Levels of Maternal Care in Massachusetts: Webinar #3

Thank you for joining! We will begin in a few moments.

BETSY LEHMAN CENTER for Patient Safety

PN QIN PERINATAL-NEONATAL QUALITY IMPROVEMENT NETWORK

MPQC Massachusetts Perinatal Quality Collaborative

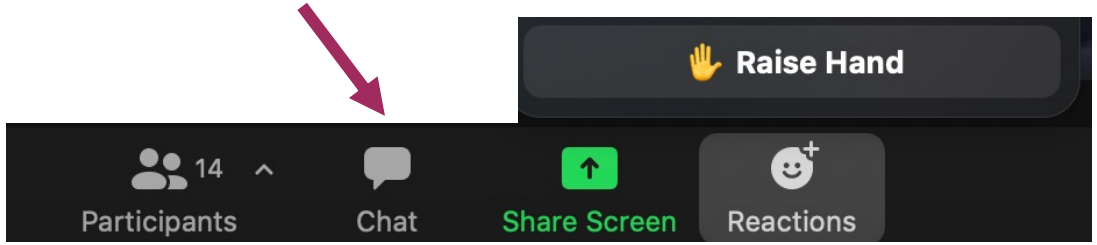
COMMONWEALTH OF MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

CDC CENTERS FOR DISEASE CONTROL AND PREVENTION

LOCATe

Tech support

- All attendees are **muted** automatically.
- Click the **Chat** button to ask questions at any time.



- Chat **Everyone** for general comments or questions.
- Chat **Meaghan Carey** for technical support.
- During Q&A, use the **Chat** feature or **Raise Hand** if you would like to speak.

You can find this info on the right hand of your screen during the whole presentation →

Levels of Maternal Care in Massachusetts

October 12, 2021

Brief Welcome

Dr. Sarah Rae Easter, PNQIN

LOCATe Results

Carla DeSisto, Centers for Disease Control & Prevention

MA Equity Results

Godwin Osei-Poku, Betsy Lehman Center for Patient Safety

Q&A and Discussion

Next Steps and Close Out

Dr. Chloe Zera, PNQIN

Dr. Sarah Rae Easter, PNQIN

Reminder:

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PN QIN PERINATAL-NEONATAL QUALITY IMPROVEMENT NETWORK

BETSY LEHMAN CENTER for Patient Safety

Our teams

PNQIN

- Sarah Rae Easter, MD (LoMC Task Force Chair)
- Ronald Iverson, MD, MPH (Co-Chair)
- Audra Meadows, MD, MPH (Co-Chair)
- Hafsatou "Fifi" Diop, MD, MPH (DPH; PNQIN PI)
- Bonnie Glass, RN, MN (MPQC Co-Founder, RN Lead)
- Kali Vitek, MPH (Project Management Specialist)
- + 36 members of LoMC Task Force!

Betsy Lehman Center

- Godwin Osei-Poku, MBCHB, MPH (Research Analytics Manager)
- Charlie Carter, MPP (Senior Program Manager)

Centers for Disease Control and Prevention

- Carla DeSisto, PhD, MPH (Maternal and Child Health Epidemiologist, Epidemic Intelligence Service Officer)
- Dave Goodman, MS, PhD (Lead, Maternal Mortality Prevention Team)
- Jennifer Wilkers (ORISE Fellow, Maternal Mortality Prevention Team)
- Alex Ewing, MPH (Associate Service Fellow)

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Agenda

12:00 - 12:10pm: Brief Welcome

- *Dr. Sarah Rae Easter, PNQIN*

12:10 - 12:25pm: LOCATe Results

- *Carla DeSisto, Centers for Disease Control & Prevention*

12:25 - 12:40pm: Massachusetts Equity Questions Results

- *Godwin Osei-Poku, Betsy Lehman Center for Patient Safety*

12:45 - 1:00pm: Q&A and Discussion

12:55 – 1:00pm: Next Steps and Close Out

- *Dr. Sarah Rae Easter, PNQIN*
- *Dr. Chloe Zera, PNQIN*

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Webinar objectives

1. Review statewide LOCATe and Equity results with participating hospitals.
2. Provide an opportunity for participating hospitals to ask questions and engage in discussion about survey results, upcoming individualized reports, and the future of LoMC in Massachusetts.
3. Share PNQIN's next steps for LoMC and offer follow-up conversation/coaching after final report distribution.

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Brief Welcome

Sarah Rae Easter, MD

Perinatal-Neonatal Quality Improvement Network of Massachusetts (PNQIN)

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Levels of Maternal Care

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Society for Maternal-Fetal Medicine
High-risk pregnancy experts

SMFM Special Report

smfm.org

Obstetric Care Consensus, Number 9: Levels of Maternal Care

(Replaces Obstetric Care Consensus Number 2, February 2015)

The American Association of Birth Centers; the American College of Nurse-Midwives; the Association of Women's Health, Obstetric and Neonatal Nurses; the Commission for the Accreditation of Birth Centers; and the Society for Obstetric Anesthesia and Perinatology endorse this document. The American Academy of Family Physicians supports this document. The American Society of Anesthesiologists has reviewed this document. This document was developed jointly by the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine in collaboration with Sarah J. Kilpatrick, MD, PhD; M. Kathryn Menard, MD, MPH; Christopher M. Zahn, MD; and the Centers for Disease Control and Prevention's representative William M. Callaghan, MD, MPH.

Levels of maternal care. Obstetric Care Consensus No. 9. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;134:e41–55.

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Examples of Levels of Care

Level	Patient	Hospital
Birth Center	Term, singleton, vertex Low-risk mother	Licensed midwives Transfer relationship
Level I (Basic Care)	Term twins Uncomplicated cesarean "Mild" term preeclampsia TOLAC / VBAC	Cesarean delivery Anesthesia available
Level II (Specialty Care)	Term severe preeclampsia Previa, no prior surgery	Basic imaging Med/Surg consultants
Level III (Subspecialty Care)	Previa, prior surgery Suspected accreta Preterm preeclampsia Adult respiratory syndrome	MFM OB anesthesia Med/Surg subspecialists Advanced imaging
Level IV (Regional Center)	Severe maternal cardiac Organ failure / transplant Neuro or cardiac surgery	Subspecialty surgeons Critical care obstetrics Subspecialty leadership

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What are the Goals?

Objectives

- To introduce uniform designations for levels of maternal care that are complementary but distinct from levels of neonatal care and that address maternal health needs, thereby reducing maternal morbidity and mortality in the United States
- To develop standardized definitions and nomenclature for facilities that provide each level of maternal care
- To provide consistent guidelines according to level of maternal care for use in quality improvement and health promotion
- To foster the development and equitable geographic distribution of full-service maternal care facilities and systems that promote proactive integration of risk-appropriate antepartum, intrapartum, and postpartum services

- Uniform designations
- Complementary but distinct from NICU
- Standardized nomenclature
- Consistent guidelines
- Equitable geographic distribution
- Proactive integration
- Risk-appropriate services

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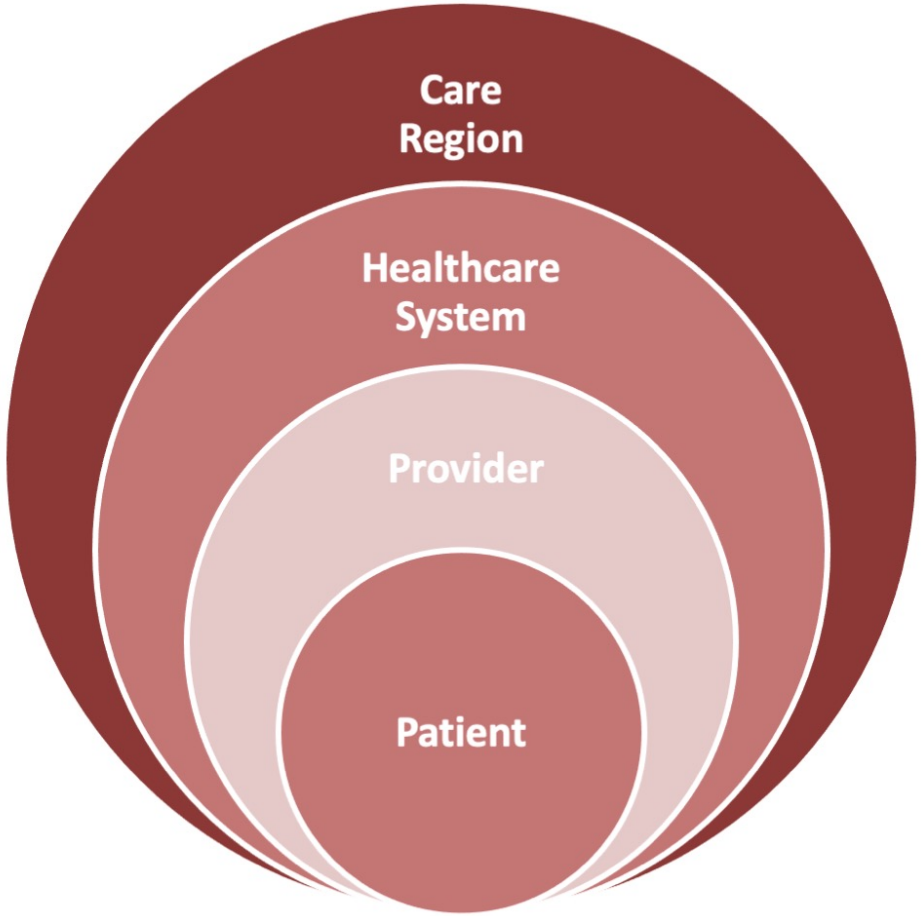
What are the Barriers?

- Lack of Evidence
- Burden of Implementation
- Psychosocial Considerations
- Equitable Access
- Financial Impact
- Provider Skill
- Medicolegal Implications
- Geography
- Population Health



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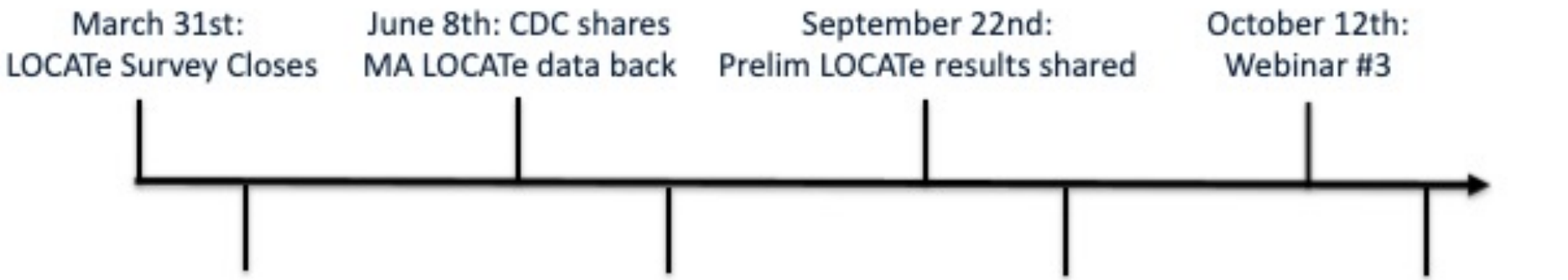
Timeline for LOCATe



February 9th: Webinar #1
February 15th: Survey Distribution
March 2nd: Webinar #2

Massachusetts Department of Public Health

LOCATe

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Special Considerations for Massachusetts

- Offer Voluntary Virtual Consultation
  - Site Visit was mutually informative in other states including ACOG pilots
  - Opportunity to see how PNQIN can support risk-appropriate care
- Eliminate Barriers to Equitable Care
  - Targeted questions about racism and disparities
  - Modified from best practices set forth in Disparities Bundle aligned with existing initiatives
- Reinforce Quality Collaborative Care
  - Assessment of existing hospital quality improvement and assurance processes
  - Identify opportunities for collaborative care within defined care networks and within existing PNQIN initiatives

Fig. 1. Summary of steps involved in the development and implementation of the levels of maternal care verification program.

Zahn. Levels of Maternal Care Verification Pilot. Obstet Gynecol 2018.

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LOCATe Results

Carla DeSisto

Centers for Disease Control & Prevention

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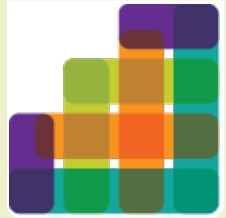
CDC Levels of Care Assessment Tool

Massachusetts Results



LOCATe™

What is LOCATe?

1) Produces standardized assessments
2) Facilitates stakeholder conversations

LOCATe

LOCATe implementation

- Massachusetts implemented Version 9.2 using REDCap
- 40 facilities responded – 100% participation!

Results: Maternal Levels of Care

Maternal Level Discrepancies

57% of facilities (n=23) had discrepancies between their self-reported level of maternal care and their LOCATe-assessed level of maternal care

- 2 of these facilities LOCATe-assessed higher than their self-report
- The remaining facilities LOCATe-assessed lower than their self-report

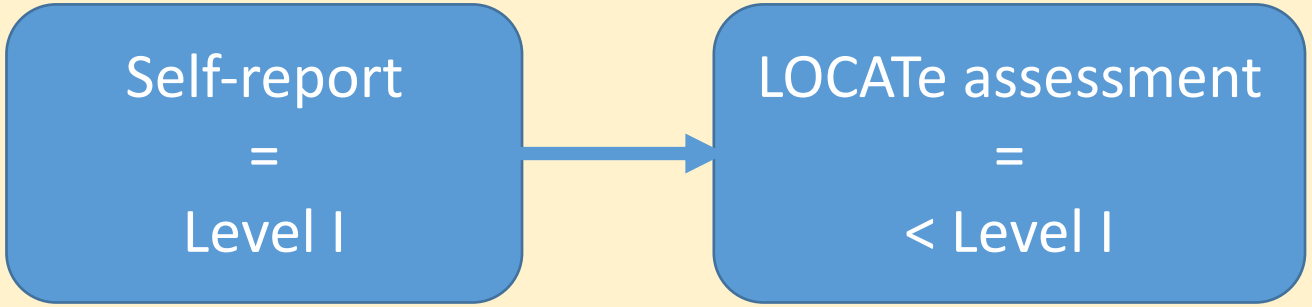
Levels of Maternal Care

Facility (n=40)	Self-Report*	LOCATe Assessment
< Level I	0	15% (n=6)
Level I	23% (n=9)	35% (n=14)
Level II	44% (n=17)	33% (n=13)
Level III	18% (n=7)	0
Level IV	15% (n=6)	18% (n=7)

*1 facility responded 'unknown'

LOCATe

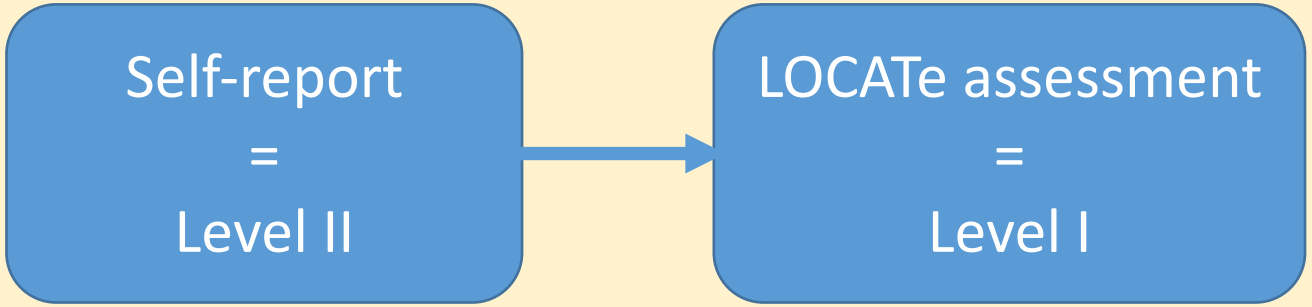
Reasons for Maternal Level Discrepancies



- The most common reasons for discrepancies were:
  - Level I required either:
    - a CRNA and/or anesthesiologist assistant readily available at all times or physically present at all times, or
    - a physician anesthesiologist readily available at all times or physically present at all times
  - Level I required either:
    - limited OB ultrasound with interpretation services readily available at all times, or
    - standard OB ultrasound with interpretation services readily available at all times

LOCATe

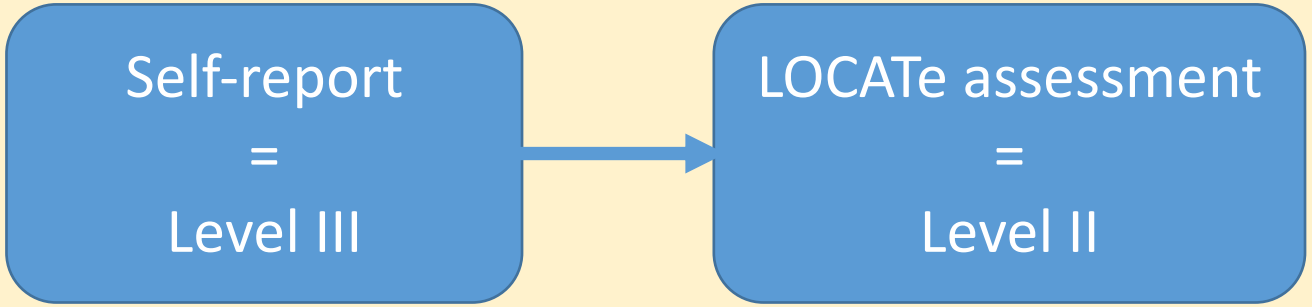
Reasons for Maternal Level Discrepancies



- The most common reasons for discrepancies were lacking:
  - MFM
  - Maternal echocardiography
  - Standard OB ultrasound with interpretation services readily available at all times
  - General surgeon physically present at all times or readily available at all times

LOCATe

Reasons for Maternal Level Discrepancies



- The most common reasons for discrepancies were lacking:
  - MFM that is readily available at all times with inpatient privileges
  - Maternal echocardiography with interpretation services readily available at all times
  - Specialized OB ultrasound with Doppler studies with interpretation services readily available at all times

LOCATe

Maternal Emergency Preparedness

	Obstetric Hemorrhage	HTN Emergency
Written policy	95%	95%
Drill in last 12 months	92%	87%

Disaster Response Drills	
Any	80%
Neonatal Unit	63%
OB Unit	69%

LOCATe Statistics

	Births/ Deliveries	Maternal deaths prior to discharge	4 or more units of blood	Admitted to ICU	Newborn Mortality
MA LOCATe	59,544/66,025	**4.5** per 100,000 deliveries (n=3)	**28.2** per 10,000 deliveries (n=186)	**29.7** per 10,000 deliveries (n=196)	**2.0** per 1,000 live births (n=119)
LOCATe Range – other states		2.0 – 39.8	8.8 – 35.7	18.2 – 36.9	1.5 – 4.7

LOCATe

Potential Opportunities

- Individual follow-up with hospitals
- Participate in multi-jurisdiction analysis
- Include level of maternal care for MMRC deaths
- Utilize MMRC and LOCATe data to identify priorities
  - Obstetric emergency preparedness
- Other areas of focus:
  - Availability of specialists and services (neonatologists, MFMs, etc.)
  - Transport analyses & policies (back and high risk/complex)

LOCATe

Thank you!
Questions?

Carla DeSisto
wup5@cdc.gov

The findings and conclusions in this presentation are those of Carla and do not necessarily represent the official position of the Centers for Disease Control and Prevention

LOCATe

Supplemental Massachusetts LOCATe Questions:

Optimizing hospital safety processes for birth equity

Godwin Osei-Poku

Betsy Lehman Center for Patient Safety

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Massachusetts specific questions added to LOCATe

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1.) Does hospital provide anti-racism and implicit bias training?

- *Check all staff that apply*: OB Providers, OB Nurses, Other Staff, No

2 & 3.) Systems or processes in place for patients, families or staff to report discrimination, racism and bias?

- *Yes/No*

4.) Does hospital provide educational programs for staff on peripartum racial and ethnic disparities?

- *Check all staff that apply: OB Providers, OB Nurses, Other Staff, No*

5. & 6.) How frequently does hospital address social determinants of health at debriefings after adverse events and at severe maternal morbidity reviews?

- *Always/Most of the time/Sometimes/Never/Do not currently perform*

7.) Does hospital perform root cause analysis/review process for cases of maternal mortality?

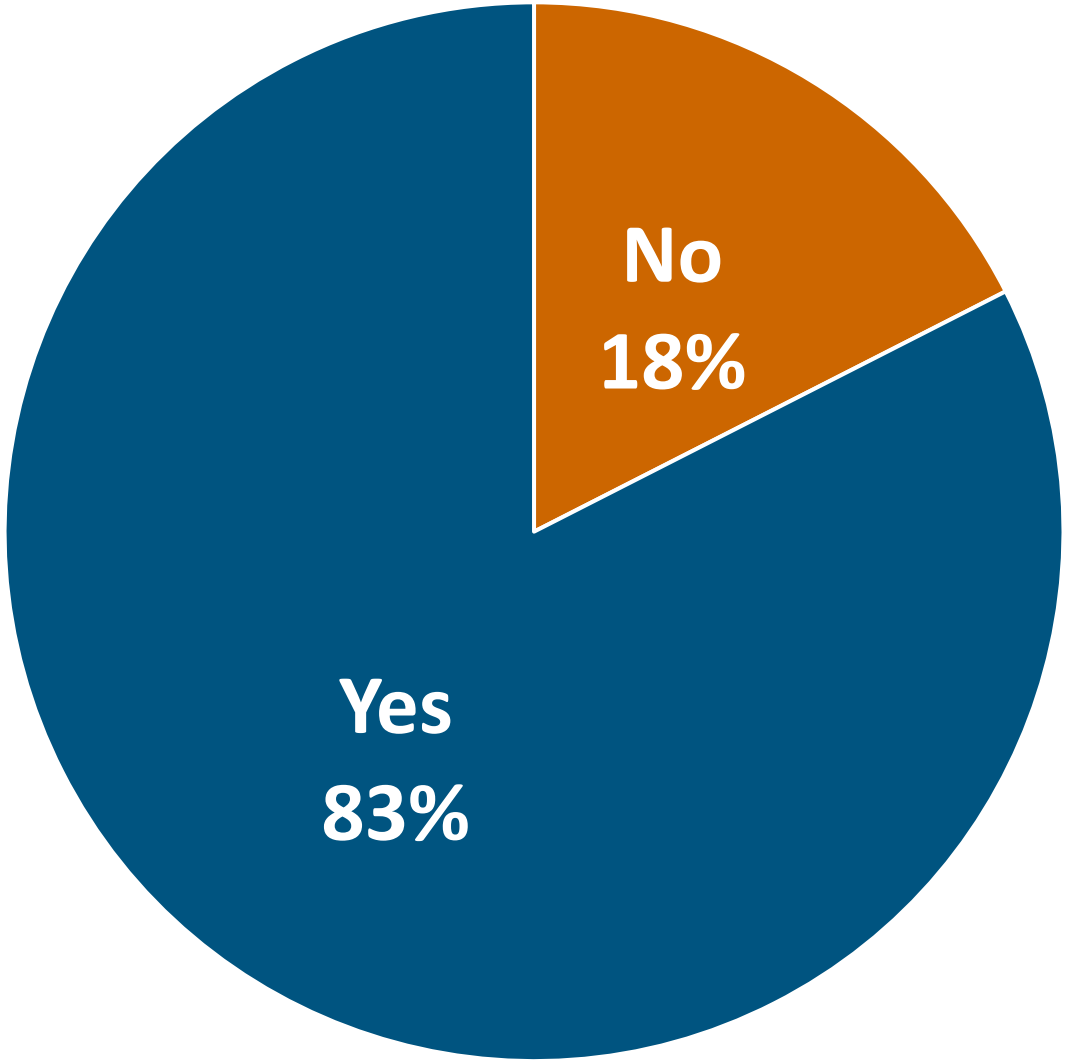
- *Yes/No*

8.) Hospital interest in voluntary consultation to review Level of Maternal Care suggested by LOCATe and PNQIN support of risk-appropriate care?

- *Yes/No/Possibly*

Results

83% of hospitals provide anti-racism or implicit bias training to staff



N = 40

MA1. *Has your hospital provided anti-racism or implicit bias training within the past two years?*

One third of hospitals provide anti-racism or implicit bias training to **all types of staff**

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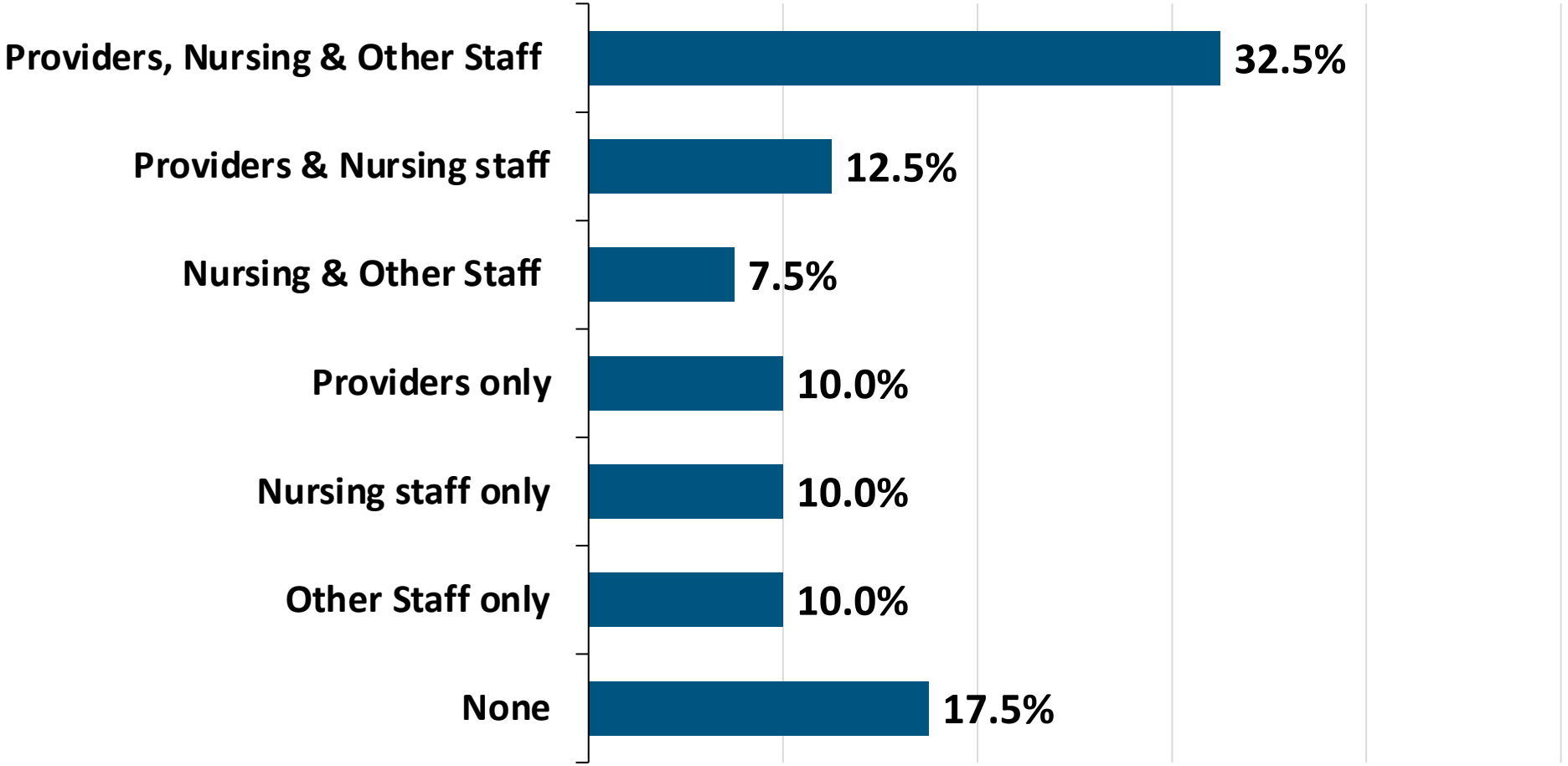
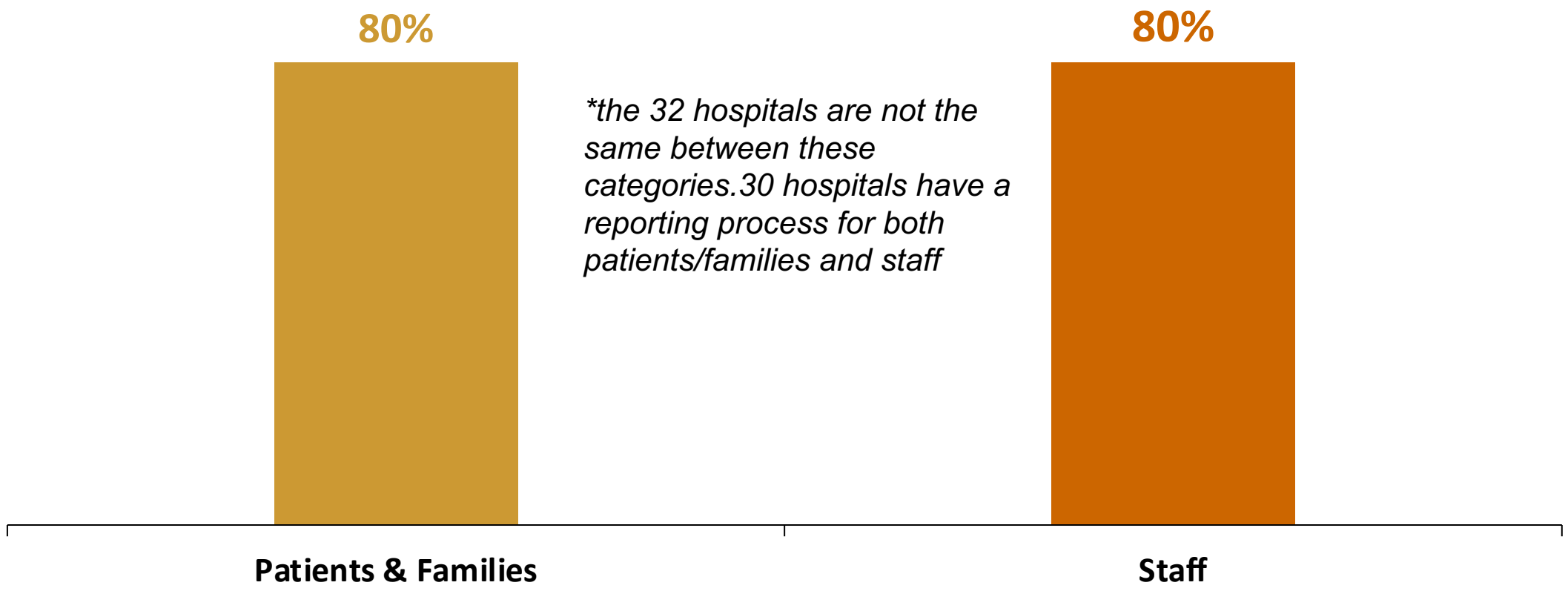


N = 40

MA1. *Has your hospital provided anti-racism or implicit bias training within the past two years? (select all that apply)*

80% of hospitals have a dedicated system or process for ***patients and families*** and for ***staff*** to report discrimination, racism and bias



N = 40

MA2 & MA3. *Does your hospital have a dedicated system or process for patients or families, or for staff to report discrimination, racism, and bias? (Yes/No)*

One third of hospitals provide regular education on peripartum racial and ethnic disparities to staff

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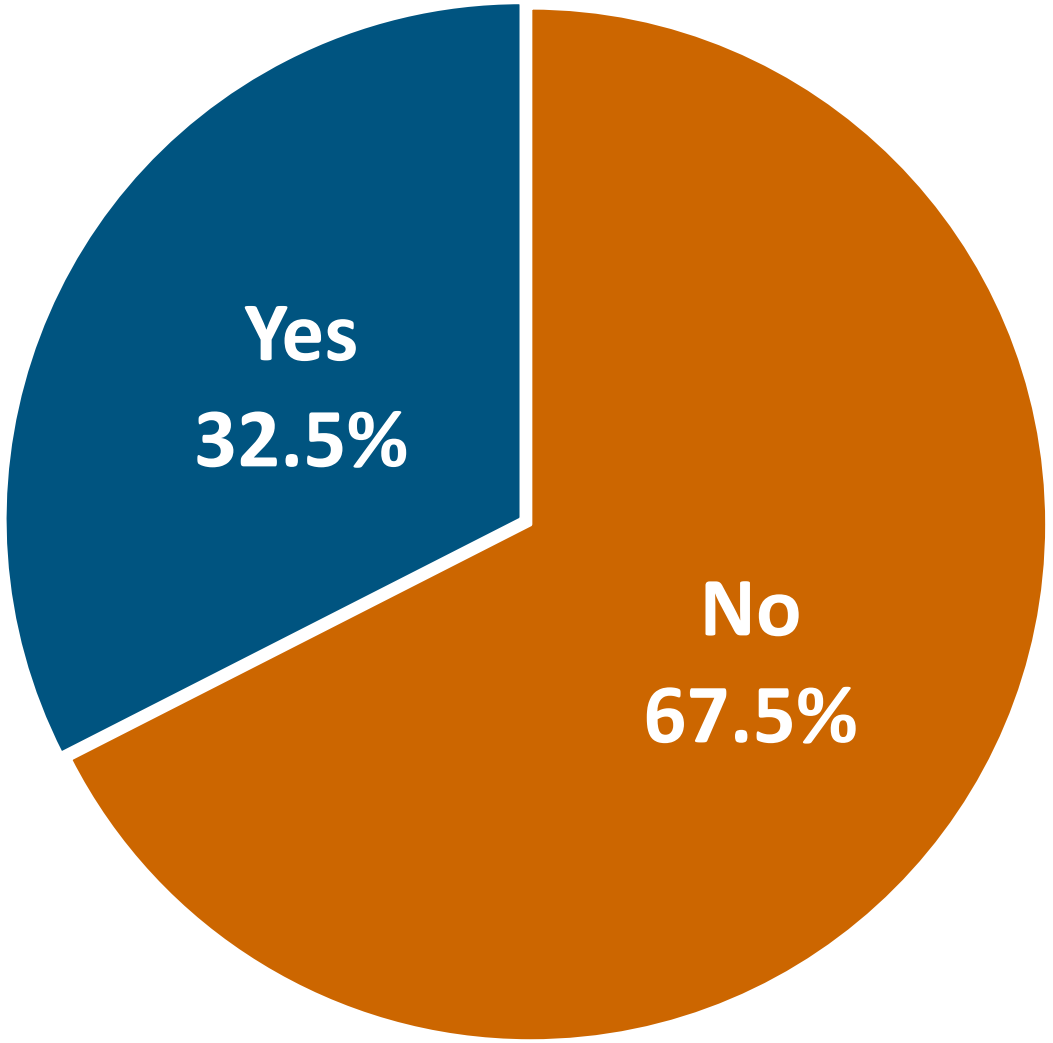
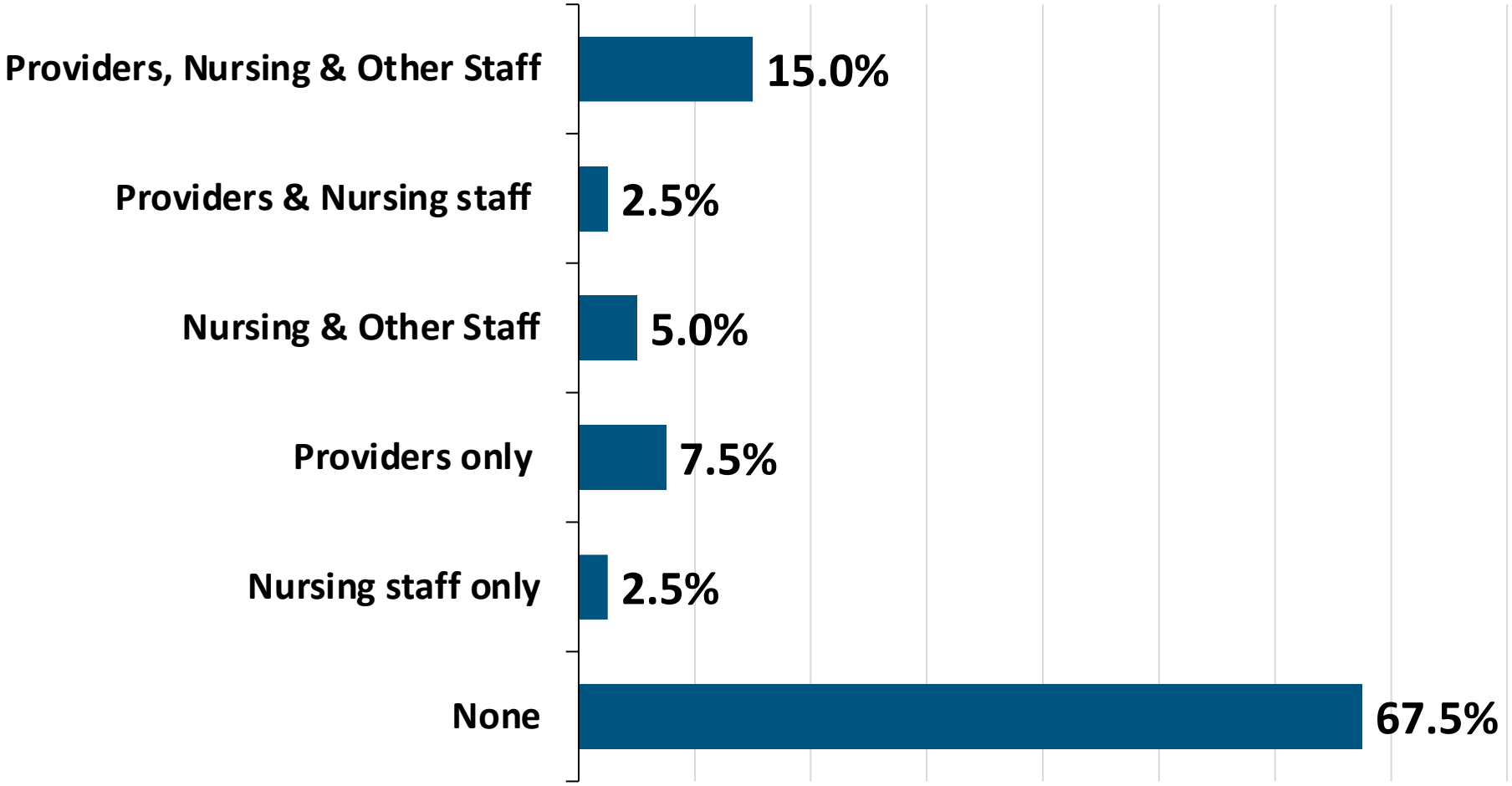


N = 40

MA4. *Does your hospital provide a regular program of education on peripartum racial and ethnic disparities?*

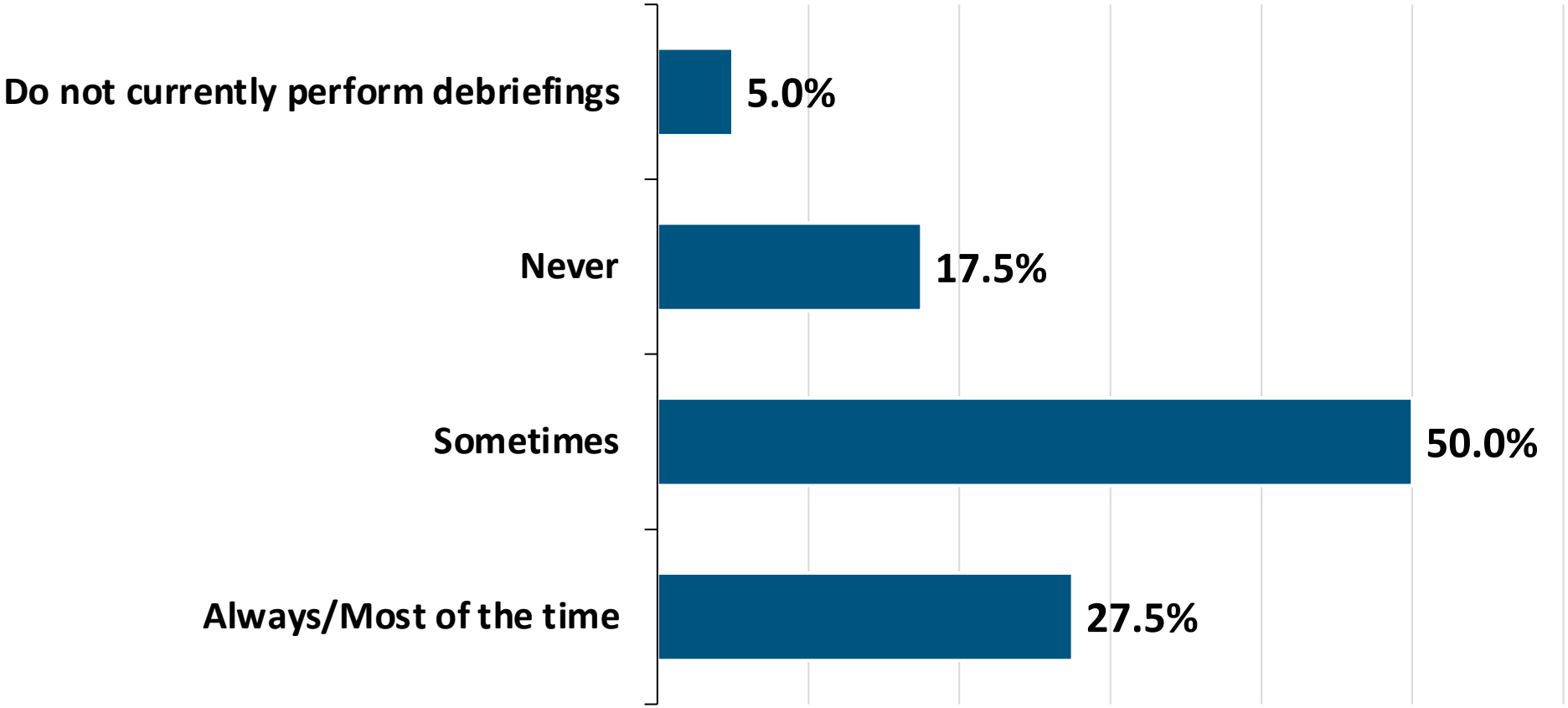
Over two thirds of hospitals do not regularly educate any of their staff on peripartum racial and ethnic disparities



N = 40

MA4. *Does your hospital provide a regular program of education on peripartum racial and ethnic disparities? (select all that apply)*

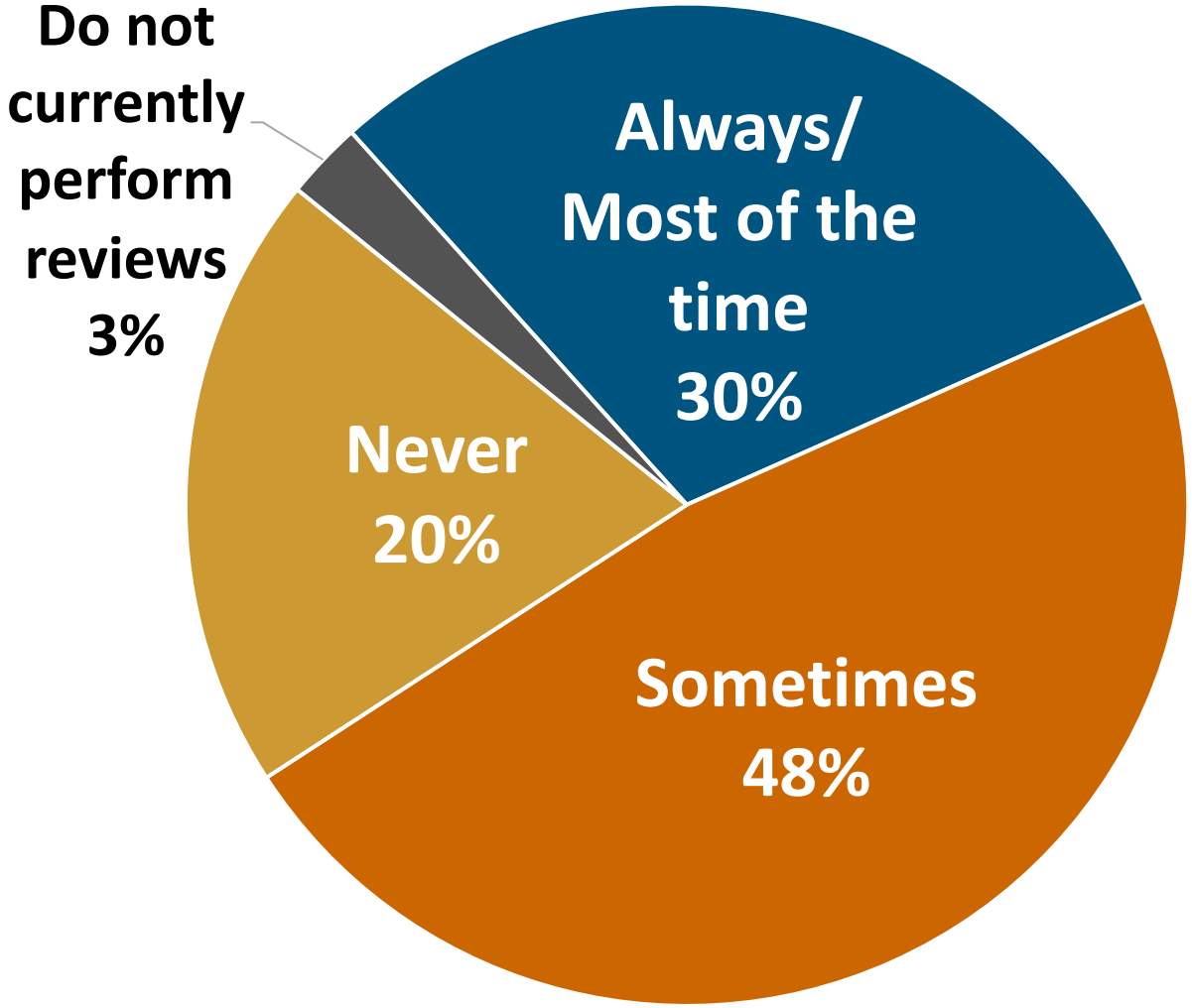
More than a quarter of hospitals ***always or mostly*** address social determinants of health after adverse clinical events; **half** of hospitals address these factors ***sometimes***



N = 40

MA5. *How frequently do debriefings after adverse clinical events for obstetric patients in your hospital systematically address patient race, ethnicity, language, poverty, literacy, or other social determinants of health?*

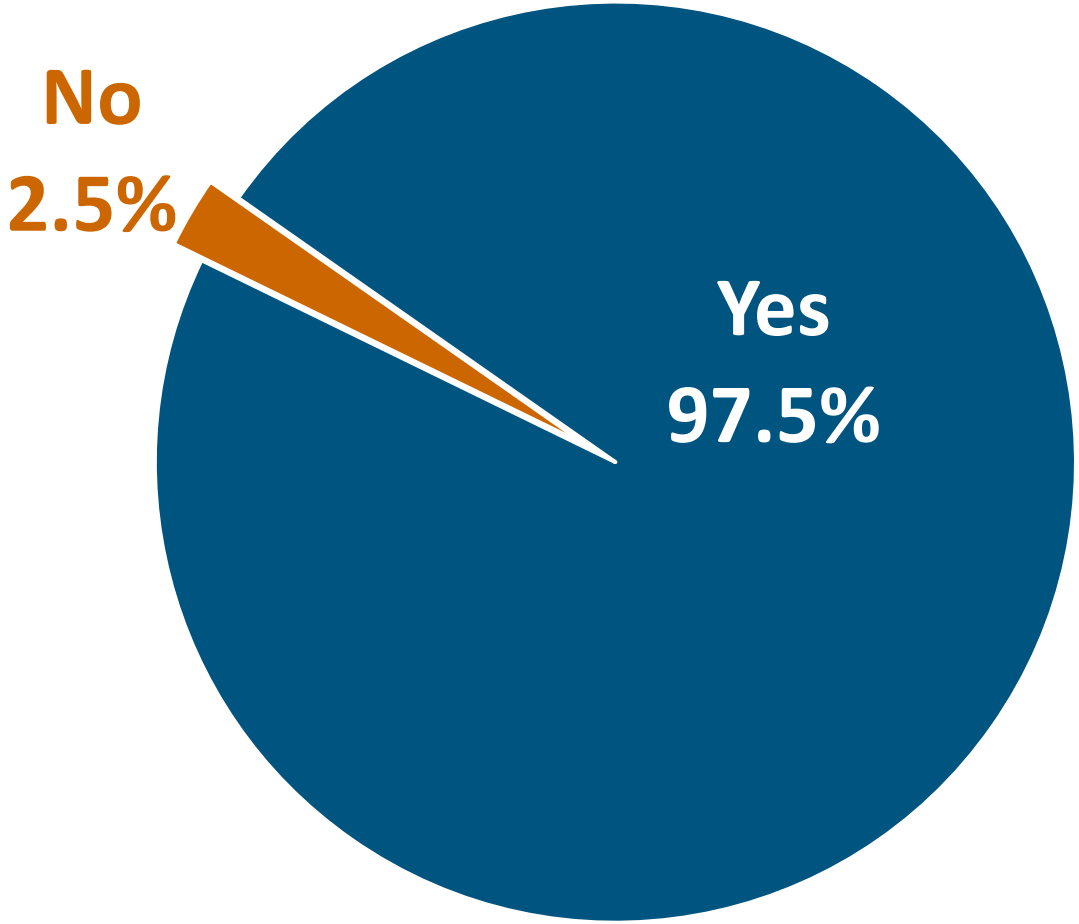
30% of hospitals always/mostly address social determinants of health during severe maternal morbidity reviews



N = 40

MA6. *How frequently do severe maternal morbidity reviews at your hospital systematically address patient race, ethnicity, language, poverty, literacy, or other social determinants of health?*

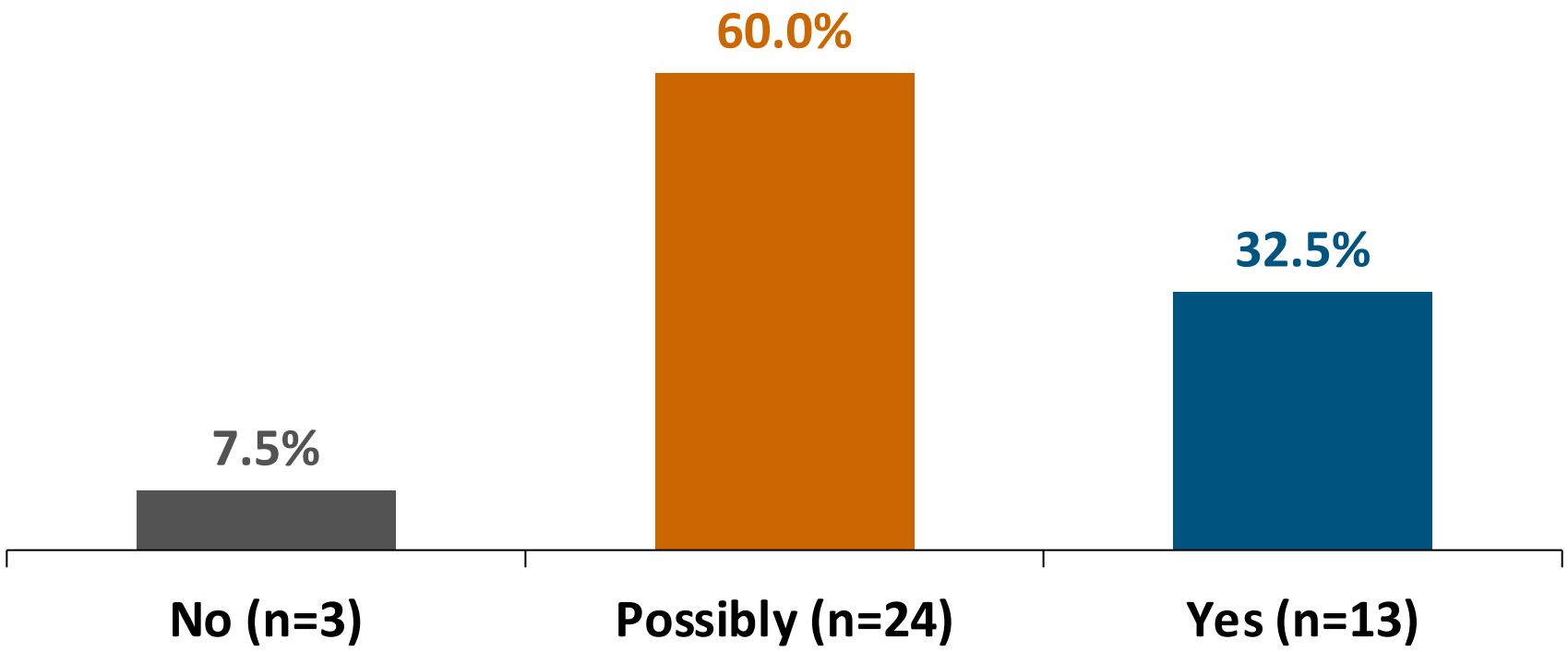
Nearly all hospitals perform root cause analyses and review processes for cases of maternal mortality



N = 40

MA7. *Does your hospital perform a root cause analysis or similar review process for cases of maternal mortality?*

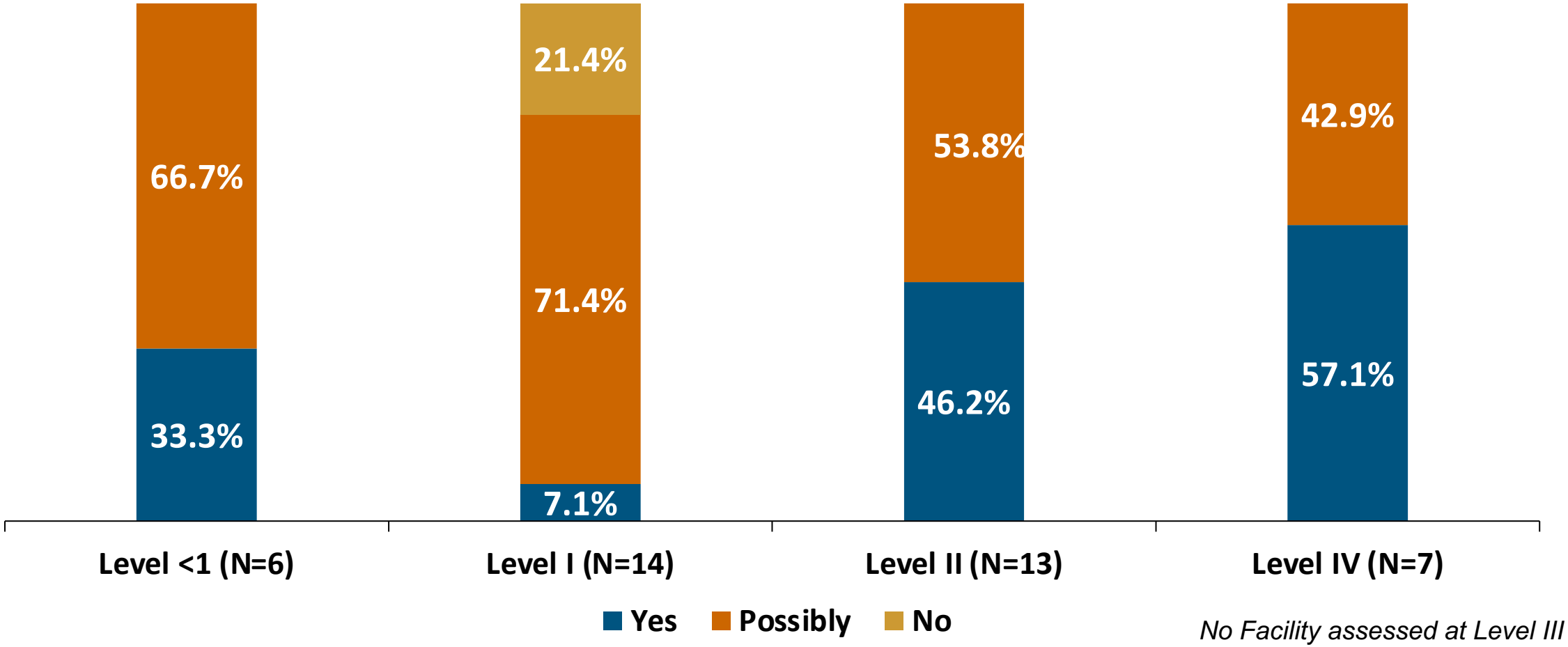
Over 30% of hospitals reported "***Yes***" to wanting a voluntary consultation



N = 40

MA8. *Would your hospital be interested in a voluntary consultation to review the Level of Maternal Care suggested by LOCATe and discuss ways PNQIN could support the provision of risk-appropriate care?*

Hospitals with lower LOCATe assessed level of care are less interested or hesitant to receive consultation support

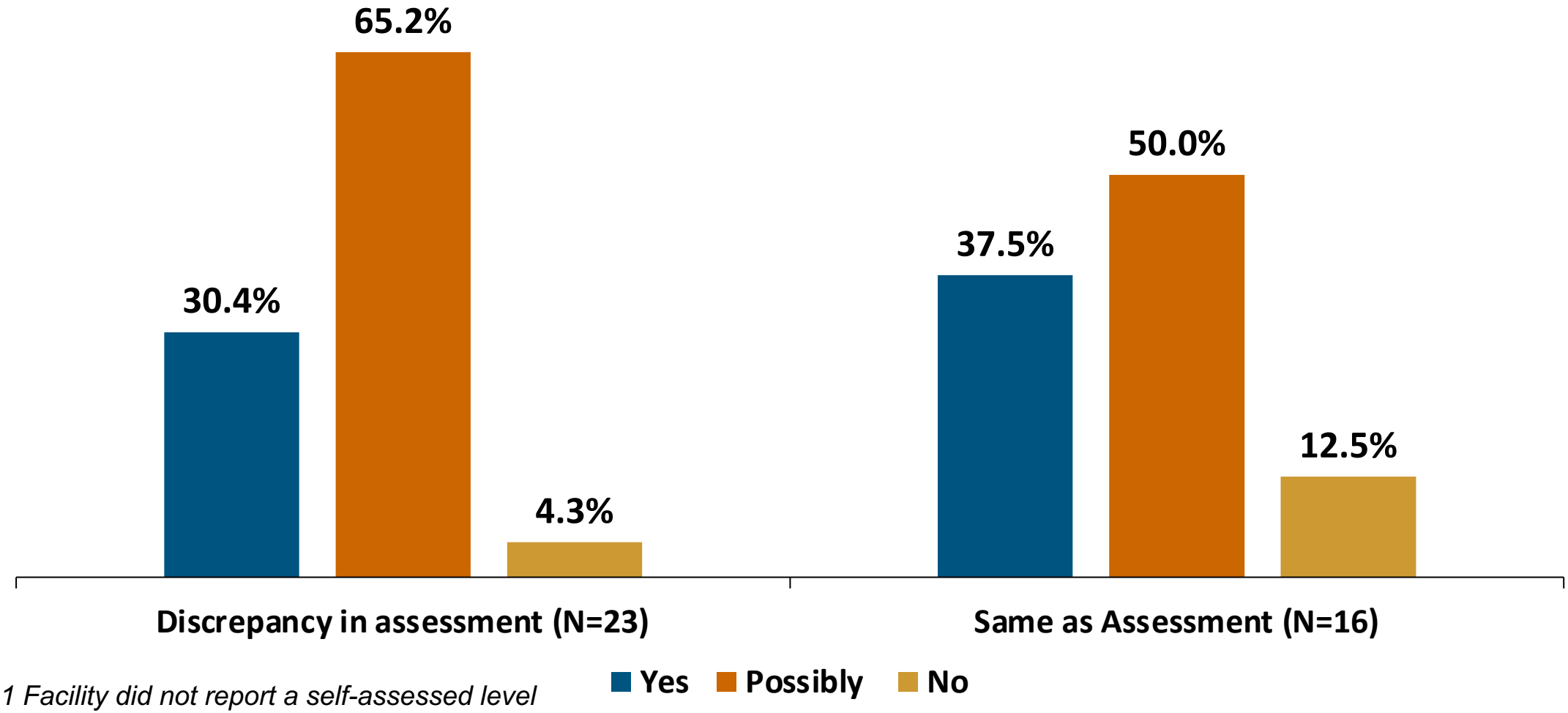


No Facility assessed at Level III

N = 40

MA8. *Would your hospital be interested in a voluntary consultation to review the Level of Maternal Care suggested by LOCATe and discuss ways PNQIN could support the provision of risk-appropriate care?*

Facilities interested in consultation by LOCATe assessed discrepancy in maternal level



1 Facility did not report a self-assessed level

N = 40

MA8. *Would your hospital be interested in a voluntary consultation to review the Level of Maternal Care suggested by LOCATe and discuss ways PNQIN could support the provision of risk-appropriate care?*

Q&A and Discussion

Levels of Maternal Care in Massachusetts

October 12, 2021

Brief Welcome

Dr. Sarah Rae Easter, PNQIN

LOCATe Results

Carla DeSisto, Centers for Disease Control & Prevention

MA Equity Results

Godwin Osei-Poku, Betsy Lehman Center for Patient Safety

➢ Q&A and Discussion

Next Steps and Close Out

Dr. Chloe Zera, PNQIN

Dr. Sarah Rae Easter, PNQIN

Reminder:

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- To ask a question, message **Everyone.**

Next Steps & Close Out

Chloe Zera, MD, MPH

PNQIN

Sarah Rae Easter, MD

PNQIN

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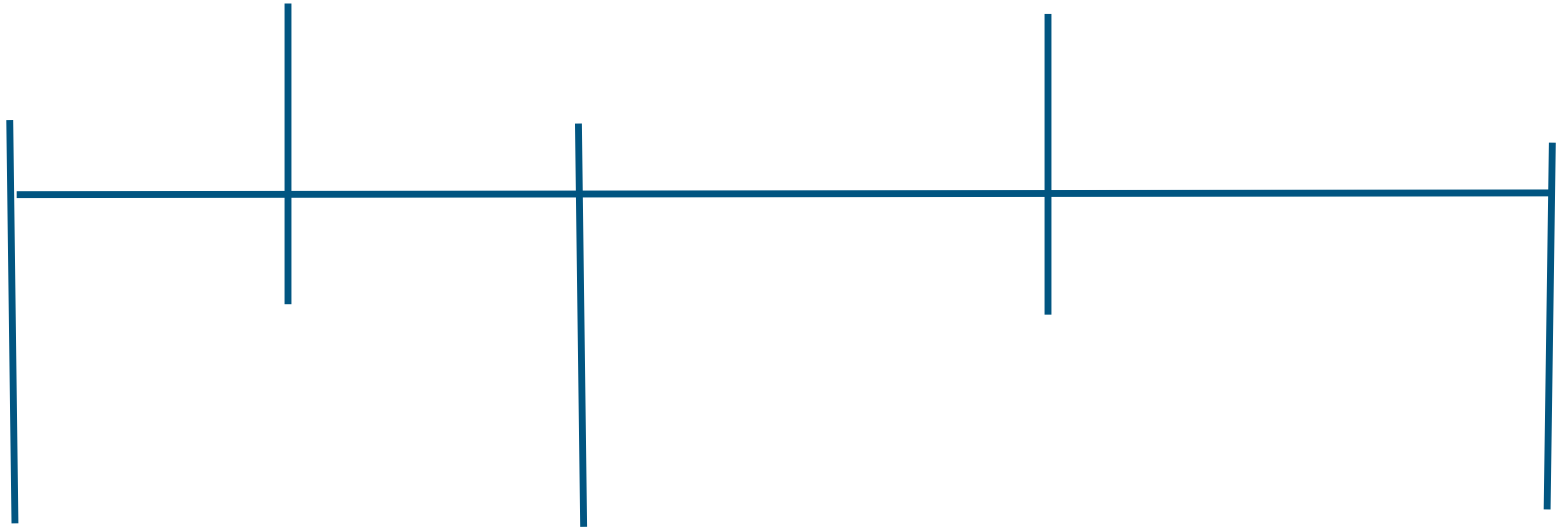
A Quality-Improvement Focused Project



September 20, 2018:
DPH-coordinated stakeholder meeting agreeing on exploring LoMC through lens of quality-improvement

June 25, 2019:
Launch of LoMC Task Force at Betsy Lehman Center for Patient Safety

March 2020:
Decision to postpone LOCATe administration to ensure equitable opportunity for participation

April 2021:
Administration of LOCATe with equity-focused questions to Massachusetts centers

October 12, 2021:
Presentation of LOCATe results and next steps for implementation into practice

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A Collaborative Process

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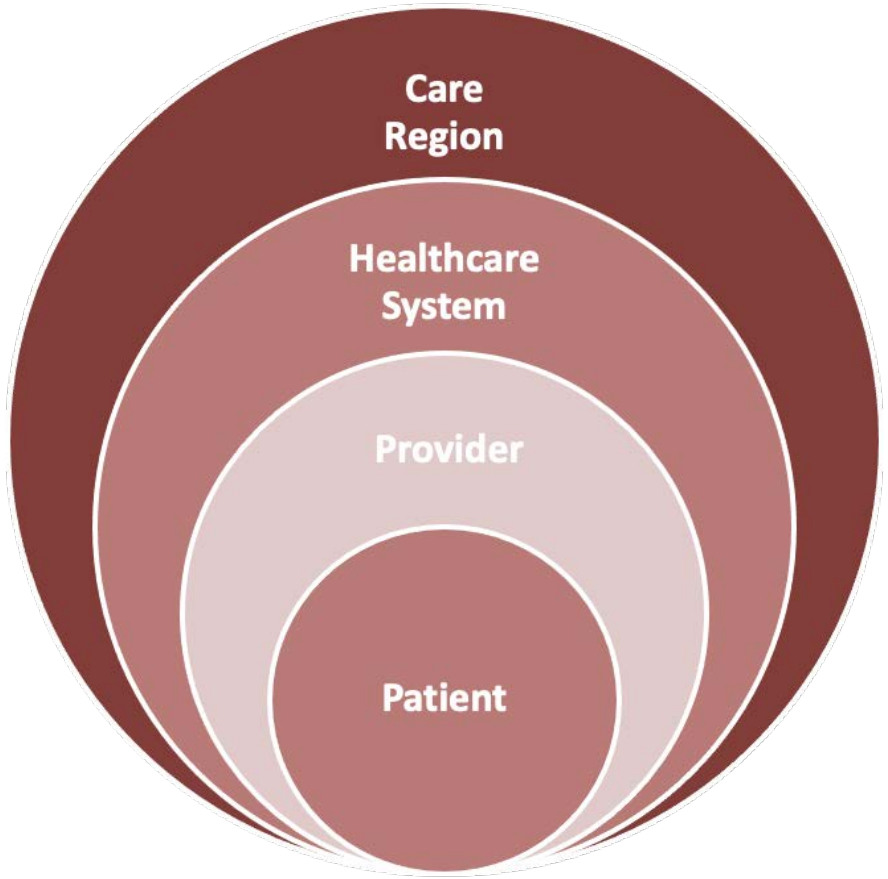
PN QIN PERINATAL-NEONATAL QUALITY IMPROVEMENT NETWORK

BETSY LEHMAN CENTER for Patient Safety

Supporting LoMC in Massachusetts

- Support Hospitals with Data
  - Review of organization-specific data and consults
  - Achieve aspirational level
  - Target areas of greatest need
- Review of Equity Questions
  - Needs assessment
  - Synergize with PNQIN efforts
- Ongoing Promotion of LoMC
  - Stakeholder Organizations (i.e. MHA, ACOG)
  - Malpractice Insurers (i.e. CRICO)
  - Hospital Network Level



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PN QIN PERINATAL-NEONATAL QUALITY IMPROVEMENT NETWORK

BETSY LEHMAN CENTER for Patient Safety

Next steps

- Individualized reports will be sent out this week!
- PNQIN and BLC teams available for optional coaching
- Integration of LoMC into existing PNQIN projects at PNQIN Advisory Board meeting on October 20th
- Advocate for collaborative quality-improvement focused lens with other organizations (ASTHO, JC)

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Questions or concerns?

Email:

PNQINadmin@pnqinma.org or

seaster@pnqinma.org

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Appendix

System or process for **patients and families** to report discrimination, racism, and bias

- **Non-clinical hospital department** *(n=27)*
  - Direct contact with a non-clinical department (e.g., patient relations, compliance, patient experience) *(n=16)*
  - Contact a patient advocate/patient liaison *(n=11)*
- **Hospital-based reporting process** *(n=12)*
  - Patient reporting or feedback process (e.g., safety reporting system, online patient feedback form, formal complaint process) *(n=7)*
  - Call a hotline (e.g., patient feedback, ethics, compliance hotlines) *(n=5)*
- **Clinical unit leadership** *(n=2)*
- **External/non-hospital reporting process** (e.g., surveys, external group such as DPH) *(n=3)*

N = 40

MA2. *Does your hospital have a dedicated system or process for patients or families to report discrimination, racism, and bias?*

System or process for **staff** to report discrimination, racism, and bias

- Staff reporting system *(n=19)*
- Specific non-clinical hospital department *(n=13)*
- Feedback hotline *(n=8)*
- Supervisors/unit leadership *(n=3)*

N = 40 ***MA3.*** *Does your hospital have a dedicated system or process for staff to report discrimination, racism, and bias?*