OB Data Overview

All NoCVA hospitals are asked to submit the following three OB measures:

<table>
<thead>
<tr>
<th>Measures</th>
<th>Status</th>
<th>Due dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Massive Transfusions</td>
<td>New</td>
<td>Submit by 20th of the following month. Ex: June data is due July 20. First data submission date is April 20.</td>
</tr>
<tr>
<td>Timely Tx of Severe Hypertension</td>
<td>New</td>
<td>Submit by 20th of the following month. Ex: June data is due July 20. First data submission date is April 20.</td>
</tr>
<tr>
<td>Early Elective Delivery Rate (TJC PC-01)</td>
<td>Ongoing</td>
<td>Submit by 20th of following quarter. Ex: Jan-Mar date is due April 20. Data submission is continuing from last year.</td>
</tr>
</tbody>
</table>

Two of these measures are new. Details on each measure are below.

For North Carolina Hospitals: All data should be submitted at NCQC’s data portal: data.ncqualitycenter.org.

For Virginia Hospitals:
- Number of massive transfusions & Timely Tx of Severe Hypertension should be submitted at NCQC’s data portal: data.ncqualitycenter.org.
- EED data should continue to be submitted through https://secure.vhhadata.com/eed/
- VHHA is considering expanding its data portal to allow submission of all measures through https://secure.vhhadata.com/eed/. If your hospital feels strongly that this option would be more efficient, please provide that feedback Abraham Segres, VP, Quality and Patient Safety (asegres@vhha.com).

Questions? Please email Christi Beals, Project Manager (cbeals@ncha.org).

Measure descriptions are adapted from materials developed by Elliott K. Main, MD (Directors, California Maternal Quality Care Collaborative).
2014 OB Learning Network Data Manual for QDS

Number of massive transfusions

Why this measure is being requested: Hemorrhage is a leading cause of maternal morbidity and mortality. Several large, multi-hospital obstetric hemorrhage QI collaboratives have found that reductions by 20-30% are achievable. This measure is harmonized with The Joint Commission’s new definition of an Obstetric Sentinel Event. In general, real patient harm is observed in the population of mothers who receive large transfusions—not just a small number such as 1 or 2 units. Finally, large numbers of units can be expensive for the hospital.

Short Description: Number of mothers receiving 4 or more units of blood products per 1,000 mothers

Denominator: All women giving birth ≥20 weeks (birth hospitalization) see DRG list in comment (1) below

Numerator: Women who received ≥4 units of blood products
   (including RBCs, FFP, Platelet packs, Cryoprecipitate)
   (This is ALSO the new definition of an Obstetric Sentinel Event by The Joint Commission so it will be required to be captured by TJC accredited hospitals)

Expected Baseline Rate: 2-4 cases per 1,000 mothers (may be higher)

Source: Hospital Blood bank data sets or ChargeMasters. Collection steps: identify maternity patients either by DRGs or obstetric ICD9/10 codes, then query the ChargeMaster (or blood bank data set) to identify the women who received ≥4 units of blood products.

Comments:
   (1) The typical maternity MS-DRGs (765, 766, 767, 768, 770,774,775) can be used to restrict the denominator to the typical labor and delivery population (≥20 weeks of gestation). While earlier pregnancies do have hemorrhages (e.g. ectopic and late miscarriages), these are quite uncommon and typically have different etiologies and would require a different QI project with a focus on different care venues (office, ER, OR). Furthermore, there is no good way of properly identifying the denominator population for earlier gestations—all pregnancies? or all pregnancies beyond 8 weeks? Etc.

   (2) The numerator identifies all blood products rather than just RBCs. This is the definition used by the Joint Commission and supported by an ACOG/CDC/SMFM consensus committee (in press).

   (3) Units of blood products is a reasonable measure to collect using Blood Bank databases or Charge Masters. A survey of California hospitals found that with little effort, an analyst can create a monthly report of patients transfused with the number of units per patient.
(4) The Joint Commission revised definition of ≥4 units of blood units transfused as an OB sentinel event (January 28, 2014) will be a powerful tool to help drive this quality initiative and it will be important to have coordinated outcome measures.

(5) Blood products are very expensive and most hospitals currently have projects underway to carefully scrutinize utilization. Therefore this project may be able to piggy-back on those efforts.

Timely Treatment for Severe Hypertension

Why this measure is being requested: Preeclampsia is now a major ACOG initiative, with revised guidelines released in 2013. Review of severe cases (near misses) and maternal deaths from preeclampsia have identified delays in diagnosis and delays in treatment as important drivers for complications such as pulmonary edema, liver injury, coagulation abnormalities, seizures, and cerebral stroke. ACOG has recently released new guidelines for treatment of new-onset severe hypertension (Systolic ≥160 or Diastolic ≥110) within 60 minutes to prevent stroke. A current preeclampsia collaborative in California has found a surprising performance gap for timely treatment with systems factors and lack of staff education being common issues.

Short Description: Treatment of mothers with severe hypertension (either Systolic ≥160 OR Diastolic ≥110) within 60 minutes per 100 severe preeclamptic mothers

Denominator: All women giving birth ≥20 weeks (birth hospitalization) with a diagnosis of Severe Preeclampsia (Eclampsia (642.6x), Severe Preeclampsia (642.5x), or Preeclampsia superimposed on pre-existing HTN (642.7x)) AND who had severe hypertension (either Systolic ≥160 OR Diastolic ≥110)

Exclusions: women with gestational hypertension or chronic hypertension without superimposed preeclampsia (642.0x, 642.1x, 642.2x, or 642.3x)

Numerator: Those who are treated within 60 minutes with first-line medications (IV labetalol or IV hydralazine or PO nifedipine if IV access has not been established)

Expected Baseline Rate: The rate of severe hypertension is 5-20 cases per 1,000 total mothers, and baseline timely treatment rate can be as low as 30%

Source: Chart review of all severe preeclampsia cases (as noted these are not a large number) with assistance of pharmacy records for the use of IV hydralazine and labetolol

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Early Elective Delivery (TJC PC-01)
Why this measure is being requested: Early elective deliveries are a major national initiative and have seen huge progress over the past two years. National data from 1300 hospitals indicate a 52% drop in EED rates, over 14,000 EEDS prevented, and 12 million dollars in costs averted. In North Carolina, a state goal of 1% has been adopted and recent data suggests hospitals are approaching this target.

Short Description: Patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed


Exclusions: See Specifications Manual Table 11.07 Table 11.07


Expected Baseline Rate: Rate of early elective deliveries should be at or below 1%

Source: Varies by hospital

Instructions for QDS Data Entry for New Measures: Timely Tx of Severe Hypertension & Number of Massive Transfusions
Only those team members from your facility that the Team Leader designates will have access to your raw data and be allowed to enter/remove/edit data there. No other facility or project participants will have access to your data entry screens or raw data. (Refer to the NoCVA Data Use Agreement for all confidentiality requirements.)

1. Go to https://data.ncqualitycenter.org/ to the email address and password log-in screen.

“QDS” (Quality Data System) log-in screen:
Enter your email address. If you have forgotten your password, click on the red lettered phrase, “Forgot your password?” The system will auto-generate a new password and will email it to you within a few minutes. This password is randomly generated and encrypted by the database software itself and there is no list of passwords anywhere. So, if you forget it, just follow these steps to get a new one; do not contact the VHHA or NC Quality Center to obtain your password, as they do not have access to it.

2. The next screen you see will be similar to the one below. Your screen will contain icons representing the modules to which you have access. You should see the Data Entry icon – circled in red below. You would only see icons for the modules to which you have been given access. Click on the Data Entry icon.

![Welcome Christi Beals](image)
3. The next screen you should see is the one below. Select your hospital and the measure **OB Hem Preeclampsia** using the drop downs:

4. Using the drop-down keys, select the desired time period:
5. The data entry fields for the measure will appear:

![Data Entry Form]

6. Enter the data into each box and hit the “Submit Answers” button at the bottom of the page once you have completed all sections.

7. Once you hit “Submit Answers”, you will get a quick message in red font telling you that your data were accepted. This message will fade away quickly. If you need to check your data or revise the data at a later date, you may do so by following the steps above.

Data entry for these two measures is now complete. For questions, contact Christi Beals at cbeals@ncha.org or (919) 677-4136.