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Housekeeping

- Thank you for joining us today. All lines have been muted to eliminate background noise
- Questions will be addressed at the end of the webinar via the chat box or Q&A
- The webinar recording will be available on the CMQCC website
- Other questions: contact vcape@Stanford.edu

CMQCC
California Maternal
Quality Care Collaborative

Improving Birth Care, Experiences and Outcomes for, by, and with Black Mothers – a Quality Improvement Approach

Elliott Main, MD

Medical Director
California Maternal Quality Care Collaborative

Professor, Department of OB/GYN
Stanford University School of Medicine

ACAPEC-1809-19 May 2019

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CME Credit Information

- Anthem Blue Cross (Anthem) supports this important work and continuing provider education
- Each webinar participant will receive one (1.0) continuing medical education (CME) unit approved by the American Association of Family Physicians
- Information will be shared at the end of the webinar on how to obtain

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About Anthem

- In California, Anthem has been a leading health benefits company in the state since 1937
- Anthem serves over 1.2 million members for the Medi-Cal program in 29 counties
- Strong focus on mobilizing community partnerships to collectively reduce health care disparities

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Learning Objectives:

Upon completion of the learning activity, the learner should be able to:

1. Recognize the contributing factors in the variation in maternal morbidity and Caesarean rates in California
2. Demonstrate an understanding of CMQCC's California Birth Equity Collaborative
3. Translate knowledge into an action plan to further increase self-awareness of birth equity within the learner's local environment

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Disclosures

- DR. MAIN DOES NOT HAVE RELEVANT FINANCIAL RELATIONSHIPS WITH COMMERCIAL INTERESTS.

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About CMQCC

- Multi-stakeholder organization established in 2006: providers, state agencies, public groups with focus on Maternal Care
- Hosts California Maternal Mortality Review Committee
- Sister organization with CPQCC (neonatal care)
- Developer of QI toolkits: Early Elective Delivery, OB Hemorrhage, Preeclampsia, VTE, CVD in Pregnancy, and First Cesarean Prevention
- Leads multiple QI Collaboratives (Hemorrhage, HTN, Support for Vaginal Birth)
- Established Maternal Data Center in 2012

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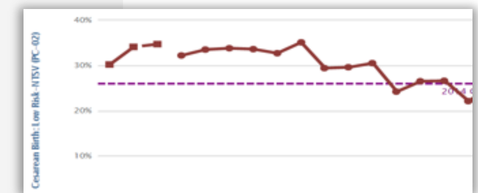
Driving Maternity QI at Scale

TOOLKITS

Evidence-based toolkits on leading causes of preventable maternal morbidity and mortality

MATERNAL DATA CENTER

Near real-time benchmarking data to support hospitals' quality improvement



IMPLEMENTATION

Coaching on how to implement best practices and sharing among member hospitals

ENGAGEMENT

Engaging partners around aligned goals and promoting patient awareness

CMQCC Current Projects

Supporting Vaginal Birth / Reducing Primary Cesareans Collaborative (>90 hospitals)

- Learning collaborative
- Unit Culture and Provider Attitudes Survey
- Multi-media teaching tools for labor support skills

Rapid-cycle Data Center:

- Active members: 213 / 237 hospitals, >95% of CA births (now also WA and OR facilities)
- Developer of perinatal quality metrics
- Public reporting of 4 measures
- User Education and Support for all 3 states

Sustainability

- Refresher programs for Hemorrhage and HTN
- Hospital check –up and coaching
- QI Academy for building team QI capacity
- Working with The Joint Commission

CMQCC Current Projects (continued…)

Perinatal Sepsis	• Taskforce ➔ QI Toolkit
Opioid Use Disorder/MAT	•Toolkit and metrics •Learning collaborative •Access to treatment
QI Academy: teaching practical tools for change	• Expanding QI capacity for hospital teams
Pilot Improving Racial Equity	• Partnerships: Community—Project—Hospital • Assessment and evaluation • Education and learning collaborative

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Health Disparities and Health Inequities Among Black Mothers and Infants

First, some language discussion

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Equality vs. Equity?

Equality

Equity

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Equity vs. Disparities

- Health equity and health disparities are intertwined
- Health equity means social justice in health (i.e., no one is denied the possibility to be healthy for belonging to a group that has historically been economically/socially disadvantaged)
- Health disparities are the metric we use to measure progress toward achieving health equity

Braveman P. What are health disparities and health equity? We need to be clear. Public Health Reports 2014; 129:5-8.

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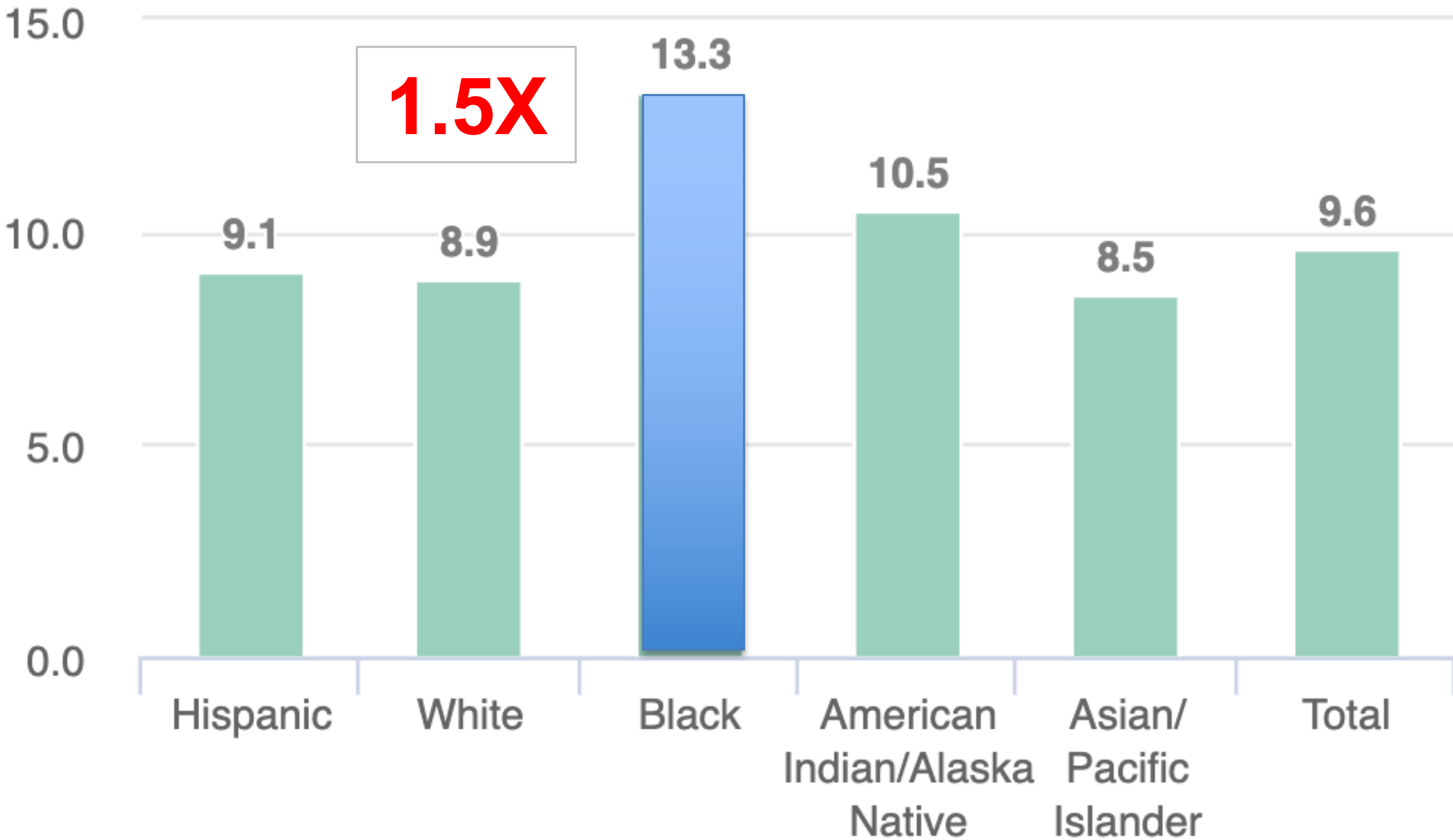
Health Disparity (Healthy Person 2020)

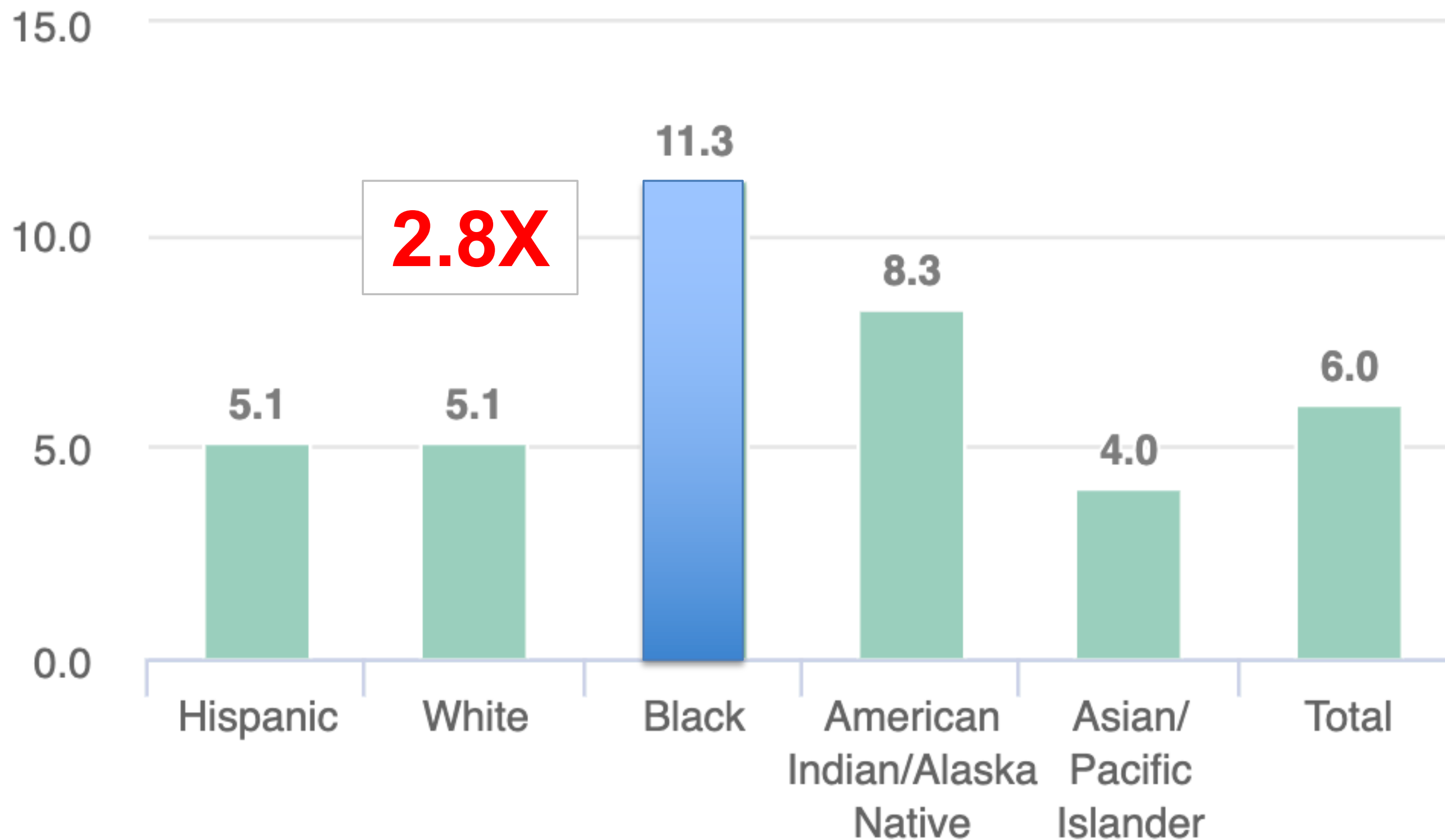
- …a health difference that is closely linked with economic, social, or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health…
- The quantity that separates a group from a reference point, often measured from the most favorable group rate

Health Inequity (Boston Public Health Commission)

- Difference in health that is not only ***unnecessary and avoidable*** but, in addition, are considered ***unfair and unjust***
- Rooted in social injustices that make some population groups more vulnerable to poor health than other groups

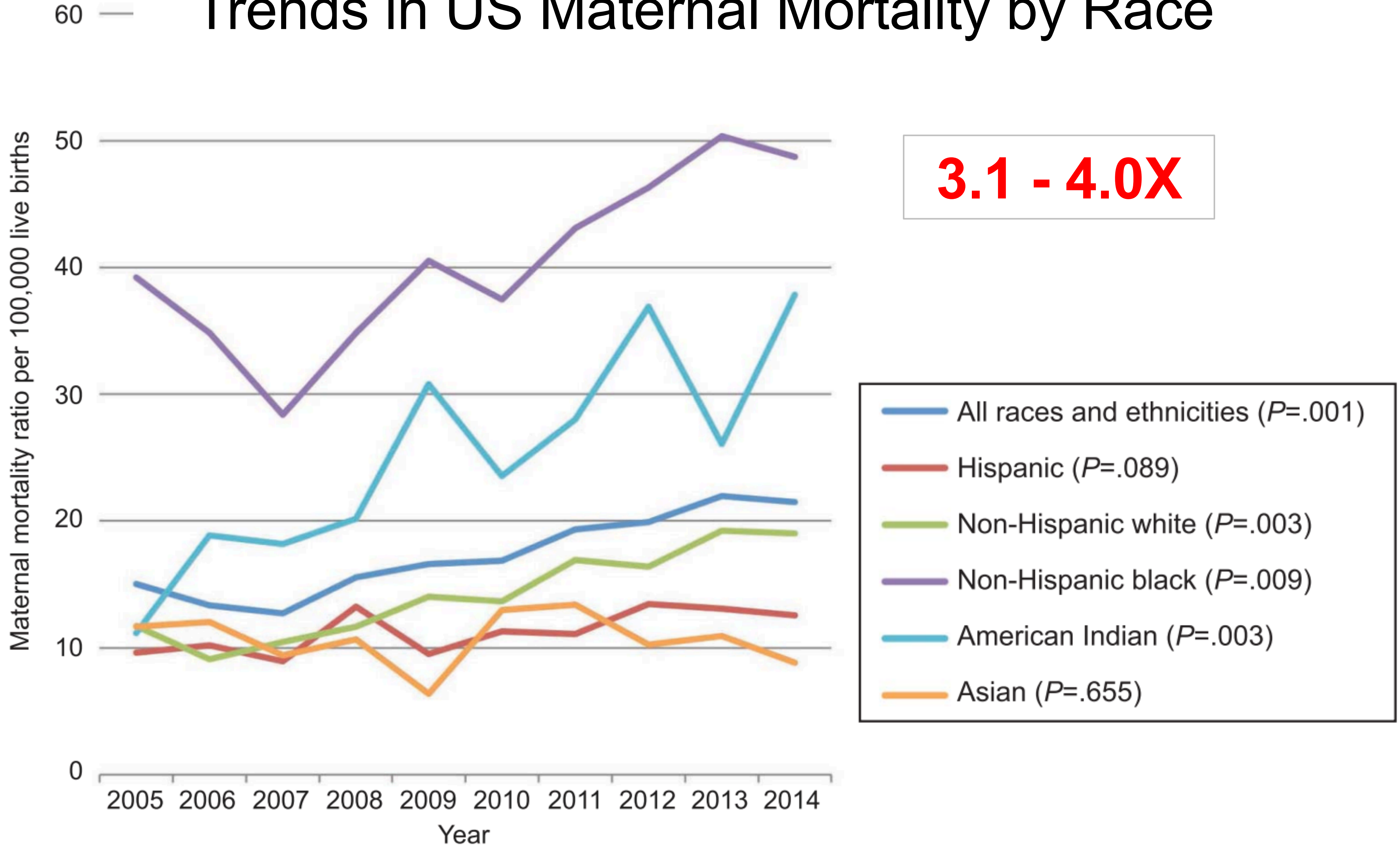


March of Dimes, PeriStats (May 1 2019. (based on data form NCHS)



March of Dimes, PeriStats (May 1 2019. (based on data form NCHS)

Trends in US Maternal Mortality by Race



Moaddab A, etal. Health Care Disparity and Pregnancy-Related Mortality in the United States, 2005-2014. Obstet Gynecol. 2018 04;131(4):707-712.

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Contributors to Health and Health Care Inequities

Health system factors

• Health services organization, financing, delivery

QI

Structural factors

• Poverty/wealth
• Unemployment
• Stability of housing
• Food security
• Racism

Patien

•Beliefs a
•Race/ethnicity
•Education and l
•Biology

factors

and attitudes
peting demands
implicit/explicit biases

Adapted from Kilbourne et al, AJPH 2006 and Allison Bryant MD MGH

Maternal Mortality Rate,
California and United States; 1999-2013

California: ~500,000 annual births, 1/8 of all US births

Maternal Deaths per 100,000 Live Births

Year	California Rate	United States Rate
1999	7.7	9.9
2000	10.9	9.8
2001	9.7	9.9
2002	10.0	8.9
2003	14.6	12.1
2004	11.8	13.1
2005	11.7	15.1
2006	16.9	13.3
2007	11.1	12.7
2008	14.0	15.5
2009		
2010		
2011		
2012		
2013		

HP 2020 Objective – 11.4 Deaths per

CMQCC → Toolkits and Collaboratives

CA Mortality Review Committee

SOURCE: State of California, Department of Public Health, California Birth and Death Statistical Master Files, 1999-2013. Maternal mortality for California (deaths ≤ 42 days postpartum) was calculated using ICD-10 cause of death classification (codes A34, O00-O95,O98-O99). United States data and HP2020 Objective use the same codes. U.S. maternal mortality data is published by the National Center for Health Statistics (NCHS) through 2007 only. U.S. maternal mortality rates from 2008 through 2013 were calculated using CDC Wonder Online Database, accessed at http://wonder.cdc.govon March 11, 2015. Produced by California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Division, March, 2015.

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How can QI Projects Affect Equity?

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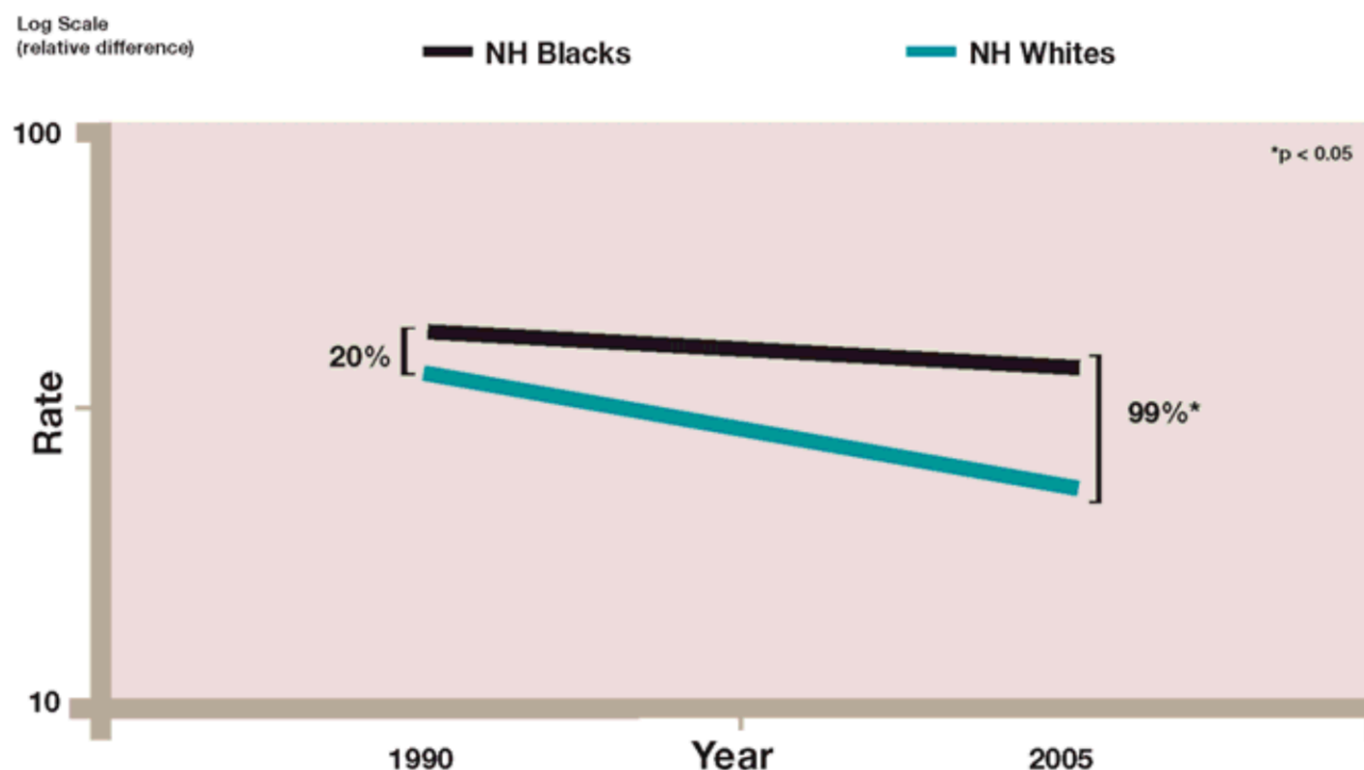
Important Case Study:



Adapted from:
(Jennifer M. Orsi, Helen Margellos-Anast, and Steven Whitman. "Black–White Health Disparities in the United States and Chicago: A 15-Year Progress Analysis." American Journal of Public Health, Vol. 100, No. 2, pp. 349-356, February 2010.)

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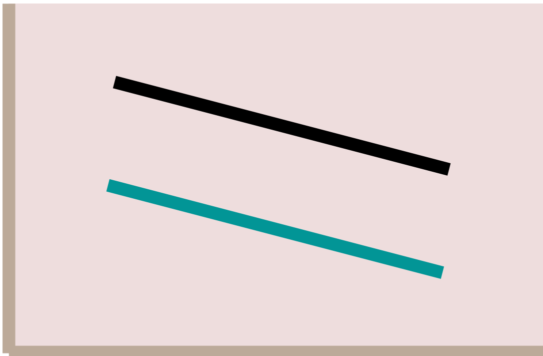
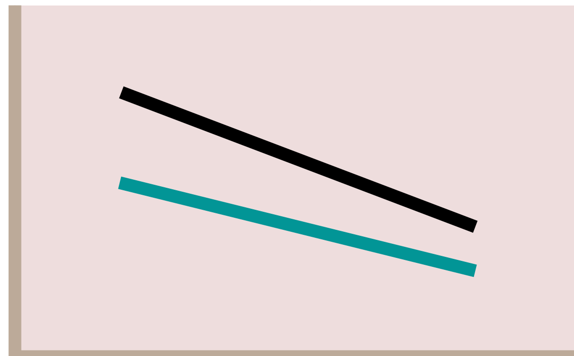
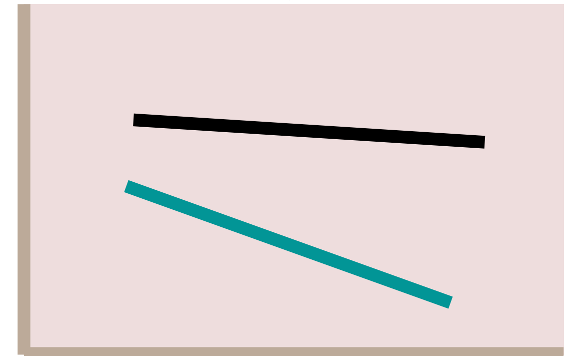
Possible Outcomes of QI Projects for Equity

Neutral	Narrowing	Widening
		
More of the same	Shows Improvement	Gap worsens
Many Projects	Childhood Immunizations	NYC Maternal Mortality

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CDPH California Department of Public Health

Maternal Mortality Rate, By Race/Ethnicity Three–Year Moving Averages; 1999-2013

California Only Data

White, Non-Hispanic
Hispanic
AA-W Mortality Disparity Ratio
African-American, Non-Hispanic
Asian, Non-Hispanic

Maternal Mortality Ratio (per 100,000 live births)

Mortality Disparity Ratio

60
50
40
30
20
10
0

10
9
8
7
6
5
4
3

27.7
29.0
32.2
35.3
41.5
45.7
51.0
46.1
41.1
33.8
37.2
29.5
26.4

3.9
3.1
3.0
3.0
3.8
3.8
4.4
3.7
3.8
3.2
3.9
4.3
3.8

9.1
7.6
7.1

1999-2001
2000-2002
2001-2003
2002-2004
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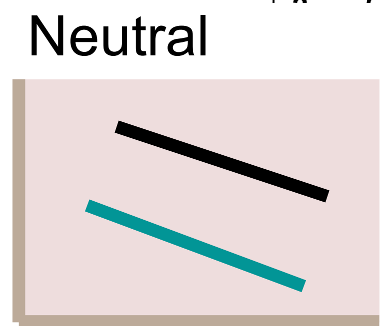
2004-2006
2005-2007
2006-2008
2007-2009
2008-2010
2009-201

Three-Year Moving Average

Neutral



More of same

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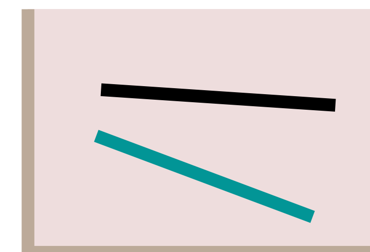
Percent low-risk Cesarean delivery by race/ethnicity, New York City, 2008–2014

22
20
18
16
14
12
10

2008 2009 2010 2011 2012 2013 2014

Black
Hispanic
White
Asian

Widening



Gap worsens

Examining Trends in Obstetric Quality Measures for Monitoring Disparities. Janevic T, Egorova NN, Zeitlin J, Balbierz A, Heber
Med Care. 2018 06;56(6):470-476.

Rates of Severe Maternal Morbidity & Select Risk Factors Among Racial/Ethnic Groups, **California,** 2008-2015 Q3 (8+ years)

Total sample (with known race): ~3.1million	Hispanic/ Latina	Non-Hispanic White	Asian/ Pacific Islander	Non-Hispanic Black	American Indian
Mothers (approx.)	52%	29%	13%	5.5%	0.3%
Severe Maternal Morbidity (SMM)	1.5%	1.2%	**1.8X**	2.2%	1.9%
Severe Maternal Morbidity Excluding Cases with Blood Transfusion alone	0.6%	0.5%	**2.0X**	1.0%	0.6%
Pre-preg. Obesity	27%	17%	8%	30%	35%
Pre-preg. Comorbidity	6%	8%	6%	14%	11%
Maternal Age ≥35 years at Delivery	14%	23%	30%	14%	12%
Total Cesarean	33%	33%	33%	38%	34%

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California Birth Equity Collaborative: Improving Care for, by and with Black Mothers: Background and Planning

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Why are birth outcomes for Black Women so much worse?

Usual explanation by doctors and nurses is that black women have more obesity, more hypertension, more diabetes, and more social disadvantages…

What If We Looked At B:W Disparity In Severe Maternal Morbidity (SMM) Only Among College Graduates?

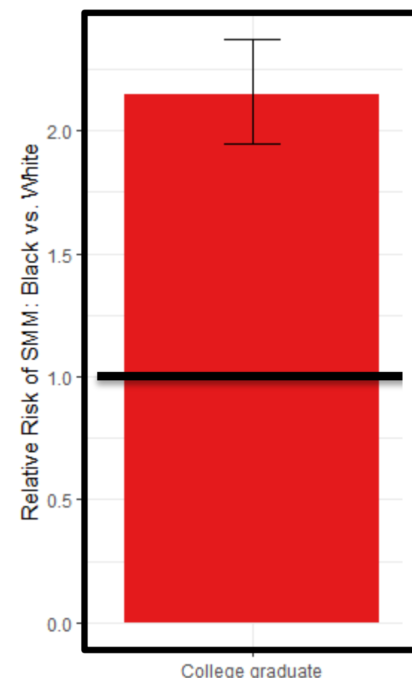
And adjusted for age, BMI and other clinical and demographic risk factors…

Black-White disparity in SMM is highest among college graduates (**2.2x higher than whites**)

Looking At Absolute Rates:

- SMM rate in Black women with college degrees: **2.4%**
- SMM rate in White women without high school diplomas: **1.6%**

California linked data: 2010-2015 Q3



Educational Attainment

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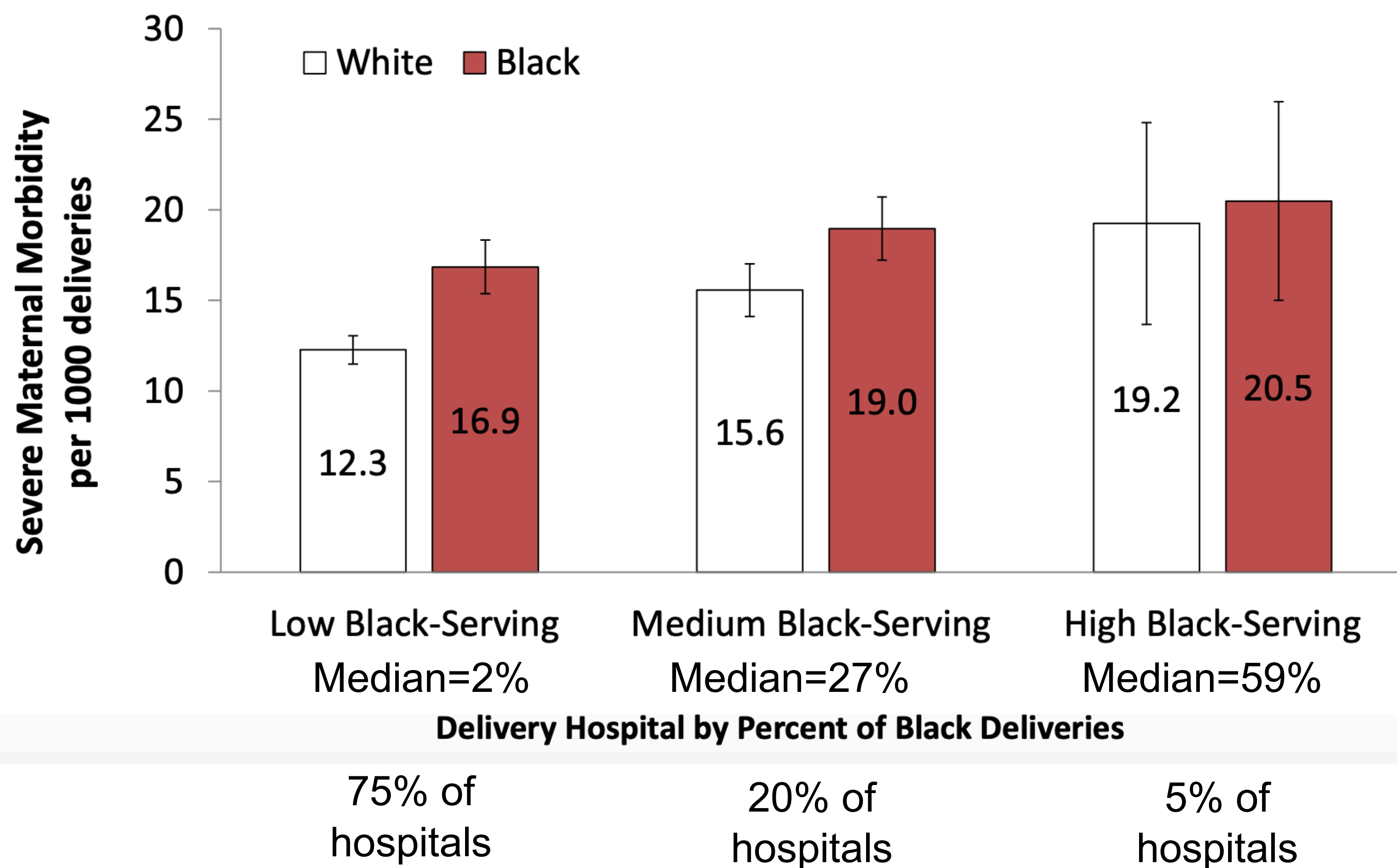
Adjusted rates of severe maternal morbidity for black and white women by black-serving hospital status



Howell et al. Racial differences in site of care and maternal morbidity. Am J Obstet Gynecol 2016

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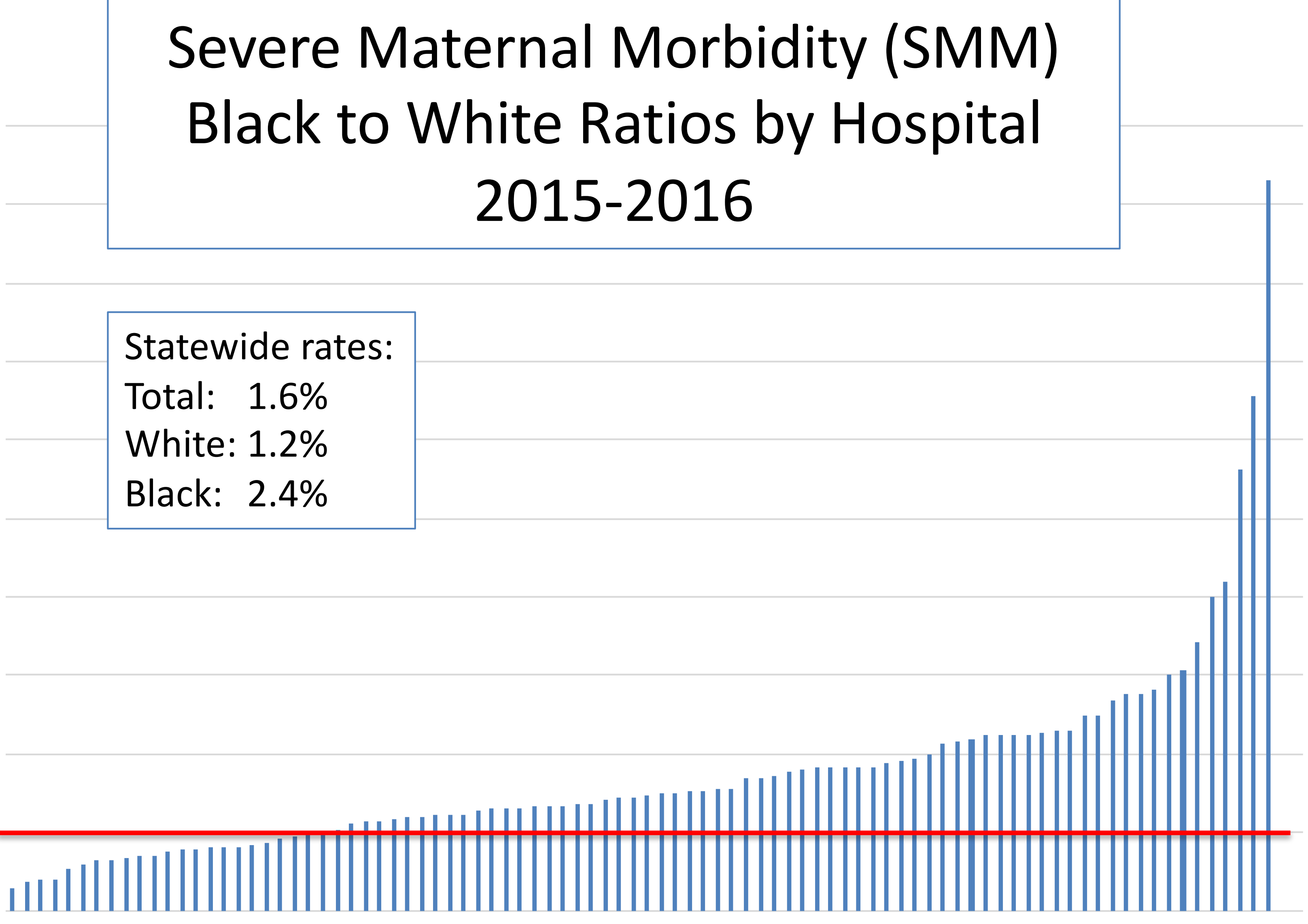

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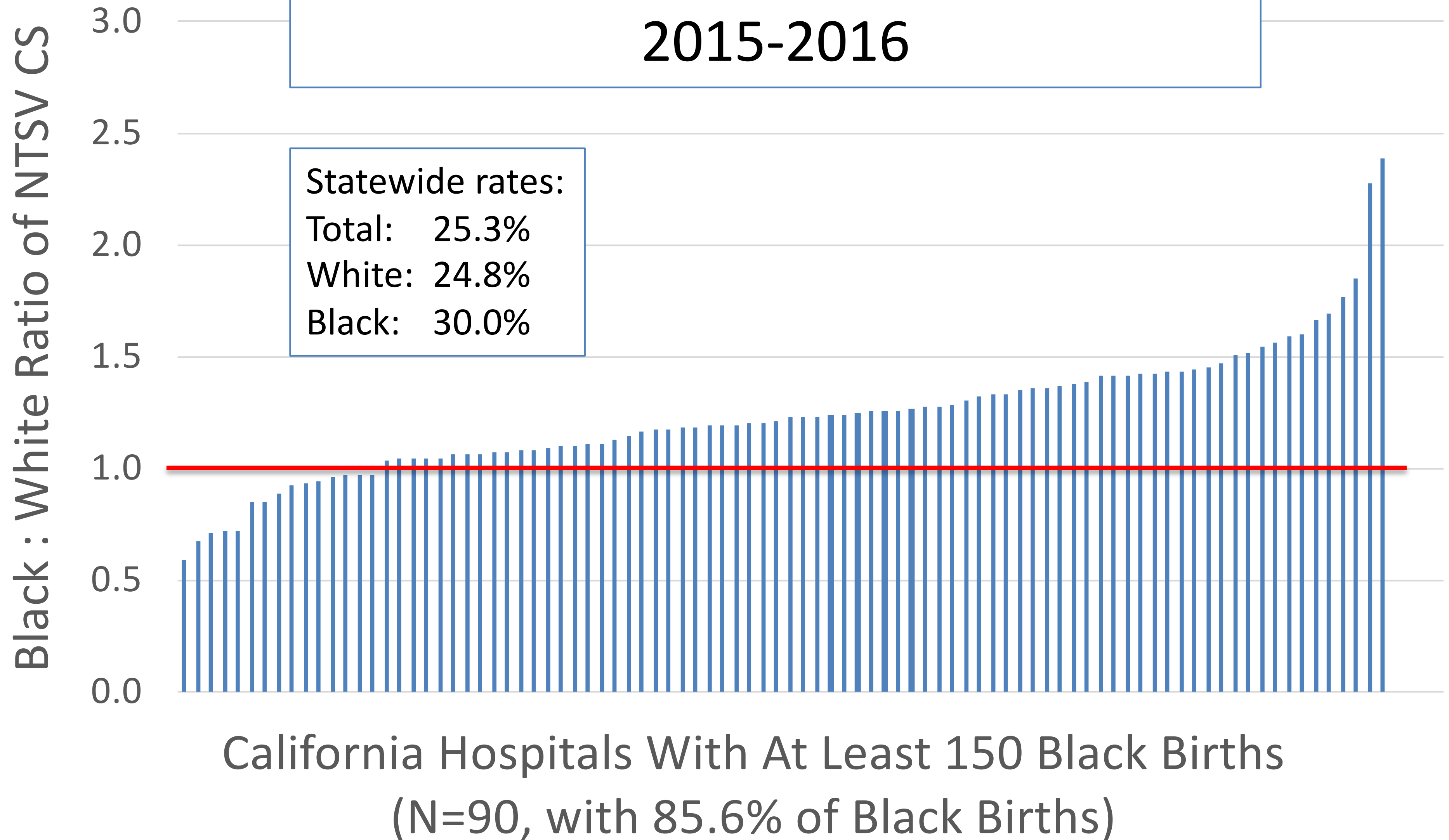


Themes from Literature and Stakeholders

- Fear and lack of trust between black women and the clinicians that care for them
- Lack of shared acknowledgement, perspectives and understanding of diversity, equity and inclusion
- Lack of shared language and meaning between black families and the clinicians that care for them
- Inability to assess disparities because they are not reliably measured and acknowledged
- Lack of effective meaning and sustainable collaboration and coordination between community and hospital.

LOST MOTHERS

Nothing Protects Black Women From Dying in Pregnancy and Childbirth

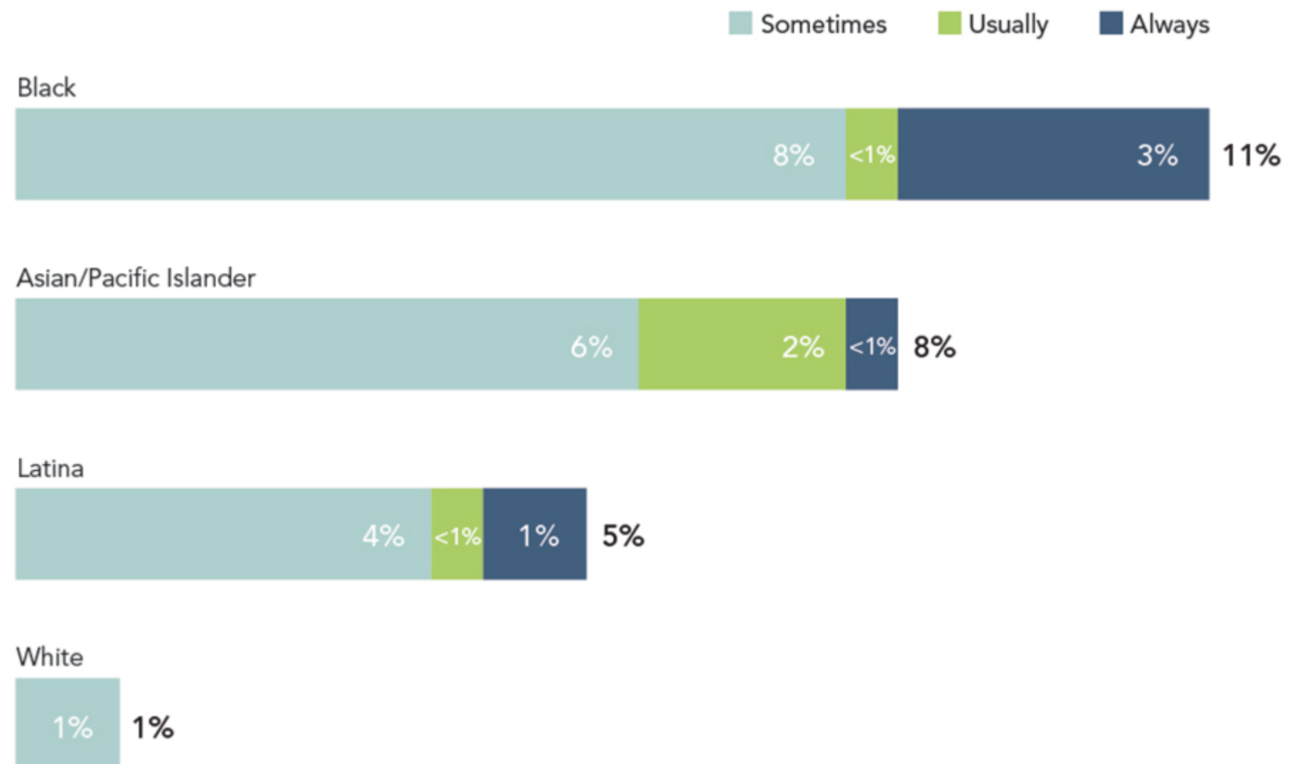
Not education. Not income. Not even being an expert on racial disparities in health care.

by **Nina Martin**, ProPublica, and **Renee Montagne**, NPR News, Dec. 7, 2017, 8 a.m. EST

Lt. Comdr. Shalon Irving PhD

Soleil Irving "just lights up a room when she smiles," Wanda Irving, her grandmother, says. (Sheila Pree Bright for ProPublica)

California Listening to Mothers 2017 – Unfair Treatment

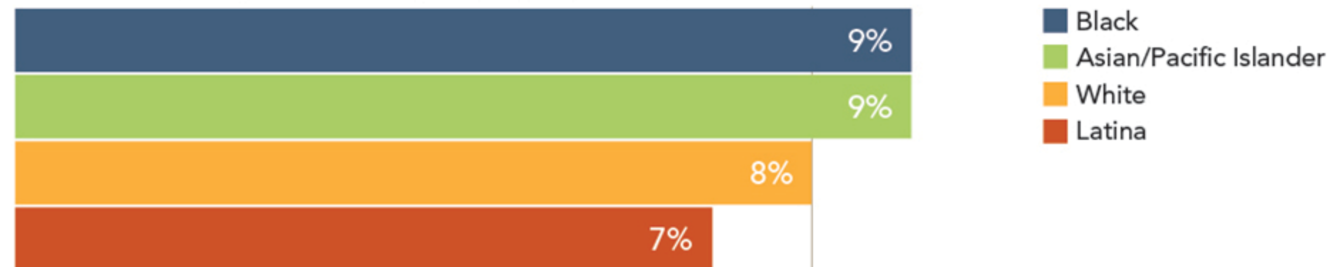


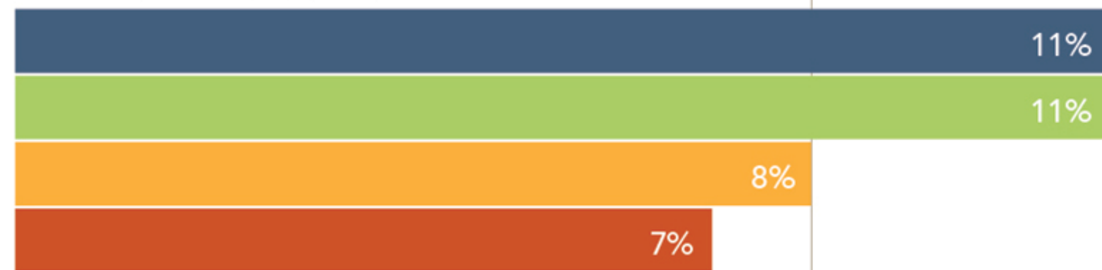
California Listening to Mothers 2017 – Harsh or Rough Treatment

Experience of Harsh Treatment
by Race/Ethnicity, California, 2016

BASE: ALL WOMEN WHO ANSWERED THIS QUESTION

During your recent hospital stay when you had your baby, did a nurse or maternity care provider ever...





Notes: Not all eligible respondents answered each item. Differences by race/ethnicity were not significant.

Source: *Listening to Mothers in California* (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018.

CA Birth Equity Collaborative

Aim: To improve birth care, experiences and outcomes by, for and with Black mothers

Karen A. Scott, MD, MPH

OB/GYN with years of working with CBO's to improve maternity care, and a University educator on racial justice

- In partnership with the Black community, multi-disciplinary, multi-organization team effort
- To build tools and QI strategies for changing the medical system: hospitals, physicians, staff, outpatient
- To pilot in a QI collaborative with a variety of CA hospitals, starting in the next months

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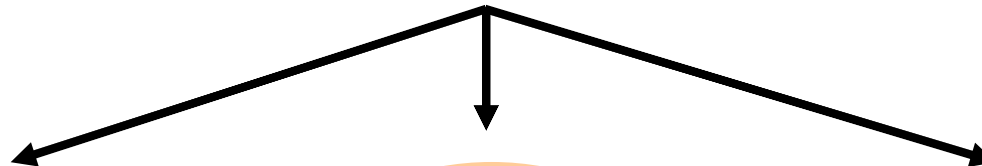
Action Plan

Two-year pilot goal: To partner with community stakeholders and hospitals in the development and testing of the following….

Community-informed model to develop patient-reported experience metric (PREM)

Online interactive, interprofessional education modules

Best practices for developing effective, sustainable community-hospital partnerships



Raise awareness & knowledge

Increase providers' understanding

Transform patient-centered communications

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Keys to success

- Create a shared language and understanding about what birth equity means
- Acknowledge & amplify the resilience of community informed knowledge
- Establish strategies to create and assess sustainable and respectful community-hospital partnerships
- Identify opportunities for education advancing a culture of birth equity
- Create community-informed patient experience measures

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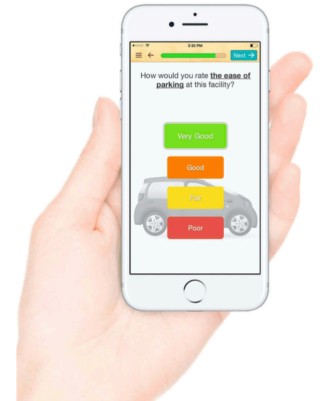
Transform Patient Voices into Action



- Co-develop with Black Community
- Culture humility framework
- Community informed knowledge
  - Respectful and dignified care in relationships, interactions, communication and shared decision making between patients and hospitals, and communities and hospitals
- Patient reported experience: stories and on-going measure reporting to drive QI

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Mobilize and Connect Partners: Community-Hospital Engagement

Structural Changes to Establish
On-going Connections / Relationships

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Educate/Train All Staff

- Raise awareness & knowledge
- Increase cultural sensitivity
- Recognize bias (implicit and explicit)
- Provide effective patient-centered communications to transform shared decision making
- Develop peer leadership and coaching

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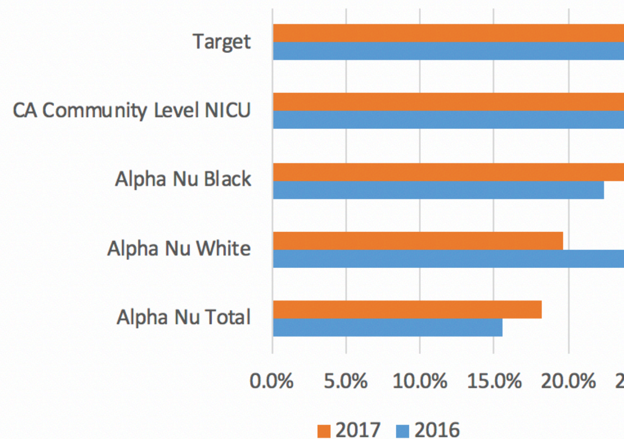
Hospital QI – Advancing Equity

Racial Disparities Gap Analysis Report

Measure: **Low Risk Cesarean Birth**: NTSV (Nulliparous, Term, Singleton, Vertex) PC-02 Current

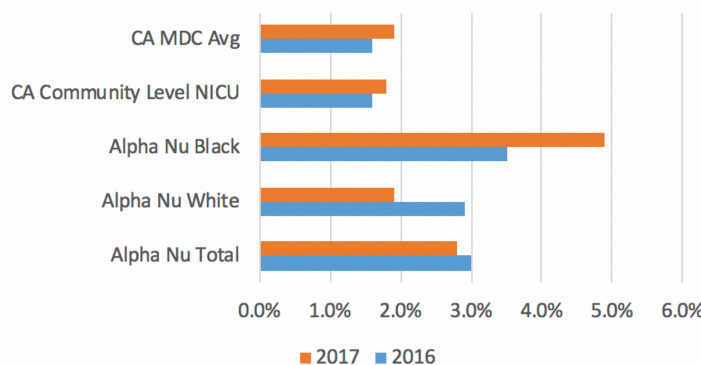
Definition: **NTSV:** Cesarean deliveries among "NTSV" births: 1) Nulliparous (first births); 2) Term (≥37 week gestation); 3) Singleton (no twins or other multiples); 4) Vertex (baby head presenting)

Target: Healthy People 2020 Goal = 23.9% NTSV rate



Measure: **Severe Maternal Mortality:** SMM

Definition: **SMM:** Delivering mothers who had major complications with: diagnoses typical for an ICU admission; major surgeries such as hysterectomy; or significant procedures such as blood transfusions.



2017 Measure Analysis of Drivers

	White	Black
TOTAL SMM RATE	**1.9%**	**4.9%**
Portion from each underlying cause:		
Hemorrhage (all types)	23.1%	40.0%
Hypertensive Disorders	9.5%	6.7%
Cardiac disease	0.0%	0.0%
Sepsis	0.0%	9.7%
Transfusion	14.3%	34.0%
Other	4.8%	4.9%
TOTAL DENOMINATOR	**210**	**206**

Recommendation: Review individual numerator cases in the Maternal Data Center to identify opportunities for improvement. www.datacenter.cmqcc.org

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Measures of success

Working together the CA Birth Equity Collaborative, communities, hospitals, and advisors will:

- Show improvement in respect and dignity PREM
- Demonstrate best practices for respectful & culturally response partnerships
- Engage hospital staff in completion of e-learning modules
- Effective use of equity dashboard by hospitals
- Advance a culture of birth equity

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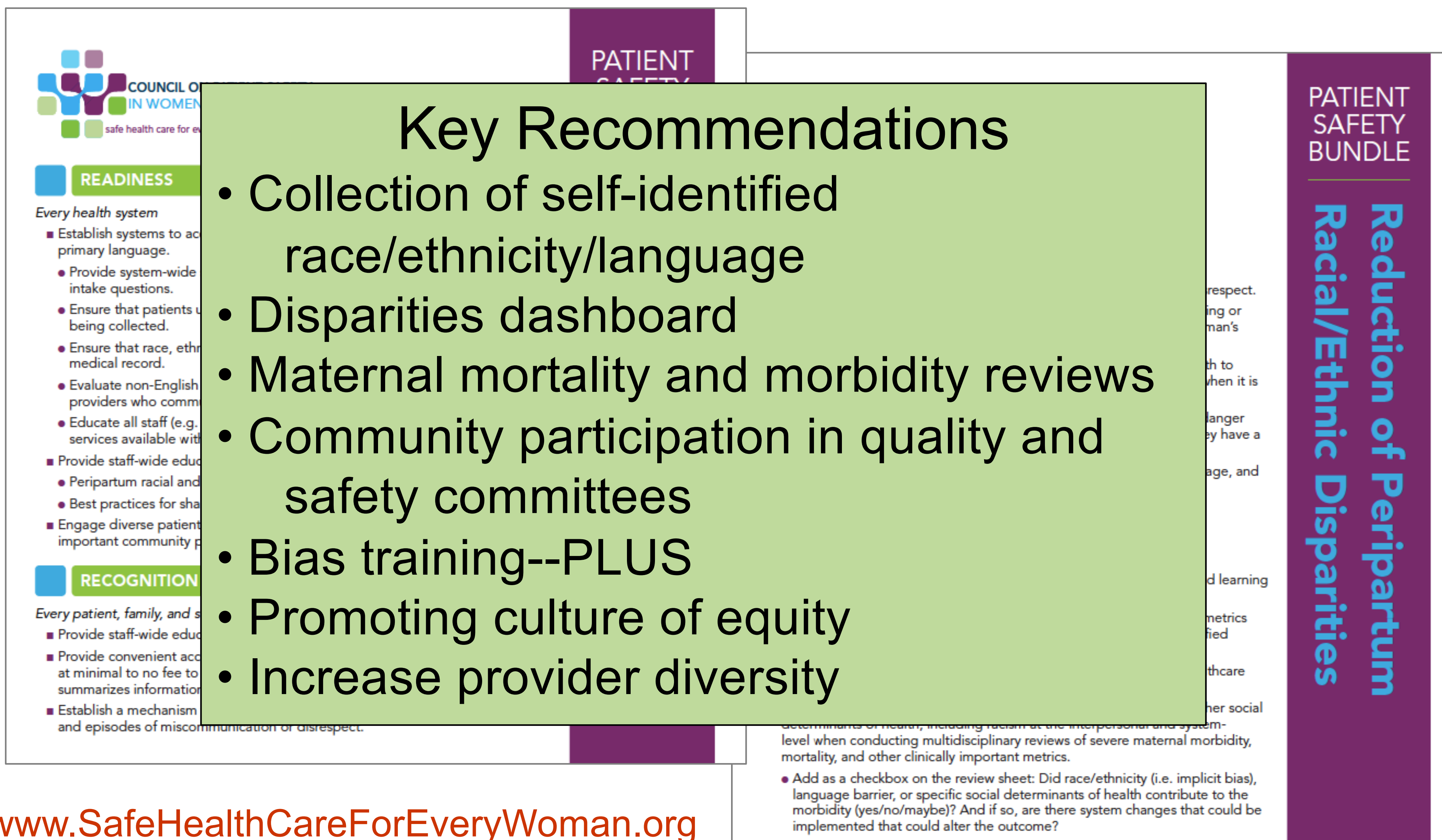
Translate the AIM Equity Bundle into a QI Toolkit



www.SafeHealthCareForEveryWoman.org

Advancing Health Equity
Leading Care, Payment, and
Systems Transformation

Roadmap to Reduce Disparities

1 Linking Quality and Equity

4 Designing the Activity

2 Creating a Culture of Equity

5 Securing Buy-in

3 Diagnosing the Disparity

6 Implementing Change

University of Chicago
Robert Wood Johnson

https://www.solvingdisparities.org/tools/roadmap

Actions you can take immediately

- Learn about birth equity – see resource list
  - Robin Diangelo. White Fragility—Why it's so hard for white people to talk about racism. Boston Beacon Press. 2018
- Examine your organization's data–by race!
- Talk to your patients and community organizations—and partner with them!
- Engage your hospital's leadership

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Resources

(for more see: https://www.cmqcc.org/qi-initiatives/birth-equity/resources)

- To Prevent Women from Dying in Childbirth, First Stop Blaming Them https://www.scientificamerican.com/article/to-prevent-women-from-dying-in-childbirth-first-stop-blaming-them/
- Why Texas is the Most Dangerous U.S. State to Have a Baby https://www.governing.com/topics/health-human-services/gov-maternal-infant-mortality-pregnant-women-texas.html
- Lost Mothers: Maternal Care and Preventable Deaths https://www.propublica.org/series/lost-mothers
- Why America's Black Mothers and Babies Are in a Life or Death Crisis https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal- mortality.html
- Pregnancy Related Deaths: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm
- Why is U.S. Maternal Mortality Rising? https://jamanetwork.com/journals/jama/fullarticle/2645089
- Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care https://www.ncbi.nlm.nih.gov/pubmed/25032386
- Maternal Mortality and Morbidity in the United States http://www.who.int/bulletin/volumes/93/3/14-148627/en/
- Racial and Ethnic Disparities in Obstetrics and Gynecology https://www.acog.org/Clinical- Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved- Women/Racial-and-Ethnic-Disparities-in-Obstetrics-and-Gynecology
- Maternal Health Care is disappearing from rural America https://www.scientificamerican.com/article/maternal-health-care-is-disappearing-in-rural- america/

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Thank you!!

Questions?

Visit: www.CMQCC.org

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- Please complete the evaluation that will be sent via email to receive CME credit certificate