Baylor College of Medicine

Texas Children's Hospital®

Incorporating Health Equity into Quality Improvement Initiatives in Maternal Health Care

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Improving Delivery and Hospital Care

- Most important factor in preventable morbidity and mortality: improved quality of care
  - ✓ Safety bundles
  - ✓ Protocols
  - ✓ Checklists
  - ✓ Triggers (such as maternal early warning criteria)
  - ✓ Simulation trainings
  - ✓ Team/staff training
  - ✓ Care coordination
  - ✓ Promotion of a safety culture

- Quality initiatives aimed at standardizing delivery care → improved care at all hospitals

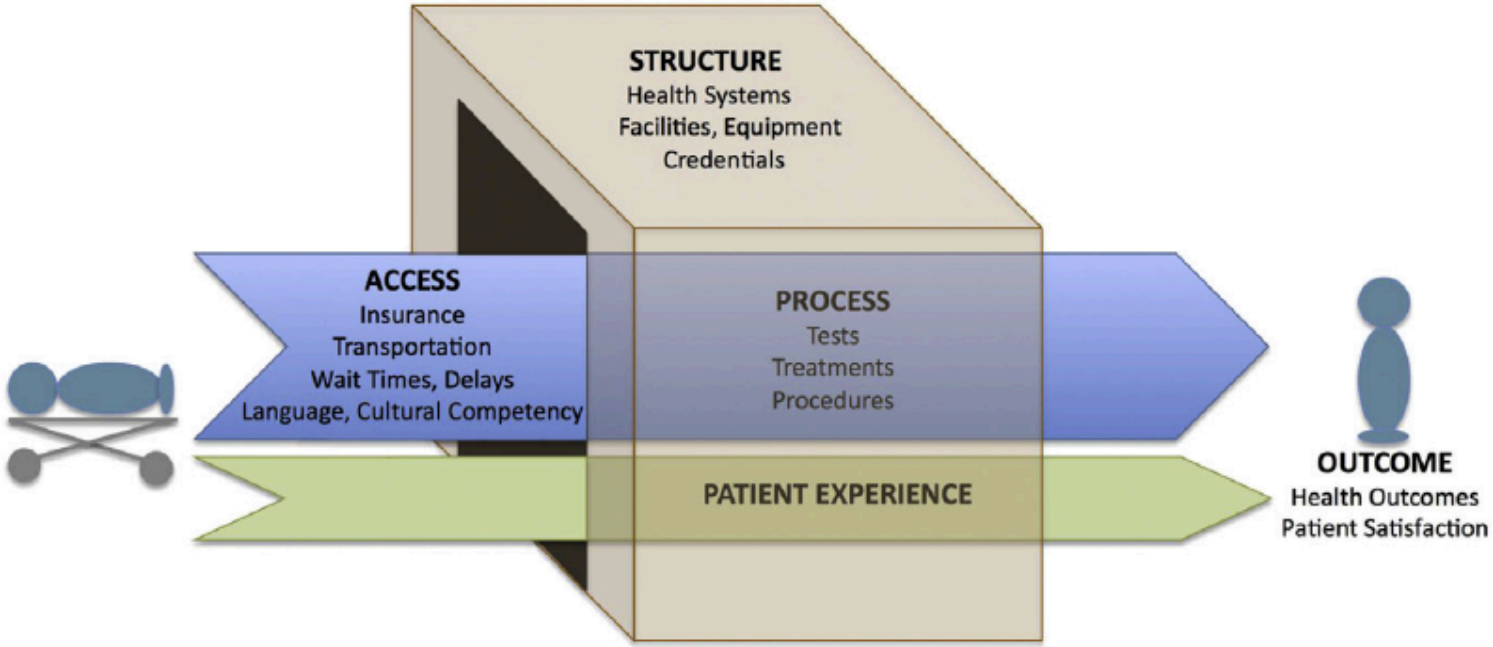
Howell, E et al. Clin Obstet Gynecol. 2018 Jun;61(2):387-399

Institute for Healthcare Improvement's Health Equity Framework

Strategy 1: Create the Data Infrastructure to Improve Health Equity
Strategy 2: Display and Use Stratified Data

Improving Health Equity: Build Infrastructure to Support Health Equity. Guidance for Health Care Organizations. Boston, Massachusetts: Institute for Healthcare Improvement; 2019. (Available at www.ihi.org)

FIGURE
Five components of health care quality



Agency for Healthcare Research and Quality 5 domains of quality.

SMFM. Measuring quality of care in obstetrics. Am J Obstet Gynecol 2016.

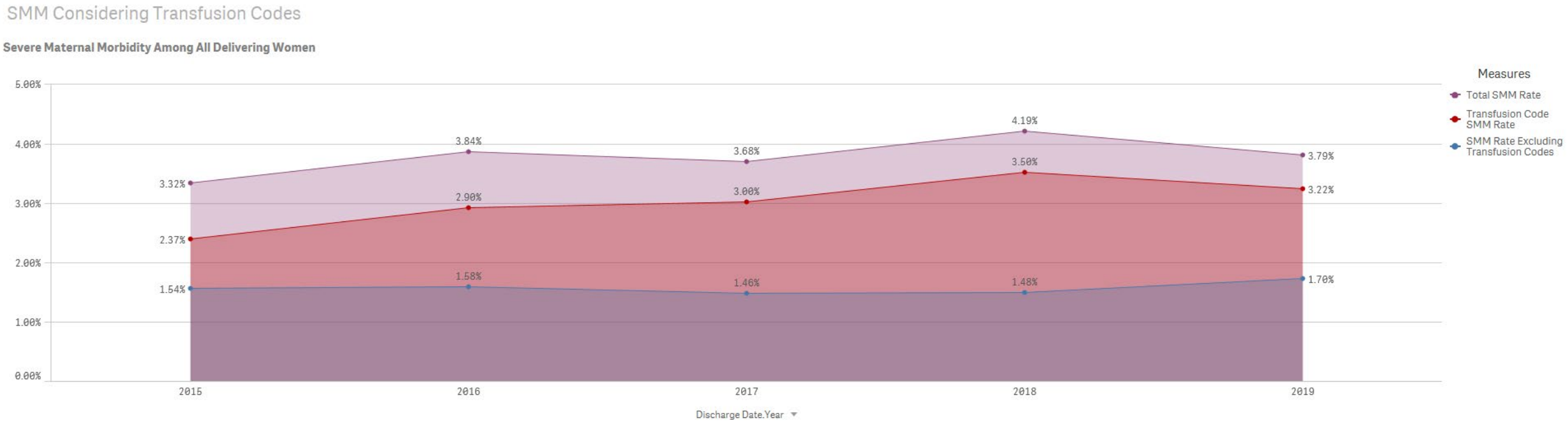
Quality Measures

TexasAIM

- Texas Department of State Health Services (DSHS) launched statewide initiative in 2018 to implement AIM Obstetric Hemorrhage patient safety bundle
- Goal: reduce SMM from hemorrhage by 25% by January 1, 2020

[Obstetric Hemorrhage AIM Patient Safety Bundle | AIM Program (Previously Council on Patient Safety) (safehealthcareforeverywoman.org)]

Data Presented at Texas Children's Pavilion for Women Department Meeting: January 2019
SMM Rates October 2015 – January 2019



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COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE

safe health care for every woman

PATIENT SAFETY BUNDLE

Reduction of Peripartum Racial/Ethnic Disparities

READINESS

Every health system

- Establish systems to accurately document self-identified race, ethnicity, and primary language.
  - Provide system-wide staff education and training on how to ask demographic intake questions.
  - Ensure that patients understand why race, ethnicity, and language data are being collected.
  - Ensure that race, ethnicity, and language data are accessible in the electronic medical record.
  - Evaluate non-English language proficiency (e.g. Spanish proficiency) for providers who communicate with patients in languages other than English.
  - Educate all staff (e.g. inpatient, outpatient, community-based) on interpreter services available within the healthcare system.
- Provide staff-wide education on:
  - Peripartum racial and ethnic disparities and their root causes.
  - Best practices for shared decision making.
- Engage diverse patient, family, and community advocates who can represent important community partnerships on quality and safety leadership teams.

RECOGNITION

Every patient, family, and staff member

- Provide staff-wide education on implicit bias.
- Provide convenient access to health records without delay (paper or electronic), at minimal to no fee to the maternal patient, in a clear and simple format that summarizes information most pertinent to perinatal care and wellness.
- Establish a mechanism for patients, families, and staff to report inequitable care and episodes of miscommunication or disrespect.

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Reduction of Peripartum Racial/Ethnic Disparities

RESPONSE

Every clinical encounter

- Engage in best practices for shared decision making.
- Ensure a timely and tailored response to each report of inequity or disrespect.
- Address reproductive life plan and contraceptive options not only during or immediately after pregnancy, but at regular intervals throughout a woman's reproductive life.
- Establish discharge navigation and coordination systems post childbirth to ensure that women have appropriate follow-up care and understand when it is necessary to return to their health care provider.
  - Provide discharge instructions that include information about what danger or warning signs to look out for, whom to call, and where to go if they have a question or concern.
  - Design discharge materials that meet patients' health literacy, language, and cultural needs.

REPORTING & SYSTEMS LEARNING

Every clinical unit

- Build a culture of equity, including systems for reporting, response, and learning similar to ongoing efforts in safety culture.
- Develop a disparities dashboard that monitors process and outcome metrics stratified by race and ethnicity, with regular dissemination of the stratified performance data to staff and leadership.
- Implement quality improvement projects that target disparities in healthcare access, treatment, and outcomes.
- Consider the role of race, ethnicity, language, poverty, literacy, and other social determinants of health, including racism at the interpersonal and system-level when conducting multidisciplinary reviews of severe maternal morbidity, mortality, and other clinically important metrics.
  - Add as a checkbox on the review sheet: Did race/ethnicity (i.e. implicit bias), language barrier, or specific social determinants of health contribute to the morbidity (yes/no/maybe)? And if so, are there system changes that could be implemented that could alter the outcome?

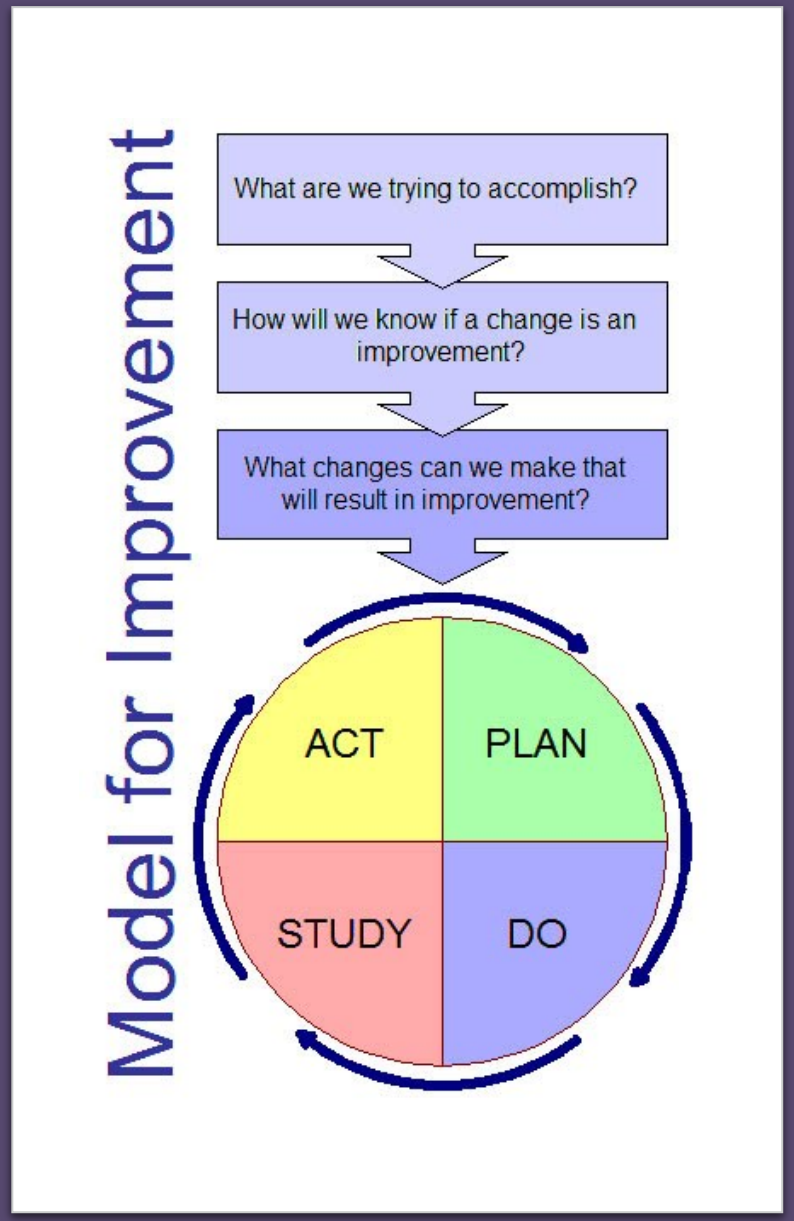
Patient Safety Bundles - Improving Maternal Health | Council on Patient Safety (safehealthcareforeverywoman.org)

Using Data Stratification to Improve Health Equity

- **What are we trying to accomplish?**
  - Provide organizational leaders with strategic measures stratified by race, ethnicity, language (REaL) to reveal disparities that can be reduced/eliminated to improve care

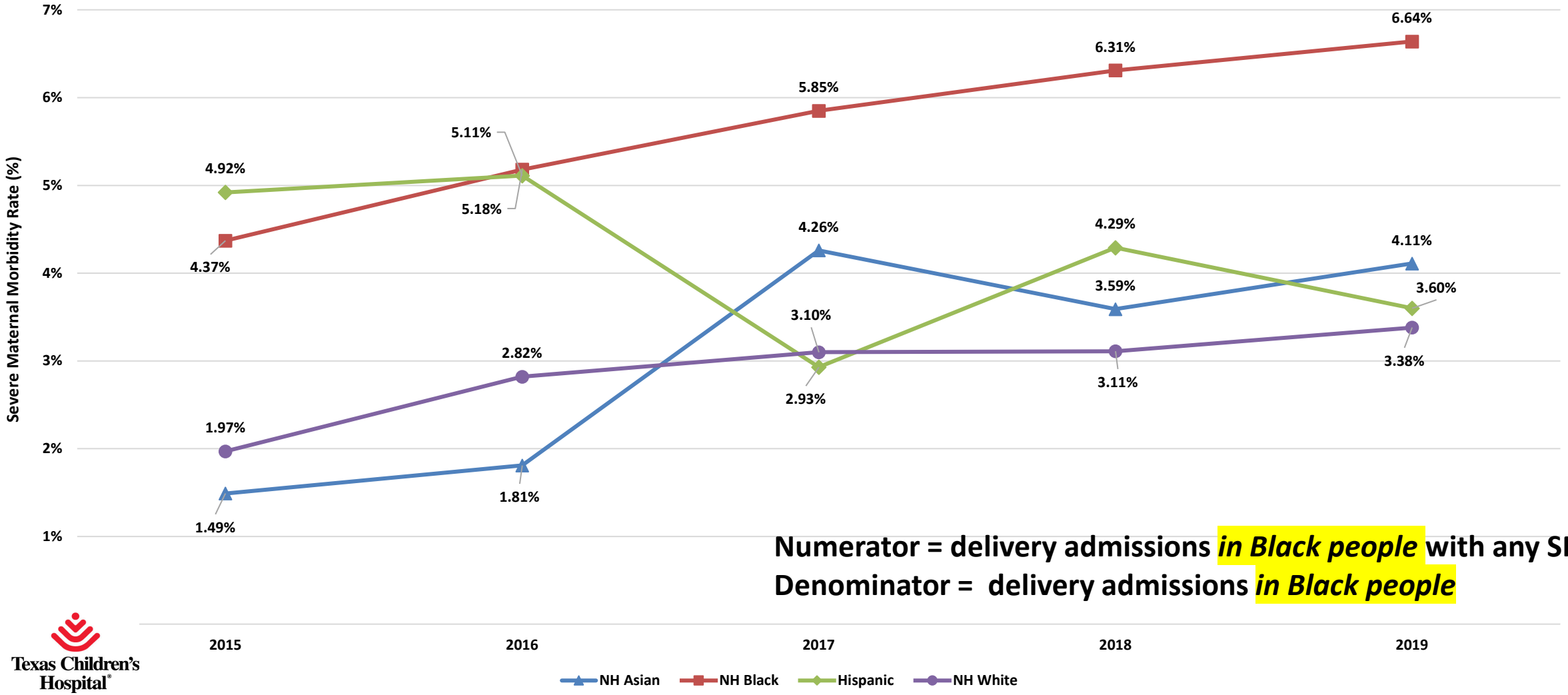
- **How will we know that a change is an improvement?**
  - Stratified data helps organizations identify inequities, inform action, improve overall performance

- **What change can we make that will result in improvement?**
  - Identify one strategic measure the organization wants to improve and provide stratified data for that measure to identify opportunities for improvement



IHI Improving Health Equity: Build Infrastructure to Support Health Equity

Data Presented at Texas Children's Pavilion for Women Department Meeting: March 2019
Rate of Severe Maternal Morbidity by Race and Ethnicity
October 2015 - Feb 2019



Numerator = delivery admissions *in Black people* with any SMM
Denominator = delivery admissions *in Black people*

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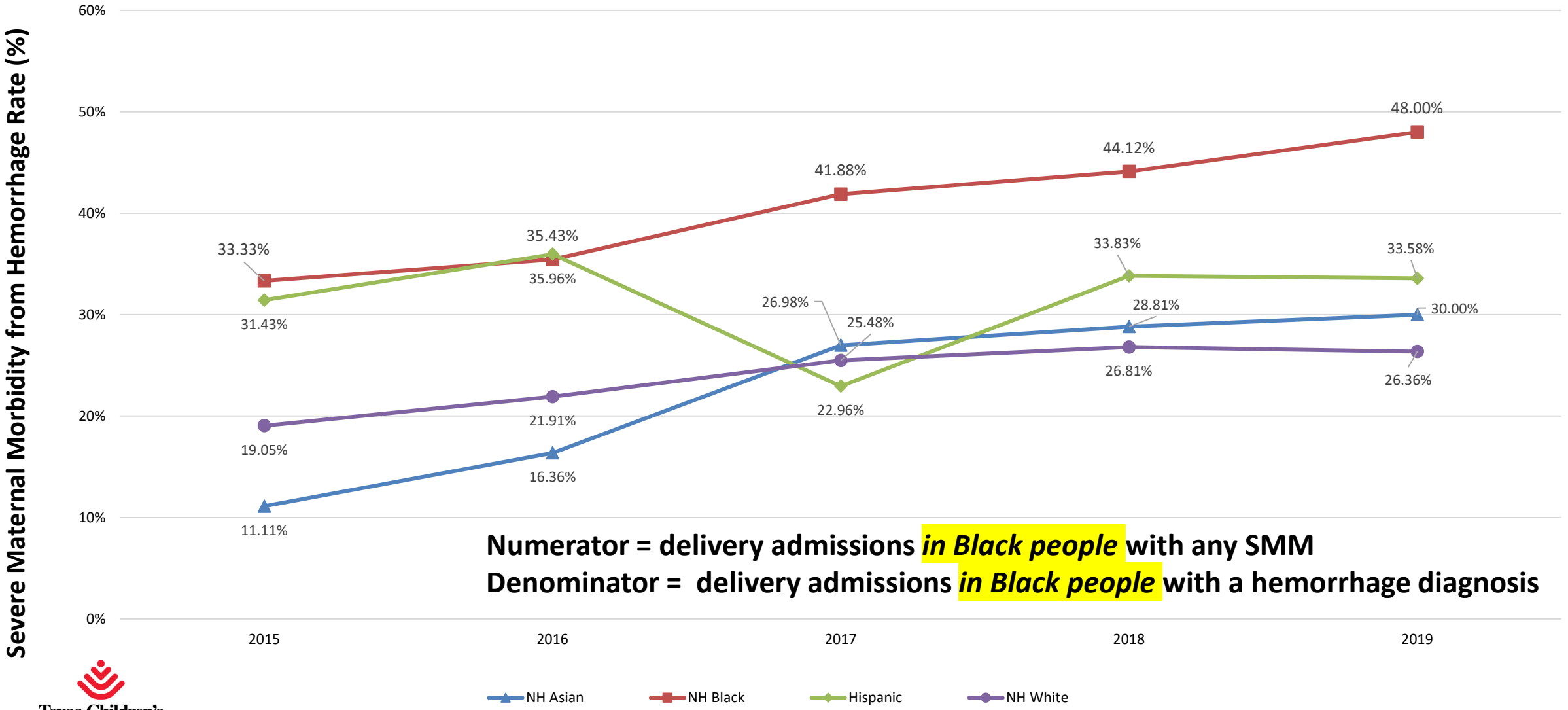
Data Presented at Texas Children's Pavilion for Women Department Meeting: March 2019

Rate of Severe Maternal Morbidity from Hemorrhage by Race and Ethnicity

October 2015 - Feb 2019



Numerator = delivery admissions *in Black people* with any SMM

Denominator = delivery admissions *in Black people* with a hemorrhage diagnosis

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Equity Impact Assessment Tool

Tool to systematically examine how groups will be affected by a proposed action or decision

Used to anticipate, eliminate, and prevent adverse consequences and discrimination/inequities in access and care

Best conducted during decision-making process, prior to enacting new proposals, programs, or policies; used to inform decisions

https://www.seattlechildrens.org/clinics/diversity-health-equity

4. EXAMINING THE CAUSES

Note: Race is a social construct and not a determining factor, risk factor, or driver of inequities. Racism is a driver of health inequities. For clinical and research initiatives, consider how race corrections (e.g., clinical decision-making tools such as the GFR kidney function test) embedded within standards of work, procedures, guidelines of care, pathways, etc. might be contributing to disparities.

What factors may be producing and perpetuating inequities associated with this initiative?

lack of preparation & standardized management, dismissal of signs/symptoms, delay in response

Are the inequities expanding, narrowing, or maintaining?

◯ Expanding ◯ Narrowing ◯ Maintaining

Does the initiative address root causes? ◯ Yes ◯ No Explain:

If the causes are unknown, describe how this initiative will help uncover the potential causes:

5. CONSIDERING ADVERSE IMPACTS

What adverse impacts or unintended consequences could result from this initiative?

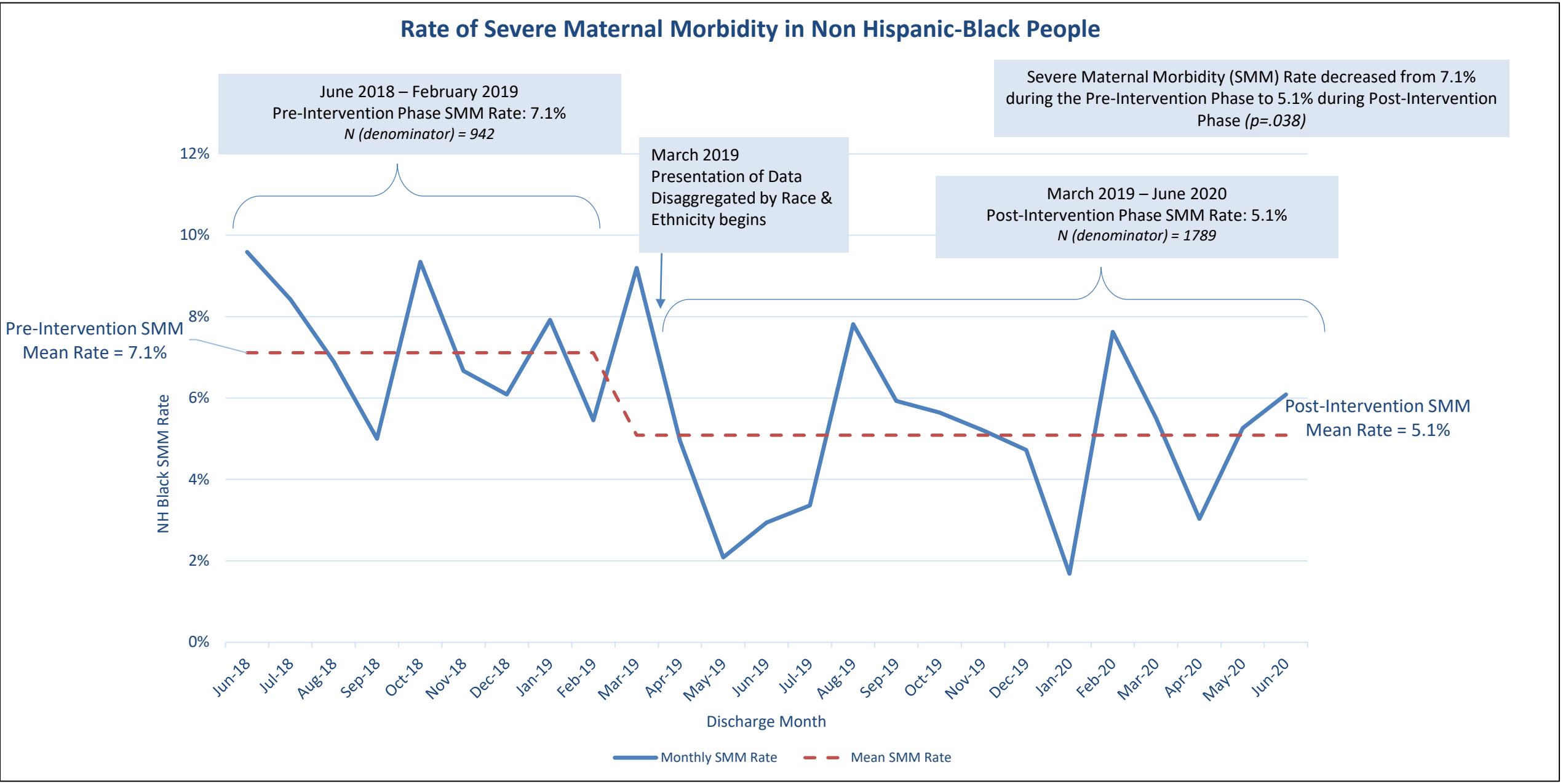
How will adverse impacts be anticipated, prevented, or minimized?

6. ADVANCING EQUITABLE IMPACTS

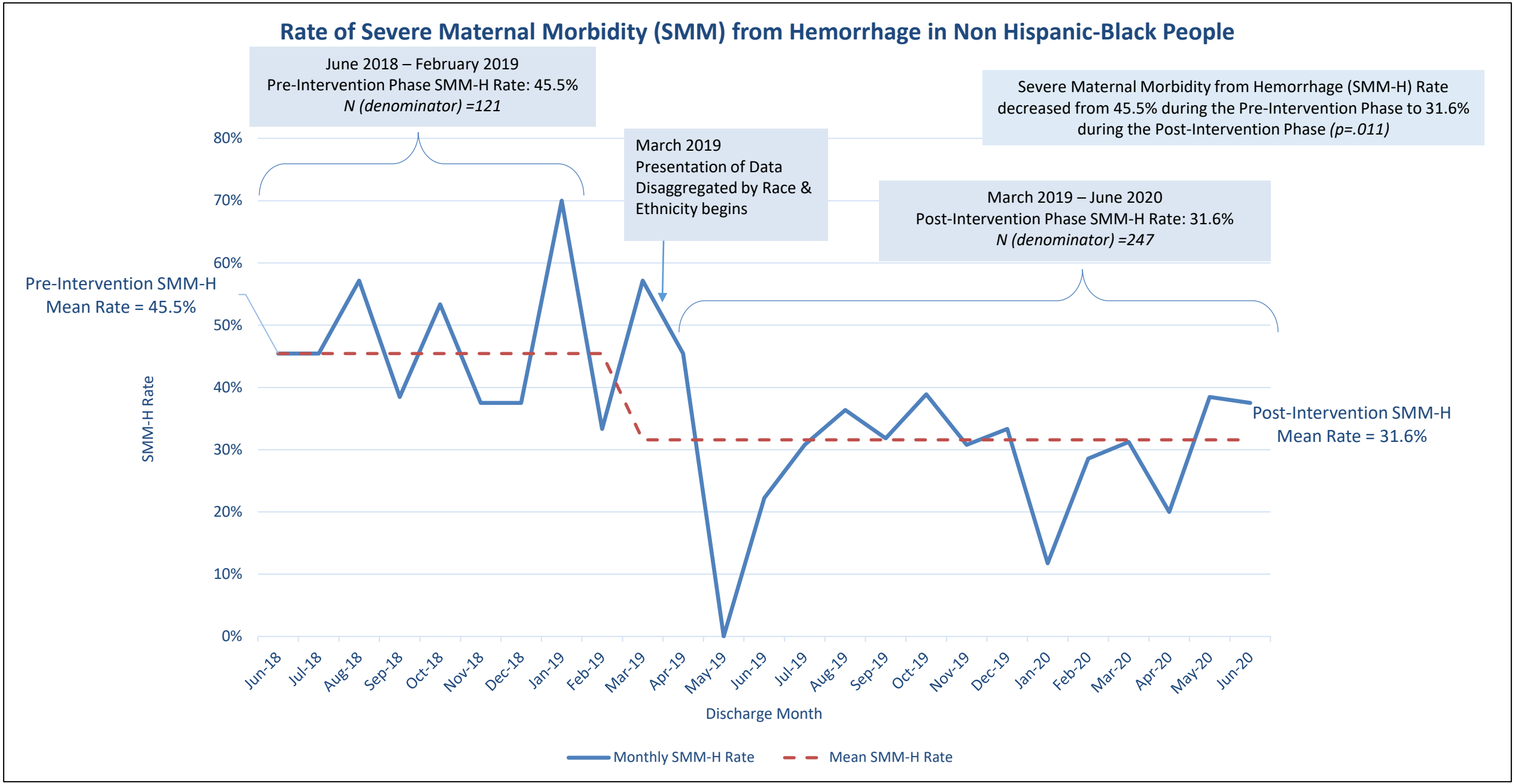
What positive impacts on equity and inclusion, if any, could result from this initiative?

7. EXAMINING ALTERNATIVES OR IMPROVEMENTS

What steps will be taken if disparities are maintained or increased because of this initiative?



Davidson C, et al. Examining the effect of quality improvement initiatives on decreasing racial disparities in maternal morbidity. BMJ Qual Saf. 2022 Apr 15



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Rate of Severe Maternal Morbidity from Hemorrhage by Race and Ethnicity
October 2015 - June 2020

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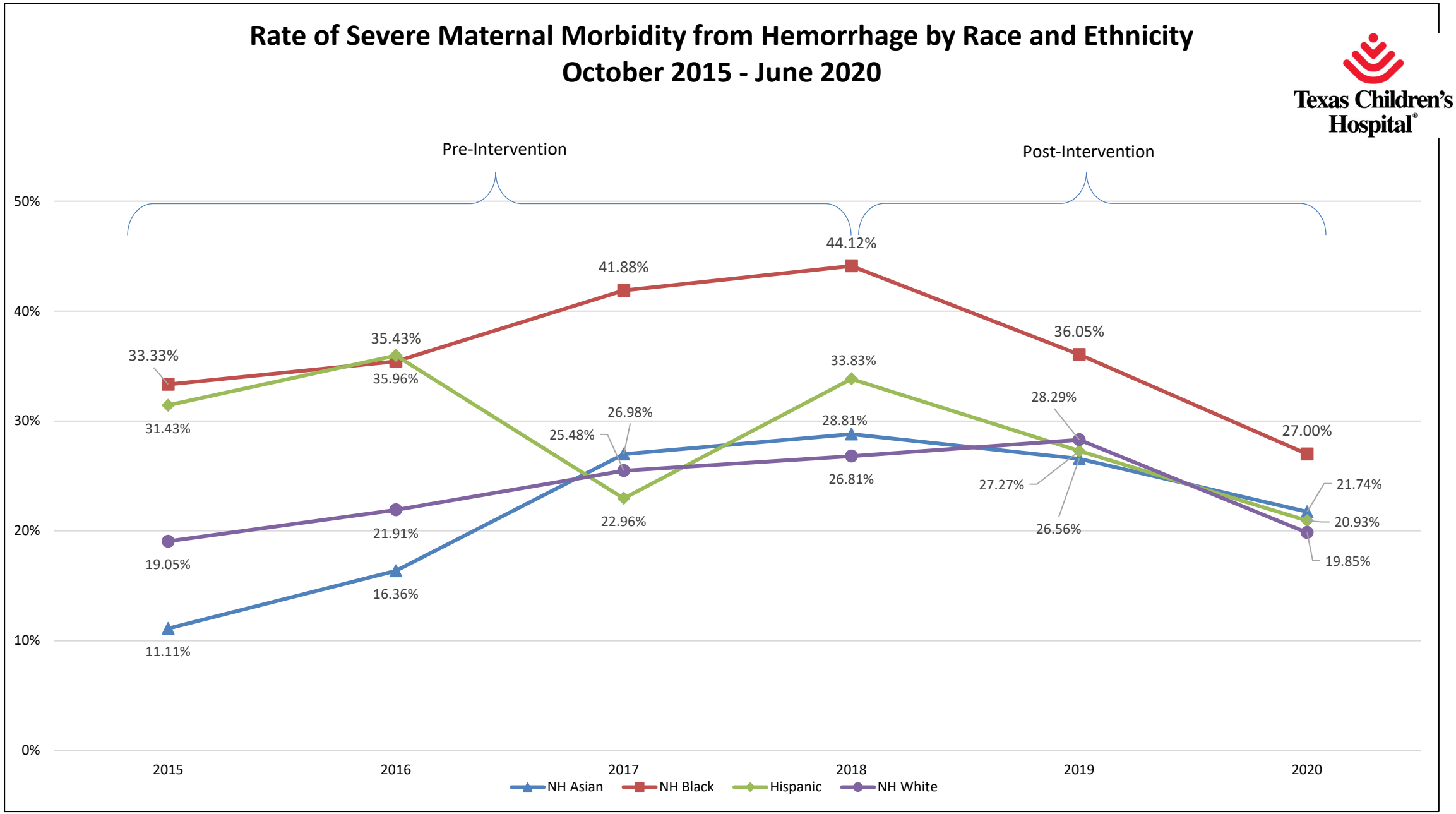


Davidson C, et al. Examining the effect of quality improvement initiatives on decreasing racial disparities in maternal morbidity. BMJ Qual Saf. 2022 Apr 15

Obstetric Hemorrhage Patient Safety Bundle

Readiness — Eve

Develop processes for
- A designated rapi to the facility's Le
- A standardized, fa and escalation po
- Emergency releas
- A protocol, includ but may accept al
- Review of policies related to the dia

Maintain a hemorrhag where antepartum, la

Ensure immediate acc obstetric hemorrhage

Conduct interprofessi simulated patients.*

Recognition — Pr

Assess and commun are identified; at a mi postpartum care.*

Measure and commu

Actively manage the t

Provide ongoing educ postpartum complicat

Obstetric Hemorrhage Patient Safety Bundle

Response — Every Event

Utilize a standardized, facility-wide, stage-based, obstetric hemorrhage emergency management plan, with checklists and escalation policies for stage-based management of patients with obstetric hemorrhage, including:
- Advance preparations made based on hemorrhage risk (e.g. cell saver, blood bank notification, etc.)
- Evaluating patients for etiology of hemorrhage;
- Use of obstetric rapid response team;
- Evidence-based medication administration or use of nonpharmacological interventions;* and
- Appropriate activation of expanded care team and clinical resources as necessary.

Provide trauma-informed support for patients, identified support network, and staff for all obstetric hemorrhages, including discussions regarding birth events, follow up care, resources, and appointments.*

Reporting and Systems Learning — Every Unit

Establish a culture of multidisciplinary planning, huddles, and post-event debriefs for every obstetric hemorrhage, which identify successes, opportunities for improvement, and action planning for future events.

Perform multidisciplinary reviews of serious complications per established facility criteria to identify system issues.*

Monitor outcomes and process measures related to obstetric hemorrhage, with disaggregation by race and ethnicity due to known racial and ethnic disparities in obstetric hemorrhage outcomes.

Establish processes for data reporting and the sharing of data with the obstetric rapid response team, care providers, and facility stakeholders to inform care and change care systems, as necessary.*

Respecful, Equitable, and Supportive Care — Every Unit/Provider/Team Member

Include each patient that experienced an obstetric hemorrhage and their identified support network as respected members of and contributors to the multidisciplinary care team and as participants in patient-centered huddles and debriefs.*

Engage in open, transparent, and empathetic communication with pregnant and postpartum people and their identified support network to understand diagnoses, options, and treatment plans, including consent regarding blood products and blood product alternatives.*

Obstetric Hemorrhage (2022)
Core Data Collection Plan

Outcome

Metric	Name	Description	Notes
O1	Severe Maternal Morbidity (excluding transfusion codes alone)	**Report N/D** **Denominator**: All qualifying pregnant and postpartum people during their birth admission **Numerator:** Among the denominator, those who experienced severe maternal morbidity, excluding those who experienced transfusion alone	Disaggregate by race and ethnicity, payor
O2	Severe Maternal Morbidity among People who Experienced an Obstetric Hemorrhage (excluding transfusion codes alone)	**Report N/D** **Denominator:** All qualifying pregnant and postpartum people during their birth admission who experienced an obstetric hemorrhage **Numerator:** Among the denominator, those who experienced severe maternal morbidity, excluding those who experienced transfusion alone	Disaggregate by race and ethnicity, payor

Process

Metric	Name	Description	Notes
P1	Hemorrhage Risk Assessment	**Report N/D** Sample patient charts or report for all patients; report N/D **Denominator:** All birth admissions, whether from sample or entire population **Numerator:** Number of birth admissions that had a hemorrhage risk assessment completed with risk level assigned, performed at least once between admission and birth	Disaggregate by race and ethnicity, payor
P2	Quantified Blood Loss	**Report N/D** Sample patient charts or report for all patients; report N/D **Denominator:** All birth admissions, whether from sample or entire population **Numerator:** Number of birth admissions that had measurement of blood loss from birth through the recovery period using quantitative and cumulative techniques	• Disaggregate by race and ethnicity, payor • Pair with S7

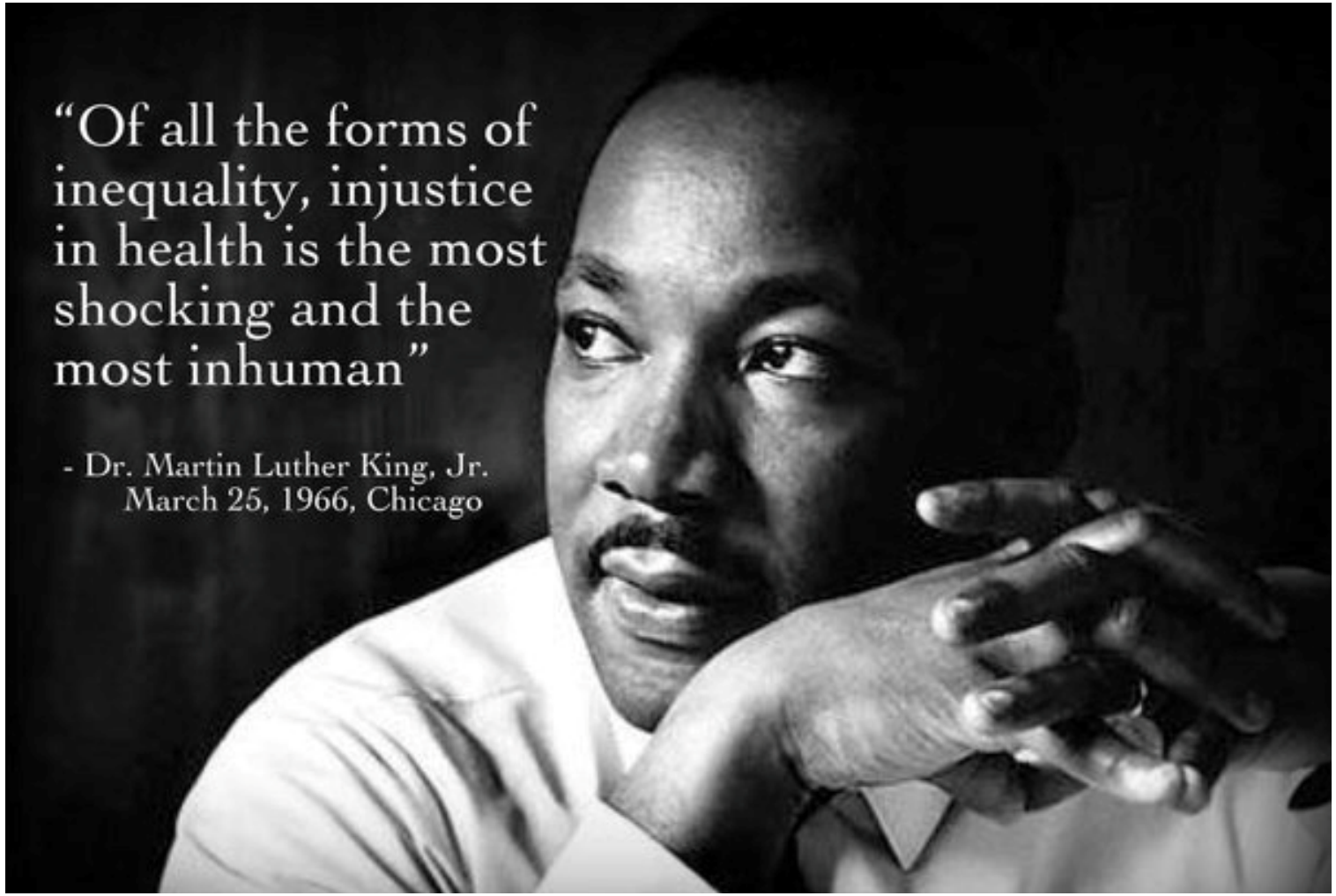
https://saferbirth.org/psbs/obstetric-hemorrhage/

Achieving Health Equity: Key Points

Standardize clinical management

Stratify quality measures by race, ethnicity, language and implement disparities dashboard

Approach every quality improvement effort with a health equity lens



THANK YOU

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