Reducing Maternal Morbidity and Mortality in Louisiana: Addressing Obstetric Hemorrhage and Severe Hypertension

Veronica Gillispie-Bell, MD, FACOG
Medical Director, Louisiana Perinatal Quality Collaborative and Pregnancy Associated Mortality Review
Obstetrics & Gynecology
Objectives

• Louisiana Maternal Mortality Report
• No improvement without EQUITY
• What is the LaPQC?
• What can we do... together?
KEY FINDINGS

• Maternal Mortality: a maternal death occurring within 42 days of termination of pregnancy

• Between 2011-2016, maternal mortality rate increased by an average of 34% per year
  - 12.4 per 100,000 live births

KEY FINDINGS

• Leading case of death
  – Hemorrhage
  – Hypertension related (cardiomyopathy, cardiovascular conditions, preeclampsia/eclampsia)

45% were deemed to be preventable
KEY FINDINGS

• Top Contributing Factors: Provider and Facility Level
  – Failure to screen/inadequate assessment of risk – 36%
  – Lack of standardized policies and procedures – 13%
  – Lack of referral or consultation – 11%
  – Poor communication/lack of case coordination or continuity of care – 11%
KEY FINDINGS

- 4 black women die for every 1 white woman
- Women age 35 years and older were 6.3 times as likely to die as women under age 25 years
- 62% of women who died had Medicaid insurance.
1. Support, expand, and sustain a robust pregnancy-associated mortality review
2. Build a culture of continuous quality improvement
3. Reduce missed opportunities for prevention in the emergency room
4. Assure access to contraceptive services and management of chronic illnesses
5. Provide fully integrated services for mental and substance use disorders during and between pregnancies
6. Address inequities in social determinants of health
Why do health disparities exist?

- **Implicit bias**
  - Implicit bias is *unconscious* judgment and/or behaviors that affect how we interact with others
  - Impacts patient-provider interactions, treatment decisions, treatment adherence and patient health outcomes³
  - [https://implicit.harvard.edu/implicit/takeatest.html](https://implicit.harvard.edu/implicit/takeatest.html)

- **Social determinants of health⁴**
  - Racial residential segregation⁵
  - Health care services
  - Socioeconomic status
  - Healthy behaviors
Change = Improvement + Equity

*Finding Answers: Solving Disparities through Payment and Delivery System Reform; solvingdisparities.org
IHI: Creating Health Equity

• Make health equity a strategic priority
• Develop structure and processes to support health equity work
• Deploy specific strategies to address the multiple determinants of health which organizations can make an impact
• Decrease institutional racism within an organization
• Develop partnerships with community organizations
Altering Outcomes

The assessments of preventability and chance to alter outcomes help prioritize future areas of intervention and action.

National Findings
Based on data from review committees in 9 other states and cities:

- 70% of deaths due to hemorrhage were thought to be preventable.
- 68.2% of deaths due to cardiovascular/coronary conditions were thought to be preventable.
- 66% of deaths occurring within 42 days of pregnancy were thought to be preventable.

Louisiana Findings

- 62.5% of hemorrhage deaths were deemed preventable.
- 62.5% of cardiomyopathy deaths were deemed preventable.
- 40% of deaths due to cardiovascular/coronary conditions were deemed preventable.
- 7 out of 8 deaths due to embolism, including thromboembolism and amniotic fluid embolism, were deemed not preventable.
What is Severe Maternal Morbidity (SMM)?

- Includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman’s health; measured 2 ways:
  - ACOG and Joint Commission: 4 units transfused or transfer to ICU
  - CDC: administrative hospital discharge data and ICD diagnosis and procedure codes
- SMM is only one way to evaluate and understand our shared impact on maternal health
Louisiana Perinatal Quality Collaborative (LaPQC)

- **What is the LaPQC?**
  - Formed in 2016, became an Initiative of Louisiana Commission on Perinatal Care and the Prevention of Infant Mortality in 2018.
  - A network of perinatal care providers, public health professionals and patient and community advocates who work to advance equity and improve outcomes for women, families, and newborns in Louisiana
  - Required for Level 3 and Level 4 Hospitals
  - 37 of 52 birthing facilities are participating
• **What is the goal of the LaPQC?**
  – Achieve a **20% reduction** in severe maternal morbidity among pregnant and postpartum women who experience *hemorrhage* or severe *hypertension/preeclampsia* in participating birth facilities by **Mother’s Day 2020**
  – **Narrow** the black-white disparity in this outcome
Louisiana Perinatal Quality Collaborative (LaPQC)

• What does the LaPQC do?
  – Facilitate collaborative learning opportunities through Learning Sessions and monthly calls
  – Identify and share best practices
  – Provide teams with a data portal to allow for real-time evaluation to guide decision-making
  – Provide subject-matter experts who are brought on as faculty
  – Coordinate a guiding Advisory Committee
  – Ensure Louisiana’s work is connected to national initiatives
LaPQC Change Package

Achieve a 20% reduction in severe maternal morbidity among pregnant/postpartum women who experience hemorrhage or severe hypertension in LaPQC participating facilities.

Narrow the black-white disparity in this outcome.

- Reliable Clinical Processes
  - Assure readiness
  - Improve recognition and prevention
  - Understand & reduce variation in response
  - Eliminate waste

- Respectful Patient Partnership
  - Design for partnership
  - Invest in improvement

- Effective Peer Teamwork
  - Reduce variation in reporting
  - Change the work environment
  - Improve work flow

- Engaged Perinatal Leadership
  - Manage for quality & systems learning
  - Enhance patient & family relationships
  - Change the work environment
Change Goals

• Make it easy to do the right thing
• Hardwire changes into routine practice
• All improvement is change, not all change is improvement
• Change structure, process, and culture
• Build measurement into processes, and learn where there are disparities
BTS: Model for Improvement

Model for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

AIMS
Measures
Changes

*Developed by the Associates in Process Improvement. Building on the work of W.E. Deming and Walter Shewhart*
Learning Through Testing

**Act**
- adapt?
- adopt?
- abandon?
- next cycle?

**Plan**
- objective questions & predictions (why)
- plan to carry out the cycle (who, what, where, when)
- next cycle?

**Study**
- complete the analysis of the data
- compare data to predictions
- summarize what was learned

**Do**
- carry out the plan (small scale)
- document problems and unexpected observations
- begin analysis
- adapt? adopt? abandon? next cycle?
Call to Action

• Learn from case reviews and debriefs to innovate
• Change the way physicians, midwives, nurses, patients and families communicate and work together (prenatal care, hospital discharge, ED)
• **WE can make change in OUR state**
• Engage all providers and facility executives – Measure, report, and sustain positive change
• Communicate with urgency, act with optimism
Our Fundamental Agreements

• Re-center the work to the **who** and the **why**
  – with, not for or to

• Make care **equitable** by making care **better** and **consistent**
  – every woman, every time

• Change is **necessary**, change is **important**, change is **personal**


