B.I.R.T.H. Equity Maryland

Adriane Burgess PhD, RNC-OB, CCE,C-ONQS, CPHQ

Director of Perinatal and Neonatal Quality and Patient Safety

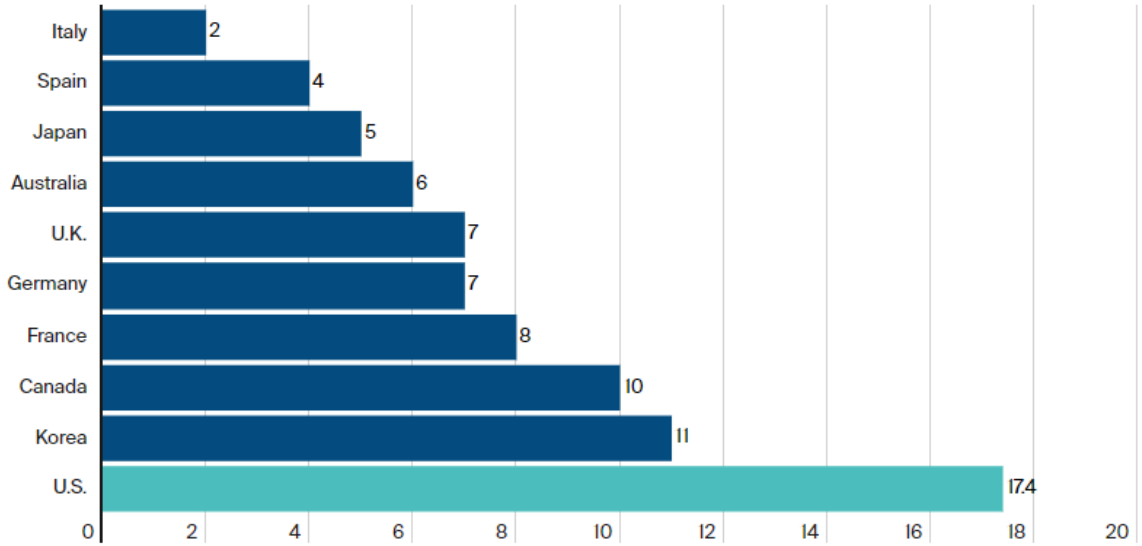
Maryland Patient Safety Center

Welcome

The U.S. has the worst MMR as compared to other industrialized countries

U.S. Maternal Mortality Ratio Compared to Industrialized Countries with 300,000+ Births, 2017–2018

Maternal deaths per 100,000 births



Download data

Data: World Health Organization et al., *Trends in Maternal Mortality, 2000 to 2017: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division* (WHO et al., 2019); and Donna L. Hoyert and Arialdi M. Miniño, "Maternal Mortality in the United States: Changes in Coding, Publication, and Data Release, 2018," *National Vital Statistics Report* 69, no. 2 (Jan. 30, 2020): 1–16.

Source: Laurie Zephyrin, M.D., and Eugene Declercq, Ph.D., "Measuring Maternal Mortality," *To the Point* (blog), Commonwealth Fund, Feb. 6, 2020. https://doi.org/10.26099/c14w-nq52

Maternal Mortality
Four in 5 pregnancy-related deaths in the U.S. are preventable

- Among pregnancy-related deaths with information on timing,
  - 22% of deaths occurred during pregnancy,
  - 25% occurred on the day of delivery or within 7 days after,
  - **53% occurred between 7 days to 1 year after pregnancy.**
- The leading underlying causes of pregnancy-related death include:
  - Mental health conditions (including deaths to suicide and overdose/poisoning related to substance use disorder) (23%)
  - Excessive bleeding (hemorrhage) (14%)
  - Cardiac and coronary conditions (relating to the heart) (13%)
  - Infection (9%)
  - Thrombotic embolism (a type of blood clot) (9%)
  - Cardiomyopathy (a disease of the heart muscle) (9%)
  - Hypertensive disorders of pregnancy (relating to high blood pressure) (7%)

Centers for Disease Control and Prevention (September 19th, 2022) Retrieved from https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html

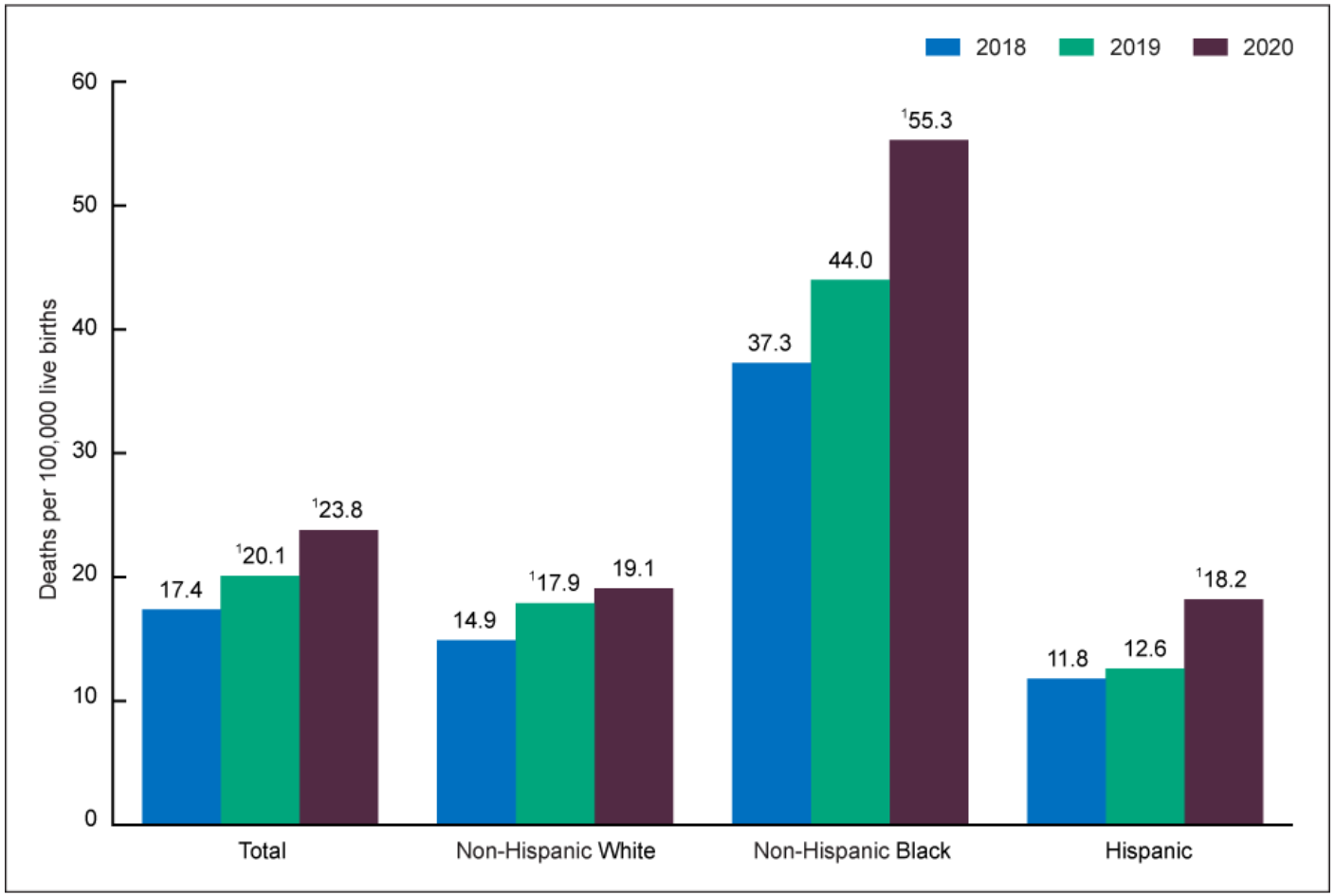
Disparities in Causes of Maternal Mortality

Leading underlying cause of death varied by race and ethnicity include:

- **Cardiac and coronary conditions** were the leading underlying cause of pregnancy-related deaths among non-Hispanic Black persons;
- Mental health conditions were the leading underlying cause of death among Hispanic and non-Hispanic White persons;
- Hemorrhage was the leading underlying cause of death among non-Hispanic Asian persons.

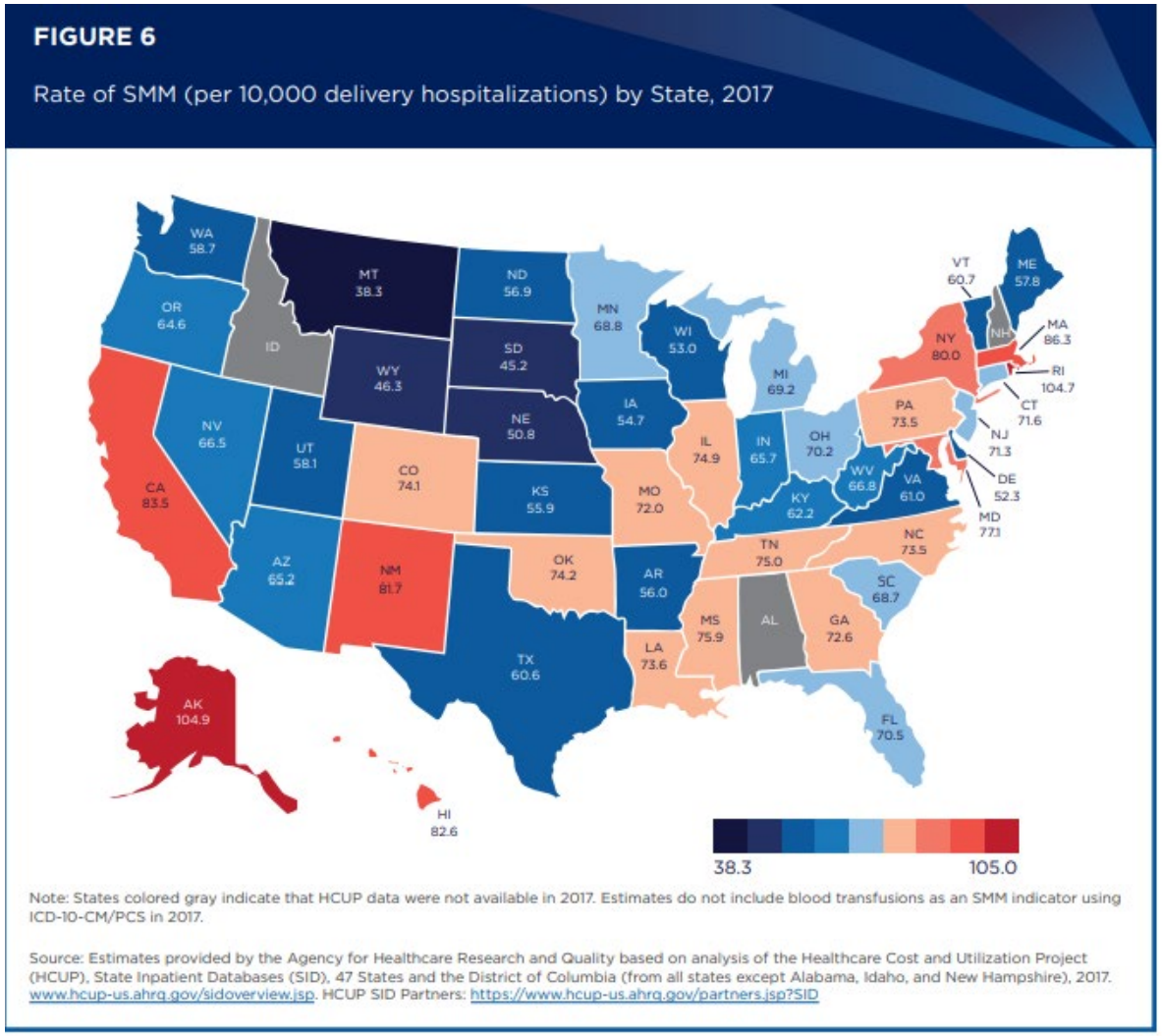
Disparities in Maternal Mortality in the U.S.

- In 2020, the maternal mortality rate for **non-Hispanic Black women was 55.3 deaths per 100,000 live births, 2.9 times the rate for non-Hispanic White women (19.1)**



[1]Statistically significant increase in rate from previous year ($p < 0.05$).
NOTE: Race groups are single race.
SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

Severe Maternal Morbidity



The SMM estimates are based on the Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project (HCUP), State Inpatient

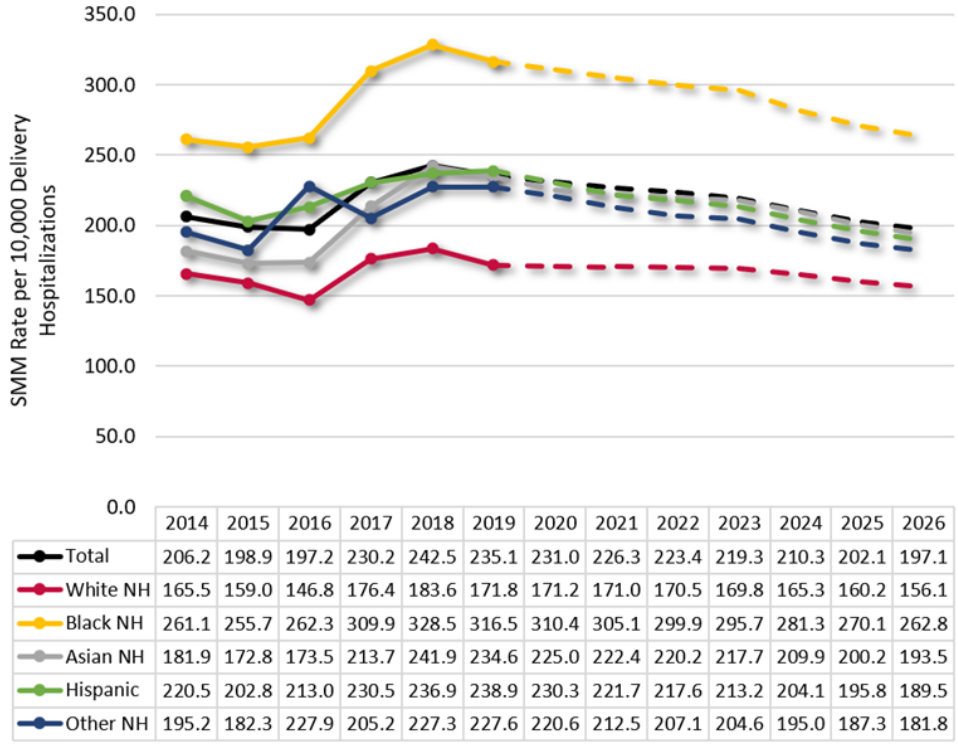
- Severe maternal morbidity (SMM) is associated with a high rate of preventability
- SMM includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health.
- **SMM disproportionately affects women of minority race or ethnicity**, especially non-Hispanic Black women, who have over twice the rates of SMM compared to non-Hispanic White women
- Maryland has higher rates of SMM as compared to other states.

Rezaeiahari M, Brown CC, Ali MM, Datta J, Tilford JM (2021) Understanding racial disparities in severe maternal morbidity using Bayesian network analysis. PLoS ONE 16(10): e0259258. https://doi.org/10.1371/journal.pone.0259258

Maryland
Hospital Association

Maryland's Commitment to Maternal Health

Rate of SMM by Race and Ethnicity, Maryland 2014-2026



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total	206.2	198.9	197.2	230.2	242.5	235.1	231.0	226.3	223.4	219.3	210.3	202.1	197.1
White NH	165.5	159.0	146.8	176.4	183.6	171.8	171.2	171.0	170.5	169.8	165.3	160.2	156.1
Black NH	261.1	255.7	262.3	309.9	328.5	316.5	310.4	305.1	299.9	295.7	281.3	270.1	262.8
Asian NH	181.9	172.8	173.5	213.7	241.9	234.6	225.0	222.4	220.2	217.7	209.9	200.2	193.5
Hispanic	220.5	202.8	213.0	230.5	236.9	238.9	230.3	221.7	217.6	213.2	204.1	195.8	189.5
Other NH	195.2	182.3	227.9	205.2	227.3	227.6	220.6	212.5	207.1	204.6	195.0	187.3	181.8

Source: Health Services Cost Review Commission. Data reflect Maryland residents in Maryland hospitals only. Changes in SMM coding from ICD-9 to ICD-10 in October 2015 may have influenced the number of SMM diagnoses in years 2016 forward.

Maryland made a binding promise to improve maternal and child health.

The state committed to reducing Maryland's rate of severe maternal morbidity by nearly 20% by 2026.

Meeting that ambitious goal depends on changing the way health care providers hear and engage with post-partum mothers, especially Black mothers who are disproportionately impacted compared to their non-Black counterparts.

Signed Commitment

Maryland
Hospital Association

MARYLAND HOSPITALS MAKE THE FOLLOWING COMMITMENTS TO IMPROVE MATERNAL HEALTH

July 2022

Rates of severe maternal morbidity and mortality are unacceptably high in Maryland, especially among Black birthing parents. Maryland's hospitals recognize that our health care system must do more to change culture and practices so that the needs, concerns, and voices of Black parents are heard and met before, during and after childbirth. To improve parents' experience of birth and to reach the state's goal of reducing severe maternal morbidity (SMM) among Black parents 20% by 2026, every Maryland hospital commits to the following:

1. To uncover implicit and explicit bias and change the dynamic among health care providers and birthing parents from historically marginalized groups, all hospitals will do the following:

    a. Require their ED and employed ambulatory clinicians and urge their affiliated ambulatory practices to complete the Maryland Patient Safety Center's BIRTH Equity training

Working Together to Reduce Maternal Mortality
What healthcare providers can do

Hear	Ask	Educate	Help	Recognize	Address	Provide
Hear Her- Listening can be your most important tool. Her hear concerns. It could help save her life	**Ask questions** to better understand the patient and things that may be affecting their lives.	**Educate patients**, and those accompanying them, understand the urgent maternal warning signs and when to seek medical attention right away.	Help patients **manage chronic conditions** or conditions that may arise during pregnancy like hypertension, diabetes, or depression.	**Recognize unconscious bias** in yourself and in your office.	**Address any concerns** patients may have.	Provide all patients with **respectful care.**


BREAKING
INEQUALITY
REIMAGINING
TRANSFORMATIVE
HEALTHCARE
Birth
EQUITY
MARYLAND
MARYLAND
Patient Safety
CENTER
Maryland
Hospital Association

Target Population: Non-Obstetric Providers

- Primary Care, Emergency Department, Community Settings
- Pregnancy-related problems were the fifth most common reason for presentation to the ED and the fourth most common ED discharge diagnosis in women aged 15 – 65 years old.
- Emergent postpartum hospital encounters in the first 42 days after birth are estimated to complicate 5 to 12% of births of which about 2% will result in readmission
- The Emergency Nurses Association and American Association of Family Physicians have statements which outline their role in promoting birth equity and timely identification of obstetric complications

Kilfoyle, K. A., Vrees, R., Raker, C. A., & Matteson, K. A. (2017). Nonurgent and urgent emergency department use during pregnancy: an observational study. American journal of obstetrics and gynecology, 216(2), 181.e1–181.e7. https://doi.org/10.1016/j.ajog.2016.10.013

Patel, S., Rodriguez, A. N., Macias, D. A., Morgan, J., Kraus, A., & Spong, C. Y. (2020). A gap in care? Postpartum women presenting to the emergency room and getting readmitted. American Journal of Perinatology. Advance online publication. https://doi.org/10.1055/s-0040-1712170

Program Objectives: B.I.R.T.H Equity Maryland

- Promote equity and anti-racism in maternal health
- Educate non-obstetric providers who care for pregnant and post-partum people on the topics of
  - disparities in maternal morbidity and mortality,
  - identification of obstetrical complications,
  - racial bias and its impact on health outcomes, and
  - the importance of providing respectful care and giving power to the patient's voice at all levels of care.
- Ensure pregnant and postpartum people are educated on signs and symptoms of obstetric complications and when to seek care during and after pregnancy.

6 Steps Towards B.I.R.T.H. Equity MD Designation

Step 1

Assess Baseline Knowledge, and Bias in Maternal Health Care Scale

Step 2

Engage Staff through Patient Impact Story and Evaluate Workflows

2 months

Step 3

Education on Racism and Bias in Healthcare and IAT

4 months

Step 4

Education on Drivers of Black Maternal Morbidity and Mortality; Clinical Encounter Checklist

6 months

Step 5

TeamSTEPPS®-Based Training

8 months

Step 6

Standardize Patient Education and Post-Implementation Bias in Maternal Health Care Scale

Implementation

IMPLEMENTATION TOOLKIT

DIGITAL PLATFORM:
READYWORKS HEALTH

INDIVIDUAL ACCOUNTS TO TRACK YOUR TEAM'S COMPLETION OF EACH STEP

Readyworks Health

BIRTH Equity Maryland - Santa Anna Hospital

- Step 1 - Baseline Assessments
- Step 2 - Engage Staff
- Step 3 - Webinar 1
- Step 4 - Webinar 2
- Step 5 - Team STEPPS
- Step 6 - Assessment and Patient Resources

- Additional Resources

READYWORKS

Patients before Paper

B.I.R.T.H. Equity Maryland Designation

How will labor and delivery units be involved?

- Be aware that your ED colleagues are doing this work
- Does your team collaborate with the ED?
  - What is your relationship with your ED colleagues?
- What does your ED's policy say—are **postpartum** people included in the policy?
- Is the ED screening for childbearing status when a patient presents?
- Are you monitoring data on the pregnant and postpartum patients in the ED?
- Does the ED have a streamlined why to contact your unit so they can get expert consultation in a timely fashion?

MARYLAND Patient Safety CENTER

Questions and Discussion

Questions

Contact

Adriane Burgess PhD, RNC-OB, CCE, C-ONQS CPHQ

aburgess@marylandpatientsafety.org

410-540-5040

MARYLAND Patient Safety CENTER