Let’s Talk **Perinatal Equity:**
Understanding Bias and Tracking Equity Progress in the Maternal Data Center

Wednesday, February 21, 2024
In order to receive contact hours (RN) for this webinar, please complete the evaluation via the link, which will be sent to you 48 hours after this webinar.

You must be in attendance on the webinar for a minimum of 50 minutes for a contact hour to be awarded.
Logistics & Slide Deck

- All attendees are muted upon entry.
- Please use the Q & A function – we will do our best to answer questions during the webinar.
- You are welcome to use any of the slides provided for educational purposes.
- If you modify or add a slide, please substitute your institutional logo and do not use the CMQCC logos.
- We welcome your feedback and recommendations for improving future webinars.
Webinar Objectives

• Understand the connection between clinician bias and quality and safety.
• Identify biased provision of care in your setting and gain knowledge of tools to begin addressing it.
• Identify tools available in the Maternal Data Center (MDC) to track progress on your interventions to improve care equity.
The webinar recording and slides will also be posted within 48 hours at: https://www.cmqcc.org/resources-tool-kits/webinars
Today’s Presenters

Amanda Williams, MD, MPH, FACOG
CMQCC Clinical Innovation Advisor

Christa Sakowski, MSN, RN, C-ONQS, C-EFM, CLE
CMQCC Clinical Lead
From Implicit Bias to Maternal Health Inequities—We Didn’t Get Here By Accident

Amanda Williams, MD, MPH, FACOG
Clinical Innovation Advisor
California Maternal Quality Care Collaborative
Adjunct Clinical Associate Professor
Department of Obstetrics and Gynecology
Stanford University School of Medicine
Currently recognized identifiers such as “birthing people,” “mother,” “maternal,” “they,” “them,” “she,” “her.” and “pregnancy-capable person” are used in reference to a person who is pregnant or has given birth. We recognize not all people who become pregnant and give birth identify as mothers or women and will use the above-recognized terms interchangeably to represent all those present in this space receiving care for pregnancy services. All persons are equally deserving of respectful patient-centered care that helps them attain their full potential and live authentic, healthy lives. The healthcare team should respect individual patient preferences regarding gendered language throughout the course of their care.

The term “family” is used to refer to any persons the pregnant or postpartum patient designates as such (alternatives: partners, husbands, wives, support persons, loved ones).

The term “clinician” is used to denote nursing and medical staff, whereas the term “provider” refers to a clinician with diagnosing and prescribing authority.
Disclosures

- Medical Director, Mahmee
  - venture backed, tech-enabled pregnancy and postpartum wrap around services company aimed at elevating maternal health equity and supplementing traditional perinatal care

- Clinical Advisor, RiskLD
  - obstetric alerts and decision support software
CMQCC Mission:

End preventable morbidity, mortality AND racial disparities in California maternity care.
What is the problem we are trying to solve?
LOST MOTHERS
Maternal Care and Preventable Deaths

The U.S. has the highest rate of deaths related to pregnancy and childbirth in the developed world. Half of the deaths are preventable, victimizing women from a variety of races, backgrounds, educations and income levels.

We're Investigating How Insurance Gaps Endanger Mothers. This Is Why.
Women are getting kicked off Medicaid as they give birth or enter the qualifying for care to begin with.

Nothing Protects Black Women From Dying in Pregnancy and Childbirth
Low education, low income, not even being an expert on racial disparities in health care.

Lost Mothers
An estimated 100 to 200 women in the U.S. die from pregnancy-related causes in 2018. We have identified 100 of them in five New York areas. July 11, 2017.

The New York Times

Huge Racial Disparities Found in Deaths Linked to Pregnancy
African-American, Native American and Alaska Native women are about three times more likely to die from causes related to pregnancy, compared to white women in the United States.

Childbirth Is Deadlier for Black Families Even When They’re Rich, Expansive Study Finds
Women Report Mistreatment During Maternity Care

By race/ethnicity:
- Black: 30%
- Hispanic: 29%
- Multiracial: 27%
- White: 19%
- AIAN/NHPI*: 18%
- Asian: 15%

By insurance type†:
- No insurance: 28%
- Public insurance: 26%
- Private insurance: 16%

*American Indian, Alaska Native, Native Hawaiian, and Pacific Islander
†At the time of delivery

Source: August 2023 Vital Signs
U.S. Maternal Mortality Rates by Race and Ethnicity, 2018-2021

California: Births by race/ethnicity 2018-2020

2020 Total California Births: 420,259

- 48.1% Hispanic
- 28.8% White
- 15.9% Asian
- 5.8% Black
- 0.4% American Indian/Alaska Native

1 in 8 US Births are in CA

All race categories exclude Hispanics. Percentages will not total 100 percent since missing ethnicity data are not shown.

Pregnancy-Related Mortality Ratio by Race/Ethnicity
California 2012-2020

Pregnancy-related mortality ratio (PRMR) = Number of pregnancy-related deaths per 100,000 live births. Pregnancy-related deaths include deaths within a year of pregnancy from causes related to or aggravated by the pregnancy or its management, as determined by expert committee review.
Pregnancy-related mortality ratio (PRMR) = Number of pregnancy-related deaths per 100,000 live births. Pregnancy-related deaths include deaths within a year of pregnancy from causes related to or aggravated by the pregnancy or its management, as determined by expert committee review. Abbreviations: CVD = Cardiovascular disease; Hem = Hemorrhage; Inf = Sepsis or infection; HDP = Hypertensive disorders of pregnancy; TPE = Thrombotic pulmonary embolism; AFE = Amniotic fluid embolism. PRMRs of American Indian/Alaska Native, Native Hawaiian/Pacific Islander, Multiple-race and other races are not shown due to small counts.

* Unstable ratio, n<10
What is health equity?
“I treat everyone the same”
How is implicit bias created?
"Inherited Disadvantage"

The physical and structural environment in which humans grow, learn, work and play shapes intergenerational population health.

Structural racism $\rightarrow$ Implicit bias

- GI bill education loans
- Civil rights /voting rights
- Federal housing administration (FHA) loans $\rightarrow$ Residential segregation
- Access to green space, physical safety
- Access to fresh groceries
- Hiring and job advancement
Strategic Framework for Operationalizing Equity

**Vision**

Health equity for women and families through identification and dismantling of perinatal healthcare disparities

- **Reliably Measure**
  Identify, document, and measure care disparities

- **Remove Barriers**
  Identify and remove care delivery system barriers

- **Empower Patients**
  Enable patients to make health promoting decisions

- **Engage Clinicians and Staff**
  Educate, activate, and recruit diverse and inclusive clinicians and staff
Where do we see bias showing up?
Operationalizing stigma and discrimination

Consistent mention of issue (e.g. drug use, race) in notes

Providers not looking at corresponding lab values versus making assumptions

“No show” to multiple appointments

Provider’s (or coroner’s) failure to assess for other causes of complaints (e.g. besides drug use)

Delay in diagnosis, treatment, finding

Lack of referrals to applied health professionals (mental health, substance use treatment, etc.)

Facility/agency lack of established behavioral health protocols/supports (no MSW visit)

Key words in the records: “refusing to cooperate” “not making eye contact” “being non-compliant” “not wanting to do…”

Multiple ED, urgent care, PCP visits for the same/similar complaint in short period

Source: From Washington State Department of Health – Maternal Mortality Review Process
Implicit bias examples

- NICU visitation
- Medical record envelopes
- Nurses station conversation
- Addressing colleagues
How do we move beyond training to integrate what we know about bias into our maternal health equity efforts?
Comprehensive Approach to Addressing Disparities

CMQCC Initiatives & Projects

- Anemia
- Community Birth Partnership
  - Team-Based Care
  - Midwife Integration
  - Partnering with Doulas
  - Improving Transfer of Care
- Preeclampsia
  - Low-Dose Aspirin Campaign
- Pregnancy Associated Mortality Review
- Sepsis
- Postpartum Redesign
New Equity Tool
Now Available to California Hospitals

CMQCC

Hospital Action Guide for Respectful & Equity-Centered Obstetric Care

Guide Home
Start Here
Module 1: Understand the Need for Birth Equity
Module 2: Collect and Share Stratified Data
Module 3: Examine Current Equity Practices
Module 4: Leverage Patient Care Process and Outcome Data to Address Obstetric Disparities
Module 5: Create a Culture of Respectful Care
Module 6: Integrating Community Collaboration
Webinars
Acknowledgments & Feedback

Welcome to the Hospital Action Guide for Respectful and Equity-Centered Obstetric Care
Learn how this guide is structured and how best to use it.

Module 1
Understand the Need for Birth Equity to Enhance Equity, Reduce Disparities, Increase Safety, and Meet Regulatory and Legislative Requirements
Shape your understanding of the problems that exist and then prepare to do the work identified in the following modules.
Module Overview

Module 1
Understand the Need for Birth Equity to Enhance Equity, Reduce Disparities, Increase Safety, and Meet Regulatory and Legislative Requirements.

Module 2
Identify Opportunities for Collecting and Sharing Stratified Data on Patient Experience and Outcomes.

Module 3
Examine Current Equity Practices to Implement Informed and Meaningful Action.

Module 4
Leverage Patient Care Process and Outcome Data to Address Obstetric Disparities

Module 5
Create a Culture of Respectful Care

Module 6
Integrating Community Collaboration
Pilots / Local Initiatives

Data & Performance Improvement Projects

Recruitment Strategies

Ongoing Unconscious Bias Training

Leveraging Technology

Ongoing Presentations & Invited Speakers

Community collaboration
NTSV Equity Structure Measures Tracking Tool

Christa Sakowski MSN, RN, C-ONQS, C-EFM, CLE
CMQCC Clinical Lead
Maternal Data Center (MDC) NTSV Equity Structure Measure Tracking Tool

- Can be accessed in the MDC by anyone with CA MDC access.

- Hospital MDC Administrator or Data-entry Status user-type needed to complete the checklist.
Structure Measures

• Capacity, systems, and processes to provide high-quality care. For example:
  • Physical equipment standardly used in care (i.e. hemorrhage cart)
  • Policies in place to guide care
  • Routine debriefing of cases
Welcome to CMQCC Accounts. Contact us with any questions.

CMQCC ACCOUNTS

Home

UPCOMING WEBINAR! Obstetric Sepsis: Improving Listening Skills and Update on Screening & Diagnostic Criteria
February 6th, 2024 - 12-1pm PST - Register HERE

CMQCC Website
Stay up to date with the latest from CMQCC and download toolkits on our website
Launch Website

Maternal Data Center
Track near real-time data and performance metrics at your hospital in the MDC
Launch CA MDC
Build your MDC expertise with these education modules
Launch MDC Education

HUDLS Labor Education
Learn Hands-on Understanding and Demonstration of Labor Support through our online education platform
Launch HUDLS
**Clinical Quality Measures**

- Early Elective Delivery (PC-01): 20.0%
- Cesarean Birth: NTSV - Nullip Term Singleton Vertex (PC-02: Current): 18.2%
- Cesareans after Labor Induction: NTSV Cases: 32.0%
- Unexpected Newborn Complications: Severe (PC-06.1): 8.6%
- SMM Excluding Transfusion-Only Cases: 1.0%

**NTSV Cesarean Equity Learning Initiative**

**Upcoming Webinar: MDC Refresher Training**

Join us for a Maternal Data Center (MDC) Refresher Training on **Tuesday, 1/30 at 12pm PT**. This webinar is a review of the basic functionality of the MDC and is intended for new MDC users, as well as any users who would like a review.

Please register in advance [here](#).
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6. Develop an ongoing review schedule for auditing policies/processes with an equity lens.
   **WHY:** Policies, procedures, and practices (PPP) can support or undermine respectful care at both the hospital and unit levels. While typically crafted to meet regulatory or operational requirements, these guardrails that guide behaviors and actions can perpetuate implicit bias and unfairly disadvantage patients and staff from particular racial and ethnic groups. These formal and informal rules must be crafted mindfully to avoid unintentional harm.

**Policies and Procedures**

**Admission/Discharge/Transfer forms**

**Mission, vision, and values statements**

**Job descriptions and professional conduct standards**

**Marketing and education materials**

7. Create equity-oriented onboarding process.
   **WHY:** Developing an approach to influence unit hiring that prioritizes cultural concordance with your community and highlights the importance of maintaining health equity principles on the unit builds trust with the community and patients served.

8. Develop a “Commitment to Respectful Care” document and dissemination process.
   **WHY:** A critical aspect of building internal and external trust with regard to equity is to embed a culture of respectful care that permeates all unit interactions. Obtaining a commitment to respectful care from all healthcare team members elevates the value of respectful care by the leadership of the unit and organization.

   **WHY:** Patient-reported experiences can yield numerous potential benefits. They can encourage improved patient engagement and be utilized to clarify your patients’ priorities, which can potentially improve shared decision-making between patients and providers. Additionally, they can identify the benefits or harms of interventions that may need to be more readily visible to the care team. Benefits to patients include a better understanding of their condition and personal care needs, improved communication regarding symptoms, and increased satisfaction and trust.

   **Show details**

10. Engage with community organizations serving perinatal patients.
    **WHY:** Community organizations have access to and the trust of the patient base. Establishing bidirectional communication with community partners can be foundational to the development of community partnerships to expand the trust of the patients and community served by the organization.
1 Engage in transparent sharing of stratified (race/ethnicity, insurance, provider, etc.) data reports.

WHY: Routine review of overall patient outcomes may create a false sense of wellbeing if the aggregated data reflects outcomes within normal limits which often masks variation within the data. Stratified data may show that not all patients are equal beneficiaries of the care practices provided. The MDC provides analyses that indicate where a hospital should concentrate in order to reduce cesarean rates. Provider-level feedback about individual NTSV cesarean rates that are unblinded and shared can have a significant and rapid effect on clinical practice.

2 Implement a protocol and support tools for patients who present in latent labor to safely encourage early labor at home.

WHY: Latent phase admission is associated with higher rates of cesarean. The decision to admit is complicated by the patient's level of discomfort and the expectation by some patients to be admitted upon arrival. Education and material with specific guidance for partners and family members as to how to best support the birthing person in early labor can assist with coping prior to the active phase. Therapeutic rest through administration of medication can be considered as an alternative to admission in many instances.

3 Perform a review of induction procedures.

WHY: Many factors affect the risk of cesarean after the decision for induction of labor has been made. These factors vary by provider and by facility. How induction is managed may be the determining factor for whether the risk of cesarean is increased. The ACOG/SMFM Consensus Statement on Safe Prevention of the Primary Cesarean Delivery gives guidance for the selection of appropriate candidates for induction of labor.

4 Implement training/procedures for identification and appropriate interventions for malpositions (e.g., OP/OT).

WHY: Vertex malpositions account for 12% of all cesarean births performed due to dystocia. Labor support techniques and positioning can assist with malpositions in the active phase. When labor dystocia occurs in the second stage, vaginal birth is optimized when clinicians determine that the woman has a malpositioned fetus early on and subsequently intervene to promote progress. Digital/manual rotation of the fetus from the OP position to the OA position is associated with lower rates of cesarean birth.

5 Integrate cesarean reduction tools (labor dystocia checklist, order sets, or other tracking tools) into the electronic health record.

WHY: Utilization of the EHR may assist with decision support, improve efficiency of care, and make quality and safety metrics and up-to-date clinical guidelines for common conditions easily obtainable. Expanded use of the EHR through the implementation of BPAs, standardized order sets, semi-automated treatment algorithms, alerts, and reminders have been shown to improve patient safety indicators, patient outcomes, and decrease length of stay.

6 Develop a policy to integrate doulas into the birth care team.

WHY: Continuous labor support is associated with a significant reduction in cesarean birth. When doulas are utilized in a way that allows them to function appropriately in their unique and integral role, they can simultaneously advocate for birthing people and act as helpful allies to nurses and providers. Because of the potential to reduce birth disparities, doula programs are rapidly growing.

7 Develop standard criteria and a process for reviewing fallout cases.

WHY: The MDC creates a case list appropriate for the improvement topic (e.g., cesarean for labor dystocia or cesarean for fetal concern). After simple chart reviews, using a labor dystocia checklist based on the ACOG/SMFM guidelines outlier cases can be identified. Ideally, this review occurs throughout the labor and is utilized as a communication tool as well.

8 Develop obstetric-specific resources and protocols to support patients, and families through an unexpected/traumatic cesarean.

WHY: Even when birthing people feel they received competent clinical care, the lack of communication afterward leaves them feeling alone. Patients of color report high rates of feeling disrespected and unheard. Clinicians should be alert for behavior or emotional states that are outside the normal range of postpartum responses (detachment, dissociation, and intrusive thoughts). Assessment and discharge planning for follow-up care is essential for all women who have experienced a potentially traumatic birth experience.
## Equity Structure Measures

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### NTSV Cesarean Equity Learning Initiative

**Alpha Medical Center**

NICU Level III/IV  
MCH Director: Emily McCormick  
MCH Director Email: emkmccormick+2@gmail.com

**Overall Percent Complete:** 77%

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Some sub-items completed

Sub-items completed and date filled in

Date filled in
Questions?
Upcoming Events

Presented by the Mid-Coastal California Perinatal Outreach Program (MCCPOP)

REGISTRATION IS NOW OPEN!

2024
Perinatal Potpourri Annual Conference

March 21 & 22, 2024

Join Stanford Medicine and CMQCC for this virtual continuing medical education opportunity featuring California and national experts discussing maternal, fetal, and neonatal advances in care.

http://tinyurl.com/MCCPOPPotpourri24

Questions?
contactmccpop@stanford.edu
Upcoming Events

IP24
A ROADMAP TO COMMUNITY ENGAGEMENT:
NEONATAL EQUITY AND ADVOCACY

HYBRID EVENT | FRIDAY, MARCH 1, 2024

Register today!
Scan the QR or use link below
http://tinyurl.com/CPQCCIP24

Join IP24 live and in person or attend virtually
Friday, March 1, 2024 from 8:00 a.m. – 4:00 p.m.
Pacific Time, Coronado Island, CA
End preventable morbidity, mortality, and racial disparities in California maternity care

Thank You For Joining Us Today!

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