Safety Action Series

When Childbirth is Deadly: Institutional Programming to Address Racial Disparities
Speakers

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Disclosures

- Debi Bucci, DNP, MSOL, BSN, RNC has no real or perceived conflicts of interest.
- Lea M. Porche, MD has no real or perceived conflicts of interest.
Objectives

- Review the impact that institutional racism and implicit bias has on maternal health
- Discuss EVMS’s initiatives set to address racial disparities in maternal mortality and morbidity
- Identify strategies to promote personalized care for every woman during pregnancy and postpartum
Maternal Mortality

• Definition - death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by pregnancy or its management (late maternal mortality: 43 days to 1 year)

• Reported as # of deaths per 100,000 live births
Maternal Mortality

2018: US - 20.7

CA - 4.5

GA - 46.8

Source:
- CDC WONDER Online Database, Mortality files
Maternal Mortality Rate in U.S. Rises, Defying Global Trend, Study Finds

"Doctors aren't listening to us. There's a lot of pre-judging... That definitely goes on. And it needs to be addressed."

Serena Williams
Disparities in Maternal Mortality

- Black women are 3-4 times more likely to die from factors related to pregnancy or child birth
Disparities in Maternal Mortality

Black women face significantly higher maternal mortality risk

Maternal deaths per 100,000 live births (2011-2013)

- Black women: 44 deaths per 100,000 live births
- White women: 13 deaths per 100,000 live births
- Women of other races: 14 deaths per 100,000 live births

Source: Centers for Disease Control and Prevention

Source:
- CDC WONDER Online Database, Mortality Files, 2011-2015
Causes of Pregnancy-Related Death
US: 2011-2014

Note: The cause of death is unknown for 6.5% of all pregnancy-related deaths.
The Black–White Disparity in Pregnancy-Related Mortality From 5 Conditions: Differences in Prevalence and Case-Fatality Rates

Myra J. Tucker, BSN, MPH, Cynthia J. Berg, MD, MPH, William M. Callaghan, MD, MPH, and Jason Hsia, PhD

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence Rate&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Case-Fatality Rate&lt;sup&gt;b&lt;/sup&gt;</th>
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<td>Postpartum hemorrhage</td>
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2017 SMFM Special Report on Drivers of Disparities in MM

- Patient
- Provider
- System
Drivers of Disparities - Patient

- Pre-existing medical co-morbidities
- Healthcare literacy
- Socio-cultural perspectives on health, illness, treatment and the healthcare system
- Relationship with provider
Pre-existing Medical Comorbidities: Hypertension

- Hypertension
  - 40% of AA in the US have HTN
  - Develops earlier in life
  - Often more severe
  - Some genetic predisposition to have increased Na responsiveness

- For any given duration of CHTN, black women are more likely to have end organ damage

- Differential antihypertensive recommendations for chronic treatment

Jain 2017, AHA 2016
Perspectives on Healthcare: Tuskegee Syphilis Experiment

• 1932-1974 in Macons Co, Alabama
• Study conducted by US Public Health Service
• 400 AA men with “bad blood” recruited by promising meals and burial funding for participation
• Once syphilis was identified, treatment was promised but never given, PCN became standard of care by 1947
• 6 mo → 40 years
• Disease course documented
“...true emancipation lies in the acceptance of the whole past, in deriving strength from all my roots, in facing up to the degradation as well as the dignity of my ancestors.”
-Pauli Murray
Drivers of Disparities - Provider

The Doctor-Patient Relationship:

Patient: Nothing my doctor said make sense.

Doctor: Nothing my patient said makes sense.

someecards user card
Relationship with Provider

• African Americans, Hispanics, and Asians remained more likely than whites to believe that ($P < .001$)
  1) they would have received better medical care if they belonged to a different race/ethnic group
  2) medical staff judged them unfairly or treated them with disrespect based on race/ethnicity
Listening to Mothers III Survey

• Survey 2400 singleton deliveries at US hospitals from 2011-2012
  – Over 40% of women reported communication problems in prenatal care
  – 24% perceived discrimination during their hospitalization for birth. Black and Hispanic (vs. white) women had higher odds of perceived discrimination due to race/ethnicity.
  – Having hypertension or diabetes was associated with higher levels of reluctance to ask questions and higher odds of reporting each type of perceived discrimination.
  – Higher education was associated with more reported communication problems among Black women only.
Explicit Bias

• Beliefs we have about a person or group on a **CONSCIOUS** level. Much of the time, these **biases** and their expression arise as the direct result of a perceived threat.

• Racism
• Sexism
• Ageism
Implicit Bias

- Attitudes or stereotypes that affect our understanding, actions, and decisions in an **UNCONSCIOUS** manner.
Implicit Bias

- Systematic review of studies assessing bias in healthcare
- 37 studies were reviewed
  - 31 found evidence of pro-White or light-skin/anti-Black, Hispanic, American Indian or dark-skin bias among a variety of HCPs across multiple levels of training and disciplines
  - 6 studies found that higher implicit bias was associated with disparities in treatment recommendations, expectations of therapeutic bonds, pain management, and empathy.
  - 7 studies that examined real-world patient-provider interaction & found that stronger implicit bias led to poorer patient-provider communication

Maina IW et al, Sco Sci Med, 2018
Implicit Bias

https://implicit.harvard.edu/implicit/education.html
System

- Logistical access to care
  - Proximity
  - Transportation
  - Understanding
  - Phone access
EVMS Institutional Initiatives to Address Disparities in Maternal Mortality
Implicit Bias Training

• Office of Diversity and Inclusion
  – Routine training modules incorporated into medical student, and resident training
  – Yearly module review required for all faculty
• Partnership between
  – VA Department of health
  – Regional Perinatal Councils
  – Virginia Home Visiting Consortium

• Intensive case management and care coordination services for women and teens during and after pregnancy
  – Screen for medical, nutritional social economic and environmental risk factors
  – Identify gaps in care
  – Develop a plan of care to address those gaps
• Multidisciplinary network of providers, hospitals, clinics and advocates
• Mission: bridge gaps in current system to expand services to all families in need of reliable prenatal and postpartum care
Parent Education

Parent education offers strategies, tools, and insight for observing, interpreting, and responding to children's behaviors in order to maximize positive outcomes for both children and families.

Support Groups

The Hampton Roads community is rich in resources for families with young children. Connect with people who understand the challenges of raising children and are committed to you and your child's well-being.

Home Visiting

Home visitors are available in every city in Hampton Roads to help every parent during those early years. Talk to someone who can help you decide what is right for your family.

Helpful Websites

No matter what your child's age or stage of development, you can increase your knowledge, skills and confidence in parenting! Find resources to help you navigate parenting questions.
Mother & Baby Mermaids Clinic

- EVMS Service Learning Projects
- Patients referred to clinic, matched with a medical student navigator
- Students will:
  - attend visits
  - regular contact with patient outside of clinic
  - helps with understanding of her pregnancy physiology and complications
  - navigating the system
  - access to available resources.
• Multidisciplinary FHR monitoring course
• 2-day course held quarterly comprised of L&D RN, residents and attendings
• Course taught by nurse leaders with years of L&D experience
• Standardized, evidence based FHR interpretation and management education
• All speaking the “same language”
OB Right Program

• Collaboration between EVMS, Sentara Healthcare and community faculty

• Mission of minimizing iatrogenic injury to the mother and infant and reducing adverse patient safety events at labor and delivery
PATIENT SAFETY

**Triggers**, bundles, protocols, and checklists—what every maternal care provider needs to know

- **Triggers**: protocol used to identify an event or condition that mandates further action
- **Bundles**: sets of evidence based, independent interventions that when implemented together significantly improve outcomes
- **Protocols & Checklists**: serve to augment memory and limit the chance of human error

Aurora et al, AJOG 2016
Continual Improvement

• Women’s Health High Performance Team
  • Interdisciplinary
    – Provider
    – Nursing
    – System Leadership
    – All Support Services

• Nursing Practice Forums
  • Coordinated Effort
    – Interdisciplinary project work groups

• Goals
  – Standardize safe practice
  – Reduce variation
  – Personalize care
Elevate Awareness: Maternal Morbidity & Racial Disparities

- Provided data to increase awareness:
  - Leadership
  - Providers
  - Bedside Staff

- Elevated concern:

- Encouraged self-awareness:
  - Implicit Bias:

  [Implicit Bias](https://implicit.harvard.edu/implicit/education.html)
Elevate Awareness: Maternal Morbidity & Racial Disparities

For 2011-2015:

- about 1/3 of deaths (31%) happened during pregnancy;
- about 1/3 (36%) happened at delivery or in the week after; and
- about 1/3 (33%) happened 1 week to 1 year postpartum.

- Heart disease and stroke caused more than 1 in 3 deaths (34%). Other leading causes of death included infections and severe bleeding.
- Black and American Indian/Alaska Native women were about 3 times as likely to die from a pregnancy-related cause as White women.
Strategies to Personalize Care

- Standardized protocols & processes:
  - Identify variation in patient condition
  - Increase awareness of risk factors
  - Create a framework for treatment
  - Provide structure for personalized care delivery
  - Elevate surveillance when variation identified

<table>
<thead>
<tr>
<th>OB Venous Thromboembolism Risk Categories:</th>
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<tbody>
<tr>
<td>Assess upon antepartum, intrapartum, and postpartum admission.</td>
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<td>Reassess prior to 12 hours post-delivery and for changes in risk factors (i.e. transfusion, pre-eclampsia)</td>
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**High Risk**

- History of unprovoked VTE
- History of VTE caused by pregnancy or high estrogen state
- Antiphospholipid Syndrome without history of VTE with previous adverse pregnancy outcome
- *Low-risk thrombophilia with history of VTE*
- *High Risk Thrombophilia without history of VTE*

**LMWH Prophylactic Dose**

- Prophylaxis for a total of 6 weeks postpartum
Implementing AIM Bundles

• **2018**
  – Safe Reduction of Primary Cesarean Birth
  – Obstetric Venous Thromboembolism

• **2019**
  – Obstetric Hemorrhage
  – Severe Hypertension in Pregnancy
Readiness

• **Assessment tools**
  – Highlights risk
  – Increases awareness
  – Prepares team

• **Access**
  – Supplies
  – Medications
  – Chain of command
Recognition & Prevention

• Protocols
  – VTE prophylaxis: Mechanical & pharmacologic
  – Cumulative blood loss: Assessment, early response
  – Severe hypertension: Standardized assessment, rapid treatment

• Education
  – Create tools
  – Set expectations
  – Monitor & report results

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Response

- Identify evidence based, best practices
  - ACOG
  - AWHONN
  - AIM
  - California Collaborative

- Seek interdisciplinary feedback & support
  - High Performance Team
  - Nursing Practice Forum

- Customize tools to promote standardized care:
  - Prevent, identify & treat OBVTE, hemorrhage, severe hypertension, decrease primary, low risk cesarean
  - Integrate in EMR whenever feasible
Reporting/Systems Learning

• **Transparent reporting:**
  – Categorize gaps
  – Identify culture
  – Set direction for improvement

• **Safety Stories**
  – Every meeting

• **Post event huddles**
  – Every event
AIM

• Participation in AIM data collection via Virginia Perinatal & Neonatal Collaborative to provide blinded benchmarking
“If anyone were to ask a Negro woman in America what has been her greatest achievement, her honest answer would be ‘I survived!’”

-Pauli Murray
Q&A Session
Press *1 to ask a question

Please note: this teleconference is being recorded. Comments from speakers and participants will be live on the website shortly.

You will enter the question queue
Your line will be unmuted by the operator for your turn

A recording of this presentation will be made available on our website:
www.safehealthcareforeverywoman.org
Announcing the 3rd Cycle of the Council’s National Improvement Video Challenge

➢ How to Participate:
  Develop a short (3 - 5 minute) video showcasing how a Council bundle has been utilized within your institution.

➢ Deadline:
  October 18, 2019

➢ Awards:
  Monetary awards are given to the top 3 entries for each cycle. Winning videos will be featured on the Council’s website.

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Positive Psychology Strategies
Provider Wellness Mini-Series, Session 3

July 18
2 pm Eastern

Al'ai Alvarez, MD
Clinical Assistant Professor,
Emergency Medicine
Stanford University

Patty de Vries, MS
Associate Director Of Enterprise Wellness,
Strategy & Innovation, Med/Hip/Bewell
Stanford University

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