Let's Talk Perinatal Equity:
Understanding Bias and Tracking Equity Progress in the Maternal Data Center

Wednesday, February 21, 2024

MDC

CMQCC

Continuing Education Notice

In order to receive contact hours (RN) for this webinar, please complete the evaluation via the link, which will be sent to you 48 hours after this webinar.

You must be in attendance on the webinar for a minimum of 50 minutes for a contact hour to be awarded.

Logistics & Slide Deck

All attendees are muted upon entry.

Please use the Q & A function – we will do our best to answer questions during the webinar.

You are welcome to use any of the slides provided for educational purposes.

If you modify or add a slide, please substitute your institutional logo and *do not use* the CMQCC logos.

We welcome your feedback and recommendations for improving future webinars.

Webinar Objectives

- Understand the connection between clinician bias and quality and safety.
- Identify biased provision of care in your setting and gain knowledge of tools to begin addressing it.
- Identify tools available in the Maternal Data Center (MDC) to track progress on your interventions to improve care equity.

Webinar Recording & Slides

- The webinar recording and slides will also be posted within 48 hours at: https://www.cmqcc.org/resources-tool-kits/webinars

Today's Presenters

Amanda Williams,
MD, MPH, FACOG
CMQCC Clinical Innovation Advisor

Christa Sakowski,
MSN, RN, C-ONQS, C-EFM, CLE
CMQCC Clinical Lead

From Implicit Bias to Maternal Health Inequities—
We Didn't Get Here By Accident

Amanda Williams, MD, MPH, FACOG
Clinical Innovation Advisor
California Maternal Quality Care Collaborative
Adjunct Clinical Associate Professor
Department of Obstetrics and Gynecology
Stanford University School of Medicine

MDC

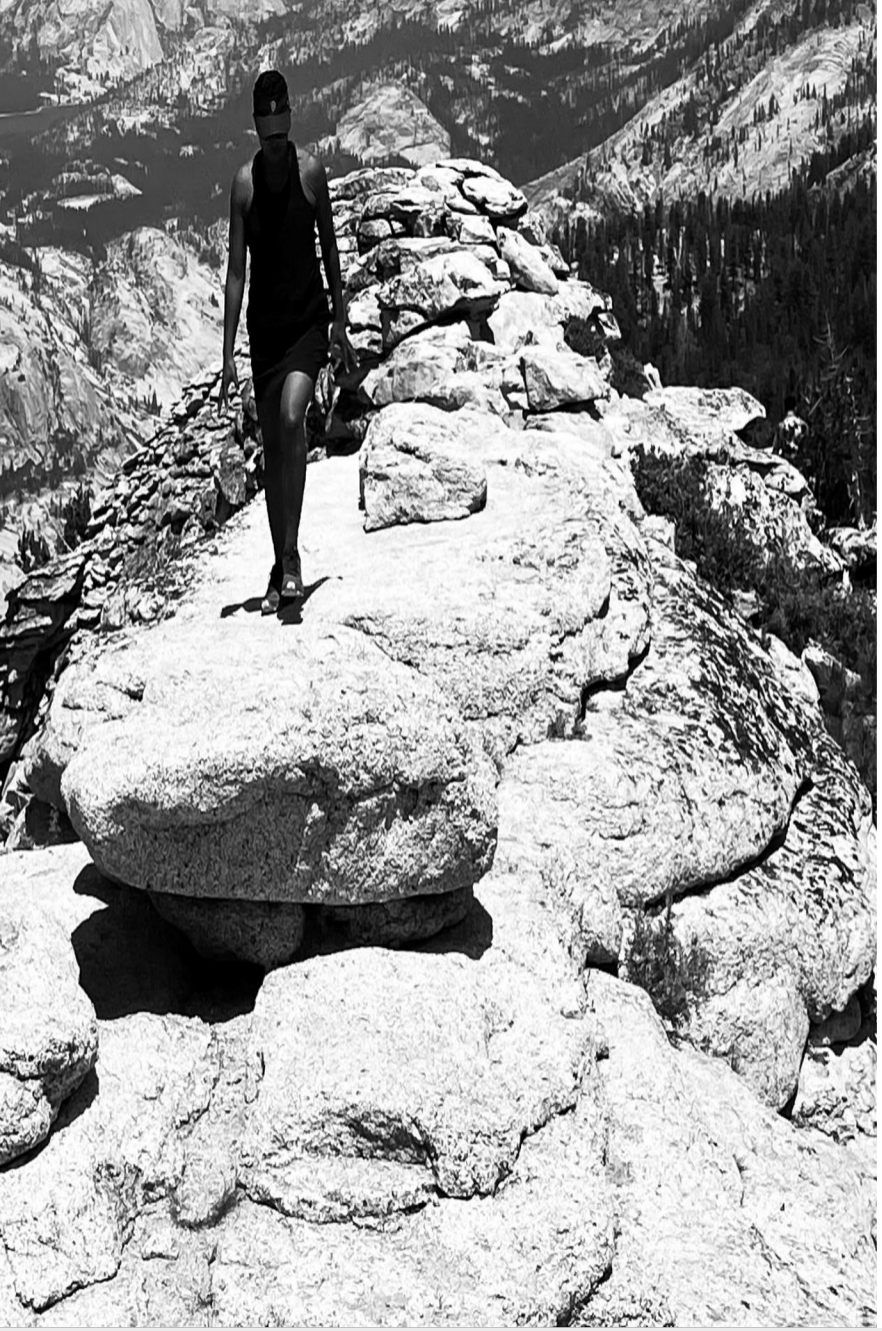
CMQCC

Inclusive Language Notice

Currently recognized identifiers such as **“birthing people,” “mother,” “maternal,” “they,” “them,” “she,” “her.”** and **“pregnancy-capable person”** are used in reference to a person who is pregnant or has given birth.
We recognize not all people who become pregnant and give birth identify as mothers or women and will use the above-recognized terms interchangeably to represent all those present in this space receiving care for pregnancy services. All persons are equally deserving of respectful patient-centered care that helps them attain their full potential and live authentic, healthy lives. The healthcare team should respect individual patient preferences regarding gendered language throughout the course of their care.

The term **“family”** is used to refer to any persons the pregnant or postpartum patient designates as such (alternatives: partners, husbands, wives, support persons, loved ones).

The term **“clinician”** is used to denote nursing and medical staff, whereas the term **“provider”** refers to a clinician with diagnosing and prescribing authority.



Disclosures

- Medical Director, Mahmee
  - *venture backed, tech-enabled pregnancy and postpartum wrap around services company aimed at elevating maternal health equity and supplementing traditional perinatal care*
- Clinical Advisor, RiskLD
  - *obstetric alerts and decision support software*

CMQCC Mission:

End preventable morbidity, mortality AND racial disparities in California maternity care.

What is the problem we are trying to solve?

ProPublica Graphics & Data Newsletters About

Racial Justice Health Care Politics Immigration More...

Summer Fundraiser Deadline: Friday. Donate Now.

LOST MOTHERS

Maternal Care and Preventable Deaths

The U.S. has the highest rate of deaths related to pregnancy and childbirth in the developed world. Half of the deaths are preventable, victimizing women from a variety of races, backgrounds, educations and income levels.

FEATURED

We're Investigating How Insurance Gaps Endanger Mothers. This Is Why.

Women are getting kicked off Medicaid quickly after giving birth or aren't qualifying for care to begin with.

by Nina Martin, ProPublica, and Julia Belluz, Vox, April 25, 2019, 5 a.m. EDT

Nothing Protects Black Women From Dying in Pregnancy and Childbirth

Not education. Not income. Not even being an expert on racial disparities in health care.

by Nina Martin, ProPublica, and Renee Montagne, NPR News, Dec. 7, 2017, 8 a.m. EST

Lost Mothers

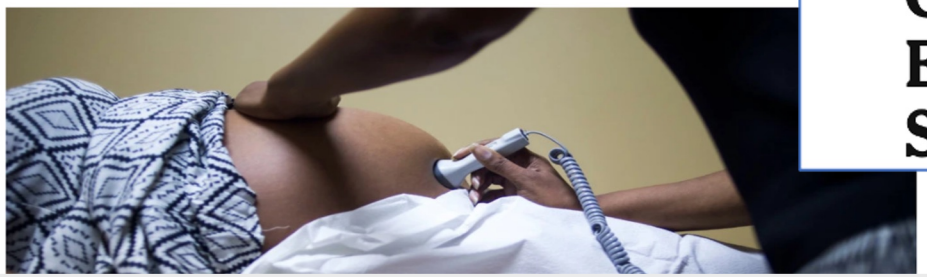
An estimated 700 to 900 women in the U.S. died from pregnancy-related causes in 2016. We have identified 120 of them so far.

by Nina Martin, July 17, 2017, 8 a.m. EDT

The New York Times

Huge Racial Disparities Found in Deaths Linked to Pregnancy

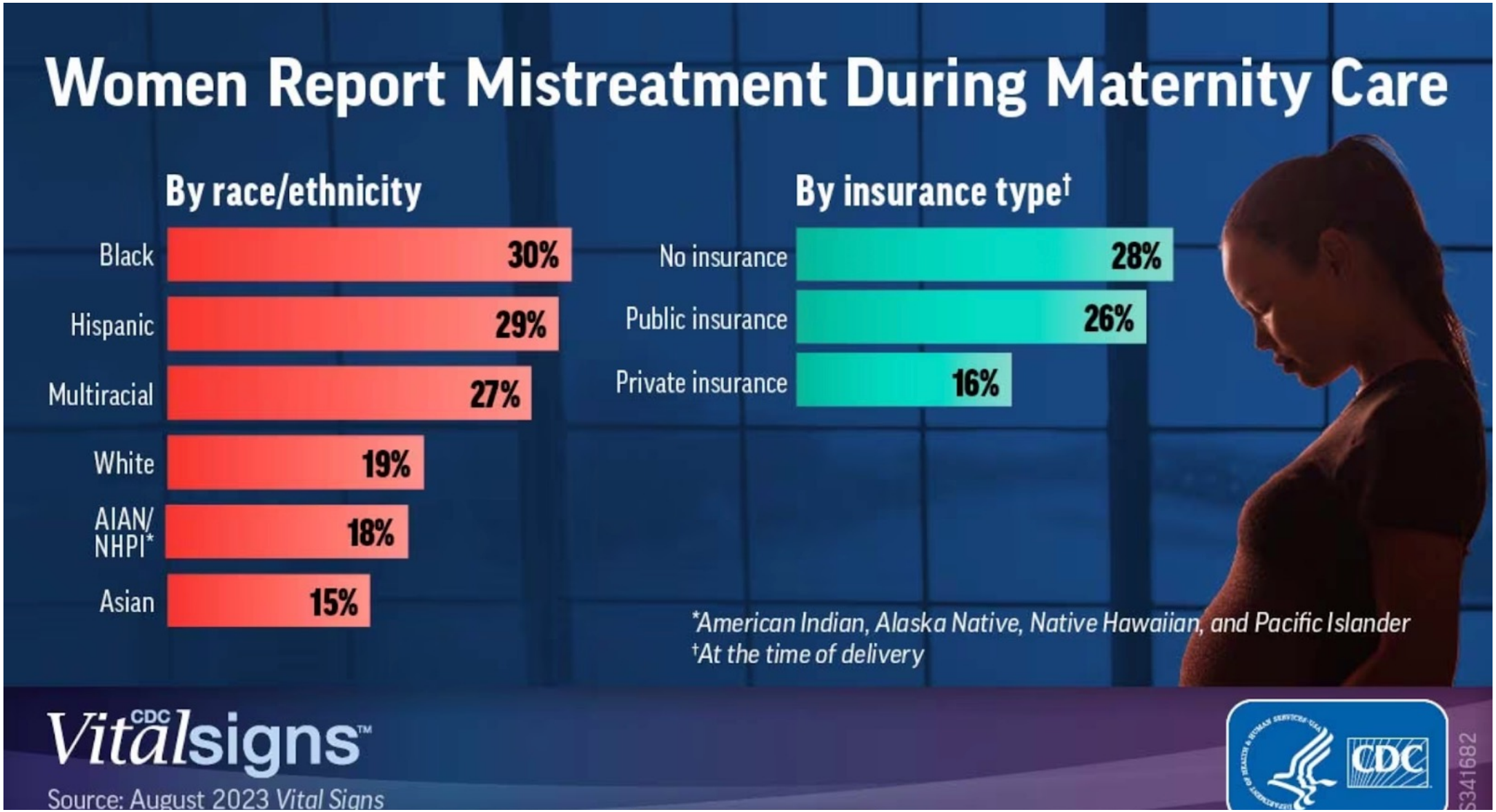
African-American, Native American and Alaska Native women are about three times more likely to die from causes related to pregnancy, compared to white women in the United State



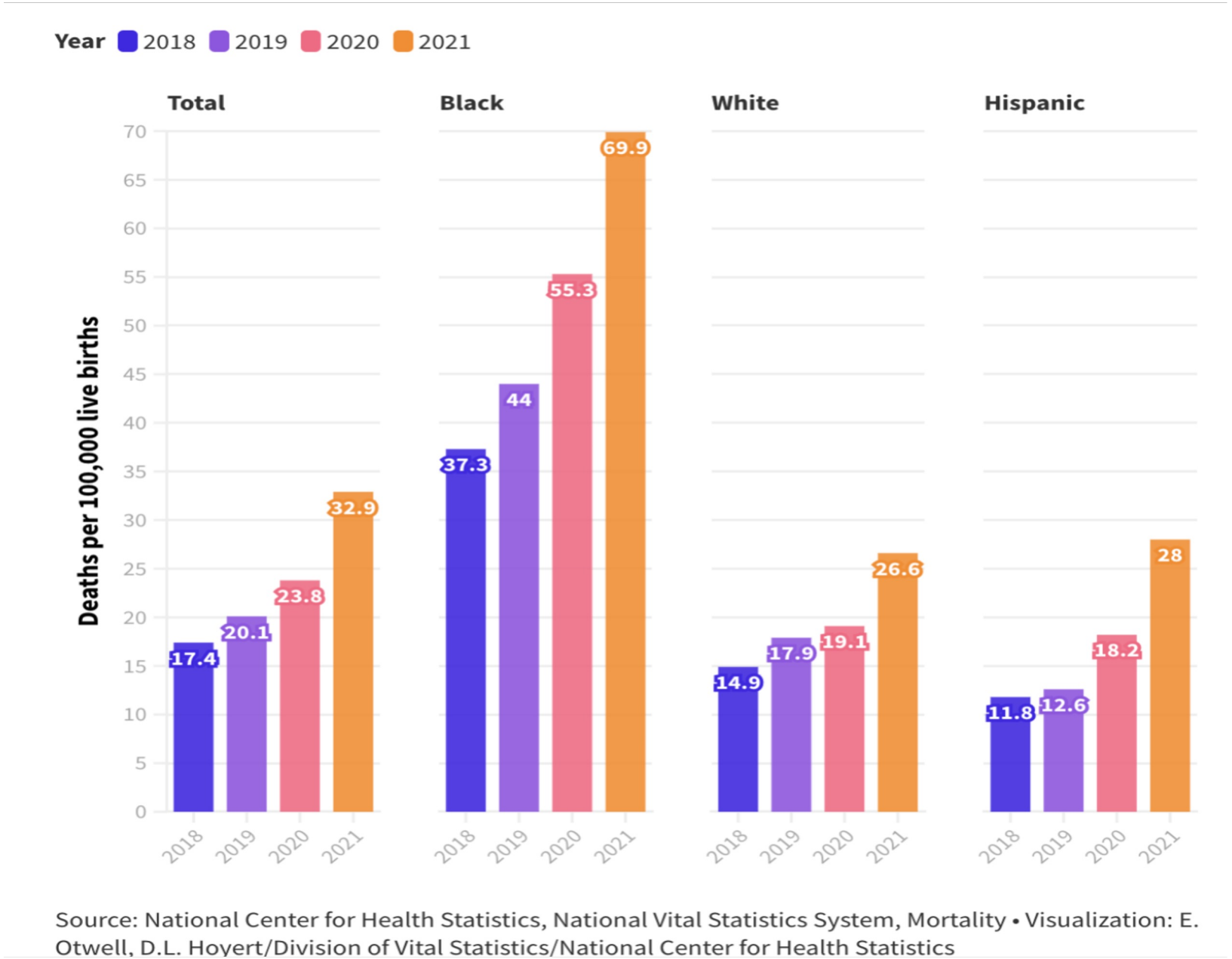
Childbirth Is Deadlier for Black Families Even When They're Rich, Expansive Study Finds

MDC

CMQCC


Women Report Mistreatment During Maternity Care
By race/ethnicity
Black 30%
Hispanic 29%
Multiracial 27%
White 19%
AIAN/ NHPI* 18%
Asian 15%
By insurance type†
No insurance 28%
Public insurance 26%
Private insurance 16%
*American Indian, Alaska Native, Native Hawaiian, and Pacific Islander
†At the time of delivery
CDC Vitalsigns™
Source: August 2023 Vital Signs
CDC
S341682

U.S. Maternal Mortality Rates by Race and Ethnicity, 2018-2021



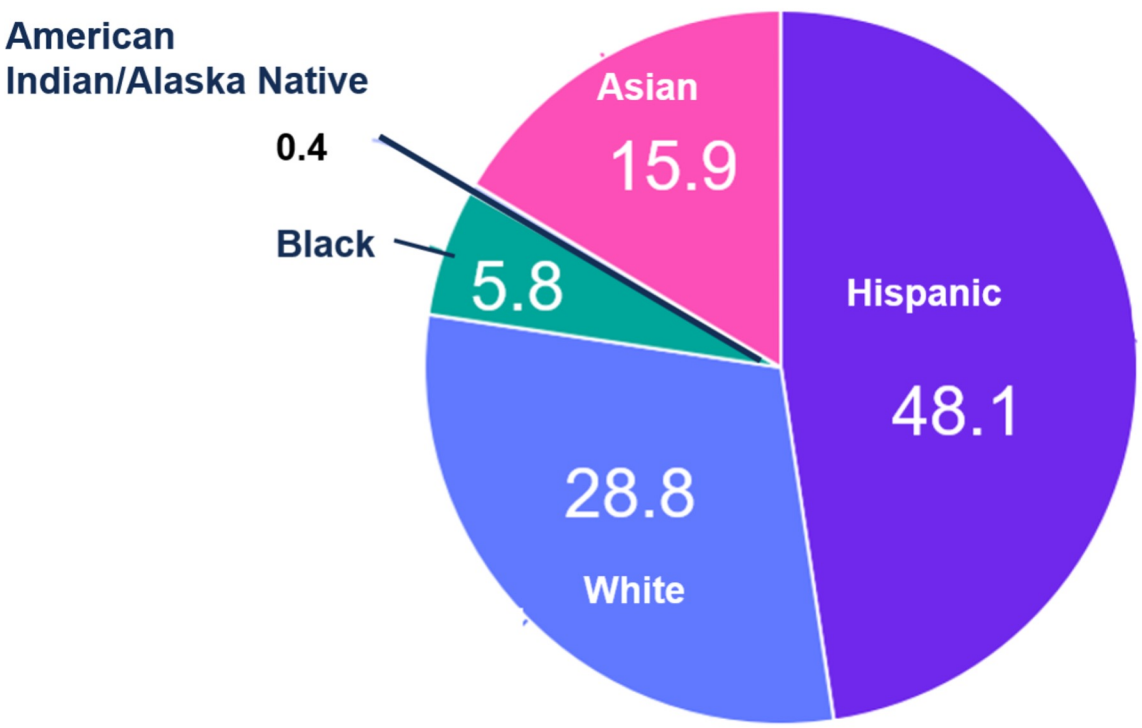
Source: National Center for Health Statistics, National Vital Statistics System, Mortality • Visualization: E. Otwell, D.L. Hoyert/Division of Vital Statistics/National Center for Health Statistics

MDC

CMQCC

California: Births by race/ethnicity 2018-2020

2020 Total California Births: 420,259



1 in 8 US Births are in CA

MARCH OF DIMES

All race categories exclude Hispanics. Percentages will not total 100 percent since missing ethnicity data are not shown.

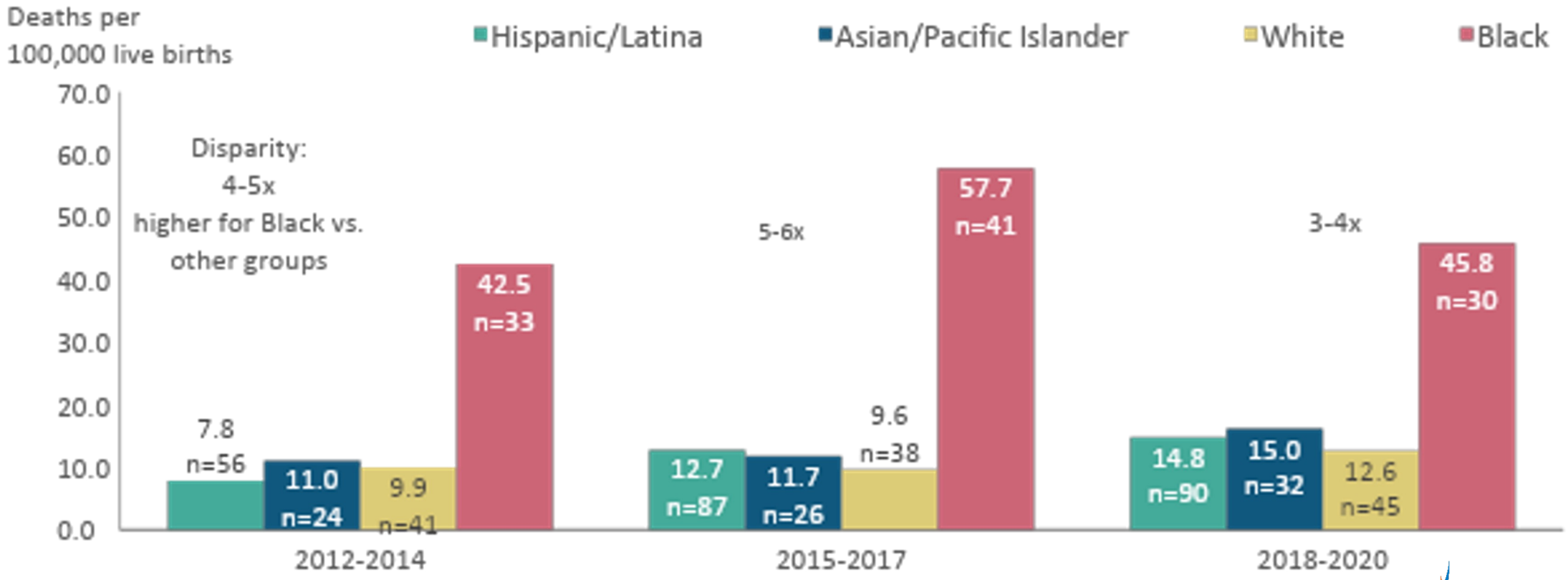
National Center for Health Statistics, final natality data. Retrieved March 29, 2023, from www.marchofdimes.org/peristats.

MDC

CMQCC

Pregnancy-Related Mortality Ratio by Race/Ethnicity

California 2012-2020



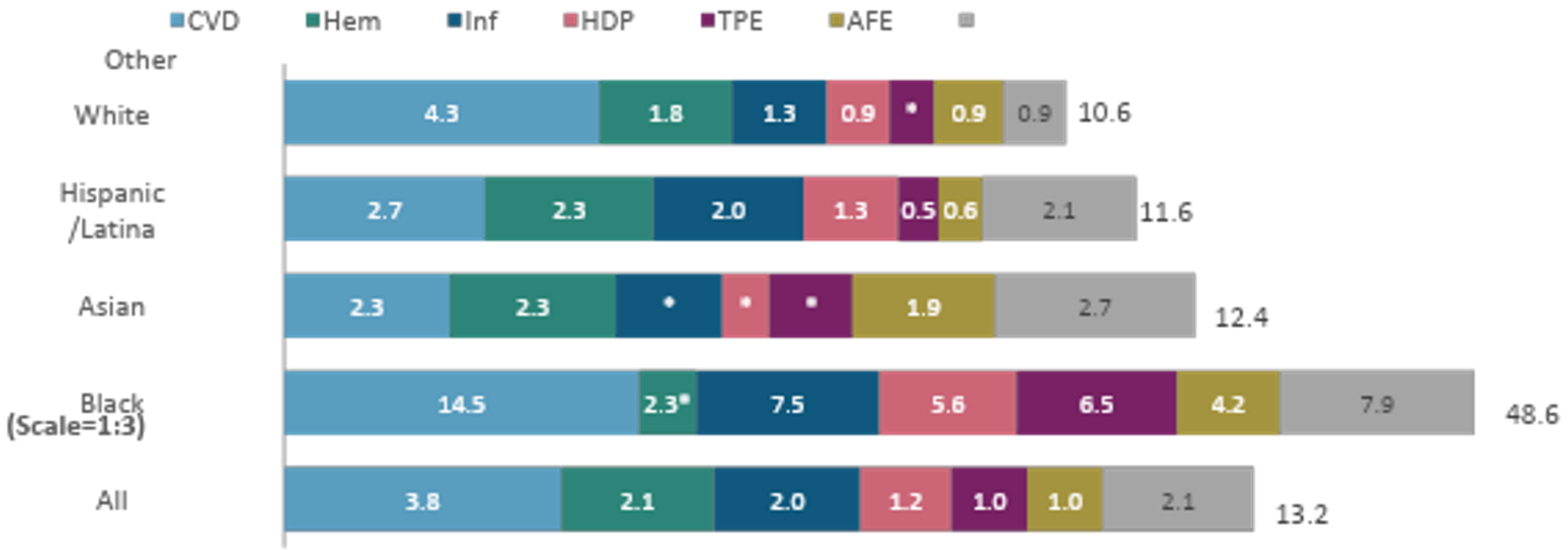
Pregnancy-related mortality ratio (PRMR) = Number of pregnancy-related deaths per 100,000 live births. Pregnancy-related deaths include deaths within a year of pregnancy from causes related to or aggravated by the pregnancy or its management, as determined by expert committee review.

CDPH | mcah

MDC

CMQCC

Pregnancy-Related Mortality Ratio by Race/Ethnicity and Cause California 2012-2020 (N=564)



Pregnancy-related mortality ratio (PRMR) = Number of pregnancy-related deaths per 100,000 live births. Pregnancy-related deaths include deaths within a year of pregnancy from causes related to or aggravated by the pregnancy or its management, as determined by expert committee review. Abbreviations: CVD = Cardiovascular disease; Hem = Hemorrhage; Inf = Sepsis or infection; HDP = Hypertensive disorders of pregnancy; TPE = Thrombotic pulmonary embolism; AFE = Amniotic fluid embolism. PRMRs of American Indian/Alaska Native, Native Hawaiian/Pacific Islander, Multiple-race and other races are not shown due to small counts

* Unstable ratio; n<10

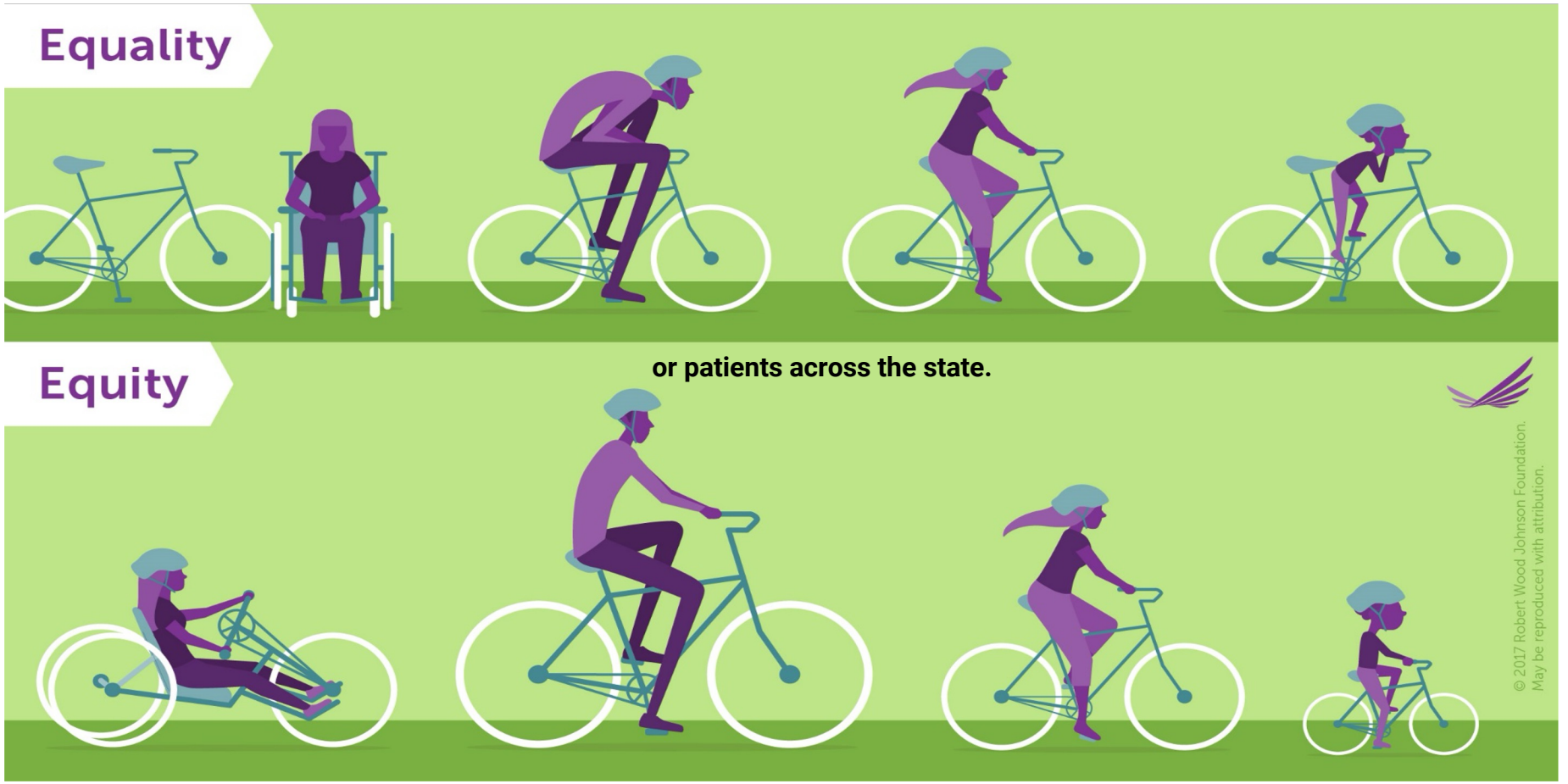
CDPH | mcah

MDC

CMQCC

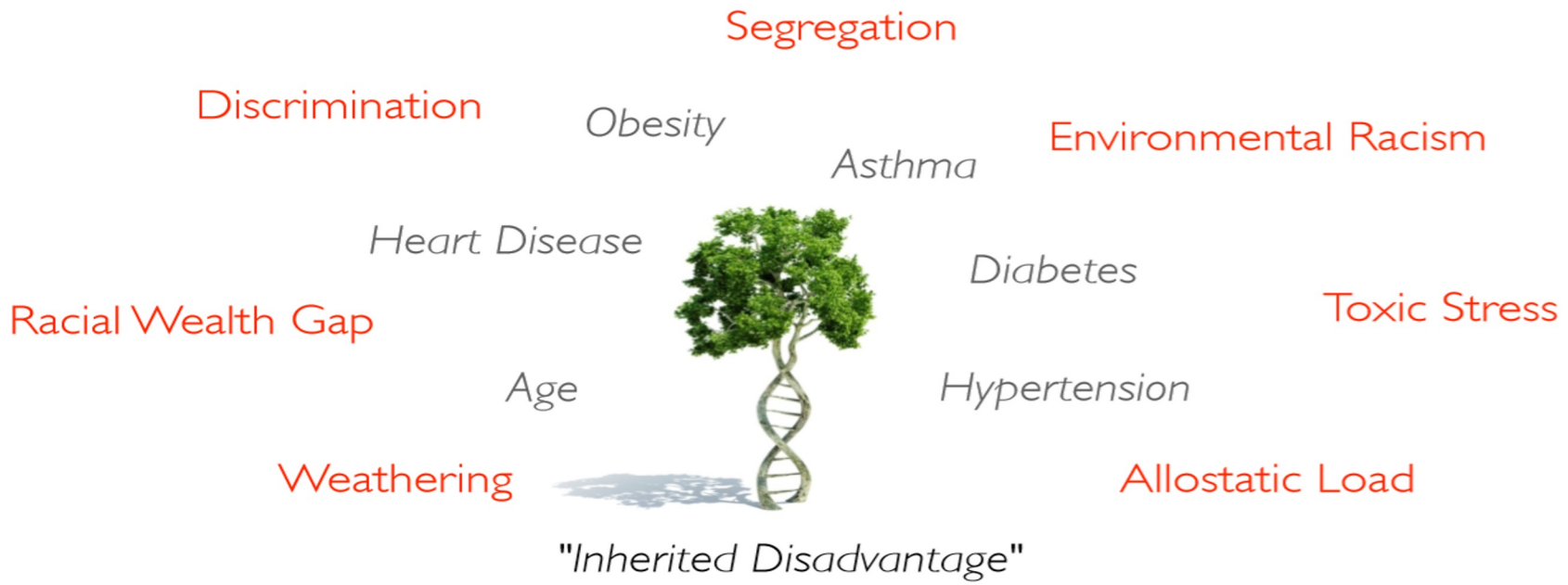
What is health equity?

“I treat everyone the same”



How is implicit bias created?

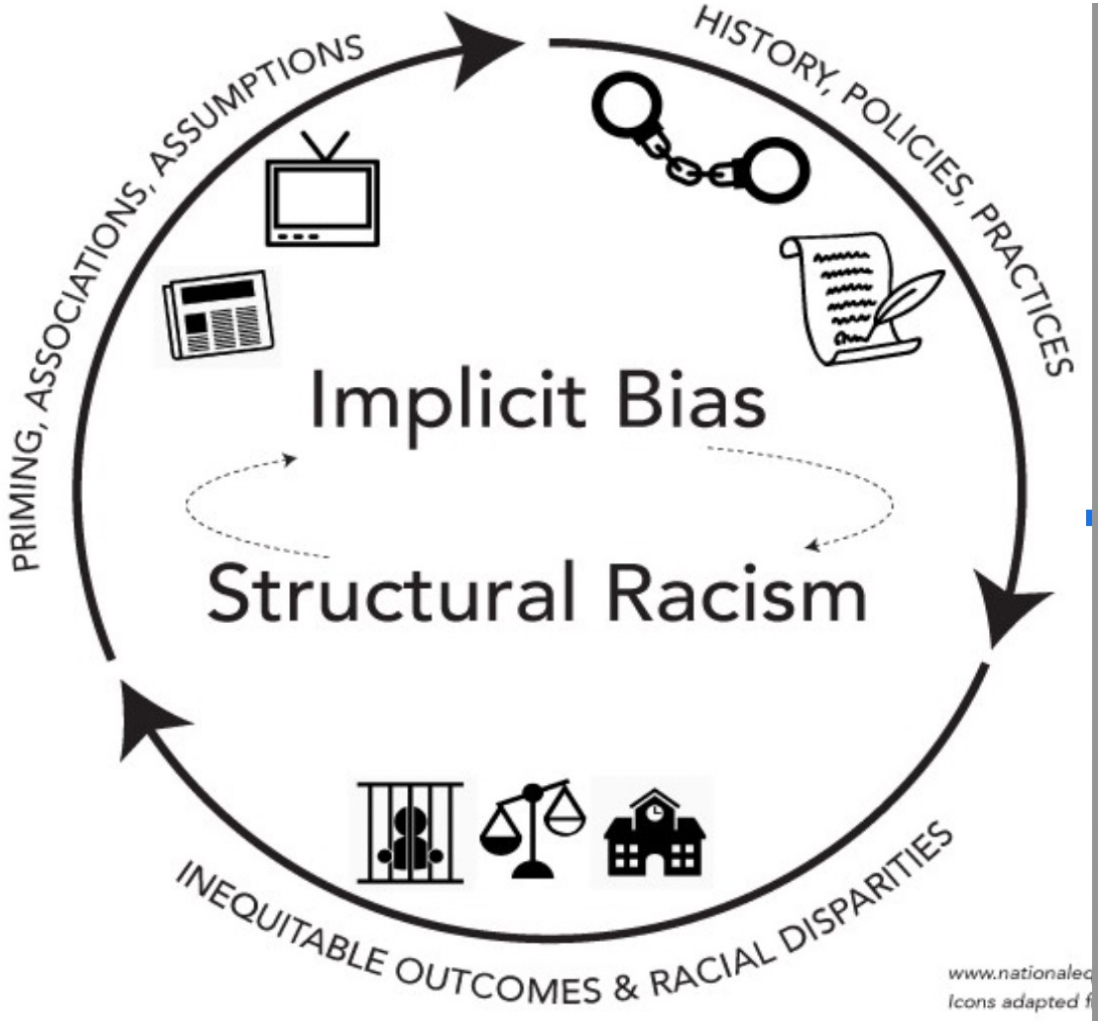
“Inherited Disadvantage”



The physical and structural environment in which humans grow, learn, work and play shapes *intergenerational* population health.

Jones CP. Levels of racism: a theoretic framework and a gardener's tale. *Am J Public Health*. 2000;90(8):1212-1215.

Structural racism → Implicit bias



- GI bill education loans
- Civil rights /voting rights
- Federal housing administration (FHA) loans--> Residential segregation
- Access to green space, physical safety
- Access to fresh groceries
- Hiring and job advancement

Strategic Framework for Operationalizing Equity

Vision

Health equity for women and families through identification and dismantling of perinatal healthcare disparities

Reliably Measure

Identify, document, and measure care disparities

Remove Barriers

Identify and remove care delivery system barriers

Empower Patients

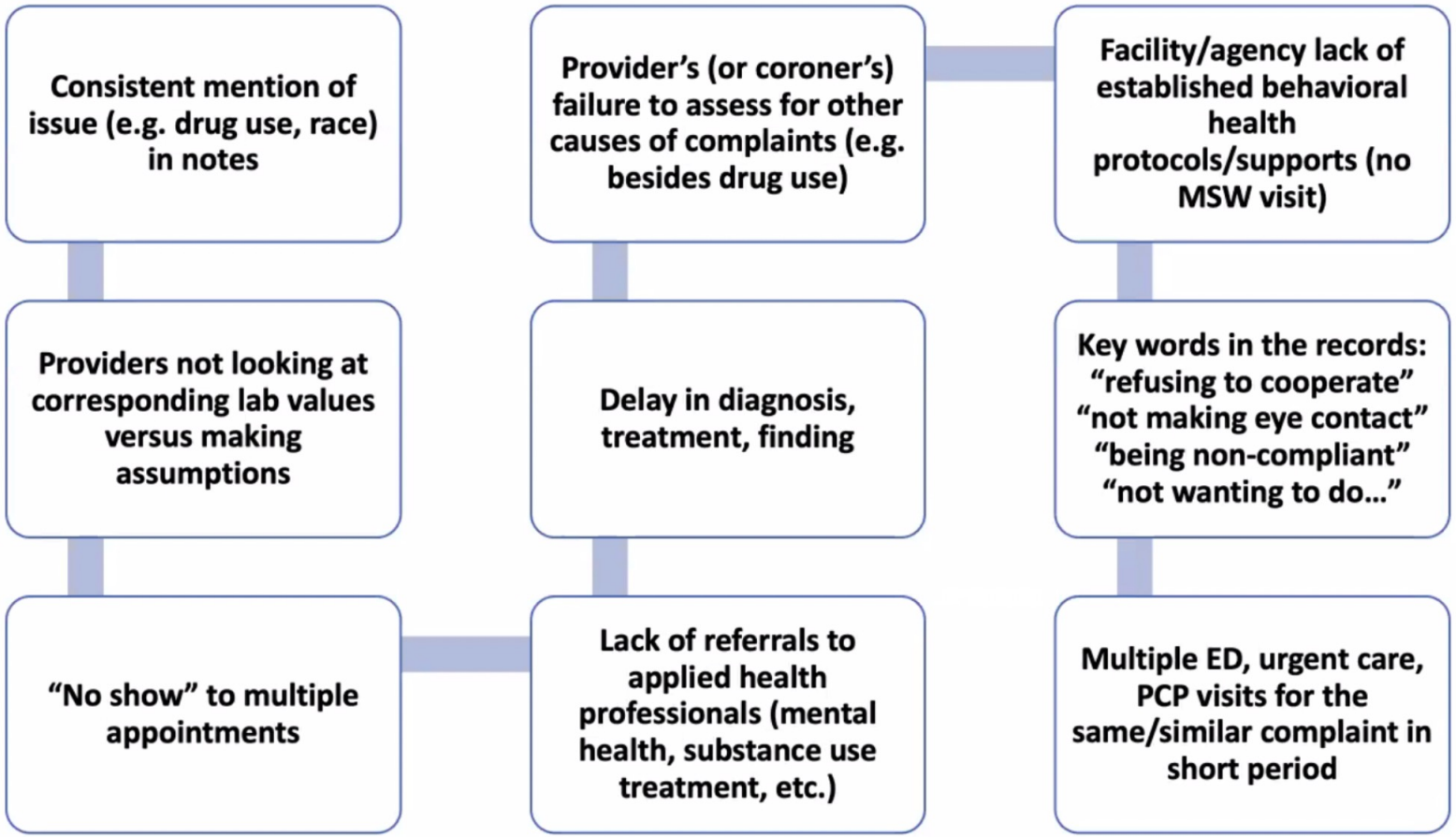
Enable patients to make health promoting decisions

Engage Clinicians and Staff

Educate, activate, and recruit diverse and inclusive clinicians and staff

Where do we see bias showing up?

Operationalizing stigma and discrimination



Source: From Washington State Department of Health – Maternal Mortality Review Process

Implicit bias examples

- NICU visitation
- Medical record envelopes
- Nurses station conversation
- Addressing colleagues

How do we move beyond training to integrate what we know about bias into our maternal health equity efforts?

Comprehensive Approach to Addressing Disparities

CMQCC Initiatives & Projects

- Anemia
- Community Birth Partnership
  - Team-Based Care
  - Midwife Integration
  - Partnering with Doulas
  - Improving Transfer of Care
- Preeclampsia
  - Low-Dose Aspirin Campaign
- Pregnancy Associated Mortality Review
- Sepsis
- Postpartum Redesign

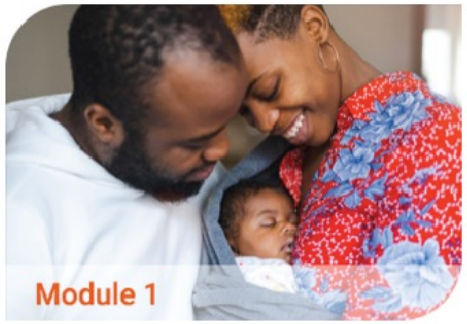
New Equity Tool Now Available to California Hospitals

CMQCC

MDC

CMQCC

Module Overview



Understand the Need for Birth Equity to Enhance Equity, Reduce Disparities, Increase Safety, and Meet Regulatory and Legislative Requirements.

Identify Opportunities for Collecting and Sharing Stratified Data on Patient Experience and Outcomes.

Examine Current Equity Practices to Implement Informed and Meaningful Action.

Leverage Patient Care Process and Outcome Data to Address Obstetric Disparities

Create a Culture of Respectful Care

Integrating Community Collaboration


US Maternal Mortality
Improved data collecti
Bias and Discrimin ation
US Healthcare Expenditures
Structural racism
No Guaranteed Health Coverage
Increasing wealth inequality
No Paid Parental Leave
Increasing cesarean rates
No Guaranteed Home Visits
Shortage OB-GYNs Midwives
Social Determinants of Health
Chronic conditions increasing
Medicaid ends 60 days PP in many states
Medicaid covers 41% of births


Data & Performance Improvement Projects
Community collaboration
Recruitment Strategies
Pilots / Local Initiatives
Ongoing Presentations & Invited Speakers
Ongoing Unconscious Bias Training
Leveraging Technology

NTSV Equity Structure Measures Tracking Tool

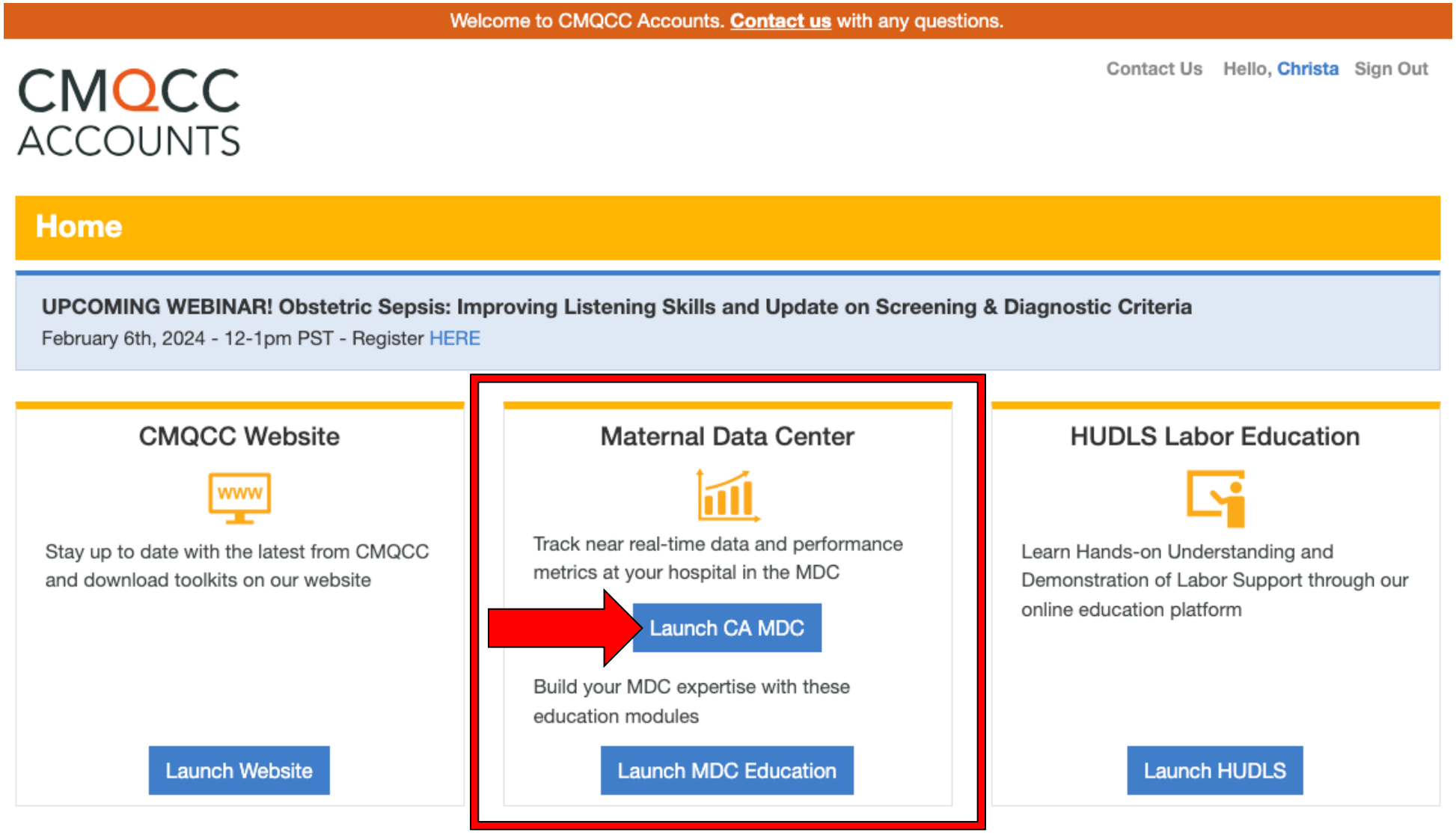
Christa Sakowski MSN, RN, C-ONQS, C-EFM, CLE
CMQCC Clinical Lead

Maternal Data Center (MDC) NTSV Equity Structure Measure Tracking Tool

- Can be accessed in the MDC by anyone with CA MDC access.
- Hospital MDC Administrator or Data-entry Status user-type needed to complete the checklist.

Structure Measures

- Capacity, systems, and processes to provide high-quality care. For example:
  - Physical equipment standardly used in care (i.e. hemorrhage cart)
  - Policies in place to guide care
  - Routine debriefing of cases


Welcome to CMQCC Accounts. Contact us with any questions.
CMQCC ACCOUNTS
Contact Us
Hello, Christa
Sign Out
Home
UPCOMING WEBINAR! Obstetric Sepsis: Improving Listening Skills and Update on Screening & Diagnostic Criteria
February 6th, 2024 - 12-1pm PST - Register HERE
CMQCC Website
www
Stay up to date with the latest from CMQCC and download toolkits on our website
Launch Website
Maternal Data Center
Track near real-time data and performance metrics at your hospital in the MDC
Launch CA MDC
Build your MDC expertise with these education modules
Launch MDC Education
HUDLS Labor Education
Learn Hands-on Understanding and Demonstration of Labor Support through our online education platform
Launch HUDLS

Alpha Medical Center Aug - Oct 2020

Data Entry Status

Favorite Measures

Anemia on Admission	25.0%
Cesarean Birth: NTSV - Nullip Term Singleton Vertex (PC-02: Current)	18.2%
Chorioamnionitis Among Maternal Cases	4.0%
Early Elective Delivery (PC-01)	20.0%
Hemorrhage Frequency	7.3%
Hypertension Frequency	11.1%
QBL Cumulative Value	100.0%
SMM Excluding Transfusion-Only Cases	1.0%

View all 15 Favorites: Table →
View all 15 Favorites: Graphs →

Clinical Quality Measures view all 130 by name, reporting org, or topic

Early Elective Delivery (PC-01)	20.0%
Cesarean Birth: NTSV - Nullip Term Singleton Vertex (PC-02: Current)	18.2%
Cesareans after Labor Induction: NTSV Cases	32.0%
Unexpected Newborn Complications: Severe (PC-06.1)	8.6
SMM Excluding Transfusion-Only Cases	1.0%

Compare Two Measures →

Data Quality Measures view all 36 by name or topic

Upcoming Webinar: MDC Refresher Training

Join us for a Maternal Data Center (MDC) Refresher Training on **Tuesday, 1/30 at 12pm PT**. This webinar is a review of the basic functionality of the MDC and is intended for new MDC users, as well as any users who would like a review.

Please register in advance here.

October 2020 Live Births	2020 Year-to-Date Live Births
265 from 291 in 2019 ↓ 8.9%	2743 from 2753 in 2019 ↓ 0.4%

Equity: Race & Ethnicity Reports & Tools

Cesarean Birth: NTSV - Nullip Term Singleton Vertex (PC-02: Current)
SMM Excluding Transfusion-Only Cases
Race & Ethnicity Distributions
Missing / Unknown Race & Ethnicity
NTSV Cesarean Equity Learning Initiative

Additional Equity Resources →

Race & Ethnicity PDF

Patient Safety Watch

Hemorrhage Patient Safety
Joint Commission Maternal Safety Standards Tool: Hemorrhage
Preeclampsia Patient Safety
Joint Commission Maternal Safety Standards Tool: HTN/Preeclampsia

NTSV Cesarean Equity Learning Initiative

Performance Trend | PDF

1 of 18

Equity Structure Measures

	Item	Confirmed in Place on (estimated)	
1	Create/enhance a unit council to address equity concerns and elevate the voices of consumers. WHY: Creating a unit equity council or identifying equity as a standard agenda item on an established quality committee elevates the importance of the equity focus and creates a designated space for interactive dialogue and action planning.	MM/DD/YYYY or Not In Place	✗
2	Define the unit equity champion role. WHY: Identifying equity as everyone's responsibility often results in it being no one's responsibility. Take the opportunity to acknowledge those passionate informal leaders who are energized to improve unit culture and equip them to be observant of opportunities to address inequities in real time.	01/01/2023 or Not In Place	✓
3	Complete an annual equity readiness assessment (e.g., SWOTT Analysis, IHI). WHY: The use of a standard tool to establish a baseline equity readiness assessment outlines the change opportunities and creates a pathway for the prioritization of change ideas. Baseline readiness assessments include 3 perspectives; organizational, staff/provider, and patient/customer. The assessment should not be viewed as a solitary checklist line item. A scheduled plan for reassessment ensures a dynamic process.	MM/DD/YYYY or Not In Place	✗
4	Administer a "Culture of Equity" survey annually and develop an action plan based on the results. WHY: The "Culture of Equity Survey" is an example of a tool that provides the unique perspective of observations of bedside staff and providers on a culture that is rooted in equitable and respectful care practices. It is imperative to capture the voices of all individuals that touch the patient/environment.	MM/DD/YYYY or Not In Place	✗
5	Develop an ongoing equity education process that goes beyond implicit bias training. WHY: Equity education does not stop with implicit bias training. It requires a multi-faceted approach that includes historical perspectives to avoid a repetition of past aggressions. Equity education should be ongoing and inclusive of interactive dialogue that is open to challenge and discomfort.	MM/DD/YYYY or Not In Place	✗

Equity Structure Measures (10)

1 Create/enhance a unit council to address equity concerns and elevate the voices of consumers.

WHY: Creating a unit equity council or identifying equity as a standard agenda item on an established quality committee elevates the importance of the equity focus and creates a designated space for interactive dialogue and action planning.

2 Define the unit equity champion role.

WHY: Identifying equity as everyone's responsibility often results in it being no one's responsibility. Take the opportunity to acknowledge those passionate informal leaders who are energized to improve unit culture and equip them to be observant of opportunities to address inequities in real time.

3 Complete an annual equity readiness assessment (e.g., SWOTT Analysis, IHI).

WHY: The use of a standard tool to establish a baseline equity readiness assessment outlines the change opportunities and creates a pathway for the prioritization of change ideas. Baseline readiness assessments include 3 perspectives; organizational, staff/provider, and patient/customer. The assessment should not be viewed as a solitary checklist line item. A scheduled plan for reassessment ensures a dynamic process.

4 Administer a "Culture of Equity" survey annually and develop an action plan based on the results.

WHY: The "Culture of Equity Survey" is an example of a tool that provides the unique perspective of observations of bedside staff and providers on a culture that is rooted in equitable and respectful care practices. It is imperative to capture the voices of all individuals that touch the patient/environment.

5 Develop an ongoing equity education process that goes beyond implicit bias training.

WHY: Equity education does not stop with implicit bias training. It requires a multi-faceted approach that includes historical perspectives to avoid a repetition of past aggressions. Equity education should be ongoing and inclusive of interactive dialogue that is open to challenge and discomfort.

6 Develop an ongoing review schedule for auditing policies/processes with an equity lens.

WHY: Policies, procedures, and practices (PPP) can support or undermine respectful care at both the hospital and unit levels. While typically crafted to meet regulatory or operational requirements, these guardrails that guide behaviors and actions can perpetuate implicit bias and unfairly disadvantage patients and staff from particular racial and ethnic groups. These formal and informal rules must be crafted mindfully to avoid unintentional harm.

- **Policies and Procedures**
- **Admission/Discharge/Transfer forms**
- **Mission, vision, and values statements**
- **Job descriptions and professional conduct standards**
- **Marketing and education materials**

7 Create equity oriented onboarding process.

WHY: Developing an approach to influence unit hiring that prioritizes cultural concordance with your community and highlights the importance of maintaining health equity principles on the unit builds trust with the community and patients served.

8 Develop a "Commitment to Respectful Care" document and dissemination process.

WHY: A critical aspect of building internal and external trust with regard to equity is to embed a culture of respectful care that permeates all unit interactions. Obtaining a commitment to respectful care from all healthcare team members elevates the value of respectful care by the leadership of the unit and organization.

9 Develop a process for equity-oriented patient feedback.

WHY: Patient-reported experiences can yield numerous potential benefits. They can encourage improved patient engagement and be utilized to clarify your patients' priorities, which can potentially improve shared decision-making between patients and providers. Additionally, they can identify the benefits or harms of interventions that may need to be more readily visible to the care team. Benefits to patients include a better understanding of their condition and personal care needs, improved communication regarding symptoms, and increased satisfaction and trust.

Show details

10 Engage with community organizations serving perinatal patients.

WHY: Community organizations have access to and the trust of the patient base. Establishing bidirectional communication with community partners can be foundational to the development of community partnerships to expand the trust of the patients and community served by the organization.

NTSV Structure Measures (8)

1 Engage in transparent sharing of stratified (race/ethnicity, insurance, provider, etc.) data reports.

WHY: Routine review of overall patient outcomes may create a false sense of wellbeing if the aggregated data reflects outcomes within normal limits which often masks variation within the data. Stratified data may show that not all patients are equal beneficiaries of the care practices provided. The MDC provides analyses that indicate where a hospital should concentrate in order to reduce cesarean rates. Provider-level feedback about individual NTSV cesarean rates that are unblinded and shared can have a significant and rapid effect on clinical practice.

2 Implement a protocol and support tools for patients who present in latent labor to safely encourage early labor at home.

WHY: Latent phase admission is associated with higher rates of cesarean. The decision to admit is complicated by the patient's level of discomfort and the expectation by some patients to be admitted upon arrival. Education and material with specific guidance for partners and family members as to how to best support the birthing person in early labor can assist with coping prior to the active phase. Therapeutic rest through administration of medication can be considered as an alternative to admission in many instances.

3 Perform a review of induction procedures.

WHY: Many factors affect the risk of cesarean after the decision for induction of labor has been made. These factors vary by provider and by facility. How induction is managed may be the determining factor for whether the risk of cesarean is increased. The ACOG/SMFM Consensus Statement on Safe Prevention of the Primary Cesarean Delivery gives guidance for the selection of appropriate candidates for induction of labor.

4 Implement training/procedures for identification and appropriate interventions for malpositions (e.g., OP/OT).

WHY: Vertex malpositions account for 12% of all cesarean births performed due to dystocia. Labor support techniques and positioning can assist with malpositions in the active phase. When labor dystocia occurs in the second stage, vaginal birth is optimized when clinicians determine that the woman has a malpositioned fetus early on and subsequently intervene to promote progress. Digital/manual rotation of the fetus from the OP position to the OA position is associated with lower rates of cesarean birth.

5 Integrate cesarean reduction tools (labor dystocia checklist, order sets, or other tracking tools) into the electronic health record.

WHY: Utilization of the EHR may assist with decision support, improve efficiency of care, and make quality and safety metrics and up-to-date clinical guidelines for common conditions easily obtainable. Expanded use of the EHR through the implementation of BPAs, standardized order sets, semi-automated treatment algorithms, alerts, and reminders have been shown to improve patient safety indicators, patient outcomes, and decrease length of stay.

6 Develop a policy to integrate doulas into the birth care team.

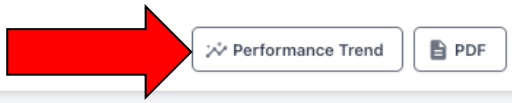
WHY: Continuous labor support is associated with a significant reduction in cesarean birth. When doulas are utilized in a way that allows them to function appropriately in their unique and integral role, they can simultaneously advocate for birthing people and act as helpful allies to nurses and providers. Because of the potential to reduce birth disparities, doula programs are rapidly growing.

7 Develop standard criteria and a process for reviewing fallout cases.

WHY: The MDC creates a case list appropriate for the improvement topic (e.g. cesarean for labor dystocia or cesarean for fetal concern). After simple chart reviews, using a labor dystocia checklist based on the ACOG/SMFM guidelines outlier cases can be identified. Ideally, this review occurs throughout the labor and is utilized as a communication tool as well.

8 Develop obstetric-specific resources and protocols to support patients, and families through an unexpected/traumatic cesarean.

WHY: Even when birthing people feel they received competent clinical care, the lack of communication afterward leaves them feeling alone. Patients of color report high rates of feeling disrespected and unheard. Clinicians should be alert for behavior or emotional states that are outside the normal range of postpartum responses (detachment, dissociation, and intrusive thoughts). Assessment and discharge planning for follow-up care is essential for all women who have experienced a potentially traumatic birth experience.



Alpha Medical Center > NTSV Cesarean Equity Learning Initiative

NTSV Cesarean Equity Learning Initiative

Performance Trend | PDF

1 of 18

Equity Structure Measures

	Item	Confirmed in Place on (estimated)	
1	Create/enhance a unit council to address equity concerns and elevate the voices of consumers. WHY: Creating a unit equity council or identifying equity as a standard agenda item on an established quality committee elevates the importance of the equity focus and creates a designated space for interactive dialogue and action planning.	MM/DD/YYYY or Not In Place	✗
2	Define the unit equity champion role. WHY: Identifying equity as everyone's responsibility often results in it being no one's responsibility. Take the opportunity to acknowledge those passionate informal leaders who are energized to improve unit culture and equip them to be observant of opportunities to address inequities in real time.	01/01/2023 or Not In Place	✓
3	Complete an annual equity readiness assessment (e.g., SWOTT Analysis, IHI). WHY: The use of a standard tool to establish a baseline equity readiness assessment outlines the change opportunities and creates a pathway for the prioritization of change ideas. Baseline readiness assessments include 3 perspectives; organizational, staff/provider, and patient/customer. The assessment should not be viewed as a solitary checklist line item. A scheduled plan for reassessment ensures a dynamic process.	MM/DD/YYYY or Not In Place	✗
4	Administer a "Culture of Equity" survey annually and develop an action plan based on the results. WHY: The "Culture of Equity Survey" is an example of a tool that provides the unique perspective of observations of bedside staff and providers on a culture that is rooted in equitable and respectful care practices. It is imperative to capture the voices of all individuals that touch the patient/environment.	MM/DD/YYYY or Not In Place	✗
5	Develop an ongoing equity education process that goes beyond implicit bias training. WHY: Equity education does not stop with implicit bias training. It requires a multi-faceted approach that includes historical perspectives to avoid a repetition of past aggressions. Equity education should be ongoing and inclusive of interactive dialogue that is open to challenge and discomfort.	MM/DD/YYYY or Not In Place	✗

Trend: Bundle: NTSV Cesarean Equity Learning Initiative

Graph & Data Downloads

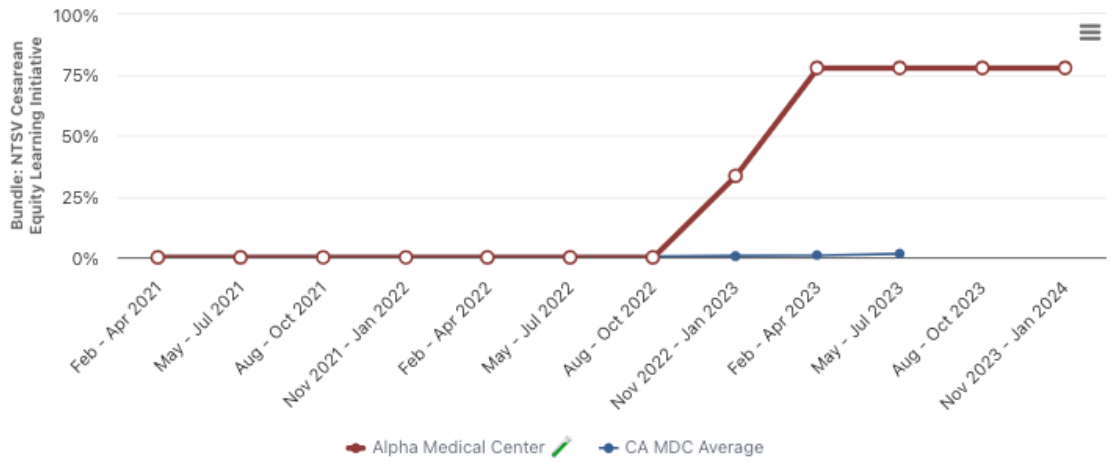
Start Date: 02/01/2021 | Frequency: Rolling Quarter | Benchmark: None

Comparisons: Alpha Medical Center, CA MDC Average

Add Filter

MEASURE

- Hospital Trend
- Definition/Algorithm
- Intervention Chart



Open circles in the trend line indicate small denominator counts (< 30) you should interpret cautiously. Click here to learn more.

	Alpha Medical Center	CA MDC Average
Nov 2023 - Jan 2024	77.8%	N/A
Aug - Oct 2023	77.8%	N/A
May - Jul 2023	77.8%	1.5%
Feb - Apr 2023	77.8%	0.8%

NTSV Cesarean Equity Learning Initiative

1 of 18

Equity Structure Measures

	Item	Confirmed in Place on (estimated)	
1	Create/enhance a unit council to address equity concerns and elevate the voices of consumers. WHY: Creating a unit equity council or identifying equity as a standard agenda item on an established quality committee elevates the importance of the equity focus and creates a designated space for interactive dialogue and action planning.	MM/DD/YYYY or Not In Place	✗
2	Define the unit equity champion role. WHY: Identifying equity as everyone's responsibility often results in it being no one's responsibility. Take the opportunity to acknowledge those passionate informal leaders who are energized to improve unit culture and equip them to be observant of opportunities to address inequities in real time.	01/01/2023 or Not In Place	✓
3	Complete an annual equity readiness assessment (e.g., SWOTT Analysis, IHI). WHY: The use of a standard tool to establish a baseline equity readiness assessment outlines the change opportunities and creates a pathway for the prioritization of change ideas. Baseline readiness assessments include 3 perspectives; organizational, staff/provider, and patient/customer. The assessment should not be viewed as a solitary checklist line item. A scheduled plan for reassessment ensures a dynamic process.	MM/DD/YYYY or Not In Place	✗
4	Administer a "Culture of Equity" survey annually and develop an action plan based on the results. WHY: The "Culture of Equity Survey" is an example of a tool that provides the unique perspective of observations of bedside staff and providers on a culture that is rooted in equitable and respectful care practices. It is imperative to capture the voices of all individuals that touch the patient/environment.	MM/DD/YYYY or Not In Place	✗
5	Develop an ongoing equity education process that goes beyond implicit bias training. WHY: Equity education does not stop with implicit bias training. It requires a multi-faceted approach that includes historical perspectives to avoid a repetition of past aggressions. Equity education should be ongoing and inclusive of interactive dialogue that is open to challenge and discomfort.	MM/DD/YYYY or Not In Place	✗

CMQCC
California Maternal Quality Care Collaborative

NTSV Cesarean Equity Learning Initiative

Alpha Medical Center ?

NICU Level III/IV
MCH Director: Emily McCormick
MCH Director Email: emkmccormick+2@gmail.com

Overall Percent Complete: 77%

	NTSV Cesarean Equity Learning Initiative	Date Completed:
1	Create/enhance a unit council to address equity concerns and elevate the voices of consumers.	*Not in Place*
2	Define the unit equity champion role.	*01/01/2023*
3	Complete an annual equity readiness assessment (e.g., SWOTT Analysis, IHI).	*01/20/2023*
4	Administer a "Culture of Equity" survey annually and develop an action plan based on the results.	*01/20/2023*
5	Develop an ongoing equity education process that goes beyond implicit bias training.	*02/01/2023*
6	Develop an ongoing review schedule for auditing policies/processes with an equity lens.	*In Progress*
	Policies and Procedures	☑
	Admission/Discharge/Transfer forms	☑
	Mission, vision, and values statements	☑
	Job descriptions and professional conduct standards	☑
	Marketing and education materials	☐
7	Create equity oriented onboarding process.	*01/20/2023*
8	Develop a "Commitment to Respectful Care" document and dissemination process.	*01/20/2023*
9	Develop a process for equity-oriented patient feedback.	*01/20/2023*
	Perform qualitative analysis of emerging trends from narrative feedback.	☑
	Perform comparative analysis of stratified results.	☑
10	Engage with community organizations serving perinatal patients.	*Not in Place*
1	Engage in transparent sharing of stratified (race/ethnicity, insurance, provider, etc.) data reports.	*02/01/2023*
2	Implement a protocol and support tools for patients who present in latent labor to safely encourage early labor at home.	*02/01/2023*
3	Perform a review of induction procedures.	*02/01/2023*
4	Implement training/procedures for identification and appropriate interventions for malpositions (e.g., OP/OT).	*02/20/2023*
5	Integrate cesarean reduction tools (labor dystocia checklist, order sets, or other tracking tools) into the electronic health record.	*02/20/2023*
6	Develop a policy to integrate doulas into the birth care team.	*02/20/2023*
7	Develop standard criteria and a process for reviewing fallout cases.	*02/20/2023*
8	Develop obstetric-specific resources and protocols to support patients, and families through an unexpected/ traumatic cesarean.	*Not in Place*

"Not in Place" button clicked

Some sub-items completed

Sub-items completed and date filled in

Date filled in

Questions?

Upcoming Events

Upcoming Events

Thank You For Joining Us Today!

End preventable morbidity, mortality, and racial disparities in California maternity care

TOOLKITS

Evidence-based toolkits on leading causes of preventable maternal morbidity and mortality

IMPLEMENTATION

Coaching on how to implement best practices and sharing among member hospitals

MATERNAL DATA CENTER

Near real-time benchmarking data to support hospitals' quality improvement

ENGAGEMENT

Engaging partners around aligned goals and promoting patient awareness

Follow us! Facebook, Instagram, Twitter, and LinkedIn