The Perinatal-Neonatal Quality Improvement Network of Massachusetts

PNQIN Maternal Equity Bundle Toolkit

Version 2, July 2025

For the most up to date version and resources please refer to the [Maternal Equity Bundle Resource webpage]

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Dear valued colleagues,

From Perinatal-Neonatal Quality Improvement Network of Massachusetts (PNQIN)'s Alliance for Innovation on Maternal Health (AIM) Initiative to improve maternal outcomes, we are excited to introduce this toolkit on the Maternal Equity Bundle. PNQIN launched the Massachusetts AIM Initiative in 2019 to answer a national call to prioritize and improve maternal health and safety for all. Rising rates of pregnancy-related death and injury are unacceptable. Persistent racial and ethnic disparities are alarming.

The maternal death rate for 2021, from the National Center for Health Statistics, is 32.9 deaths per 100,000 live births, an increase from the rate in 2020 at 23.8 per 1000,000. Inequities persist as well. **Black and Indigenous birthing people remain three to four times more likely than others to die from pregnancy-related causes.** A rate of 69.9 is reported for non-Hispanic Black birthing people; almost three times higher than non-Hispanic white (26.6). Maternal death is a tragic event, and although total numbers are small, there is no acceptable number. Investigators estimate that **more than 80% of all maternal deaths are preventable**. Eliminating preventable deaths and the Black-white gap in maternal outcomes is a public health priority.

For every birthing person who dies, many more suffer life-threatening complications resulting from or worsened by pregnancy (SMM – severe maternal morbidity). This is also highest among Black and Native birthing people. **Massachusetts also has rising rates of SMM and racial inequities.** This initiative aims to improve birth outcomes for birthing people and families across Massachusetts.

The Maternal Equity Bundle was put together based on a comprehensive literature review and 25 interviews with invested parties and experts in maternal health equity, respectful care, and obstetric care quality. Bundle measures were created based on AIM Bundle in Reduction of Peripartum Racial & Ethnic Disparities, California and Illinois Equity Bundles and root codes and themes from interviews.

This toolkit can be used to help implement the Maternal Equity Bundle. We encourage and support all birthing hospitals in Massachusetts to participate, collaborate, learn and use these tools to examine and eliminate racial disparities. Equity is a central mission for PNQIN as well; our initiative addresses ways to integrate equity measures into previous AIM Hypertension and Hemorrhage bundles.

Standardization of health care delivery, collaborative quality improvement and listening to birthing people have been shown to improve outcomes and quality of care for all.

Thank you for supporting and participating in this important project. If you have questions regarding the enclosed materials, please contact us at PNQINAdmin@pnqinma.org.

Sincerely,
The PNQIN Maternal Equity Bundle Advisory Group

Sources: Hoyert DL. Maternal mortality rates in the United States, 2021. NCHS Health E-Stats. 2023. DOI: https://dx.doi.org/10.15620/cdc:124678
Trost S, Beauregard J, Chandra G, et al. Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019 | CDC. https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html
Diop H et al. Trends and inequities in severe maternal morbidity in Massachusetts: A closer look at the last two decades. doi:10.1371/journal.pone.0279161

PNQIN's implementation strategies are based on the Institute for Healthcare Improvement's (IHI) model for improvement and the AIM program implementation toolkit.

References:

1. Langley G, Nolan K, Nolan T, Norman C, Provost L. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance. 2nd ed. Jossey-Bass Publishers; 2009.
2. The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. Available at: www.IHI.org. Retrieved January 12,2021.

The PNQIN Equity Initiative

Year	Phase	Description
2016	Raise Awareness	Established PNQIN as an equity-based organization, noted in the mission
2018	Raise Awareness	Partnered with MA DPH initiative to shift organizational culture toward equity
2019	Raise Awareness	Joined AIM and launched AIM safety bundles with equity focus
2020	Build Equity Culture	Address racial inequities through measurement: • Utilize AIM SMM race/ethnicity data to engage teams • Racism & bias upstander training for teams & staff
2021	Drive Equity Action	Pair data with QI action: • Racial equity training • MA maternal equity legislation • Maternal equity bundle development
2022 - 2027	Drive Equity Action	Drive equity through action: • Maternal equity bundle launch • Webinar series to guide bundle • Monthly review of data to target areas of improvement

ACOG AIM Bundle:

Reduction of Peripartum Racial & Ethnic Disparities

READINESS

Every health system

- Establish systems to accurately document self-identified race, ethnicity, and primary language.
  - Provide system-wide staff education and training on how to ask demographic intake questions.
  - Ensure that patients understand why race, ethnicity, and language data are being collected.
  - Ensure that race, ethnicity, and language data are accessible in the electronic medical record.
  - Evaluate non-English language proficiency (e.g. Spanish proficiency) for providers who communicate with patients in languages other than English.
  - Educate all staff (e.g. inpatient, outpatient, community-based) on interpreter services available within the healthcare system.
- Provide staff-wide education on:
  - Peripartum racial and ethnic disparities and their root causes.
  - Best practices for shared decision making.
- Engage diverse patient, family, and community advocates who can represent important community partnerships on quality and safety leadership teams.

RECOGNITION

Every patient, family, and staff member

- Provide staff-wide education on implicit bias.
- Provide convenient access to health records without delay (paper or electronic), at minimal to no fee to the maternal patient, in a clear and simple format that summarizes information most pertinent to perinatal care and wellness.
- Establish a mechanism for patients, families, and staff to report inequitable care and episodes of miscommunication or disrespect.

RESPONSE

Every clinical encounter

- Engage in best practices for shared decision making.
- Ensure a timely and tailored response to each report of inequity or disrespect.
- Address reproductive life plan and contraceptive options not only during or immediately after pregnancy, but at regular intervals throughout a woman's reproductive life.
- Establish discharge navigation and coordination systems post childbirth to ensure that women have appropriate follow-up care and understand when it is necessary to return to their health care provider.
  - Provide discharge instructions that include information about what danger or warning signs to look out for, whom to call, and where to go if they have a question or concern.
  - Design discharge materials that meet patients' health literacy, language, and cultural needs.

REPORTING & SYSTEMS LEARNING

Every clinical unit

- Build a culture of equity, including systems for reporting, response, and learning similar to ongoing efforts in safety culture.
- Develop a disparities dashboard that monitors process and outcome metrics stratified by race and ethnicity, with regular dissemination of the stratified performance data to staff and leadership.
- Implement quality improvement projects that target disparities in healthcare access, treatment, and outcomes.
- Consider the role of race, ethnicity, language, poverty, literacy, and other social determinants of health, including racism at the interpersonal and system-level when conducting multidisciplinary reviews of severe maternal morbidity, mortality, and other clinically important metrics.
  - Add as a checkbox on the review sheet: Did race/ethnicity (i.e. implicit bias), language barrier, or specific social determinants of health contribute to the morbidity (yes/no/maybe)? And if so, are there system changes that could be implemented that could alter the outcome?

PATIENT SAFETY BUNDLE

Reduction of Peripartum Racial/Ethnic Disparities

Source: https://www.mpqcma.org/_files/ugd/fdc477_774af615132a4d299df8a71fc44d7590.pdf

Building a Plan for Improvement

Embed Intrinsic Motivation for Change within the Team

Change Management

PHASE 1	• Understand the need for change • Enlist a core team • Develop a vision and strategy
PHASE 2	• Create a sense of urgency • Communicate the vision often • Empower others to act on the vision • Inspire and celebrate small wins
PHASE 3	• Maintain interest in the improvement • Create systems so the process is less dependent on the leader

Source: Kotter, JP. Leading Change. Boston: Harvard Business School Press, 1996.

Adapted Donabedian Model for Measuring Healthcare Quality

Health Care Structures	Physical and organizational characteristics of the health system • I.e. Policies, Procedures, & Trainings
Health Care Processes	What is done in the delivery of care and how it is done • I.e. Interpersonal Interactions (Patient-Provider Communication) & Treatment Decisions
Health Care Outcomes	Effect of health care on patients • I.e. Racial Inequities in Maternal Mortality & Severe Maternal Morbidity and Patient Experience

Source: Donabedian A. Evaluating the Quality of Medical Care. Milbank Q. 2005;83(4):691-729. doi:10.1111/j.1468-0009.2005.00397.x

PNQIN Equity Bundle Measures

Structure Measures

1. Does your hospital have a formal equity team based in obstetrics/reproductive health that includes diversity of roles, race/ethnicity, and community member representation?

2. Has your hospital developed and communicated their obstetric equity goals to the perinatal faculty and staff including SMART or AIM equity goals, an antiracism statement, and change statements?

3. Does your hospital collect race, ethnicity and language data upon registration/entry for obstetric care? Is it collected through self-report?

4. Does your hospital stratify process and outcome data by race, ethnicity and language?

5. Has your hospital adapted and implemented a Patient Reported Experience Measure (PREM)?

Process Measures

*Chart sampling instructions are on page 37

†data requested as disaggregate by non-Hispanic White and non-Hispanic Black

1. Among your OB staff (physicians, midwives, nurses, etc.), how many completed a training program on implicit bias, racism, and racial disparities in the past 2 years (training must include education on implicit bias and racial disparities, e.g., SPEAK UP)?

2. Among the number of birthing people with persistent (twice within 15 minutes) new-onset Severe HTN (Systolic: ≥160 or Diastolic: ≥110), excludes birthing people with an exacerbation of chronic HTN], how many were treated within 1 hour with IV Labetalol, IV Hydralazine, or PO Nifedipine?*†

3. Among the birth admissions, how many had a hemorrhage risk assessment completed with risk level assigned?*†

4. Among the birth admissions, how many had measurement of blood loss from birth through the recovery period using quantitative and cumulative techniques?*†

Outcome Measure

Year 1, 2022-2023

1 Severe maternal morbidity (SMM) rates by race, ethnicity

Severe maternal morbidity (SMM), is an unexpected and life-threatening peripartum illness. SMM is a physically and mentally traumatic event for the patient, family, and community and 100 times more common than maternal mortality. The Center for Disease Control and Prevention defines SMM by a list of 21 diagnostic indicators that includes blood transfusion (SMM21) or without blood transfusion (SMM20).

SMM21

1. **Acute myocardial infarction**
2. **Aneurysm**
3. **Acute renal failure**
4. **Adult respiratory distress syndrome**
5. **Amniotic fluid embolism**
6. **Cardiac arrest/ventricular fibrillation**
7. **Conversion of cardiac rhythm**
8. **Disseminated intravascular coagulation**
9. **Eclampsia**
10. **Heart failure/arrest during surgery or procedure**
11. **Puerperal cerebrovascular disorders**
12. **Pulmonary edema/Acute heart failure**
13. **Severe anesthesia complications**
14. **Sepsis**
15. **Shock**
16. **Sickle cell disease with crisis**
17. **Air and thrombotic embolism**
18. **Blood transfusion**
19. **Hysterectomy**
20. **Temporary tracheostomy**
21. **Ventilation**

SMM20 includes 20 indicators and DOES NOT include blood transfusion

Structure Measures

Building an Equity Team

Creating a Team: Identifying Invested Parties

1. Identify a co-champion pair (we suggest an OB-physician/midwife and nurse pair)
2. Create a rough aim statement for your project
   a. This will be further modified once your team has been created
   b. Further guidance on how to create an Aim Statement, using the SMARTIE framework, can be found within the "Structure Measures" section.
3. Think about which systems might be affected by your aim, and why these systems, in particular, might be impacted
4. Identify change agents that include representatives from the systems brainstormed in the previous step, use the CAST framework (see below)

Champion – individual who believes in change, but may or may not be able to implement change at a unit/hospital level
ex: Junior Physician, Midwife, Patient Partner, L&D Unit Director

Agent** – individual who is responsible for implementing change at a unit/hospital level
ex: Hospital Team Lead

Sponsor – individual with authority who can express, model, and reinforce
ex: Physician Chair, CEO, CNO

Target** – individual to whom change is happening
ex: OBs, L&D nurses, Midwives, Resident Physicians, Anesthesiologist, Patients

**since the aim of this bundle is BIG the agents and targets may change for each individual project (eg. staff education vs collecting self-reported race/ethnicity data)

Example:

- **Champions:** H. Jones, DO, chair of OB & M. Wells, RN, nurse manager
- **Rough aim:** To eliminate racial and ethnic disparities in maternal outcomes in the X hospital L&D unit
- **Systems that might be affected by our efforts:**
  - Nursing, physicians, social work, nurse educator, staff educator, medical trainees and students, IT, quality improvement department, pharmacy
- **Invested Parties:**
  - Champion: see above
  - Agent: L&D nurses, resident
  - Sponsor: OBGYN department chair
  - Target: patients, IT, nurses, physicians, doulas

Creating a Team: Family Engagement

Before Engagement

1. Make a department commitment to including patients and family into the quality improvement work
2. Use data to understand the demographics of patients most severely affected by SMM rates at your institution
3. Develop a mechanism for compensation (can go beyond monetary including child care or food)
4. Create an outline of expected roles and responsibilities, time commitment and compensation

Initial Engagement

1. Develop an engagement plan. Examples:
    a. Connect with family or community-based organizations and support groups
    b. Create an interest form for patients and family
2. Create an agreement outlining expectations and confidentiality which both participant and hospital team leader should sign

Continued Engagement

1. Provide mentorship and support
    a. Aim for two or more participants
    b. Utilize organizations like MoMMA's Voice for empowerment training
2. Ensure meeting materials are written in plain language and sent to all participants ahead of time, with ability to add to the agenda
3. Provide options to participate in meetings (eg. Zoom)
4. Maintain open communication to continually assess how the participant is engaged and how to better incorporate them in the core work

Sources:

- CPCQC FIRST Program
- Dworetzky, Beth, Clarissa G. Hoover, and Deborah Klein Walker. "Family Engagement at the Systems Level: A Framework for Action." Maternal and Child Health Journal (2023): 1-9.
- ILPQC Patient and Family Engagement Toolkit

Creating a Team: Family Engagement Interest Form, example

Using a paper or online form can be helpful in allowing patients and family to fill out the form and think about the opportunity on their own without feeling coerced.

At the top of the form you can explain who your team is, the time commitment and compensation rate. Also, be explicit if you are trying to engage a patient from a specific population for example: "*We are looking for a patient or a family member of a patient who had a birthing experience in Massachusetts and identifies as Black.*"

PNQIN Equity Bundle Workgroup Family Consultant Interest Form:

1. Name
2. Email
3. Phone number
4. How would you like to be contacted?
    a. Email
    b. Phone
5. What languages do you speak?
6. What are your pronouns (ex. she/her, he/him, they/them, ze/zem)?
7. Please select what your role is/was during the birthing experience: (check all that apply)
    a. Patient
    b. Family Member
    c. Caretaker
    d. Provider
    e. Other:
8. Why are you interested in joining the PNQIN Equity Bundle Workgroup?
9. Being part of the PNQIN Equity Workgroup will take about 2.5-4 hours per month. You will be part of the Workgroup for up to 1-year (check all that apply)
    a. I can agree to work on the PNQIN Equity Bundle Workgroup for 1-year (2.5-4hrs/month)
10. Please notify me of other shorter-term projects (variable)
11. Other comments or concerns:

Creating a Team: Engaging Partners

1

Present at department wide meetings, grand rounds or organize a snack party to...

1. Instill a **need for change** and a sense of **urgency**
   a. Present your hospital data and/or national/state data on maternal health inequities
      - Admon LK et al. Racial and Ethnic Disparities in the Incidence of Severe Maternal Morbidity in the United States, 2012–2015. doi:10.1097/AOG.0000000000002937
      - Diop H et al. Trends and inequities in severe maternal morbidity in Massachusetts: A closer look at the last two decades. doi:10.1371/journal.pone.0279161
      - Hoyert DL. Maternal mortality rates in the United States, 2021. NCHS Health E-Stats. 2023. DOI: https://dx.doi.org/10.15620/cdc:124678
2. Instill a sense of **hope, agency** and **possibility of change**
   a. Most of severe maternal morbidity (SMM) is preventable
      - Trost S et al. Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019. Access here.

   b. Safety bundles work to eliminate racial gaps in SMM
      - Davidson C et al. Examining the effect of quality improvement initiatives on decreasing racial disparities in maternal morbidity. doi:10.1136/bmjqs-2021-014225

2

Make yourself known and reach out to people doing related work

3

Coordinate a time for bimonthly or monthly meetings

- In the beginning, full group meetings will be needed to create teamwide goals but later on the meeting time might be used for subgroups to meet with larger group meetings happening less often

PN QIN

Creating Equity Goals

SMARTIE Aim Statement

Specific- What's the problem or opportunity?

Measureable- By how much will you improve?

Achievable- Is this doable in the time you have?

Realistic- Do you have the resources needed?

Time- By when?

Inclusive- Who is most impacted? Are appropriate representatives on your team?

Equitable- Does the goal address inequities in the outcomes and processes?

Complete aim statement:

- [ ] Is the problem or opportunity clearly stated?
- [ ] Do you know what the team is going to do about the problem?
- [ ] Has the team set a numerical goal to quantify the amount of improvement they'd like to make?
- [ ] Do you know the calendar date by which the team plans to achieve the goal?
- [ ] Is it clear who will benefit from the improvement?
- [ ] Is the scope of the project clear?
- [ ] Do you know why this improvement effort is important?

Ask a colleague to check your work and recommend improvements:

SMARTIE Aim Statement, example

Specific- What's the problem or opportunity?

To prevent denial and delay in diagnosis of OB HEM, we will implement and use a QBL system for all deliveries.

Measureable- By how much will you improve?

Increase from baseline of 25% of deliveries to 100% of deliveries

Achievable- Is this doable in the time you have?

Yes, the goal is not too much or too little

Realistic- Do you have the resources needed?

Yes, we have the staff and resources to accomplish this goal

Time- By when?

In 6 months (by November 1, 2021)

Inclusive- Who is most impacted? Are appropriate representatives on your team?

Black patients have the highest rates of hemorrhage at our institution, we will recruit 2 Black identifying patients with lived experience on our team

Equitable- Does the goal address inequities in the outcomes and processes?

Inequities are seen mostly in racial differences, the goal is to specifically lessen that gap

Complete aim statement:

To prevent denial and delay in the diagnosis and management of obstetric hemorrhage, we will increase the percentage of births using QBL to measure blood loss from 25% to 100% by November 1, 2021 by implementing changes developed with a team including 2 patient representatives.

Uncovering Opportunities for Change

**All QI tools not discussed in this toolkit are in the QI Toolkit

Category	Tool	Description
Uncover Patterns	Stratification	• Examine population by subgroups • Compare subgroups
Uncover Patterns	Frequency Histogram	• Display variation in continuous data • Recognize & analyze patterns
Uncover Patterns	Scatter Plot	• Examine association between 2 variables • See unusual patterns • How change idea measures affect outcomes • Determine relationship between measures
Explore Challenges	Driver Diagram	• Identify factors that contribute to outcome of interest according to themes • Themes ranked according to relative importance • Specify theoretical causal pathway for achieving aim
Explore Challenges	Cause-and-Effect Diagram	• Graphic tool to display possible causes of an effect; causes are often grouped into major themes • Themes and elements of the diagram can become primary & secondary drivers on a driver diagram
Explore Challenges	Flow Diagram	• Visual display of the activities of a process or system; helps to understand a current process • Helps the team see the system in which they are working and identify opportunities for improvement
Prioritize Goals	Pareto Chart	• Type of bar chart in which factors that contribute to an effect are arranged according to magnitude of effect • Identify factors that will have the greatest impact to focus improvement work
Prioritize Goals	Priority Matrix	• Tool that helps you rank potential change ideas within an improvement project • Helps you decide which improvement or change idea to start with • Impact-Effort grid

Explore Challenges: Driver Diagram

In order to achieve your aim, the team should have a strong theory about what will lead to the intended improvement. Driver diagrams are one method to share your theory about how you'll achieve the aim.

Most important influencers on the aim, and you will have only a few (2 - 5);

Influencers on (or natural subsections of) the primary drivers, and you may have many. In most cases, teams will benefit from tying a process measure (see further on for more information about measures) to each of the primary drivers.

Primary Drivers
contribute directly to achieving the aim

Secondary Drivers
components of the primary drivers, and specific change ideas to test for each secondary driver

SMARTIE Aim

Add arrows to represent the connection between the secondary and priamry drivers

Remember
It's unlikely that a single individual has a clear view of an entire complex system. When developing a driver diagram, enlist the help of team members who are familiar with different aspects of the system you intend to improve

Example: Maternal Equity Driver Diagram

AIM

By September 2023, more than fifteen of forty Massachusetts birthing hospitals will be participating in the Birth Equity Initiative and more than 75% of participating hospitals will have all key strategies in place.

Outcomes: Process and Structure measures

Readiness
- Make equity a key institutional goal with appropriate staffing support
- Establish a sense of urgency
- Implement system for collecting race, ethnicity and language data

Change ideas:
- Form an equity workgroup including a nursing lead, physician lead, perinatal leadership, trainees, marketing, risk management, and community member. This workgroup should be diverse
- Provide staff education and training on how to ask demographic intake questions.
- Ensure that patients understand why race, ethnicity, and language data are being collected.
- Educate staff on available interpreter services.
- Set a SMART AIM statement to define equity goal.
- Provide staff-wide education on root causes of disparities.

Measures:
- S1: Create equity team to lead projects
- S2: Create and distribute equity goals and statements

Recognition/Prevention
- Identify, understand and track the disparities
- Educate prenatal and postpartum patients to this system

Change ideas:
- Communicate equity goals and progression of data over time visibly.
- Create and Communicate an Anti-racism statement.
- Provide discharge instructions that include information with care suggestions and warning signs that meet patients' health literacy, language, and cultural needs

Measures:
- S3: Collect accurate self-reported data on patient race, ethnicity, language, ability, sexual orientation and gender identity.
- S4: Stratify all patient data by race, ethnicity, language, ability, sexual orientation and gender identity.

Reporting
- Foster a culture of safety and equity
- Incorporate change into culture

Change ideas:
- Implement a system to be able to stratify feedback by race/ethnicity
- Develop a disparities dashboard that monitors age, race, ethnicity, language, geography, and ability
- Establish a mechanism for patients, families, and staff to report inequitable care and episodes of miscommunication or disrespect.

Measures:
- S5: Implement a PREMs
- P2: Ensure all perinatal care standards are met across race/ethnicity

Response
- Timely response to reports of inequitable care
- Incorporate patient experience/feedback into changes in practice

Change ideas:
- Engage in best practices for shared decision making.
- Respond to patient feedback.
- Ensure a timely and tailored response to each report of inequity or disrespect.
- Establish discharge navigation and coordination systems post

Respectful Care
- Provide culturally competent care and information
- Create and implement a system for reporting of respectful maternity care

Change ideas:
- Integrate questions on respectful care delivery onto standard debrief forms

Measures:
- P1: Increase number of staff undergoing bias and respectful care training

Explore Challenges: Using a Driver Diagram Cause-and-Effect (Ishikawa) Diagram

It is hard to know exactly where to start, a cause-and-effect diagram (also known as Ishikawa and fishbone) can help to determine the root causes of the issue you are trying to change.

Category

Category

Cause

Cause

Cause

Brainstorm all the causes of the issue. Do not worry if some of the causes are out of your scope

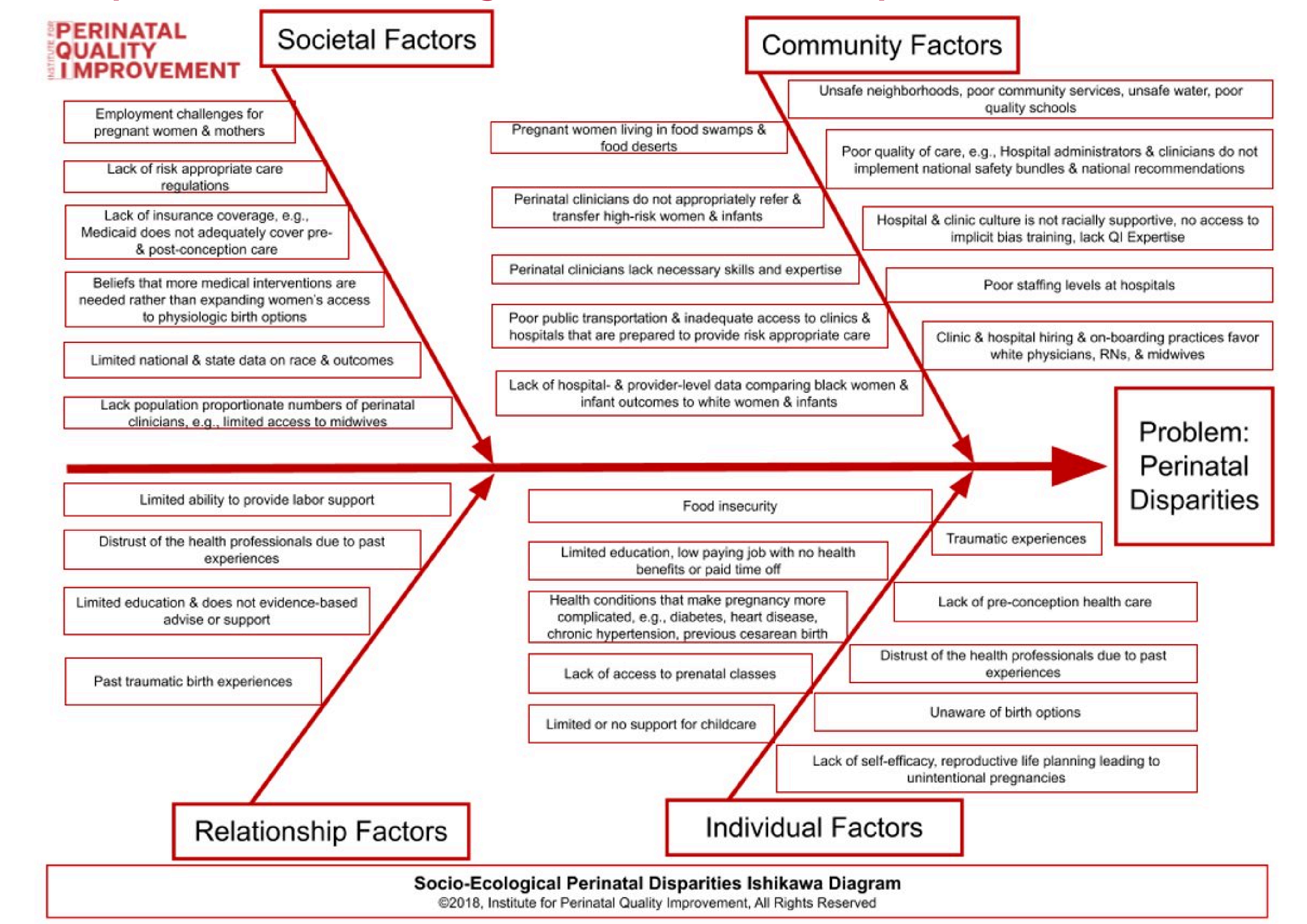
Problem

Category

Category

Organize the causes into categories. Start with 4-6 categories. Standard categories are: materials, methods, equipment, environment, and people, but feel free to adjust to what makes sense.

Example: Socio-Ecological Perinatal Disparities Ishikawa Diagram

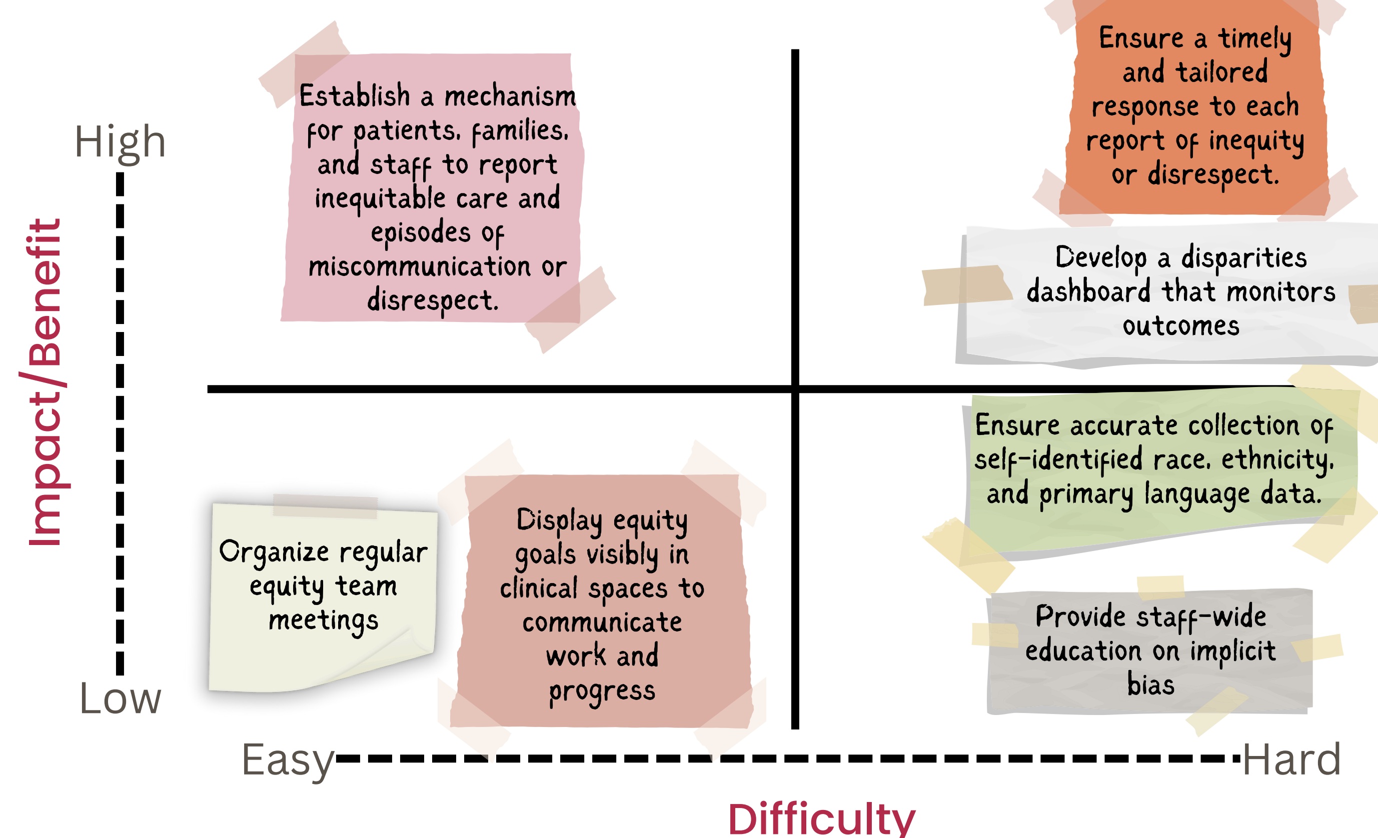


Source: Bingham D, Jones DK, Howell EA. Quality Improvement Approach to Eliminate Disparities in Perinatal Morbidity and Mortality. Obstet Gynecol Clin North Am. 2019;46(2):227-238. doi:10.1016/j.ogc.2019.01.006

Prioritize Your Goals: Priority Matrix

Once you have identified multiple change ideas, use a priority matrix to help prioritize where to start. Thought all the change ideas are important and necessary to get to your aim, they are not all equally impactful or easy to implement

Example: Reduction of Peripartum Race/Ethnic Disparities Bundle



Keep track of what you have done and what you want to do.

Change Idea	Not yet tested	Plan to test	Currently testing	Implemented
Ensure accurate collection of self-identified race, ethnicity, and primary language data.		X		
Provide staff-wide education on implicit bias.				X
Establish a mechanism for patients, families, and staff to report inequitable care and episodes of miscommunication or disrespect.			X	
Ensure a timely and tailored response to each report of inequity or disrespect.			X	
Develop a disparities dashboard that monitors outcomes	X			

PN QIN

Anti-Racism Statement

The 4 A's:
Key Components for an Anti-Racism Statement

ACKNOWLEDGE the History Past and Present

- Define racism and acknowledge that it is both conscious and unconscious
- Acknowledge racist history contributed to the issues of today and that there's no excuse for past or present inequities
- Systemic racism exists, and we must distinguish intent from impact including recognizing privilege and power

ANALYZE Impact

- State who "**WE**" are as an organization – where the organization stands regarding racism externally and internally
- Identify specific areas needing change and create an organization challenge to make those changes

ACTION Pledge

- Organizational dedication and commitment to learning about anti-racist action and implementing organizational change
- Tangible and measurable steps to address and disrupt racism by developing antiracist policies and creating a culture of antiracism

ACCOUNTABILITY for Reconciliation

- Announcing the expectation of a commitment from all employees, healthcare team members and administration
- "No tolerance policy" for racist actions

Byfield, R. (2023). The 4 A's: Key Components for an Anti-Racism Statement. Institute for Perinatal Quality Improvement, LLC.

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Anti-Racism Statement

The anti-racism statement should be a living document. Make it visible on statement that will be reviewed on regular basis and is subject to change.

4 A's: Key Components for an Anti-Racism Statement

1. ACKNOWLEDGE the history, past and present

- Define racism and acknowledge that it is both conscious and unconscious
- Acknowledge racist history contributed to the issues of today and that there's no excuse for past or present inequities
- Systemic racism exists, and we must distinguish intent from impact including recognizing privilege and power

Examples

ACOG: *We recognize that race is a social construct, not a biologically based. We know that it is racism not race that impacts health care, health and health outcomes. Systemic and institutional racism are pervasive in our country and in our country's health care institutions, including fields of obstetrics and gynecology.*

University of New Hampshire College of Health and Human Services: *We acknowledge that racism can be unconscious or unintentional and that identifying racism is an issue does not automatically mean those involved in the act are racist or intended the negative impact(s) they have on our organization, its systems and its people. We will also challenge ourselves to understand and correct any inequities we may discover and gain a better understanding of ourselves during this purposeful process.*

2. ANALYZE impact

- State who "WE" are as an organization – where the organization stands regarding racism externally and internally.
- Identify specific areas needing change and create an organization challenge to make those changes.

Examples

Brigham and Woman's: *We are dedicated to directly investigating and exposing the role racism plays in how our health care system fails to serve all patients and how—and by whom—our research is conducted. We commit to designing and implementing interventions that promote and support health equity. We seek to eradicate racist policies and practices across the health care system, engaging directly with underserved populations, locally and nationally, to prioritize and direct our research. We are unwavering in our pursuit of a more just health care system for all patients.*

UMass Women's Health Department: *We will track information on race, ethnicity, language, sexual orientation, and gender identity, as it relates to health outcomes, to better identify disparities so that we may actively seek ways to eliminate identified health care inequities.*

3. ACTION pledge

- Organizational dedication and commitment to learning about anti-racist action and implementing organizational change
- Tangible and measurable steps to address and disrupt racism by developing antiracist policies and creating a culture of antiracism

Example

Massachusetts General Hospital: *United Against Racism has created policies and workstreams to address the structural racism that results in racial inequity in our patient care. We aim to:*

- *Improve collection of race/ethnicity and language clinical data*
- *Eliminate racialized medicine practices*
- *Increase access to interpreter services and written translation*
- *Address disparities in specialty practices with the formation of racial equity projects in 18 clinical departments (made up of multiple member organizations)*
- *Expand screening and response to social risk factors and integrate community health workers at 22 primary care practices across our system*
- *Ensure equitable access to virtual health*

University of California, San Diego OBGYN Department: We commit to intentional anti-racist actions across our department, health system, and community. These actions include:

- Ensuring high visibility of our department anti-racism statement.
- Elevating antiracist training through Culture and Justice Grand Rounds, required implicit bias training, and trainee and faculty curricula.
- Ensuring accountability through regular quantitative and qualitative assessment of anti-racism culture, including update of the department journey map.
- Establishing and evaluating a timeline for planned anti-racism activities.
- Financially supporting the Culture and Justice Quorum and its mission areas.
- Creating and utilizing a micro-reporting system for ongoing accountability of equity and justice.

4. ACCOUNTABILITY for reconciliation

- Announcing the expectation of a commitment from all employees, healthcare team members and administration
- "No tolerance policy" for racist actions
- Implementing a system for collecting public comments on the statement on a rolling basis and regular review of comments

Examples

Brigham and Woman's: *We will...require anti-racist and unconscious bias training for affiliated researchers, promoting an equitable and just work environment.*

UMass Women's Health Department: *Racism, sexism, xenophobia, homophobia and transphobia will not be tolerated.*

Additional resources:

- Watch the PQI-PNQIn webinar on anti-racism statements here
- Read about how UC San Diego OBGYN department created an equity team and created a statement in the journal article: The Culture and Justice Quorum at University of California, San Diego: A Departmental Approach to Dismantling Structural Racism

Demographic Data Collection

We know that *racism*, not race, is a risk factor for poor health outcomes. In order to address health disparities we must have accurate data regarding what populations are impacted the most so quality improvement projects can be directly targeted to those populations. Since race and ethnicity are a social construct and not based in biological differences, it is important that patients self-report their race and ethnicity.

In year 1, we focus heavily on gathering and disaggregated by race, ethnicity and language due to the disparities in Massachusetts. As the bundle progresses we will also explore other demographics including ability status, gender and sexual orientation.

Tips:

- Ensure the people collecting the data understand why data on race, ethnicity and language is important
- When patients understand ***why*** these data are being collected, they are more likely to feel comfortable answering
- Race and ethnicity data should **always** be self-reported
- Validate the data by asking patients at every visit or annually
- To increase the number of completed answers ask questions in this order: 1. language, 2. ethnicity, 3. race
- Do not wait for language, ethnicity and race data to be captured perfectly before using it, start with what you have!

Source: NNPQC and IHI. 2022. *Using Data to Advance Equity*. [webinar]. Watch here

Example Script

1. What language do you like to speak when talking about your health?

As part of [institution name] policy to understand the racial and ethnic backgrounds of our patient population and make sure we are providing fair and equal treatment to everyone. Your answers will have no effect on your treatment at [institution]. If you choose not to select an ethnicity or race, we are required to select for you based on visual identification or other available information.

2. Are you Hispanic/Latino?
   a. Yes (yes = a person of Cuban, Mexico, Puerto Rican, South or Central America or other Spanish culture or origin, regardless of race)
   b. No
3. Please check one or more of the follow groups in which you consider yourself to be a member.
   a. American Indian/Alaska Native - a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment
   b. Asian - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam)
   c. Black or African American - A person having origins in any of the Black racial groups of Africa
   d. Native Hawaiian or Other Pacific Islander - A person having origins in any of the original people of Hawaii, Guam, Samoa, or other Pacific Islands
   e. White - A person having origins in any of the original people or Europe, the Middle East or North Africa

Racial and Ethnic groups that should always be included to be consistent with US Census data are: Hispanic/Latino, American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander and White.

Depending on your community, adding additional categories may be beneficial (ex: Middle Eastern, North African).

Source: https://www.kff.org/policy-watch/proposed-changes-to-federal-standards-for-collecting-and-reporting-race-ethnicity-data-what-are-they-and-why-do-they-matter/

Patient Reported Experience Measure (PREM)

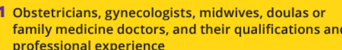
Respectful Care

Pregnant patients have low trust and confidence in their obstetrical care. In order to track patient experience and our ability to deliver respectful care to all patients in Massachusetts, we must collect the data. This PREMs was developed in collaboration with TeamBirth, and based on the tenets of respectful care below.

New York City Standards for Respectful Care at Birth

EDUCATION

You deserve to ask for and receive simple information that you can easily understand about your health care, health care provider and birthing experience options. This includes information about the following:



1. Obstetricians, gynecologists, midwives, doulas or family medicine doctors, and their qualifications and professional experience
2. Options for where to give birth, such as a hospital, a birthing center or your home
3. The policies and practices of the place where you choose to give birth
4. Resources to prepare for childbirth and feeding your baby, such as childbirth education classes and nursing counselors
5. A description of all possible outcomes of birth for you and your baby
6. Information and referrals for benefits and services you may need, such as housing, food, legal support and health insurance*

QUALITY OF CARE

You deserve the highest-quality health care. This includes:

1. Timely attention to your needs, including taking your pain level seriously, for your entire stay at a hospital or birthing center, or during the birthing experience at your home
2. A safe and clean environment during your labor and delivery, and a quiet and safe room after you give birth
3. Providers who are trained and skilled in current best practices for care during pregnancy and childbirth

4. Courteous staff who introduce themselves when they enter the room. If you have a negative experience or do not feel comfortable with a staff member for any reason (e.g., behavior, skill or experience level, etc.), you can ask for and receive a different staff member

DECISION-MAKING

You deserve to decide what happens with your body and to make decisions for your baby. This includes:

1. Making health care choices, such as which medical procedures you will and will not allow to be performed on you, based on your values, religion and beliefs
2. Deciding where to give birth, whether at a hospital, birthing center or your home
3. Choosing how to feed your baby – whether with breastfeeding/chest feeding, formula or a combination of both – and receiving the help you need to feed your baby
4. Holding your baby immediately after birth (also known as skin-to-skin), even if you have had a C-section
5. Making choices about the care of your baby, such as whether or not to be with your baby for their medical tests and procedures (unless there is a medical reason not to) and where your baby stays (in the same room with you or in the nursery)
6. Having your decisions documented and that you understand their associated possible risks

INFORMED CONSENT

You deserve to know and make your own decisions about all of your medical procedures. This is called "informed consent" and is a legal right.** Providers should share accurate, judgment-free explanations and information in a language you can understand so that you can make the decision that is right for you, when you are ready. After you have made your decision, you have the right to change your mind and have your new decisions respected – even if your health care provider disagrees with you. Informed consent includes:

1. Your health care provider's recommendations about procedures, tests, treatments or drugs
2. Any risks, benefits and alternative procedures

DIGNITY AND NONDISCRIMINATION

You deserve to be treated with dignity and respect during pregnancy, labor and childbirth, as well as after childbirth – no matter what.*** This means health care providers are expected to:

1. Treat you and your family fairly, regardless of race, gender, religion, sexual orientation, age, disability, HIV status, immigration status, housing status, income level or form of insurance
2. Provide an interpreter so that you can understand your health care provider and they can understand you
3. Protect your privacy and keep your medical information confidential
4. Let you decide who you do and do not want in the room, including staff members, during exams and procedures, and respect this decision
5. Ask for and use the name and gender pronouns you prefer
6. Use the name and gender pronouns you use to refer to your baby
7. Respect the decisions you have made about your family, such as whether you have a spouse or partner, what your spouse's or partner's gender is, how many children you have, or if you have chosen to place a baby for adoption
8. Acknowledge concerns or complaints you may have about your health care, and give you information about how to file a complaint about any aspect of your care

SUPPORT

You deserve to receive support during pregnancy, labor and childbirth, as well as after childbirth. This includes:

1. Having the people you choose present during delivery and other procedures, such as your partner, family members, friends or doula (a trained professional who provides information and support before, during and shortly after childbirth)
2. Receiving information, counseling and support services if you experience depression after giving birth (also known as postpartum depression)
3. Receiving information, counseling and support services for you and your family if you experience a miscarriage, stillbirth or loss of an infant

Illinois PQC Respectful Care Commitments to *EVERY* Patient

1. **Treating you with dignity and respect** throughout your hospital stay
2. **Introducing ourselves and our role** on your care team to you and your support persons upon entering the room
3. **Learning your goals for delivery and postpartum:** What is important to you for labor and birth? What are your concerns regarding your birth experience? How can we best support you?
4. **Working to understand you,** your background, your home life, and your health history so we can make sure you receive the care you need during your birth and recovery
5. **Communicating effectively** across your health care team to ensure the best care for you
6. **Partnering with you for all decisions** so that you can make choices that are right for you
7. **Practicing "active listening"**—to ensure that you, and your support persons are heard
8. **Valuing personal boundaries and respecting your dignity and modesty at all times,** including asking your permission before entering a room or touching you
9. **Recognizing your prior experiences with healthcare may affect how you feel during your birth,** we will strive at all times to provide safe, equitable and respectful care
10. **Making sure you are discharged after delivery with an understanding of postpartum warning signs,** where to call with concerns, and with postpartum follow-up care visits arranged
11. **Ensuring you are discharged with the skills, support and resources** to care for yourself and your baby
12. **Protecting your privacy** and keeping your medical information confidential
13. **Being ready to hear any concerns** or ways that we can improve your care

Respectful Care: Massachusetts, example

Our Respectful Care Commitments to *Every* patient

1. **Treat you with dignity and respect** *throughout your hospital stay*
2. **Introduce ourselves and our role** *on your care team to you and your support persons when entering the room*
3. **Learn your goals for birth and after**: *What is important to you for your birthing experience? What are your concerns? How can we best support you?*
4. **Work to understand you**, *your background, home life, and health history so we can make sure you receive the care you need*
5. **Communicate well** *across your health care team to ensure the best care for you*
6. **Partner with you for all decisions** *so that you can make choices that are right for you*
7. **Value personal boundaries and always respect your dignity and modesty** *including asking your permission before entering a room or touching you*
8. **Practice "active listening"** *to make sure you, and your support persons are heard*
9. **Recognize your prior experiences with healthcare may affect how you feel during your birth**, *we will strive at all times to provide safe, equitable and respectful care*
10. **Make sure you are discharged with an understanding of warning signs**, *where to call with concerns, and with follow-up care visits arranged*
11. **Ensure you are discharged with the skills, support and resources** *to care for yourself and your baby*
12. **Protect your privacy** *and keep your medical information confidential*
13. **Be ready to hear any concerns** *or ways that we can improve your care*
14. **Attend to your needs in a timely way**, *including taking your pain level seriously*

Ariadne Labs and the Perinatal-Neonatal Quality Improvement Network (PNQIN) of Massachusetts work together to make sure all patients receive respectful and high-quality care.

Download the poster **HERE**

Example: PNQIN-TeamBirth PREM

For an example, please see the link here.

Please describe your experiences during your labor and delivery at this birth facility.

Answer choices: Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, Strongly Disagree, Prefer Not to Answer

1. I could take part in decisions about my care.
2. I could ask questions about my care.
3. My health care team did a good job listening to me, I felt heard.
4. My health care choices were respected by my health care team.
5. My health care team understood my background, home life and health history.
6. My health care team introduced themselves to me, and my support persons, and explained their role in my care when they entered my room.
7. My health care team asked for my permission before carrying out exams and treatments.
8. I felt pressured by my health care team into accepting care I did not want or did not understand.
9. When my health care team could not meet my wishes, they explained why.
10. I trusted my health care team to take the best care of me.
11. My health care team did everything I wanted to help me with my pain.
12. My health care team responded to my requests in a timely manner.

Example: PNQIN-TeamBirth PREM, demographics

1. How old are you? Select one.
    a. Under 20 years old
    b. 20-24 years old
    c. 25-29 years old
    d. 30-34 years old
    e. 35-39 years old
    f. 40-45 years old or over
    g. Prefer not to answer

2. Are you of Hispanic, Latina or Spanish origins? Select one.
    a. Yes
    b. No
    c. Prefer not to answer

3. What is your race? Select all that apply.
    a. American Indian or Alaskan Native
    b. Asian
    c. Black or African American
    d. Native Hawaiian or other Pacific Islander
    e. White
    f. Other
    g. Prefer not to answer

4. What is the highest level of education you have completed? Select one.
    a. Some elementary/grammar school
    b. Some high school
    c. High school graduate
    d. Some college
    e. College degree
    f. Some postgraduate
    g. Postgraduate degree (e.g. Masters, MD, PhD, JD)
    h. Prefer not to answer

5. What kinds of health insurance or health care coverage do you have? Select all that apply.
    a. Medicaid (MassHealth)
    b. Private health insurance
    c. Other government program: Please describe:
    d. No coverage of any type
    e. Prefer not to answer

6. Is this your first baby? Select one.
    a. Yes
    b. No
    c. Prefer not to answer

7. How was this baby (or how were these babies) born? Select all that apply if there is more than one baby.
    a. Vaginal delivery
    b. Vaginal delivery with forceps
    c. Vaginal delivery with vacuum
    d. Cesarean delivery
    e. Prefer not to answer

8. Was your labor induced? Select one.
    a. Yes, for a medical reason
    b. Yes, not for a medical reason (elective induction)
    c. No
    d. Don't know
    e. Prefer not to answer

9. Please share any additional thoughts or comments you have about your birth experience.

Process Measures

Education on Bias

Suggested Trainings:

- Institute of Perinatal Quality Improvement (PQI) SPEAK UP Against Racism training program
- National Birth Equity Collaborative training series: Birth Equity Foundations, Deconstructing Bias, and Respectful Maternity Care
- Harvard Project Implicit association test
- Diversity Science Implicit Bias and Reproductive Justice Training
- March of Dimes Awareness to Action: Dismantling Bias in Maternal and Infant Healthcare™
- US Health and Human Services training on Culturally and Linguistically Appropriate Services (CLAS) in Maternal Health Care

How to Track Staff Trainings:

- Work with your institution's training system (eg. Healthstreams) to incorporate a question about anti-racism and implicit bias training
  - If unable to integrate the training program, then you can inquire through a self-report attestation
- Use common spaces to allow people to write their name if they have undergone one of the above trainings in the past year
  - This can be motivating to other staff members and reassuring to patients that the department is committed to eliminating racial disparities

Hypertension and Hemorrhage

When examining severe maternal morbidity (SMM) in Massachusetts, we found that from 2008 to 2017 the greatest gap in SMM between Black non-Hispanic birthing people and their peers was due to obstetric hemorrhage and severe hypertension in pregnancy (Table 1). For this reason, the clinical outcome of the Maternal Equity Bundle will assess obstetric hemorrhage and hypertension.

Table 1. Rates of SMM Event with or without Comorbidities in Massachusetts, 2008-2017

Race/ethnicity	SMM plus Transfusion (N=11,965)	SMM with no Transfusion (N=5,971)	SMM with Transfusion and hemorrhage	SMM with Transfusion and hypertension
Black, non-Hispanic	2.77%	1.54%	23.9%	5.4%
Hispanic	2.03%	0.97%	20.7%	4.0%
Native American/Aleutian	1.79%	1.04%	20.5%	4.2%
Asian/Pacific Islander	1.78%	0.87%	17.7%	3.7%
White, non-Hispanic	1.50%	0.73%	19.1%	2.7%
Total (n=685,663)	**1.75%**	**0.87%**	**20.7%**	**3.3%**

Source: *Massachusetts Pregnancy to Early Life Longitudinal (PELL) data system*

Chart Sampling

Hypertension

Chart Sampling Example with Non-Hispanic Black (NHB) birthing individuals (same instructions are used for chart samples of Non-Hispanic White birthing individuals):

Chart review of NHB birthing individuals with persistence (twice within 15 mins) new-onset severe hypertension (systolic ≥ 160, diastolic ≥ 110), excluding birthing people with an exacerbation of chronic hypertension in [month of data entry].

Note: if you had 10 or fewer births this month to NHB birthing individuals with severe hypertension, people review ALL charts, if you had more than 10, please take random sample using the instructions below:

1. Divide the total number of live births to NHB birthing individuals with severe hypertension occuring at your facility in a given month by 10.
2. Select every nth chart where 'n' is the result of that division

Example: If your hospital has 102 births to NHB birthing individuals with severe hypertension in a month, divide 102 by 10 (= 10.2). You will select every 10th birth for that month.

Hemorrhage

Chart Sampling Example with Non-Hispanic Black (NHB) birthing individuals (same instructions are used for chart samples of Non-Hispanic White birthing individuals):

Chart review of NHB birthing individuals who delivered at your hospital during [month of data entry].

Note: if you had 10 or fewer births this month to NHB births this month people review ALL charts, if you had more than 10, please take random sample using the instructions below:

1. Divide the total number of live births to NHB birthing individuals with severe hypertension occuring at your facility in a given month by 10.
2. Select every nth chart where 'n' is the result of that division

Example: If your hospital has 28 NHB births in a month, divide 28 by 10 (= 2.8). You will select every 2nd birth for that month.

Maternal Equity Bundle

Site Team Expectations

Step 1
Teaming

- Identify improvement team
- Send team to PNQIN Admin
- Gather, review, upload your baseline data (S/P measures)
- Review your site Equity policies

Step 2
Designing

- Complete your AIM statement
- Identify key drivers specific to your site/data, priority matrix
- Identify interventions to address drivers

Step 3
Operationalizing

- Create workflow to implement change ideas
- Model for Improvement/PDSA /Measure
- Attend webinars

Agreement Summary

Before submitting data to the Betsy Lehman Center for Patient Safety (BLC), an independent center within the Massachusetts Center for Health Information and analysis, hospitals must sign a Memorandum of Understanding (MOU). Below is a short summary of what the MOU entails

Responsibility of hospital teams:

- To submit aggregate and de-identified data in compliance with HIPAA
- To submit data through unique record identifier on REDCap (provided by BLC)
- May publish their own data and analysis using statewide aggregated data with prior review by BLC

Responsibility of BLC:

- Data submitted to BLC is not public record, is confidential
- Host a REDCap password protected database for hospital data submission
- Submit de-identified hospital level data to American College of Obstetricians and Gynecologists (ACOG) quarterly
- Share data, including hospital names, with PNQIN personnel so they can advise hospital teams
- In collaboration with PNQIN, may publish aggregate and di-identified data and analysis
- No representation to the accuracy or usability of the data as it is provided by third parties
- Store hospital provided data for 7 years then delete and destroy that data
- BLC may request updates to the MOU as data and project needs shift

Both BLC and hospital teams:

- Can terminate the MOU by BLC or the hospital team with or without cause
- Neither can use the name, trademark, service mark or other identifying characteristic of the other without prior written approval

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