Using Health Administrative Data to evaluate practice and outcomes:

Surveillance, Data Capture and Quality, Burden on the System, Getting Quality Information to Assist with Informed Decision Making

Perinatal Program
Newfoundland Labrador
www.ppnl.ca

Phil A. Murphy, BSc (Hons), MSc
Clinical Epidemiologist – PPNL
Professional Associate – MUN (Ob/Gyn, Pediatrics)
Expert Advisory Committee – CPSS - PHAC
phil.murphy@easternhealth.ca

NLCAHR's Cost and Value in Healthcare Research Exchange Group

November 27, 2017

Google

PPNL

Perinatal Program Newfoundland Labrador

Outline

- Overview of PPNL
- Data Capture & Surveillance
- Quality
- Decision Support
- Burden on the Healthcare System

Perinatal Program
Newfoundland Labrador

PPNL - about us

- Established in 1979
- Mandate - improve pregnancy outcomes and provide a follow-up clinic to infants at high risk for developmental delay.

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PPNL - high risk clinic

FOLLOW-UP CLINIC ADMISSION CRITERIA*	PERCENTAGE OF 2015-16 CLINIC INTAKE	PERCENTAGE OF 2014-15 CLINIC INTAKE
Maternal Substance Use	36.2%	38.2%
Birth Weight ≤1500 grams	35.6%	24.4%
Ventilated for 48 hours or more	20.8%	28.5%
Specific Physician Request	10.1%	10.6%
Complex Surgery	6.7%	8.1%
Seizures in 1st 28 days of life	3.4%	10.6%
APGAR Score ≤ 3 for ≥ 5 minutes	0.7%	7.3%
Cord Blood pH < 7	1.3%	6.5%
Intraventricular Hemorrhage (IVH)	4.0%	0.8%
Meningitis in 1st 28 days of life	0.7%	3.3%
Periventricular Leukomalacia (PVL)	0.7%	0.8%
* Criteria changed in Sept 2015		

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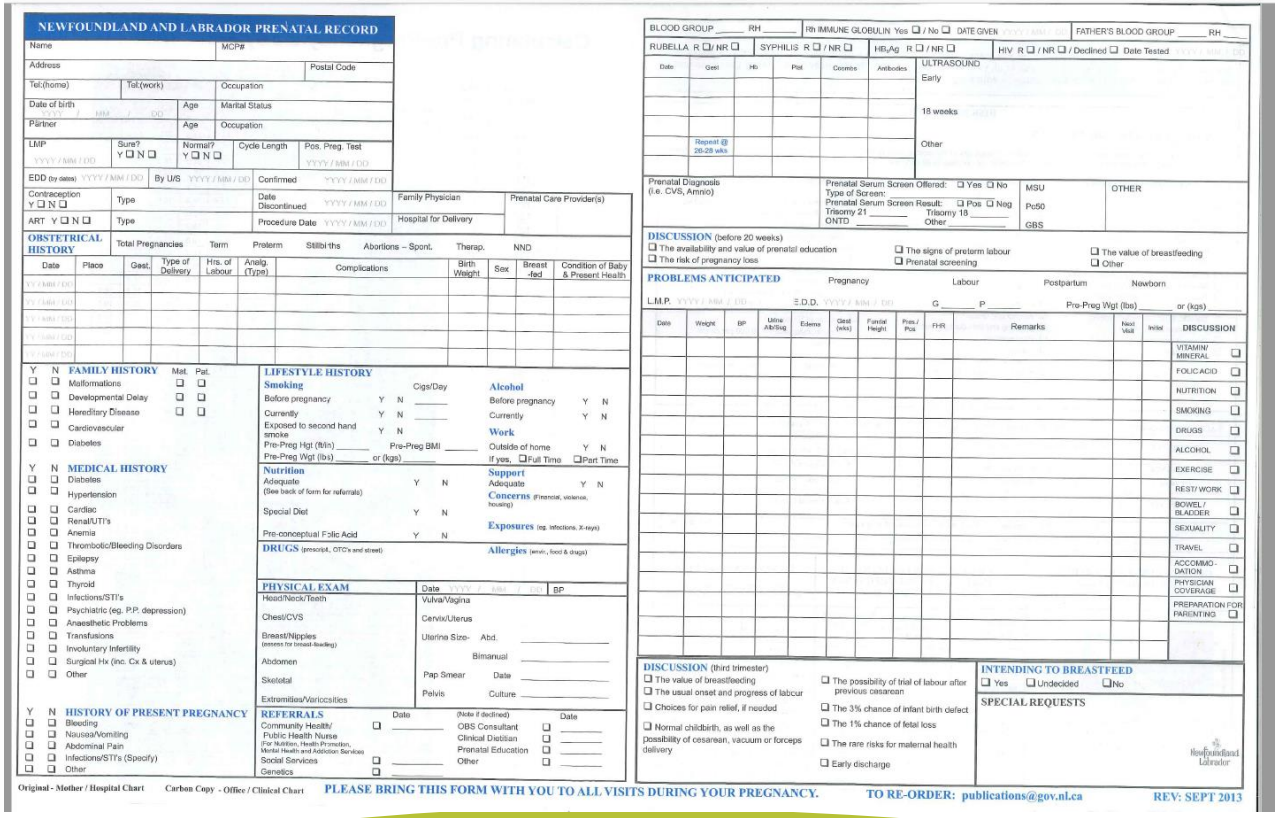
PPNL – what else to we do

- Data Collection: Follow-up, Surveillance Program, Congenital Anomalies (Barb)



NEWFOUNDLAND AND LABRADOR PRENATAL RECORD

Name | MCP# | Address | Postal Code | Tel:(home) | Tel:(work) | Occupation | Date of birth | Age | Marital Status | Partner | Age | Occupation | LMP | Sure? | Normal? | Cycle Length | Pos. Preg. Test | EDD (by dates) | By U/S | Confirmed | Contraception | Type | Date Discontinued | Family Physician | Prenatal Care Provider(s) | ART | Type | Procedure Date | Hospital for Delivery

OBSTETRICAL HISTORY — Total Pregnancies | Term | Preterm | Stillbirths | Abortions – Spont. | Therap. | NND

Date	Place	Gest.	Type of Delivery	Hrs. of Labour	Anesth. (Type)	Complications	Birth Weight	Sex	Breast -fed	Condition of Baby & Present Health

FAMILY HISTORY — Mat. / Pat.: Malformations; Developmental Delay; Hereditary Disease; Cardiovascular; Diabetes

MEDICAL HISTORY: Diabetes; Hypertension; Cardiac; Renal/UTI's; Anemia; Thrombotic/Bleeding Disorders; Epilepsy; Asthma; Thyroid; Infections/STI's; Psychiatric (eg. P.P. depression); Anaesthetic Problems; Transfusions; Involuntary Infertility; Surgical Hx (inc. Cx & uterus); Other

HISTORY OF PRESENT PREGNANCY: Bleeding; Nausea/Vomiting; Abdominal Pain; Infections/STI's (Specify); Other

LIFESTYLE HISTORY

Smoking — Cigs/Day: Before pregnancy; Currently; Exposed to second hand smoke; Pre-Preg Hgt (ft/in); Pre-Preg BMI; Pre-Preg Wgt (lbs) or (kgs)

Alcohol: Before pregnancy; Currently

Work: Outside of home; If yes, Full Time / Part Time

Nutrition: Adequate (See back of form for referrals); Special Diet; Pre-conceptual Folic Acid

Support: Adequate

Concerns (Financial, violence, housing)

Exposures (eg. Infections, X-rays)

DRUGS (prescript., OTC's and street)

Allergies (envir., food & drugs)

PHYSICAL EXAM — Date | BP

Head/Neck/Teeth; Chest/CVS; Breast/Nipples (reasons for breast-feeding); Abdomen; Skeletal; Extremities/Varicosities; Vulva/Vagina; Cervix/Uterus; Uterine Size- Abd.; Bimanual; Pap Smear Date; Pelvis Culture

REFERRALS — Date | (Note if declined) | Date

Community Health/ Public Health Nurse (For Nutrition, Health Promotion, Mental Health and Addiction Services); Social Services; Genetics; OBS Consultant; Clinical Dietitian; Prenatal Education; Other

BLOOD GROUP ____ RH ____ | Rh IMMUNE GLOBULIN Yes ☐ / No ☐ DATE GIVEN | FATHER'S BLOOD GROUP ____ RH ____

RUBELLA R ☐/ NR ☐ | SYPHILIS R ☐ / NR ☐ | HBsAg R ☐ / NR ☐ | HIV R ☐ / NR ☐ / Declined ☐ Date Tested

Date	Gest	Hb	Plat	Comms	Antibodies
	Repeat @ 26-28 wks				

ULTRASOUND: Early; 18 weeks; Other

Prenatal Diagnosis (i.e. CVS, Amnio)

Prenatal Serum Screen Offered: ☐ Yes ☐ No | Type of Screen: | Prenatal Serum Screen Result: ☐ Pos ☐ Neg | Trisomy 21 | Trisomy 18 | ONTD | Other | MSU | Pc50 | GBS | OTHER

DISCUSSION (before 20 weeks)
☐ The availability and value of prenatal education ☐ The signs of preterm labour ☐ The value of breastfeeding
☐ The risk of pregnancy loss ☐ Prenatal screening ☐ Other

PROBLEMS ANTICIPATED — Pregnancy | Labour | Postpartum | Newborn

L.M.P. | E.D.D. | G ____ P ____ | Pre-Preg Wgt (lbs) ____ or (kgs) ____

Date	Weight	BP	Urine Alb/Sug	Edema	Gest (wks)	Fundal Height	Pres./ Pos	FHR	Remarks	Next Visit	Initial

DISCUSSION: VITAMIN/MINERAL; FOLIC ACID; NUTRITION; SMOKING; DRUGS; ALCOHOL; EXERCISE; REST/ WORK; BOWEL/ BLADDER; SEXUALITY; TRAVEL; ACCOMMO-DATION; PHYSICIAN COVERAGE; PREPARATION FOR PARENTING

DISCUSSION (third trimester)
☐ The value of breastfeeding ☐ The possibility of trial of labour after previous cesarean
☐ The usual onset and progress of labour ☐ The 3% chance of infant birth defect
☐ Choices for pain relief, if needed ☐ The 1% chance of fetal loss
☐ Normal childbirth, as well as the possibility of cesarean, vacuum or forceps delivery ☐ The rare risks for maternal health
☐ Early discharge

INTENDING TO BREASTFEED ☐ Yes ☐ Undecided ☐ No

SPECIAL REQUESTS

Original - Mother / Hospital Chart | Carbon Copy - Office / Clinical Chart | PLEASE BRING THIS FORM WITH YOU TO ALL VISITS DURING YOUR PREGNANCY. | TO RE-ORDER: publications@gov.nl.ca | REV: SEPT 2013

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PPNL – what else to we do

- Education (Clare, Susan, Janine): FHS, NRP, ACoRN, Obstetrical updates & Collaborative Neonatal Education, Breastfeeding

Neonatal Resuscitation Program™

ACoRN Acute Care of at-Risk Newborns

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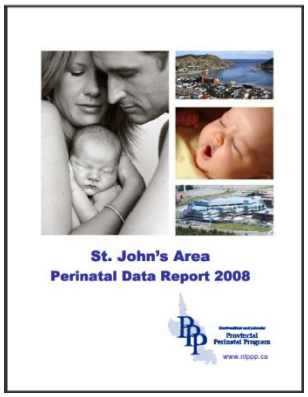
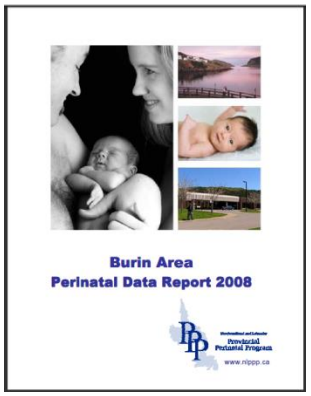
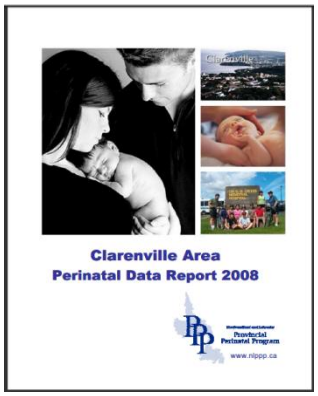
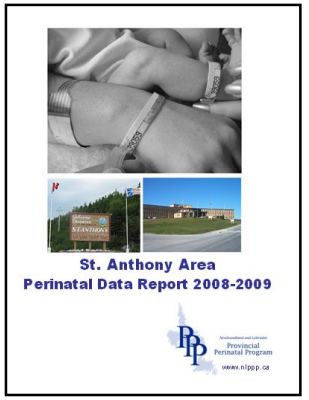
PPNL – what else to we do

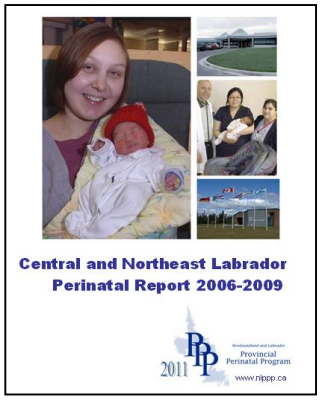
- Surveillance Reports: All RHAs

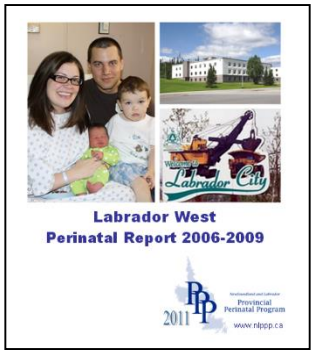


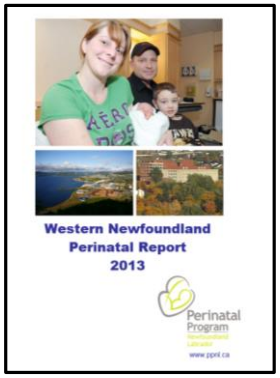


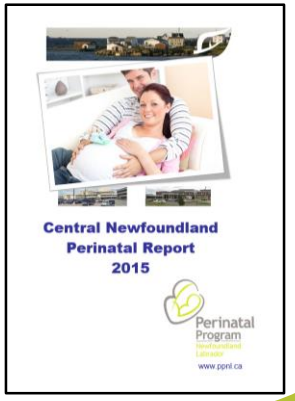












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PPNL – what else to we do

- Decision Support
- Resident Project Support
- Applied Research

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PPNL – what else to we do

- Canadian Congenital Anomalies Surveillance Network (CCASN)
- To support the development and maintenance of high quality population-based surveillance systems of congenital anomalies that will provide information to improve the health of Canadian children and their families.

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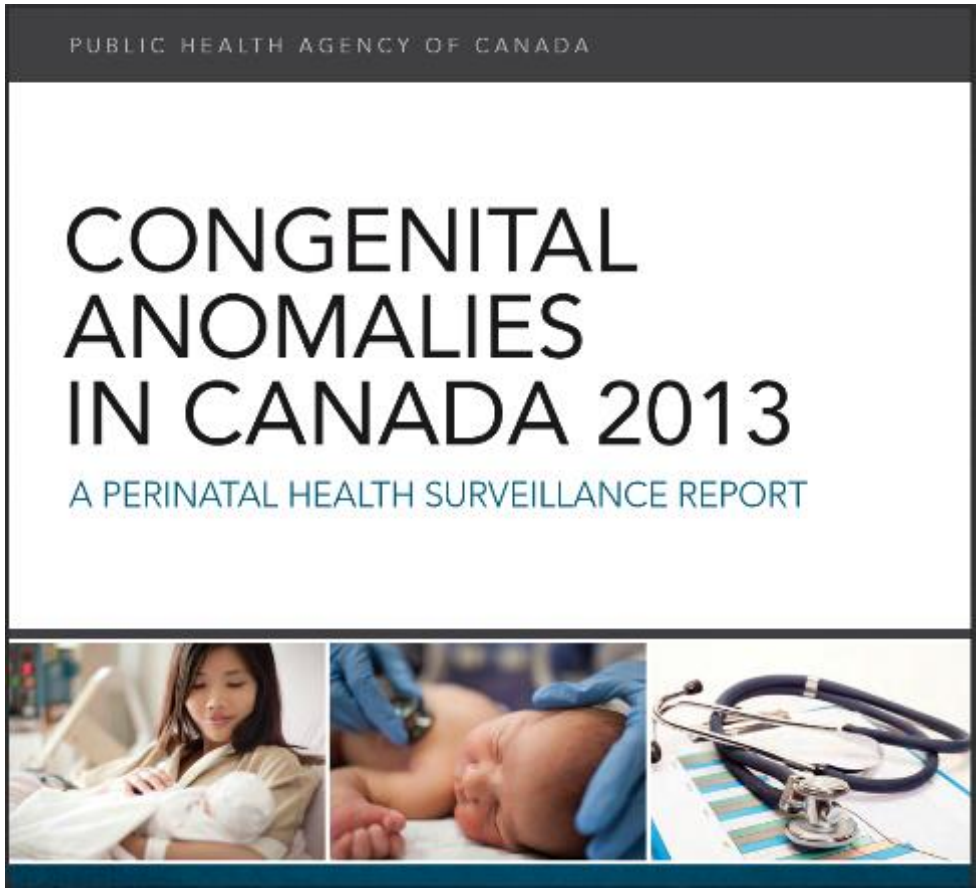
CCASN

"Approximately 1 in 25 infants is diagnosed yearly with one or more congenital anomalies. For families, a congenital anomaly diagnosis can involve profound psychological, emotional and financial burdens."



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Benefits of Surveillance Reporting

- Provide timely identification and communication of epidemiological trends
- A valuable resource for healthcare providers, government organizations and researchers to inform public health programs
- Support evidence-based decision making
- Ultimately contribute to reducing the burden

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Benefits of Surveillance Reporting

PUBLIC HEALTH AGENCY OF CANADA

PERINATAL HEALTH INDICATORS FOR CANADA 2017

A REPORT FROM THE CANADIAN PERINATAL SURVEILLANCE SYSTEM

PROTECTING CANADIANS FROM ILLNESS

Public Health Agency of Canada / Agence de la santé publique du Canada

Canada

CONTRIBUTORS

PUBLIC HEALTH AGENCY OF CANADA

Jenna Coles
Paromita Deb-Rinker
Mary Lou Decou
Susie Dzakpasu
Juan Andres Leon
Shiliang Liu
Wei Luo
Myuri Manogaran
Chantel Nelson
Victoria Otterman
Jocelyn Rouleau
Manal Sallbi
Judy Snider

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FOR EXTERNAL DATA USED IN THIS REPORT:

Canadian Institute for Health Information (CIHI)

Statistics Canada (Vital Statistics)

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Exploring data to examine practice

J Obstet Gynaecol Can. 2013 Mar;35(3):206-214. doi: 10.1016/S1701-2163(15)30992-0.

Examining caesarean section rates in Canada using the Robson classification system.

Kelly S[1], Sprague A[1], Fell DB[1], Murphy P[2], Aelicks N[3], Guo Y[4], Fahey J[5], Lauzon L[5], Scott H[6], Lee L[7], Kinniburgh B[7], Prince M[1], Walker M[8].

Author information

Abstract

OBJECTIVE: To determine the groups within the obstetric population contributing most substantially to the Caesarean section rate in five Canadian provinces.

METHODS: Hospital births from five participating provinces were grouped into Robson's 10 mutually exclusive and totally inclusive classification categories. The relative contribution of each group to the overall CS rate, relative size of group, and CS rate were calculated for British Columbia, Alberta, Ontario, Nova Scotia, and Newfoundland and Labrador for the four-year period from 2007-2008 to 2010-2011.

RESULTS: In all five provinces (accounting for approximately 64% of births in Canada), and for all years examined, the group making the largest relative contribution to the CS rate was women with at least one previous CS and a term, singleton, cephalic-presenting pregnancy (Robson Group 5). The CS rate for this group ranged from 76.1% in Alberta to 89.9% in Newfoundland and Labrador in 2010 to 2011, accounting for 11.3% of all deliveries. The rate of CS for Group 5 decreased slightly over the four years, except in Ontario. The next largest contributing group was nulliparous women with a term, singleton, cephalic-presenting pregnancy. Those with induced labour or Caesarean section before labour (Robson Group 2) had CS rates ranging from 34.4% in Nova Scotia to 44.6% in British Columbia (accounting for 13.1% of all deliveries), and those with spontaneous onset of labour (Robson Group 1) had CS rates of 14.5% to 20.3% in 2010 to 2011 (accounting for 23.6% of all deliveries).

CONCLUSION: All hospitals and health authorities can use this standardized classification system as part of a quality improvement initiative to monitor Caesarean section rates. This classification system identifies relevant areas for interventions and resources to reduce rates of Caesarean section.

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Exploring data to examine practice

RESULTS:

In all five provinces (accounting for approximately 64% of births in Canada), and for all years examined, the group making the largest relative contribution to the CS rate was women with at least one previous CS and a term, singleton, cephalic-presenting pregnancy (Robson Group 5). The CS rate for this group ranged from 76.1% in Alberta to 89.9% in Newfoundland and Labrador in 2010 to 2011, accounting for 11.3% of all deliveries.

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Exploring data to examine outcome

Arch Dis Child Fetal Neonatal Ed. 2017 May;102(3):F235-F234. doi: 10.1136/archdischild-2016-311228. Epub 2016 Oct 6.

Determinants of developmental outcomes in a very preterm Canadian cohort.

Synnes A[1], Luu TM[2], Moddemann D[3], Church P[4], Lee D[5], Vincer M[6], Ballantyne M[7], Majnemer A[8], Creighton D[9], Yang J[4], Sauve R[9], Saigal S[10], Shah P[4], Lee SK[4]; Canadian Neonatal Network and the Canadian Neonatal Follow-Up Network.

Collaborators (56)

Harrison A, Ting J, Yee W, Aziz K, Toye J, Kalapesi Z, Sankaran K, Daspal S, Seshia M, Alvaro R, Shivananda S, Da Silva O, Nwaesei C, Lee KS, Dunn M, Rouvinez-Bouali N, Dow K, Pelausa E, Kovacs L, Barrington K, Drolet C, Piedboeuf B, Riley SP, Claveau M, Faucher D, Bertelle V, Masse E, Canning R, Makary H, Ojah C, Monterrosa L, Andrews W, Deshpandey A, McMillan D, Afifi J, Pillay T, Synnes A, Sauvé R, Reichert A, Bodani J, Sankaran K, Nwaesei C, Daboval T, Dow K, Ly L, Kelly E, Helou SE, Pelausa E, Riley SP, Levebvre F, Demers C, Bélanger S, Canning R, Monterrosa L, Makary H, Murphy P.

Author information

Abstract

OBJECTIVES: Identify determinants of neurodevelopmental outcome in preterm children.

METHODS: Prospective national cohort study of children born between 2009 and 2011 at <29 weeks gestational age, admitted to one of 28 Canadian neonatal intensive care units and assessed at a Canadian Neonatal Follow-up Network site at 21 months corrected age for cerebral palsy (CP), visual, hearing and developmental status using the Bayley Scales of Infant and Toddler Development-Third Edition (Bayley-III). Stepwise regression analyses evaluated the effect of (1) prenatal and neonatal characteristics, (2) admission severity of illness, (3) major neonatal morbidities, (4) neonatal neuroimaging abnormalities, and (5) site on neurodevelopmental impairment (NDI) (Bayley-III score < 85, any CP, visual or hearing impairment), significant neurodevelopmental impairment (sNDI) (Bayley-III < 70, severe CP, blind or hearing aided and sNDI or death.

RESULTS: Of the 3700 admissions without severe congenital anomalies, 84% survived to discharge and of the 2340 admissions, 46% (IQR site variation 38%-51%) had a NDI, 17% (11%-23%) had a sNDI, 6.4% (3.1%-8.6%) had CP, 2.6% (2.5%-13.3%) had hearing aids or cochlear implants and 1.6% (0%-3.1%) had a bilateral visual impairment. Bayley-III composite scores of <70 for cognitive, language and motor domains were 3.3%, 10.9% and 6.7%, respectively. Gestational age, sex, outborn, illness severity, bronchopulmonary dysplasia, necrotising enterocolitis, late-onset sepsis, retinopathy of prematurity, abnormal neuroimaging and site were significantly associated with NDI or sNDI. Site variation ORs for NDI, sNDI and sNDI/death ranged from 0.3-4.3, 0.04-3.5 and 0.12-1.96, respectively.

CONCLUSION: Most preterm survivors are free of sNDI. The risk factors, including site, associated with neurodevelopmental status suggest opportunities for improving outcomes.

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Exploring data to examine risks

J Matern Fetal Neonatal Med. 2017 Aug 11:1-6. doi: 10.1080/14767058.2017.1362552. [Epub ahead of print]

A comparison of breastfeeding rates by obesity class.

Ramji N[1], Challa S[2,3], Murphy PA[1,4,5], Quinlan J[6], Crane JMG[1].

Author information

Abstract

PURPOSE: The purpose of this study is to compare breastfeeding initiation rates for women across body mass index (BMI) classes, including normal BMI (18.50-24.99 kg/m^2), overweight (25.00-29.99 kg/m^2), obese (30.00-39.99 kg/m^2), morbidly obese (40.00-49.99 kg/m^2) and extreme obesity (≥50.00 kg/m^2).

MATERIALS AND METHODS: Retrospective cohort of women with singleton pregnancies, delivering in St. John's, NL between 2002 and 2011. The primary outcome was any breastfeeding on hospital discharge. Breastfeeding rates across BMI categories were compared, using univariate analyses. Multivariate analysis included additional maternal and obstetric variables.

RESULTS: Twelve thousand four hundred twenty-two women were included: 8430 breastfed and 3992 did not breastfeed on hospital discharge. Progressively decreasing rates of breastfeeding were noted with increasing obesity class: normal BMI (71.1%), overweight (69.1%), obese (61.6%), morbidly obese (54.2%), and extremely obese women (42.3%). Multivariate analysis confirmed that increasing obesity class resulted in lower odds of breastfeeding: overweight (adjusted odds ratios (aOR) 0.86, 95%CI 0.76-0.98), obese (aOR 0.65, 95%CI 0.57-0.74), morbidly obese (aOR 0.57, 95%CI 0.44-0.74), and extreme obesity (aOR 0.37, 95%CI 0.19-0.74).

CONCLUSION: Women in higher obesity classes are progressively less likely to initiate breastfeeding. Women with the highest prepregnancy BMIs should be particularly counseled on the benefits of breastfeeding.

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Data Capture and Quality

Save each 3M report as an excel file

Copy/link each excel report into 1-2 worksheets via UPI

Import excel file into SPSS and create separate MPS files prior to linking mom and baby records

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Data Quality

- Data are of high quality “if they are fit for their intended uses in operations, decision making and planning”

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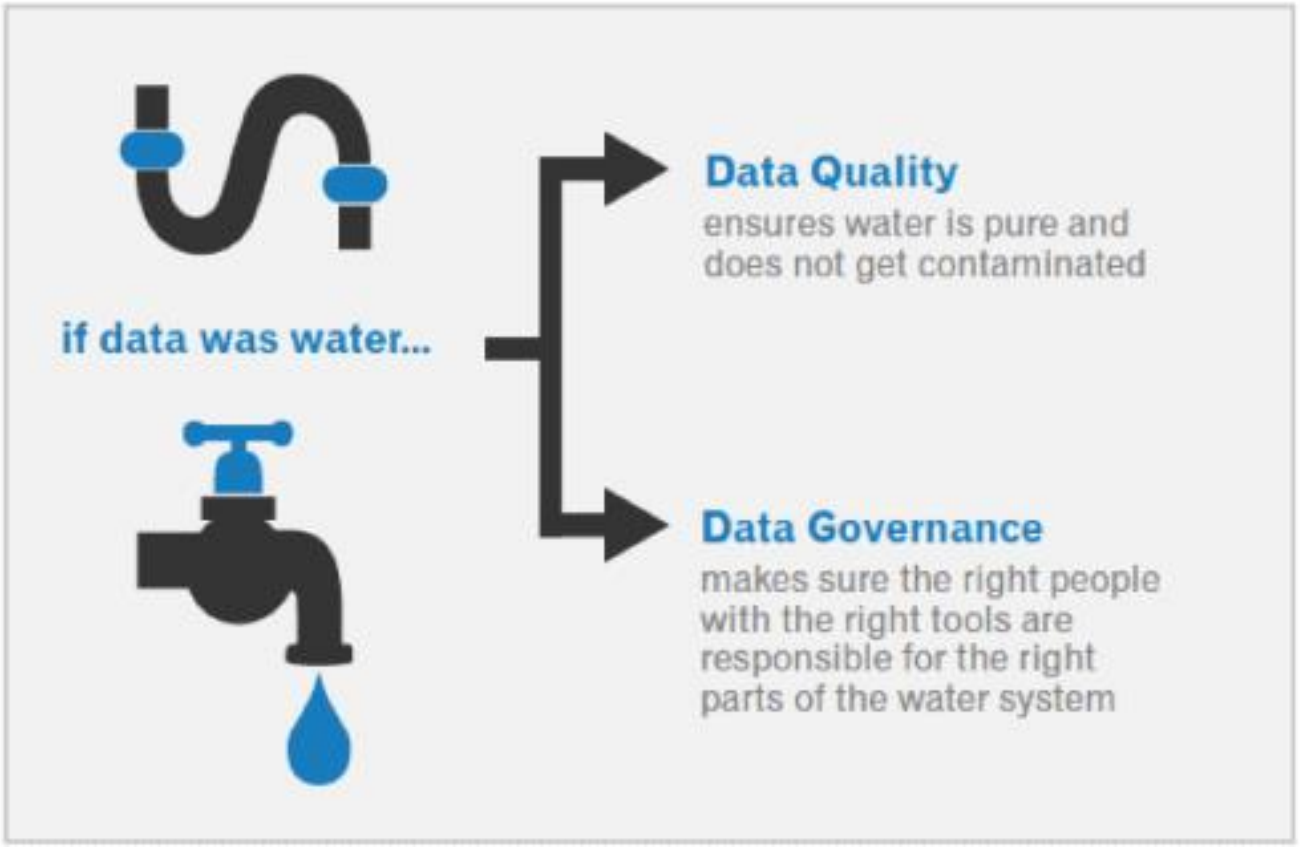
Data Quality



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Data Quality

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Data Quality

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Data Quality

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Data Quality

- "Missing records were excluded from the denominator used to calculate the estimates (rates) on all indicators (more common on self-reported data) and reported based on degree missing. If less than 10% of data are missing, then this is simply stated. If 10%-30% of data are missing, the reader is cautioned with respect to interpretation. If missing data exceeds 30%, then the value is suppressed and not presented."

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Data Quality

- Hmm, “the data” – it is a two-edged sword, with a potential for enormous good and the potential for… well, bad things can happen with poor quality data.

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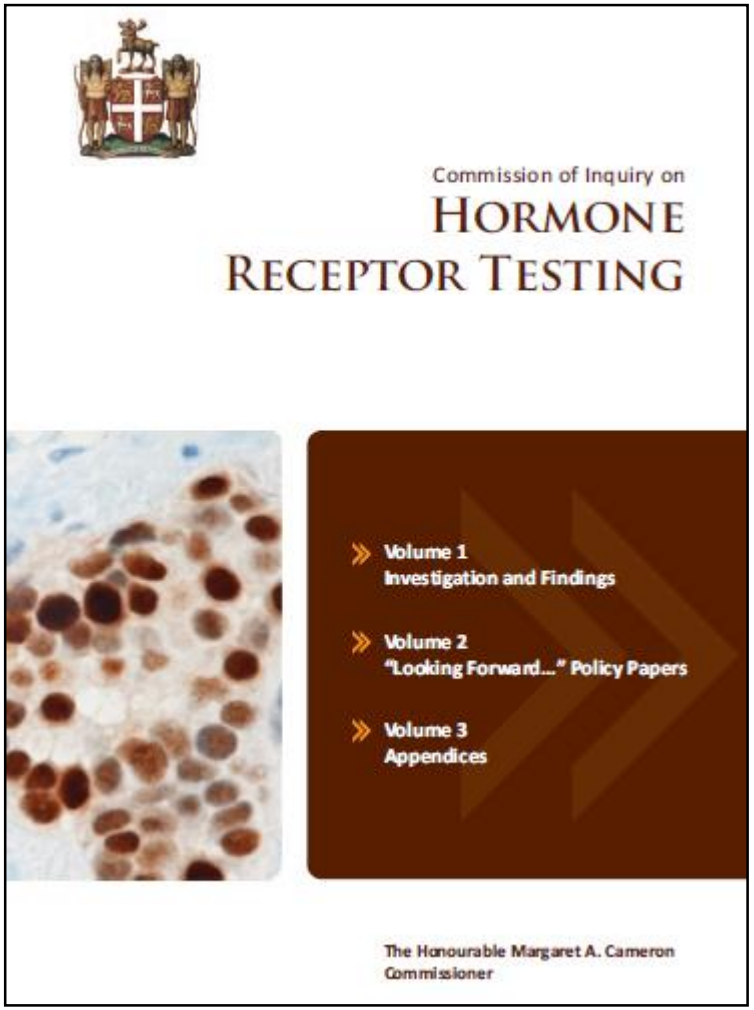
Data Quality

- Bad Things Do Happen



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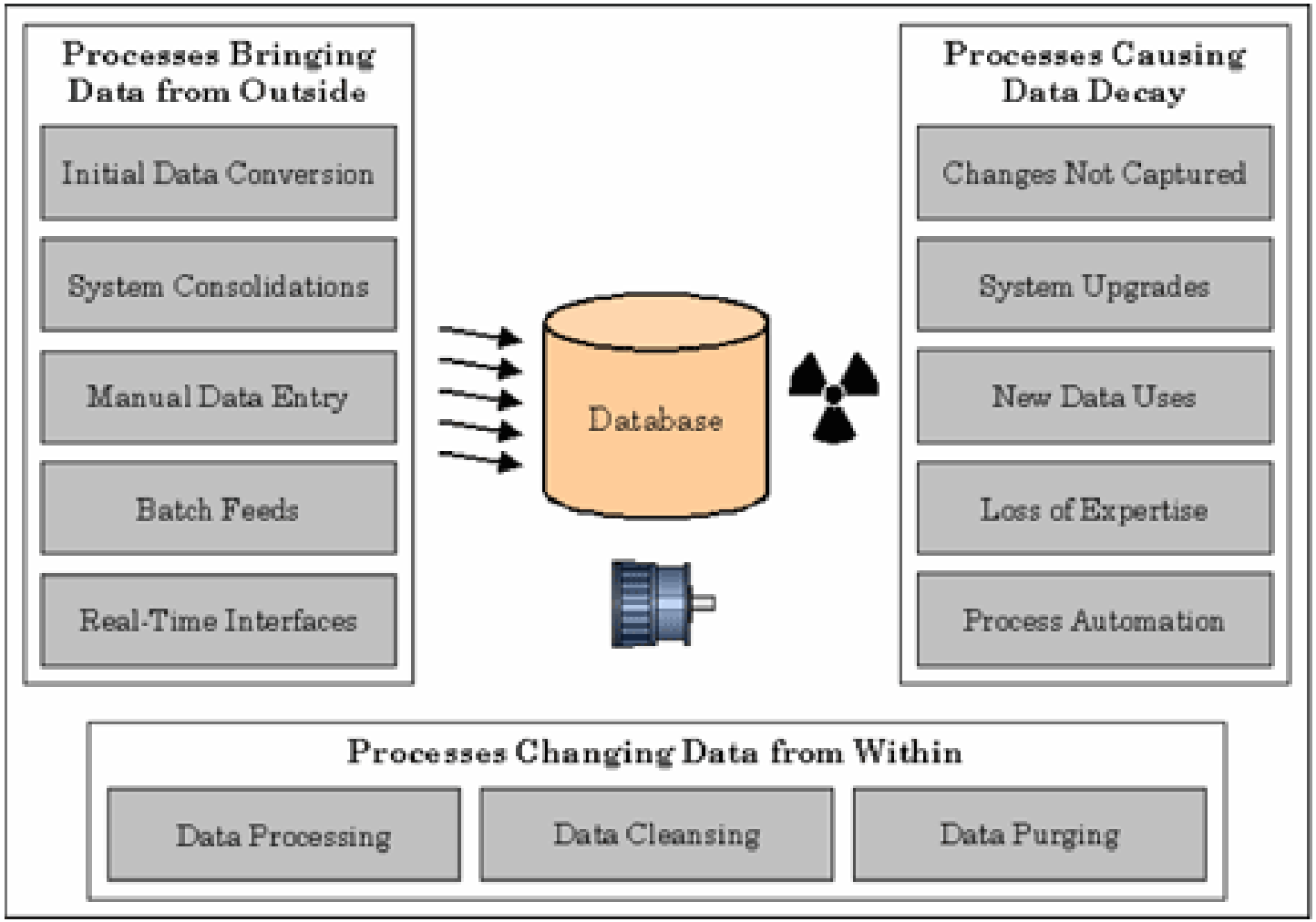
Data Quality



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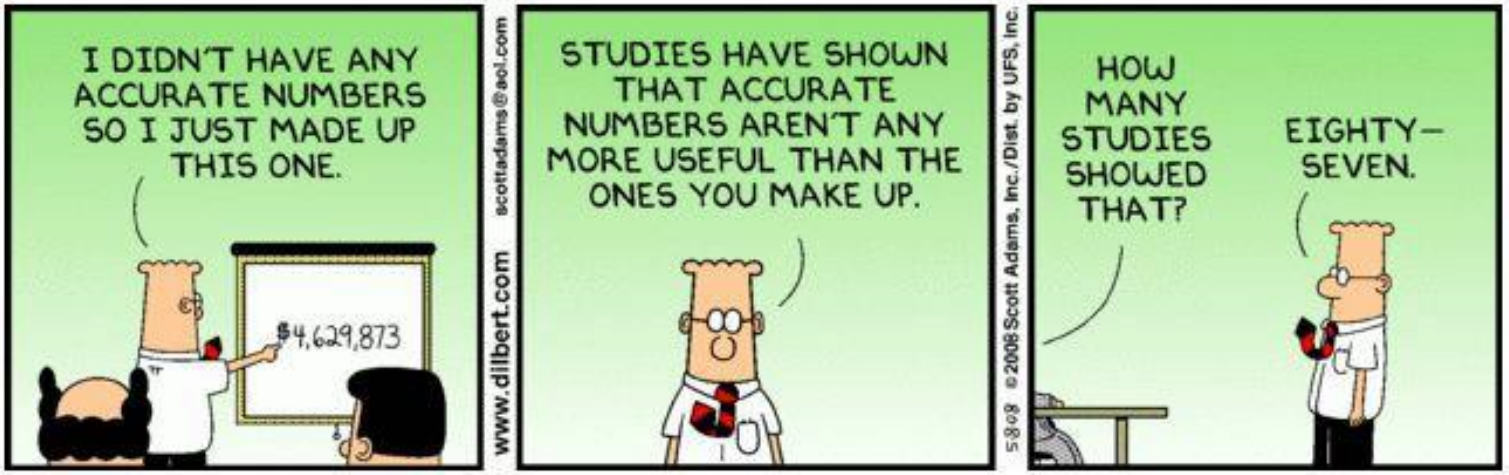
Data Quality



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Data Quality

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Communication

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Communication

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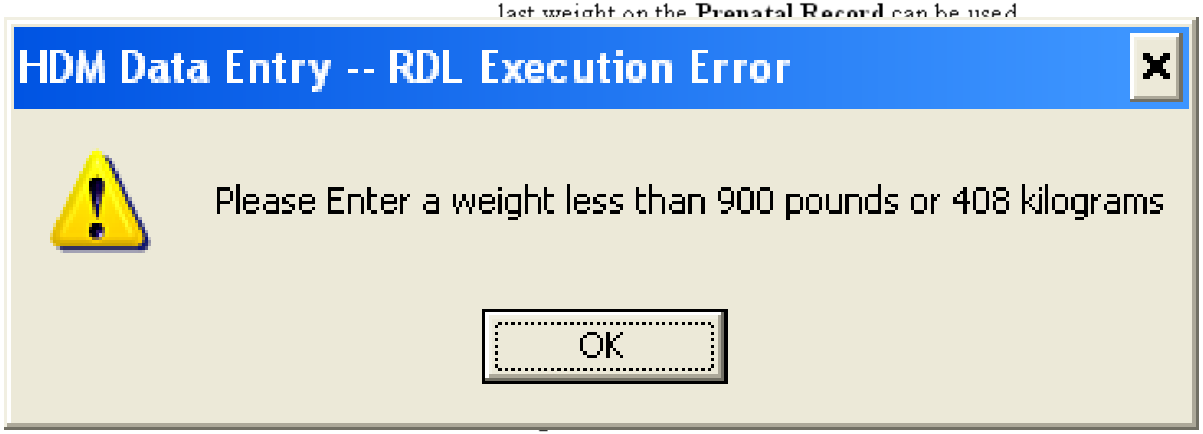
Mis/Non- Communication

3M Prompt
Data Entry (Pre *Delivery Wgt kgs*)
Reporter (*PerDelwgtkg*)

If the pre-delivery weight is not available on the **Obstetrical Nursing Care Plan**, the patient's last weight on the **Prenatal Record** can be used



e.g. 70 - 75 kg. = 75

If pre-delivery weight is unknown, add pre-pregnancy weight and weight gain.

Code 999 for an unknown value.

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Quality Assurance

A data quality assurance program is an explicit combination of organization, methodologies, and activities that exist for the purpose of reaching and maintaining high levels of data quality. The term assurance puts it in the same category as other functions corporations are used to funding and maintaining. Quality assurance, quality control, inspection, and audit are terms applied to other activities that exist for the purpose of maintaining some aspect of the corporation's activities or products at a high level of excellence. Data quality assurance should take place alongside these others, with the same expectations.

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Quality Assurance - examples

- Gestational Age
- Date of Delivery
- Where From
- Link Number
- Dx (Multiple Births, Diabetes, Induction)
- Height and Weight
- APGAR, Caregiver at Delivery
- Breastfeeding, Type of 1st Feed, MSS

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Quality Assurance - examples

AdmitDate	DischDate	DeliveryTime	DELIVERY YEAR	CalendarYear	YEARMATCH
06-MAR-2004	10-MAR-2004	03/06/2004 18:56	2004	2004	1.00
20-SEP-2006	22-SEP-2006	09/21/06 00:47:00	2006	2006	1.00
09-MAY-2007	12-MAY-2007	05/09/2007 16:13	2007	2007	1.00
29-SEP-2005	05-OCT-2005	10/02/2005 0:16	2005	2005	1.00
24-APR-2009	26-APR-2009	04/24/08 23:55:00	2008	2009	2.00
15-APR-2009	24-APR-2009	04/22/08 08:23:00	2008	2009	2.00
27-MAR-2009	30-MAR-2009	03/28/08 05:12:00	2008	2009	2.00

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Quality Assurance - examples

InstitutionFrom	AdmittedFrom	institutionfrom_CONCAT_admitfrom	IFjiveswithAF
038 Central NF Regional Health C	2 Home	038 Central NF Regional Health C2 Home	NO
038 Central NF Regional Health C	2 Home	038 Central NF Regional Health C2 Home	NO
038 Central NF Regional Health C	2 Home	038 Central NF Regional Health C2 Home	NO
035 Nain Nursing Station	3 Hospital/Health Centre	035 Nain Nursing Station 3 Hospital/Health Centre	YES
032 Labrador South Health Centre	No Entry	032 Labrador South Health CentreNo Entry	NO
032 Labrador South Health Centre	No Entry	032 Labrador South Health CentreNo Entry	NO
032 Labrador South Health Centre	No Entry	032 Labrador South Health CentreNo Entry	NO
032 Labrador South Health Centre	3 Hospital/Health Centre	032 Labrador South Health Centre3 Hospital/Health Centre	YES
032 Labrador South Health Centre	3 Hospital/Health Centre	032 Labrador South Health Centre3 Hospital/Health Centre	YES
032 Labrador South Health Centre	3 Hospital/Health Centre	032 Labrador South Health Centre3 Hospital/Health Centre	YES
032 Labrador South Health Centre	3 Hospital/Health Centre	032 Labrador South Health Centre3 Hospital/Health Centre	YES
032 Labrador South Health Centre	3 Hospital/Health Centre	032 Labrador South Health Centre3 Hospital/Health Centre	YES
032 Labrador South Health Centre	3 Hospital/Health Centre	032 Labrador South Health Centre3 Hospital/Health Centre	YES
028 MANI ASHINI(Northwest River	2 Home	028 MANI ASHINI(Northwest River 2 Home	NO

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Quality Assurance - examples

Audit_of_link	momMPS	babyMPS	mombabylink	babymomlink
linked	51 OBS Delivered	97 Neonatology	HI000223/07	HI000223/07
linked	51 OBS Delivered	54 Newborn	HI007079/07	HI007079/07
error in baby link	51 OBS Delivered	54 Newborn	HI008432/02	HI008421/02
HI000902/01	51 OBS Delivered	54 Newborn	HI000902/01	HI00902/01
HI000902/01	filter out	54 Newborn	HI00902/01	HI00902/01
HI000091/02	51 OBS Delivered	54 Newborn	HI000091/02	HI00091/02
correct MPS? stillborn	correct MPS? stillborn	54 Newborn	SI302280/06	SI302280/06
HI001266/03	filter out	54 Newborn	hi001266/03	hi001266/03

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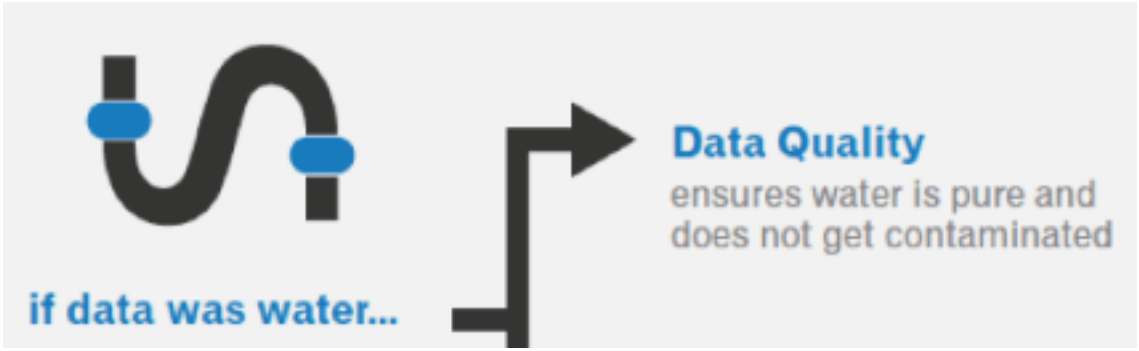
Quality Assurance



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Decision Support

- Request from care providers, other departments, prov/fed government, researchers, public
- datawarehouses, cubes
- Requires planning, human resources, funding

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CIHR Call for Perinatal Health Systems Improvement

- Tiers of Service – organizing a framework for a coordinated health service
- Prevention, Primary & Emergent Services up to Provincial Subspecialty Health Services
- May not be the same for type of patient
- Can be assigned by acuity or complexity

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CIHR Call for Perinatal Health Systems Improvement

- Rural Maternity Care – 18% of births (CIHI ‘13)
- 40% travel more than 1 hour to access services
- 1 in 6 rural women travel more than 2 hours
- Greater distance great risk or poorer outcomes
- Risk for perinatal death for AOOH births is 6X
- Emergency transport, clinical prediction model

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Burden on the health system

- 2006 report
- 10% spending on mom and babies ($821M in 02/03), other costs pre/during/post
- VD $2700 vs $4600 for CS
- Spending for babies ranged from $795 to $117,806
- NICU rates are rising

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Burden on the health system

The Facts

The costs and performance of Canada's health system

What we are spending and how

The Commission carried out its work against a very specific historical backdrop. Our health-care system has been largely built upon a reactive, sickness model, where treatment services dominate and care is focused in clinics, hospitals and other institutions. Physicians are typically the access point for this acute care system.

Some $200 billion, closing in on 50 per cent of some provincial budgets, are now spent to keep this system operating each year — based on GDP, the world's sixth most expensive health-care system per capita.1 2 Of this amount, more than three quarters (about 76 per cent) is spent for hospitals and other institutions, physicians' fees and drugs 3 Hospital costs include expenditures such as nurses' salaries.

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Burden on the health system

- "An integrated system of continuing care is a cornerstone of high-performing health care systems" – John G. Abbott March 2012

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Who Plays A Role

- Careproviders
- Health Information Management Professionals (aka the Health Record Coders)
- Data/Research Analysts, Epidemiologists, IT
- Clinical Educators, Managers, Vendors
- Program Evaluators, Policy Writers
- Quality, Decision Support, Advisory, Government, University Researchers

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Everyone's Role is Crucial

Data Carries Weight

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Final Points

- Accurate surveillance contributes to our knowledge of the possible causative factors and impact of preventive measures on the burden of _____ in Canada.

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Final Points

- An increase in passion leads to an increase in quality
- Information Sharing Helps everyone
- Can Impact Decision Support and Research
- Better Data, Better Measurement, Better Management, Better Care, Better Practice, Increase Savings, Decrease Burden

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Final Points

- Important to have a strong link with all stakeholders

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A Reason to be Passionate

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Thank You for Listening

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Questions?

Phil A. Murphy, MSc. phil.murphy@easternhealth.ca
Clinical Epidemiologist - Perinatal Program Newfoundland Labrador
Professional Associate - Memorial University (Ob/Gyn, Pediatrics)

Janeway Children's Health and Rehabilitation Centre
300 Prince Philip Drive St. John's, NL Canada A1B 3V6
Tel 709-777-4867
Fax 709-777-4125
www.ppnl.ca.ca

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