association QBS

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

<table>
<thead>
<tr>
<th>Threshold</th>
<th>&gt;1.7%</th>
<th>1.7 – 0.7%</th>
<th>0.6 – 0.1%</th>
<th>&lt;0.1%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point Award</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

This measure is used in the quality incentive for acute care hospitals with maternity units.

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015
Elective Delivery External Review

• The hospital will conduct an internal review to determine whether the case should be submitted to the Health Care Authority for external review. The internal review should include at least two Obstetric providers from a different provider group(s) than the provider group whose patient is being reviewed.

If there is no other internal provider group, the additional providers can be from another hospital.

• If the internal review determines that an external review is warranted, a request for a case review can be submitted to the Health Care Authority by faxing the request form located on the Washington State Hospital Association website in the Medicaid Quality Incentive section at http://www.wsha.org/0558.cfm to: the Washington State Health Care Authority: 360-586-9551.

• The request form asks hospitals and attending providers to provide a brief (250 words or less) narrative case-description that includes a description of the clinical circumstances justifying the early-term delivery as medically indicated.

• Based on review of the narrative, the committee may decide that the early-term delivery was medically indicated; if so, no further review is needed. In order for an early-term delivery to be deemed “medically indicated” on the basis of the narrative alone, the review panel must be in unanimous agreement.
Elective Delivery External Review

• If the committee is unsure or believes on the basis of the narrative that the delivery may not have been medically indicated, then a full review via phone that includes committee members, a hospital representative(s), and attending provider(s) will be conducted. Full reviews via teleconference will be scheduled on an ad hoc basis; while every effort will be made to accommodate hospital representatives and attending physicians, scheduling will be based primarily on the availability of the Panel.

• During the teleconference the hospital and attending provider(s) will have 5 minutes to present their case followed by a brief period for panel members to ask any clarifying questions. The person(s) presenting the case will then be excused from the call and the review panel will deliberate. HCA will send a notification of the review panel’s decision to the hospital contact within 7 days.

• The Panel’s decisions will be determined by a formal vote of the panel. If 50% or more of the voting panel members concur that an early-term delivery was medically necessary, the hospital will be so informed and shall classify the delivery as such; otherwise, the delivery shall be classified as not medically indicated.

• The deadline to request an external review is February 1, 2016.
Cesarean Rate for Low Risk First Born (NTSV)

- **Numerator**: From among the denominator, patients with a cesarean delivery
- **Denominator**: Nulliparous patients delivering a live term singleton newborn in vertex presentation.
- **Exclusions**: Intrapartum transfers for a higher level of care and transfers where the intended place of birth was not at current hospital (i.e. delivery intended at home or birth center) with transfer occurring less than 3 days from delivery date.

**Data collection period**: September 1, 2015 – December 31, 2015

**Reporting deadline**: Submitted monthly, 75 days following the end of a month

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

### Cesarean Rate for Low Risk, First Born Award Table:

<table>
<thead>
<tr>
<th>Threshold</th>
<th>&lt;0.5% reduction of hospital’s baseline* (calendar year 2014)</th>
<th>0.5-0.99% reduction of hospital’s baseline* (calendar year 2014)</th>
<th>1.0-1.99% reduction of hospital’s baseline* (calendar year 2014)</th>
<th>&gt;=2% reduction of hospital’s baseline* (calendar year 2014) OR &lt;= Healthy People 2020 goal of 23.9%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point Award</td>
<td>0</td>
<td>3</td>
<td>5</td>
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Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015
Featured Presentation
PREGNANCY
AND THE
BARIATRIC PATIENT

Washington State Hospital Association Webinar
June 18, 2015

Loren Molina, MD, FACOG
Chair, Women’s Health Services
Tacoma General Hospital / Allenmore Hospital
MultiCare Regional Maternal-Fetal Medicine

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015
Start with the definition…

Super Obese
Morbidly Obese
Severely Obese
Obese
Overweight
Ideal BMI
Underweight

Class I
Class II
Class III

-19 19-25 25-30 30-34 35-39 40-49 +50

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015
Start with the definition...

In a 5'4” woman...

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015
No Surprise…

We are getting bigger.
No Surprise…

We are getting bigger.

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015
No Surprise…

We are getting bigger.
No Surprise…

We are getting bigger.
No Surprise…

The U.S. is the most obese country in the world

More than 1/3 of U.S. adults are obese = 78.6 million people
It’s not just us...

The U.S. may be the most obese country in the world, but...
Drastic Measures...

Dubai pays its citizens **IN GOLD** to lose weight!

New Zealand has declined renewal of work visas for overweight visitors.

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015
The Costs of Obesity

In 2008, the estimated annual medical cost of obesity in the U.S. was $147 billion dollars.

- Heart Disease
- Stroke
- Diabetes
- Cancer
- Sleep apnea
- Dysmenorrhea
- Osteoarthritis
- Dyslipidemia

The medical costs for an obese patient were $1,429 higher than those of an ideal weight patient.\(^3\)

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015

Molina, 2015
How does this rate impact Obstetrics?

[Bar chart showing percentage for total, men, and women across different age groups.]

Molina, 2015

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015
How does this rate impact Obstetrics?

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015
How does obesity impact Obstetrics?

Racial disparities in U.S. female obesity rates:\(^5\):
- Non-Hispanic Black: 58.6%
- Hispanic: 40.7%
- Non-Hispanic White: 33.4%

Socioeconomic disparities

Molina, 2015
Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015
How does obesity impact Obstetrics?

- **Gestational Diabetes**: Increased in Class I and II obese (OR 2.6), further increase in Class III (OR 4.0), with prevalence increase of 0.8% for each 1 mg/kg² increase of BMI⁷,¹⁰

- **Preeclampsia**: Increased in obese (OR 1.6), with the risk doubling for each increase of BMI by 5 mg/kg². In Class III obesity, OR is 3.3⁸,⁹

- **C-Section**:  
  - C/S rates increased in a dose-response effect¹⁰,¹¹  
    - Ideal weight: 20.7%  
    - Obese: 33.8%  
    - Morbidly Obese: 47.4%  
    - Super Obese: >50%  
  - Increased rate of emergency C-Section (32% vs. 9.3%)¹²,¹³  
  - Increased time to delivery and operative time¹⁴

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015
How does obesity impact Obstetrics?

% of Cesarean Deliveries

<table>
<thead>
<tr>
<th>BMI Range</th>
<th>% of Cesarean Deliveries</th>
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<tbody>
<tr>
<td>BMI Under 30</td>
<td>27.7%</td>
</tr>
<tr>
<td>BMI 30 to 39</td>
<td>36.8%</td>
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<tr>
<td>BMI 40 to 49</td>
<td>47.4%</td>
</tr>
<tr>
<td>BMI 50 to 59</td>
<td>63.3%</td>
</tr>
<tr>
<td>BMI 60 to 69</td>
<td>61.5%</td>
</tr>
<tr>
<td>BMI 70 and Over</td>
<td>80.0%</td>
</tr>
</tbody>
</table>

Delivery Data, 2012-2014

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015

Molina, 2015
How does obesity impact Obstetrics?

- **VBAC:**
  - Inverse relationship between BMI and VBAC success rate
    - Failed TOL in 39.3% of obese vs. 15.2% ideal weight
    - Failed TOL in 87% in women weighing >300 lbs\(^{15}\)
  - Increased risk of uterine rupture / dehiscence (2.1% vs. 0.9%)
  - Failed VBAC with a 6-fold increase in maternal morbidity than a successful VBAC
  - Overall composite maternal morbidity of attempted TOL (failed + successful TOL) vs. elective repeat C/S is 7.2% vs. 3.8%, respectively\(^{16}\)

- **Wound Complications:** Dose-dependent increase in complication rate by BMI, up to 30% wound complication rate in the super obese\(^ {17}\)

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015

Molina, 2015
How does obesity impact Obstetrics?

- **Postpartum hemorrhage**: Increased frequency of uterine atony and transfusion, directly proportional to BMI (aOR 2.1 for BMI >40)\(^\text{18}\)

- **Anesthesia**: Increased rate of repeat epidural attempts or failed regional anesthesia and increased rates of difficult intubation\(^\text{14,19}\)

- **Thromboembolic risk**: Obesity is a risk factor for venous thrombotic event (OR 5.3), likely dose-related\(^\text{8}\)

- **LOS**: Women weighing >300 lbs more likely to hospitalized >4 days postpartum\(^\text{14}\)

- **Maternal mortality**: Increased with BMI >30 (OR 2.7), likely dose-dependent, with an increased representation of obesity in VTE and cardiac deaths\(^\text{20,21}\)

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015
How does obesity impact Obstetrics?

• **Fetal anomalies**: Increased risk of fetal anomalies, especially neural tube defects and cardiac anomalies, with a decreased ability to visualize anomalies for prenatal diagnosis.²²⁻²³

• **Macrosomia**: 2-3 fold increase, regardless of diabetes.²⁴

• **Shoulder dystocia**: Rate doubled in morbid obesity (1.8% vs. 0.8%).²⁵

• **IUFD**: Risk increases with increasing gestational age.²⁶
  - 28-36 wks: aOR 2.1
  - 37-39 wks: OR 3.5
  - >40 wks: aOR 4.6

• **Long term**: Risk of childhood obesity 2.4-2.7 times greater.²⁷
<table>
<thead>
<tr>
<th>How does obesity impact Obstetrics?</th>
</tr>
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<tbody>
<tr>
<td>Gestational Diabetes</td>
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<tr>
<td>Preeclampsia</td>
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<tr>
<td>C-Section Rates</td>
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<tr>
<td>VBAC Rates</td>
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<tr>
<td>Wound Complication</td>
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<tr>
<td>Postpartum hemorrhage</td>
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<tr>
<td>Anesthesia issues</td>
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<tr>
<td>Thromboembolic risk</td>
</tr>
<tr>
<td>Length of Stay</td>
</tr>
<tr>
<td>Maternal mortality</td>
</tr>
<tr>
<td>Fetal anomalies</td>
</tr>
<tr>
<td>Macrosomia</td>
</tr>
<tr>
<td>Intrauterine demise</td>
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<tr>
<td>Childhood obesity</td>
</tr>
</tbody>
</table>

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015
How does obesity impact Obstetrics?

- Gestational Diabetes
- Preeclampsia
- C-Section Rates
- VBAC Rates
- Wound Complications
- Postpartum hemorrhage
- Anesthesia issues
- Thromboembolic risk
- Length of Stay
- Maternal mortality
- Fetal anomalies
- Macrosomia
- Intrauterine demise
- Childhood obesity

32% ???

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015

Molina, 2015
How does obesity impact Obstetrics?

Delivery Data, 2012-2014

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Molina, 2015
How do we manage this?
Divide and Conquer

Antepartum (#1)

Intrapartum

Operative (#3)

Postpartum (#4)

Labor (#2)

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Divide and Conquer

OB Provider
- Guidelines for Care
- Equipment needs
- Order sets

Anesthesia
- Guidelines for Care
- Equipment Needs
- Order Sets

Nursing
- Guidelines for Care
- Equipment needs
- Personnel

Patient Experience
- Education
- Managing Risk
- Community Resources

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015
Baseline Data / Resources

- Build your workgroups as multidisciplinary teams

- Determine your baseline population / patient volume
  - Stratify by BMI, if possible

- Determine what resources you already have at your facility
  - Bed weight limits (Labor and OR beds)
  - Lifts or Hover Mats
  - Blood pressure cuff / SCD sizes
  - Bariatric operative instruments
  - Bariatric wheel chairs / Motorized beds
What are the best practices?

Population

Resources

EVIDENCE

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What are the best practices?

- ACOG Committee Opinion #549 “Obesity in Pregnancy”\textsuperscript{28}
  - Limited RCTs for best practices in the bariatric OB population
  - Lack of consensus guidelines or recommendations for care

- Weight loss prior to pregnancy is ideal
  - Decrease BMI pre-conceptually
  - Healthy lifestyle / exercise
  - Bariatric surgery for BMI >40 or BMI >35 with co-morbidities may improve pregnancy outcomes\textsuperscript{29}

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015

Molina, 2015
Disclaimer...

In the absence of formal recommendations from ACOG regarding standard of care in this population, each facility should determine what they deem to be the best practices based on the available evidence, their specific patient population, available facility-specific resources, and provider consensus.
Determining your best practices

ANTEPARTUM

**BMI >30:**
- Early Glucola\(^{30}\)
- 1\(^{st}\) trimester, anatomic, and 3\(^{rd}\) trimester growth ultrasound

**BMI >40:**
- As above
- Baseline preeclampsia labs (24 hour urine, CMP, CBC)
- Anesthesia consultation, if co-morbidities
- EKG, if co-morbidities

**BMI >50 or >350 lbs:**
- As above
- Anesthesia consultation

These statements represent preliminary facility-specific opinion only and are not intended to be interpreted as formal recommendations regarding standard of care or universal best practices

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015

Molina, 2015
Determining your best practices

ANTEPARTUM

- Care not to be universally recommended at this time:
  - Routine EKG
  - Routine maternal echocardiogram
  - Antenatal testing for sole indication of obesity\(^3\)\(^1\)
  - Labor induction >39 weeks

- Patient Education
  - IOM Weight gain recommendations (11-20 lbs)\(^3\)\(^2\)
  - Community resources
    - YMCA
    - WIC / Nutrition Services
    - SNAP-ED pilot grant

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Molina, 2015

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015
Determining your best practices

ANTEPARTUM

- Inpatient
  - DVT prophylaxis
  - Nutrition consultation
  - Bariatric bed
  - Patient assignments of lift rooms
  - Emergency move procedures

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Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015

Molina, 2015
Determining your best practices

**LABOR**

- **Induction:**
  - Misoprostol as 1\textsuperscript{st} line, may have superiority to cervidil\textsuperscript{33}
  - Medium or high dose Pitocin protocol\textsuperscript{34}

- **Fetal monitoring:**
  - Internal monitors when possible / necessary
  - Trial: Monica monitor vs. wide abdominal bands vs. current bands

- **Antibiotics\textsuperscript{35}:**
  - Early start of GBS prophylaxis
  - Weight-based dosing for Vancomycin, Gentamycin

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Determining your best practices

LABOR

- **DVT prophylaxis**: SCD’s in prolonged labor

- **Anesthesia**:
  - Consultation upon admission for BMI > 40
  - Early epidural placement, possible spinal-epidural

- **Labor management**
  - Type and cross 2u PRBC on admission
  - Establish 2 IVs, at least 18 gauge
  - No change in labor bundle recommendations

- **Care not to be universally recommended at this time**:
  - Invasive monitors (Central line, arterial line)
  - Intrapartum magnesium levels and dose adjustments in preeclampsia

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Determining your best practices

LABOR

- **Nursing**
  - Weight limitations for patient care
  - Patient rotation in prolonged labor
  - Lifts vs. Hover Mats
  - Leg positioning during delivery
  - Nurse : Patient ratio
  - Emergent transport

- **Equipment needs**
  - Larger speculums, vaginal retractors
  - Extended epidural needles
  - Larger capacity stirrups (Yellow Fin / White Platinum)

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Molina, 2015
Determining your best practices

OPERATIVE

- Patient positioning
  - Bolsters for left lateral tilt
  - Shoulder bolster for Anesthesia
  - SCD’s in OR

- Instruments
  - Bariatric drape / retractor use
  - Extended length surgical instruments
    - “Peel packs” vs. Bariatric trays

- Surgical practices\textsuperscript{38-40}
  - Increased pre-operative Ancef dosing (2g)
  - Double layer uterine / Subcutaneous / Subcuticular skin closure
  - Prophylactic negative pressure dressing

These statements represent preliminary facility-specific opinion only and are not intended to be interpreted as formal recommendations regarding standard of care or universal best practices

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Molina, 2015
Determining your best practices

**POSTPARTUM**

**Recovery**
- Location based on mode, anesthesia type for risk stratification
- Note available resources
- SVD, epidural = Routine postpartum
- C/S and/or general anesthesia = Monitored bed

**DVT prophylaxis**
- SVD = SCD’s and ambulation
- C/S = SCD’s and prophylactic anticoagulation (Lovenox 0.5 mg/kg BID)

**Wound care**
- PICO dressing, as per current protocol
- 1 week postpartum wound check with primary OB provider
- Referral to wound care only PRN

These statements represent preliminary facility-specific opinion only and are not intended to be interpreted as formal recommendations regarding standard of care or universal best practices

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015
Determining your best practices

POSTPARTUM

- Postpartum / Interpregnancy Weight Loss
  - Encourage breastfeeding
  - Encourage weight loss before subsequent pregnancy
  - Consideration for bariatric surgery

- Postpartum depression surveillance by OB provider
  - Prevalence correlates positively with BMI
  - Reported as high as 40% in Class III obesity

- Contraception
  - Progesterone-only likely best, IUD optimal
  - Estrogen-containing with higher failure rate, 10-fold increase in VTE

These statements represent preliminary facility-specific opinion only and are not intended to be interpreted as formal recommendations regarding standard of care or universal best practices

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015
What I hope we accomplished…

• Understanding the current state of the obesity epidemic and how significantly this impacts Obstetric care

• Understanding of the risks associated with obesity in pregnancy and how to best manage these risks

• How to start the process in your own system to manage the bariatric OB patient
  • Cooperation and understanding across multidisciplinary groups
  • Determining your system’s best practices and recommendations

Presented at Washington State Hospital Association Safe Table Webcast 6/18/2015
References

2. OECD Health Data (2012), Measured height and weight.


References


Discussion/Questions
Upcoming Meetings

2015

- Roadmap Monthly (webcast) 7:00am – 8:00 am

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<tr>
<th>March 12</th>
<th>August 20</th>
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<tr>
<td>April 30</td>
<td>October 15</td>
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<td>May 21</td>
<td>November 19</td>
</tr>
<tr>
<td>June 18</td>
<td>December 17</td>
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<tr>
<td>July 16</td>
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</tbody>
</table>

- Safe Tables (in-person) 9:00am – 2:30 pm
  - September 8

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Thank You!

Mara Zabari, Executive Director of Integration
206-216-2529
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Safe Deliveries Roadmap Website
http://www.wsha.org/0513.cfm%20