Mother-Focused Care
Is Data-Driven

Estefania Rubio, MD, MPH
Benjamin Gessner, MPH, CPH
By 12/2024, each hospital will:
1. Achieve a 20% increase from baseline in the % of patients with a positive SDOH screen who were referred to appropriate services
2. Have 80% of providers and nurses attend an RMC training~ since January 2023

**Primary Key Driver**

**Secondary Drivers**

**Data Insights**
Learn about the mothers served: characteristics, risk factors, & outcomes across populations

**Improve the collection of individual patient characteristics**

**Use PQI & Differences in Perinatal Outcomes to identify differences. Share findings, and build ongoing plans to address identified gaps**

*Respectful care is a universal component of every driver & activity*
High percent of “unknown” in few FL hospital
Race and Ethnicity Misclassification in Hospital Discharge Data: Impact on Differences in Severe Maternal Morbidity Rates in FL

Misclassification **varies by racial and ethnic** subgroup with NH-API and NH-AIAN women being the **most misclassified** and NH-Black women being the **least misclassified**.
“Data is the new oil; it is both valuable and plentiful but useless if unrefined”

Clive Humbly, Northwestern University
Burden and Improvement Potential

• EHRs collect between 86-131 discrete data elements per patient during the delivery admission

• Nurses spend 2-4 hours per shift on EHR charting

• EHR charting is a significant source of stress and burnout for nurses, specially when the system collects more data elements than necessary for direct patient care

• Streamline documentation processes
• Reduce unnecessary documentation requirements
• Utilize available data to identify improvement opportunities
Improve the collection of individual patient characteristics
Hospitals capture patient individual characteristics by:
- Self-report
- Observation
- Indirect estimation (based on prior knowledge)

Self-report respects "individual dignity" by allowing an individual to determine how he or she classifies himself or herself as opposed to classification being assigned by another person (OMB, 1997a)
Challenges to Collecting Race, Ethnicity, & Language Data

Box 1-1. Barriers to Collection of Race, Ethnicity, and Language Data

System Level Patient

- Lack of standardization of categories.
- Lack of understanding why data are collected.
- Provided response categories not sufficiently descriptive for local populations.
- Health IT limitations (number of fields, comparability of categories among systems).
- Space on collection forms (paper or electronic).
- Discomfort on part of person collecting.

Provider-Patient Encounter

- Lack of standardization of categories.
- Lack of understanding why data are collected.
- Provided response categories not sufficiently descriptive for local populations to self-identify with
- Privacy concerns.

Developing process maps of key personnel, activities/steps, tools, information systems and timing, for collecting, correcting and documenting demographic intake questions and individual patient characteristics.

Strategy #1

Implementing a process to collect, document, and correct patient self-reported race, ethnicity, primary language, and other patient characteristics.

Strategy #2

Improve collection of individual patient characteristics
Using institution’s / sample language *to collect race and ethnicity data, L&D or admission staff obtain patient reported race & ethnicity data.

Patient self reports race & ethnicity data?

Yes

accurately document in provided categories?

Staff respect patient’s hesitancy and document “Declined” in the record

Patient declines

No

Staff can accurately document in provided categories?

Yes

Staff document patient’s self-reported data into the EMR

Unsure

Staff clarifies terms describing race/ethnicity as needed:

- People of African descent have varying ways of identifying themselves, including Black or African American.
- People who identify as American Indian, Alaska Native, or Indigenous have varying preferences regarding terminology, including tribal affiliation.
- People may identify themselves as “Hispanic,” while others may prefer “Latinx,” “Latino/a,” or other terms.

Clinical staff should:
- Continue to build trust and rapport with patient
- Offer an additional opportunity for patient to self report race and ethnicity once relationship is established and as appropriate for patient.
Implementing a strategy to educate patients on the importance of self-reported race, ethnicity, and language data for all patients who have questions regarding why this information is being collected
Sample Language to Request Patient Race & Ethnicity Data

Sample 1:
“We want to make sure all patients are getting the best care possible, can you tell us what you consider your race, your ethnicity, and your preferred language?”

(ILPQC Focus Groups)

Sample 2:
“<Insert hospital name> is committed to giving you and all of our patients the best care possible. In order to do this we ask you to tell us how you would describe your race, your ethnicity and your preferred language. If you would like to tell us your country of origin, we would be interested in that, too.”

(Health Partners)

Use PDSA cycles to test out a few versions to find the language that best fits your institution and patients' preferences.
Sample Language to Request Patient Race & Ethnicity Data

Sample 3:
"We want to make sure that all our patients get the best care possible. We would like you to tell us your racial/ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care."

(American Hospital Association)

Sample 4:
We want to make sure that all our patients get the best care possible. We're going to ask you some questions regarding your race and ethnicity, so that we can review the best treatment that our patients can receive and make sure that everyone of every background gets the highest quality of care. We'll keep this information confidential and will update it in your medical record.

AHRQ

Use PDSA cycles to test out a few versions to find the language that best fits your institution and patients' preferences.
We Ask Because We Care.

By asking about your race, ethnicity and language, we are better able to deliver health care equally to all patients.

What is your race?
What is your ethnicity?
What is your preferred language?

We ask all of our patients to provide information about their race, ethnic background and preferred language.

What is your race?
What is your ethnicity?
What is your preferred language?

The information you give us will be kept private. It will help us understand who you are, your needs and how we can provide the best care possible.

Respecting every difference, treating each equally.

GET REAL
Race, Ethnicity, and Language

FOR MORE INFORMATION ABOUT WE ASK BECAUSE WE CARE, VISIT HANTS.ORG/AHEI

We Ask Because We Care is sponsored by Advancing Healthcare Excellence and Inclusion, a program of the Healthcare Association of New York State.
Establishing an EHR process to automatically input positive SDOH screens into patient Z-Codes
How many Z-Codes are Submitted to the EHR?

Of 33.1 million, 1.59% of continuously enrolled Medicare FFS beneficiaries had Z-Codes affiliated with their claim.

(Centers for Medicaid and Medicaid Services, 2021)

Of 14.2 million total admissions during 2016-2017, only 1.9% included Z-Codes in their EHR.

(Truong, et al, 2022)

What type of Impact do SDOH have?

It is estimated that SDOH impact as much as 50% of County Variation in health outcomes.

(Whitman, et al., 2022)
• 70% of patients completed SDOH screening
• 26% screened positive for one or more SDOH
• Referral guides automatically printed with available resources
• EHR prompts provider to address any issues raised by the patient
• Each positive SDOH screen result is linked to an ICD-10 visit diagnosis code (accurate data reporting and insight)
<table>
<thead>
<tr>
<th>Social Determinant</th>
<th>ICD-10 Code/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficult/Unstable housing or housing support services instability</td>
<td>Z59.0 Lack of housing or Z59.1 Inadequate housing or Z59.8 Other problems related to housing and economic circumstances</td>
</tr>
<tr>
<td>Environmentally-compromised housing (e.g. Lead)</td>
<td>Z77.1 Contact with and (suspected) exposure to other environmental pollution</td>
</tr>
<tr>
<td>Food insecurity</td>
<td>Z59.4 Lack of adequate food and safe drinking water</td>
</tr>
<tr>
<td>Transportation difficulty</td>
<td>Z91.89 Other specified personal risk factors, not elsewhere classified</td>
</tr>
<tr>
<td>Interpersonal Violence</td>
<td>Z91.41 Personal history of adult abuse</td>
</tr>
<tr>
<td>Economic difficulties</td>
<td>Z59.9 Problem related to housing and economic circumstances, unspecified</td>
</tr>
<tr>
<td>Lack of social support</td>
<td>Z60.4 Social isolation, exclusion and rejection</td>
</tr>
</tbody>
</table>
Use PQI & differences in perinatal outcomes dashboard to identify differences. Share findings, and build ongoing plans to address identified gaps.
Use PQI and Differences in Perinatal Outcomes

Physician practices and individual hospitals
- Understand the population being served and the extent to which their needs are being met
- Address differences in care
- Monitor improvements over time

Health plans or states
- Make cross-institutional comparisons to detect variations in quality of care between entities serving similar populations
- Funding and state led interventions!

National reporting and aggregation
- Population data can indicate where consistent differences in care exist nationally
**DETECTING**
- Define differences in outcomes
- Define vulnerable populations
- Measure differences in outcomes in vulnerable populations
- Consider selection effects and confounding factors

**UNDERSTANDING**
- Identifying differences in perinatal outcomes at the following levels:
  - Patient/individual
  - Provider
  - Clinical encounter
  - Health care system

**REDUCING**
- Intervene
- Evaluate
- Translate and disseminate
- Change policy

*Source: Kilbourne et al., 2006*
Differences in Perinatal Outcomes (Last 12 months of available data)

<table>
<thead>
<tr>
<th>% State</th>
<th>% Hospital</th>
<th>RATIOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>% NTSV (low-risk) Cesareans (Birth Cert.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NH-White</td>
<td>NH-Black</td>
<td>Hispanic</td>
</tr>
<tr>
<td>% SMM- w/o BT (Hospital Discharge)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NH-White</td>
<td>NH-Black</td>
<td>Hispanic</td>
</tr>
<tr>
<td>% Severe Hypertension (Hospital Discharge)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NH-White</td>
<td>NH-Black</td>
<td>Hispanic</td>
</tr>
<tr>
<td>% Obstetric Hemorrhage (Hospital Discharge)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NH-White</td>
<td>NH-Black</td>
<td>Hispanic</td>
</tr>
<tr>
<td>% Neonatal Abstinence Syndrome (Hosp. Discharge)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NH-White</td>
<td>NH-Black</td>
<td>Hispanic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race-Ethnicity</th>
<th>Education</th>
<th>Insurance</th>
<th>BMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Non-medically Indicated Early-term Deliveries (Linked)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NH-White</td>
<td>NH-Black</td>
<td>Hispanic</td>
<td>1.13</td>
</tr>
<tr>
<td>% Low Risk Non-Medically Indicated (NMI) Induction (Linked)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NH-White</td>
<td>NH-Black</td>
<td>Hispanic</td>
<td>0.89</td>
</tr>
<tr>
<td>% Low risk Cesarean NMI Inductions (Linked)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NH-White</td>
<td>NH-Black</td>
<td>Hispanic</td>
<td>0.81</td>
</tr>
<tr>
<td>% Severe Unexpected Complication of the Newborn (Linked)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NH-White</td>
<td>NH-Black</td>
<td>Hispanic</td>
<td>1.02</td>
</tr>
<tr>
<td>% Moderate Unexpected Complication of the Newborn (Linked)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NH-White</td>
<td>NH-Black</td>
<td>Hispanic</td>
<td>0.82</td>
</tr>
</tbody>
</table>
Detecting Differences in Outcomes

**Race-Ethnicity**

- **% Severe Hypertension (Hospital Discharge)**
  - NH-White: ref
  - NH-Black: 1.80
  - Hispanic: 0.91

**Insurance**

- **% Severe Hypertension (Hospital Discharge)**
  - Medicaid: 1.14
  - Private: ref
Hospital rate is among highest in FL

Rates are higher for all groups
Framework for Reducing Differences in Outcomes in Health Care Systems

**DETECTING**
- Define differences in outcomes
- Define vulnerable populations
- Measure differences in outcomes in vulnerable populations
- Consider selection effects and confounding factors

**UNDERSTANDING**
- Identifying differences in perinatal outcomes at the following levels:
  - Patient/individual
  - Provider
  - Clinical encounter
  - Health care system

**REDUCING**
- Intervene
- Evaluate
- Translate and disseminate
- Change policy

Source: Kilbourne et al., 2006
# Examples of Potential Interventions

<table>
<thead>
<tr>
<th>Example of Activities</th>
<th>Examples of Who it Can Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural competency training</td>
<td>Providers; clinical staff</td>
</tr>
<tr>
<td>Language and literacy service enhancement</td>
<td>Patients</td>
</tr>
<tr>
<td>Restructuring care team or department</td>
<td>Microsystem (departments or care teams)</td>
</tr>
<tr>
<td>Providing financial incentives</td>
<td>Organization</td>
</tr>
<tr>
<td>Engaging the community; establishing community partners or participating in community coalitions</td>
<td>Community</td>
</tr>
</tbody>
</table>

**Source:** Healthy Quality Innovator Network: Health Equity Guide, 2021

**Visuals:**
- In-person
- Telecommunications
- Internet
- Information technology
- Print
- Multimedia
Each hospital will define the:

1. Differences in perinatal outcomes and the specific population(s) of focus
2. Improvement goal
3. Strategies and resources needed to achieve the goal, and
4. Process that will be used to monitor and report progress

Aligned with TJC accreditation requirement
PQI WEBINAR

Date: Wednesday, May 31, 2023
12:00 PM – 01:00 PM EDT

• Data definitions, sources, timelines
• Understand your PQI report
• Strategies to utilize your PQI report for MFC
• Identify issues and drill down
• Online access
MFC DATA WEBINAR

Date: Thursday, May 4, 2023
12:00 PM – 01:00 PM EDT

• Importance of data for the MFC initiative
• Data definitions, inclusion criteria
• Data tools - data collection sheets
• Processes to submit data
• Review of a sample report
• Using your report to guide improvement
## Individual Hospital Levels of Participation are Required by FDOH

MFC Hospitals will receive a star for each of the metrics.

### Attendance and Engagement

<table>
<thead>
<tr>
<th>Coaching Call (CC) Attendance</th>
<th>Patient-Level Data Submitted every month on the 21st</th>
<th>Hospital-Level Data (Quarterly) submitted every quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance</td>
<td>Patient-Level Data Last Submitted on February 2023</td>
<td>Hospital-Level Data Last Submitted on December 2022</td>
</tr>
<tr>
<td>100%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th># of CCs your hospital attended</th>
<th>Total # of Coaching Calls</th>
<th># of Months your hospital reported</th>
<th>Total # of Reporting Months</th>
<th># of Quarters your hospital reported</th>
<th>Total # of Reporting Quarters</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
Questions?
fpqc@usf.edu
www.fpqc.org/MFC

Florida Perinatal Quality Collaborative
@TheFPQC
@thefpqc

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