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

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Objectives

- Louisiana Maternal Mortality Report
- No improvement without EQUITY
- What is the LaPQC?
- What can we do… together?

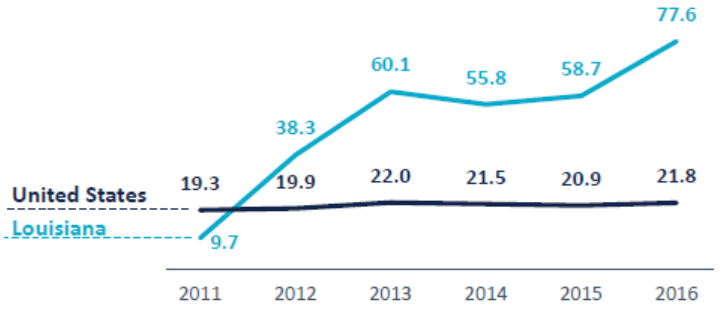
LOUISIANA MATERNAL MORTALITY REVIEW REPORT

2011-2016

August 2018

KEY FINDINGS

- Maternal Mortality: a maternal death occurring within 42 days of termination of pregnancy[1]
- Between 2011-2016, maternal mortality rate increased by an average of 34% per year
  - 12.4 per 100,000 live births



Ref: Kieltyka L, Mehta P, Schoellmann K, Lake C. Louisiana Maternal Mortality Review Report 2011-2016. August 2018.

LOUISIANA MATERNAL MORTALITY REVIEW REPORT

2011-2016

August 2018

KEY FINDINGS

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

LOUISIANA MATERNAL MORTALITY REVIEW REPORT

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August 2018

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%

LOUISIANA MATERNAL MORTALITY REVIEW REPORT

2011-2016

August 2018

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.

LOUISIANA MATERNAL MORTALITY REVIEW REPORT

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RECOMMENDATIONS

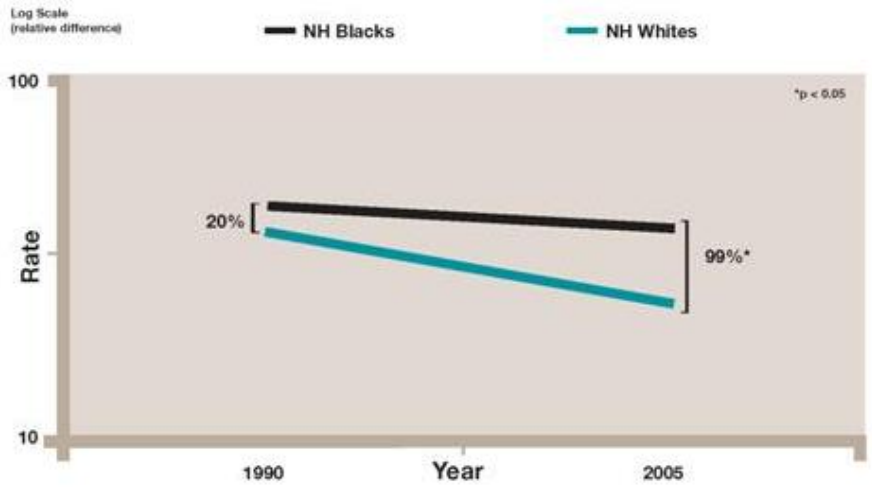
1. Support, expand, and sustain a robust pregnancy-associated mortality review
2. Build a culture of continuous quality improvement
3. Reduce missed opportunities for prevention in the emergency room
4. Assure access to contraceptive services and management of chronic illnesses
5. Provide fully integrated 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 outcomes[3]
  - https://implicit.harvard.edu/implicit/takeatest.html
- **Social determinants of health[4]**
  - Racial residential segregation[5]
  - Health care services
  - Socioeconomic status
  - Healthy behaviors

Change = Improvement + Equity

Breast Cancer Mortality Among Non-Hispanic Blacks and Non-Hispanic Whites in Chicago: 1990-2005



*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:[8]

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

Louisiana Perinatal Quality Collaborative (LaPQC)

- **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

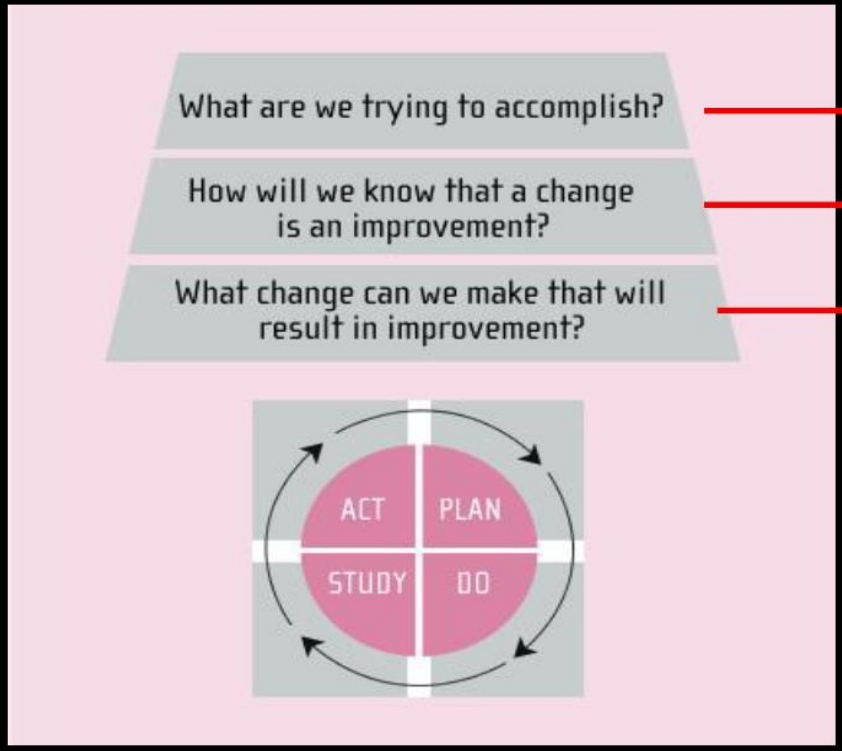
Reliable Clinical Processes	• Assure readiness • Improve recognition and prevention • Understand & reduce variation in response • Eliminate waste
Respectful Patient Partnership	• Design for partnership • Invest in improvement
Effective Peer Teamwork	• Reduce variation in reporting • Change the work environment • 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

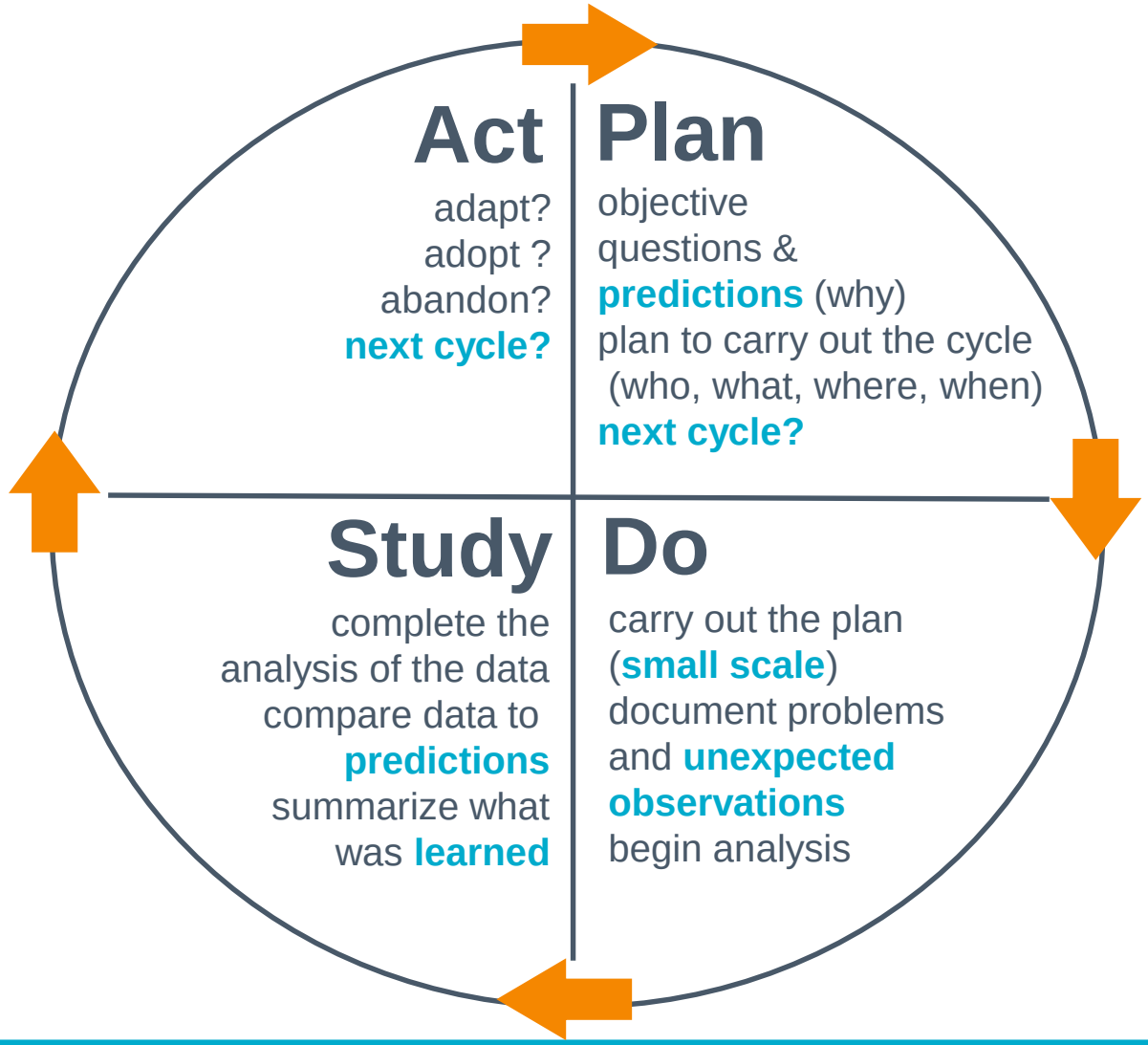
BTS: Model for Improvement

Model for Improvement



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

Learning Through Testing



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**

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