Implementing Shared Decision Making and Respectful Care to Reduce Cesarean Births and Increase the Experience of Health Equity

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OBI Core Faculty

Maternal Infant Health Equity Summit June 2023

Acknowledgement to:
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Obstetrics Initiative, University of Michigan

Blue Cross Blue Shield Blue Care Network of Michigan

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OBSTETRICS INITIATIVE

Disclosure

- Support for OBI is provided by Blue Cross and Blue Shield of Michigan and Blue Care Network as part of the BCBSM Value Partnerships program.
- Although Blue Cross Blue Shield of Michigan and OBI work collaboratively, the opinions, beliefs, and viewpoints expressed by the author do not necessarily reflect the opinions, beliefs, and viewpoints of BCBSM or any of its employees

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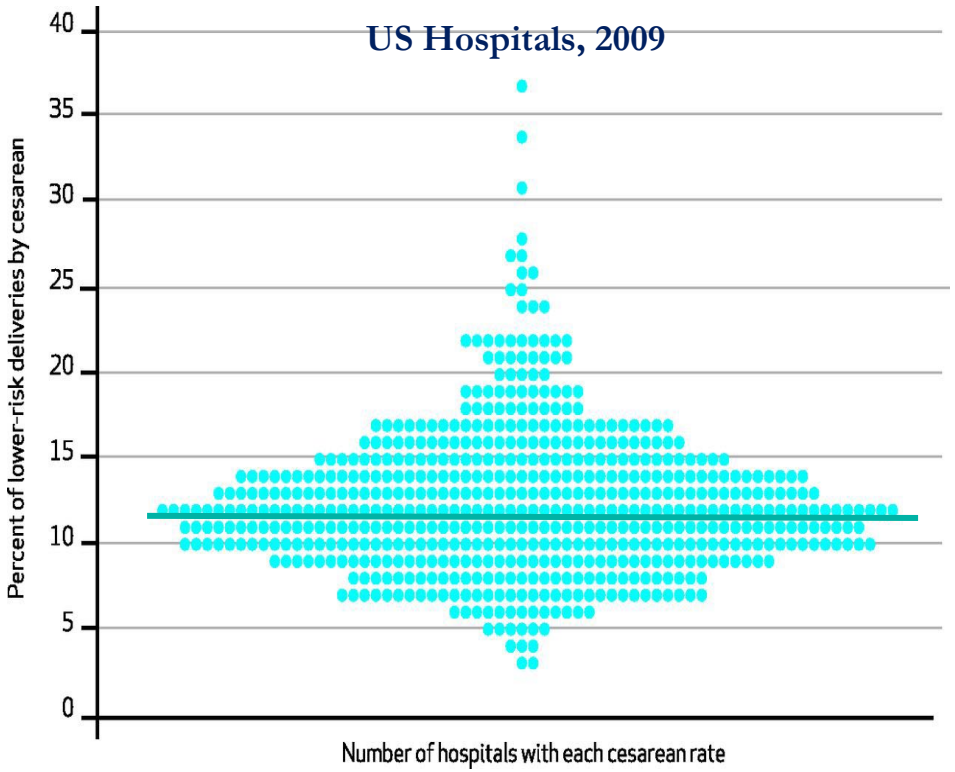
Hospital Variation in Cesarean Delivery Rates



Low Risk Births:
At Term <37 weeks
Singleton
Vertex
no previous CD

Source: Kozhimannil, *Health Aff* 2013;32:527-535 | MVC Registry Data, 2017.

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CR Consumer Reports

Your Biggest C-Section Risk May Be Your Hospital

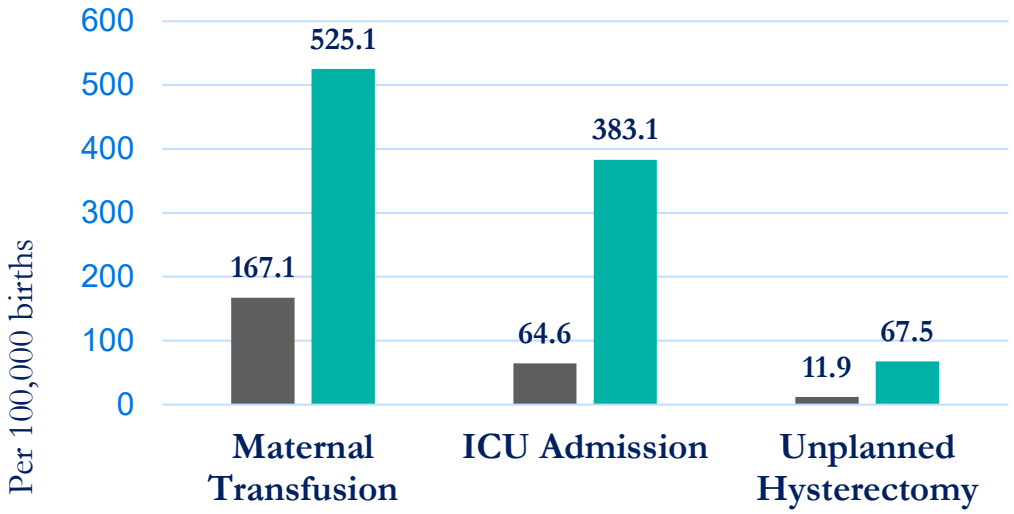
Health & Science

'Time's Up': Covered California Takes Aim At Hospital C-Section Rates

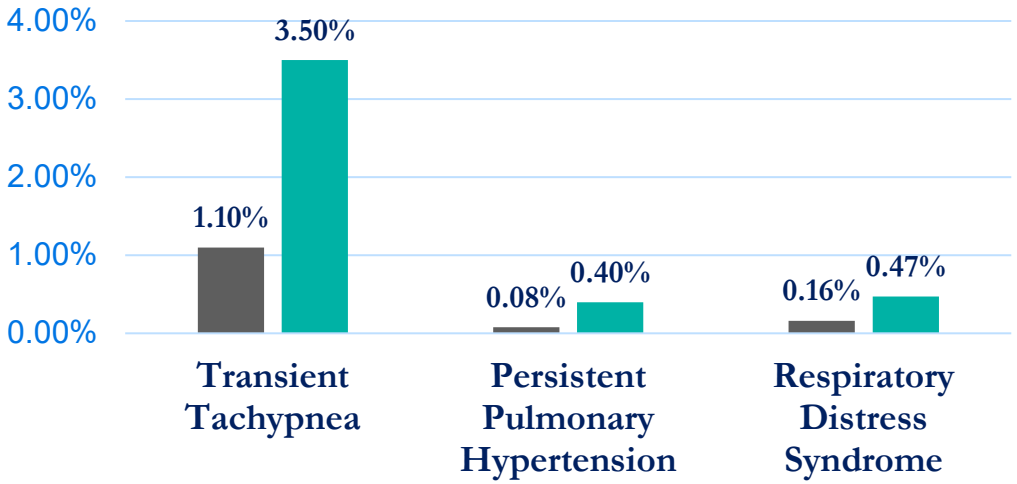
"…by the end of 2019, we want networks to only include hospitals that have achieved that target [23.9% for primary CD rate]"

Dr Lance Lang, chief medical officer for Covered California

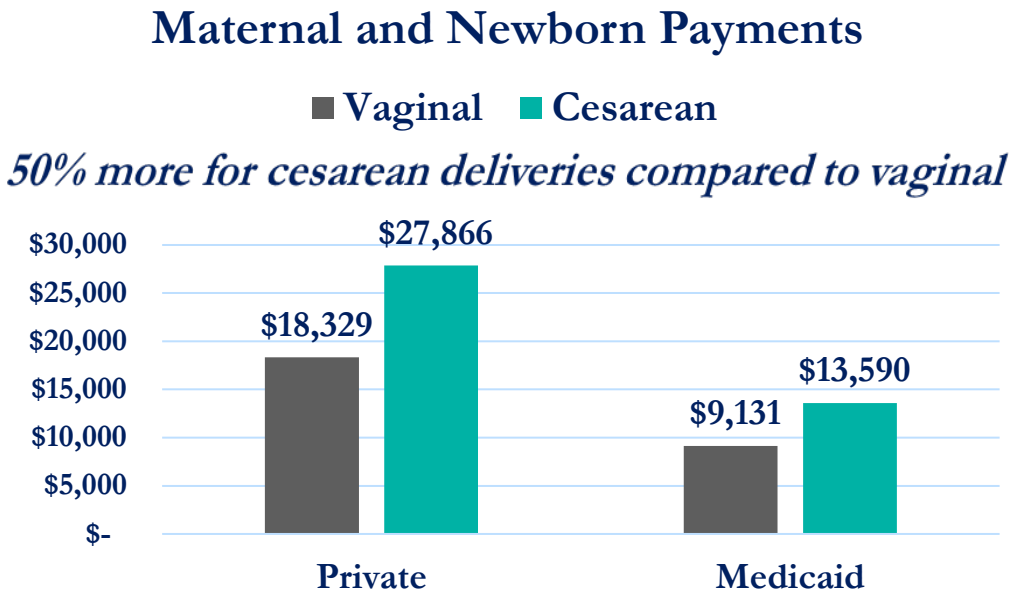
Maternal Morbidity After Birth



Neonatal Morbidity After Birth



Expenses for Vaginal and Cesarean Birth



Source: https://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr_04.pdf

Obstetrics Initiative

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MISSION

Leading statewide collaboration to create optimal maternity care experiences for Michigan families

VISION

A trusted statewide partner in optimizing healthcare services for childbearing families.

OBI Data to drive Quality Improvement

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Safely Reducing NTSV Cesarean Birth Rates across Michigan

Labor Progress

Labor Care/Support

Shared Decision Making

Shared Decision Making in Maternity Care

From the Literature

Must include 3 essential elements[1,2]

1) clinician and patient agreement that a decision is required

2) clinician and patient knowledge and understanding of the evidence regarding the risks and benefits for each of the available options

3) account for the clinician's guidance and the patient's values and preferences

With an OBI Lens

- Impact on birth experience
- Opportunity for patients/families to learn common maternity care language, starting in the prenatal setting

Goal: statewide OBI community implements shared decision making with a common definition/understanding

1. Moore et al., 2015, 2. Legare & Witteman, 2013

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MODELS OF SHARED DECISION MAKING

- Choice Talk
- Option Talk
- Decision Talk

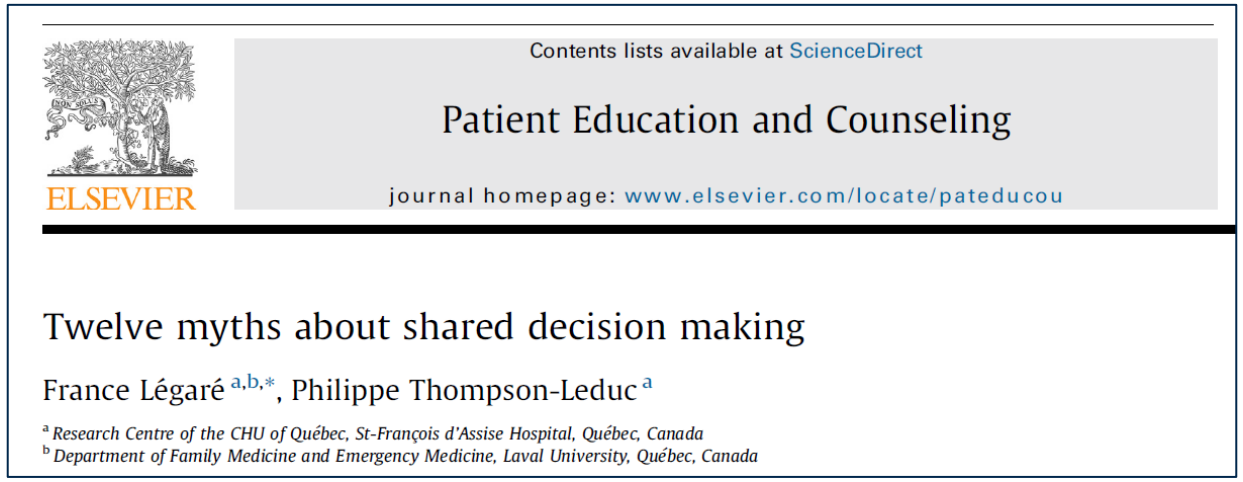
Elwyn G, at al. Implementing shared decision making in the NHS. British Medical Journal 2010;341:c5146

Shared Decision Making

- *Collaborative communication process* between patients and providers to confirm a plan of care.
- Components include choice, options and decision talk.
- Care is person-centered and aligned with the individual's care preferences.

(Breman et al 2022; Elwyn et al., 2012)

Perceived Barriers to Shared Decision Making



Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou

Twelve myths about shared decision making

France Légaré [a,b,*], Philippe Thompson-Leduc [a]

[a] Research Centre of the CHU of Québec, St-François d'Assise Hospital, Québec, Canada
[b] Department of Family Medicine and Emergency Medicine, Laval University, Québec, Canada

Myth #6: It takes too much time

Myth #7: We're already doing it!

Myth #9: It's not compatible with clinical practice guidelines

Legare & Thompson-Leduc, 2014

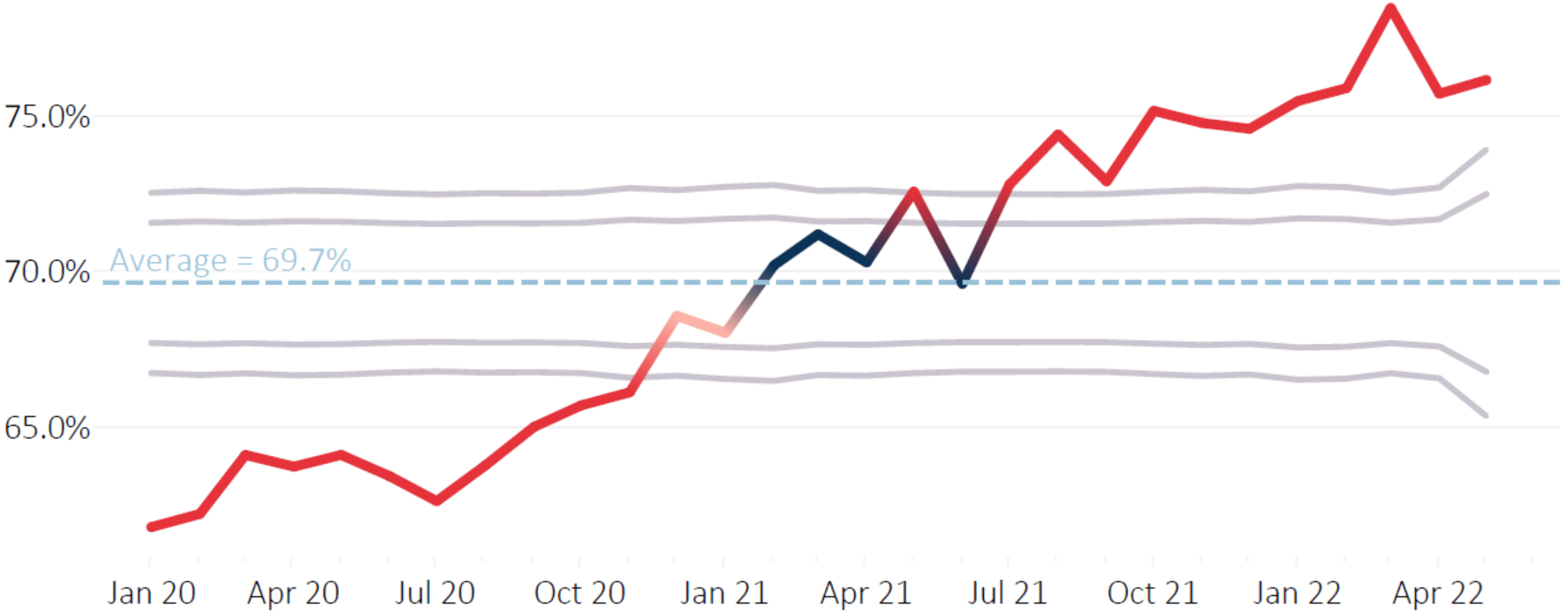
Strategies to Promote Shared Decision Making

- 2020 Keynote lecture
  - Webinars
- 2021 Introduced requirement for participation in standardized shared decision-making program or hospital-based education
- 2022 Continued to promote shared decision making as key to care process and monitored implementation
  - Use of Patient Centered Huddles.

Approach

- Use of shared decision making was monitored using chart abstraction
  - Scanned document (Labor Partnership Document)
  - Nurse Documented Episode
  - Provider Documented Episode in Admission H &P
  - Provider documented episode in Labor Progress Note (2022)

Proportion of births with any shared decision making has increased steadily since 2020 into 2022.



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Does it Make a Difference in the Outcome?

- Aim: Assess the relationship between birthing people's experience of shared decision making and their risk of having an unplanned Cesarean birth during labor.

- Design: Retrospective cohort study
- Population: Low risk: Nulliparous, Term, Singleton, Vertex
- Data: Obstetrics Initiative Clinical Data Registry, chart abstracted
- Analysis: Descriptive statistics, Pearson's Chi-squared tests, mixed logistic regression models, linear regression models

- 67,915 included in analysis across 68 hospitals
- 17,588 (25.9%) experienced an unplanned Cesarean
- 47,696 (70.2%) experienced some form of shared decision making

- Experience of Shared Decision Making varies Significantly by
  - Race/Ethnicity
  - Insurance Status

Characteristics of birthing people by whether they had any Shared Decision Making

	Any SDM		
Characteristic	**No**, N = 20,218[1]	**Yes**, N = 47,696[1]	**p-value**[2]
Unplanned Cesarean			0.15
Yes	5,312 (30.2%)	12,276 (69.8%)	
No	14,906 (29.6%)	35,420 (70.4%)	
Race-ethnicity			<0.001
White, Non-Hispanic	11,473 (26.3%)	32,093 (73.7%)	
American Indian/Alaskan Native, Non-Hispanic	46 (17.9%)	211 (82.1%)	
Asian/Pacific Islander, Non-Hispanic	772 (29.6%)	1,836 (70.4%)	
Black, Non-Hispanic	**4,291 (40.1%)**	**6,403 (59.9%)**	
Hispanic	1,293 (33.0%)	2,623 (67.0%)	
More Than One Race, Not Hispanic/Latino	94 (22.6%)	322 (77.4%)	
Race And/Or Ethnicity Unknown	2,242 (34.9%)	4,187 (65.1%)	
Insurance status			<0.001
Private only	11,712 (28.0%)	30,056 (72.0%)	
Medicaid only	**7,649 (33.4%)**	**15,280 (66.6%)**	
Self-pay/none	108 (27.2%)	289 (72.8%)	

[1]n (%); Mean (SD)

[2]Pearson's Chi-squared test; Wilcoxon rank sum test

Relationship between NTSV CB and Shared Decision Making (SDM)

- Aggregate SDM (charted, scanned) was not associated with having CB in adjusted models.
- Having a nurse documentation of preferences was not associated with having an increased risk for CB
- A scanned document alone was associated with an **increased** risk of CB (aOR 1.07, 95% CI 1.01 - 1.14).
- H&P statement was associated with a **decreased** risk for CB (aOR 0.92, 5% CI 0.87 - 0.97).
- Labor progress note was associated with a **decreased** risk of CB (aOR 0.67, 5% CI 0.58 - 0.76).

Implications

- Shared decision-making process varies and may impact quality of the experience
- Active approaches are better
- Risk for implicit bias impacting who experiences shared decision
- Strategies to structure the process of shared decision may improve outcomes

https://www.nytimes.com/2021/03/11/nyregion/birth-centers-new-jersey.html

Lessons Learned

- Research vs Quality Improvement
  - Data elements
  - Fidelity
  - Retrospective Chart Review
- Proxy Measure for Shared Decision Making
  - Documentation
  - Content of Shared Decision Making
- Context Matters
  - Equity in use of Shared Decision Making
  - Provider-led vs Patient Experience

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What is Birth Equity?

"The assurance of the conditions of optimal births for all people with a willingness to address racial and social inequalities in a sustained effort.".

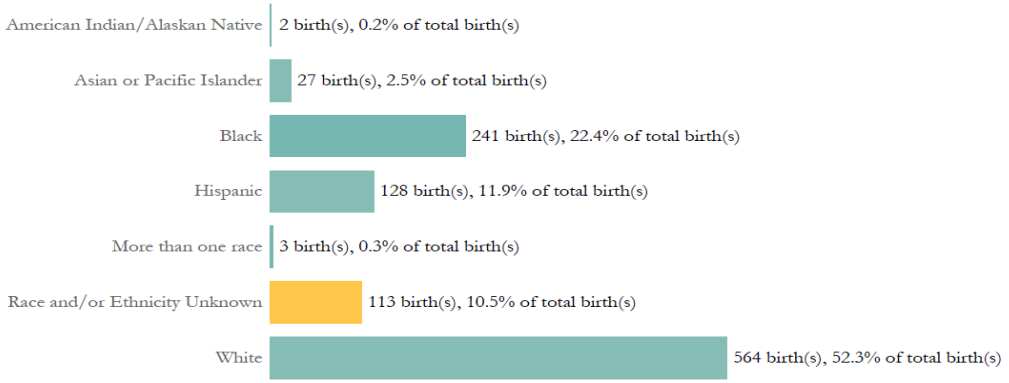
~Dr. Joia Crear-Perry, MD
Founder and President

NBEC NATIONAL BIRTH EQUITY COLLABORATIVE

Comparing Maternal Race/Ethnicity for NTSV births in 2020:

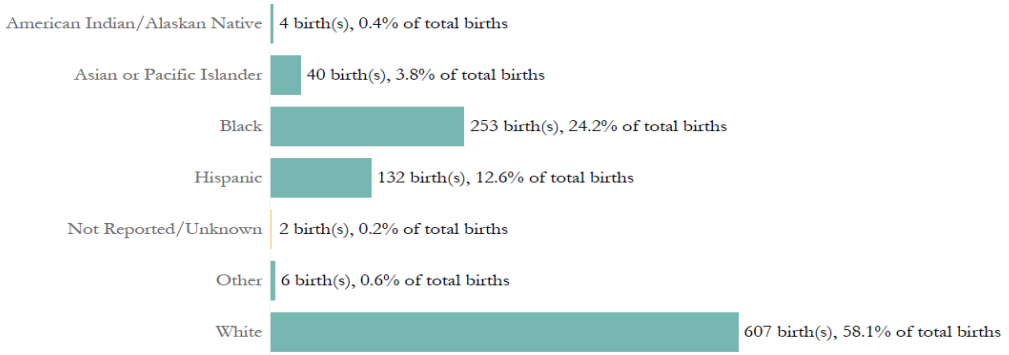
OBI Workstation Data (1,078 births)

10.5% of cases had unknown race/ethnicity



Michigan Birth Certificate Data (1,044 births)

0.2% of births had race/ethnicity not reported or unknown



Discrepancies between the OBI Workstation and Michigan Birth Certificate data exist for a variety of reasons, including different NTSV classification and race/ethnicity reporting processes for patients. These discrepancies can result in a misclassification of data for analysis and interpretation. OBI strongly recommends that each health system ensure a consistent process that includes patient-reported race and ethnicity.

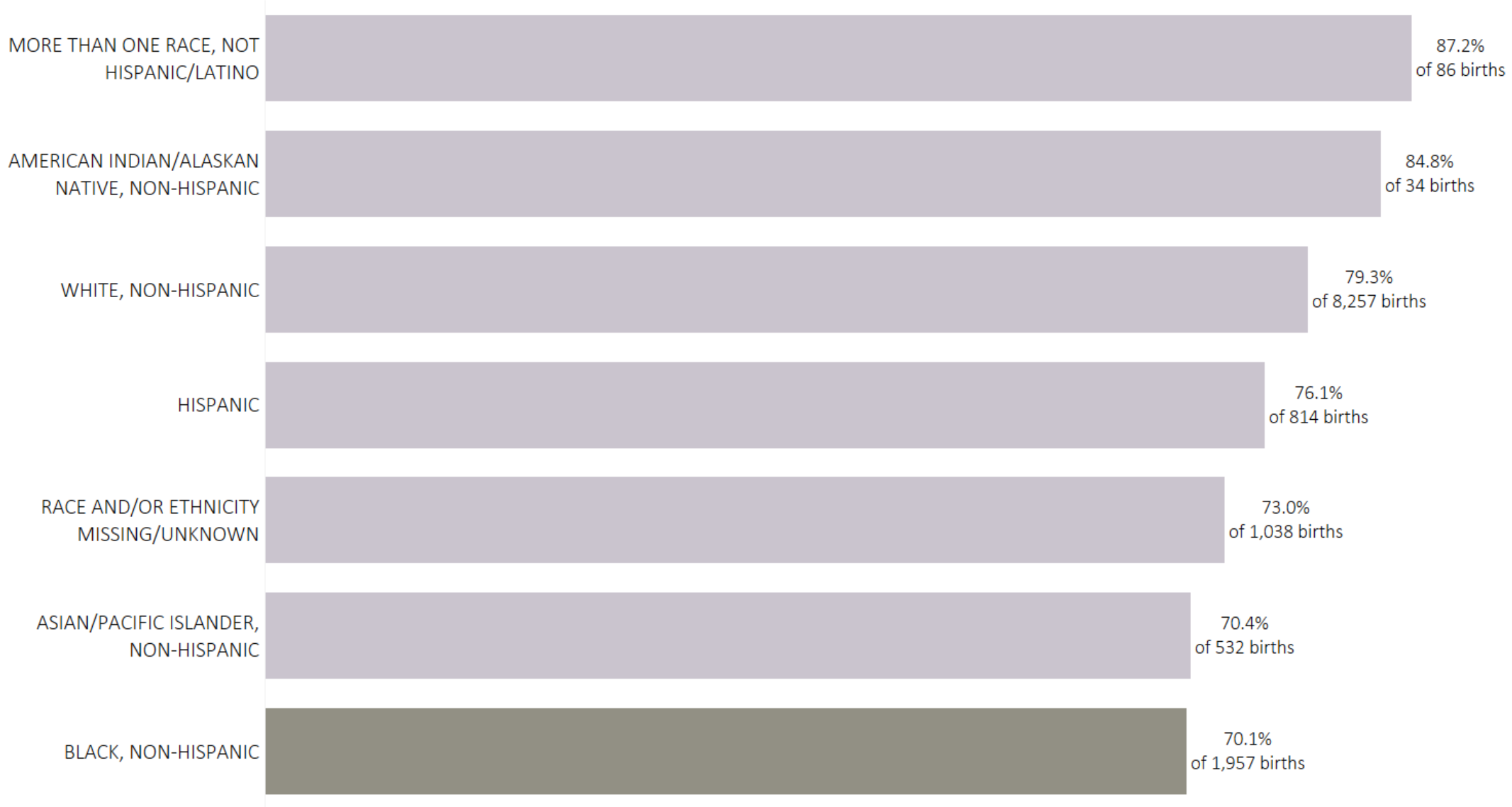
OBI Birth Equity Report

Summer 2022 Birth Equity report for ..

Social determinants of health are "the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels" (World Health Organization).

OBI's birth equity work thus far has focused on identifying discrepancies in health outcomes by race-ethnicity and insurance status across the collaborative. Differences in health outcomes including severe maternal morbidity and mortality, Cesarean birth, and others are understood to be a result of social determinants of health and discriminatory care practices rather than biological differences. In other words, this report uses race-ethnicty as a proxy for the experience of racism and insurance as a proxy for the experiences of classism and income inequality.

Black patients are the least likely to have any shared decision making at their birth in 2022 ($p < 0.0001$)*.



*Chi Square

Includes complete cases 1/1/2022 - 6/24/2022

Teamwork

ARIADNE LABS

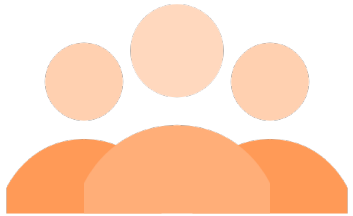
Labor and Delivery Planning Board

Team	Plan
Preferences	Next Assessment

Source: Ariadne Labs TeamBirth Project

Labor and Delivery Planning Board

TEAM

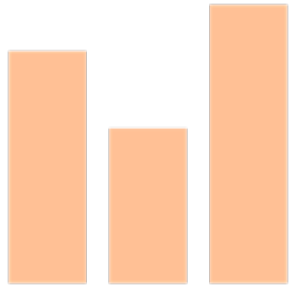


PREFERENCES

PLAN

Mom:

Baby:



Labor Progress:

NEXT ASSESSMENT

EARLY LABOR ACTIVE LABOR PUSHING

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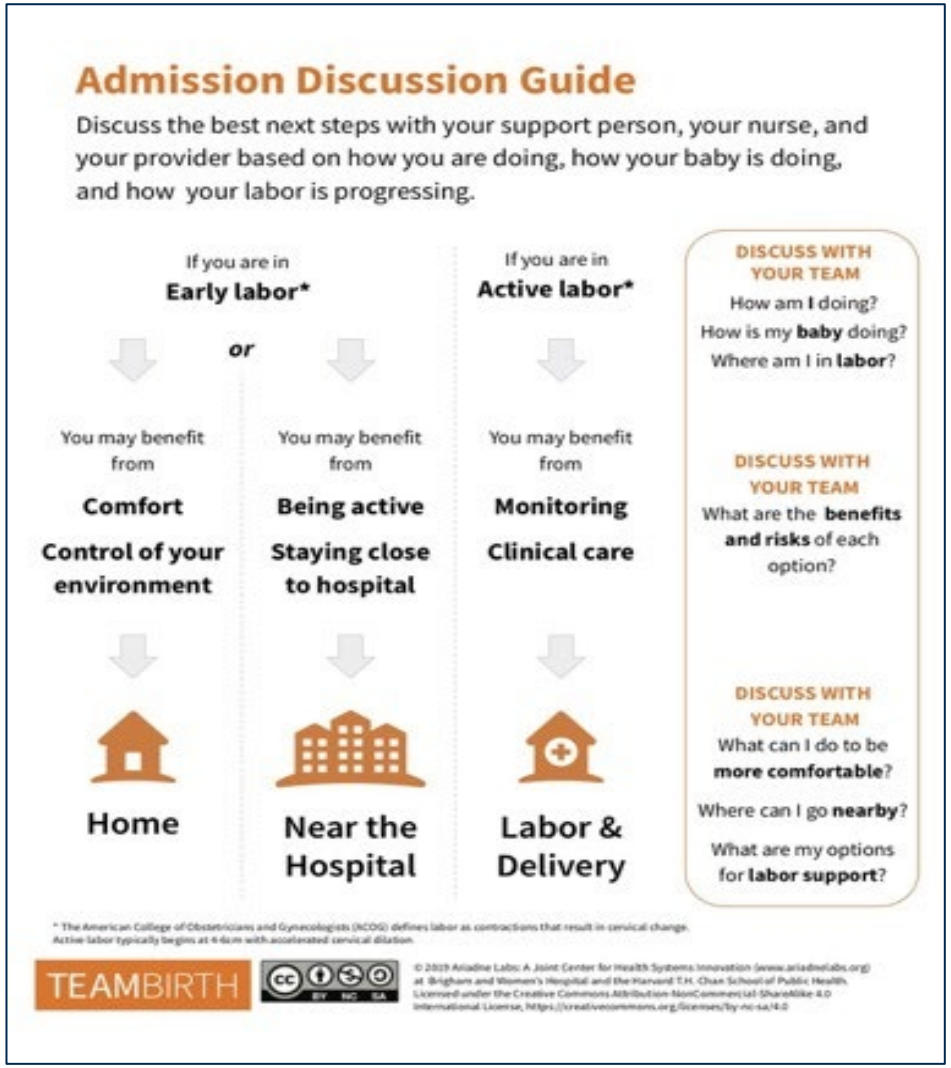
Labor and Delivery Planning Board developed by the Delivery Decisions Initiative at Ariadne Labs. 04-01-2018

Source: Ariadne Labs TeamBirth Project

Discussion & Decision Aids



Admission Discussion Guide

Discuss the best next steps with your support person, your nurse, and your provider based on how you are doing, how your baby is doing, and how your labor is progressing.

If you are in **Early labor*** or	If you are in **Active labor***	DISCUSS WITH YOUR TEAM
		How am I doing? How is my **baby** doing? Where am I in **labor**?
You may benefit from **Comfort** **Control of your environment** **Home**	You may benefit from **Monitoring** **Clinical care** **Labor & Delivery**	DISCUSS WITH YOUR TEAM What are the **benefits and risks** of each option?
You may benefit from **Being active** **Staying close to hospital** **Near the Hospital**		DISCUSS WITH YOUR TEAM What can I do to be **more comfortable**? Where can I go **nearby**? What are my options for **labor support**?

* The American College of Obstetricians and Gynecologists (ACOG) defines labor as contractions that result in cervical change. Active labor typically begins at 6 cm with accelerated cervical dilation.

TEAMBIRTH

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Source: Ariadne Labs TeamBirth Project

Labor Partnership Document

The goals of this labor partnership are to help you prepare for childbirth, to engage with you in decision making, and to improve your chances for a safe and healthy delivery.

Please fill in the blanks below with your information:

Your preferred name: _____

Your preferred pronoun: _____

Your due date: _____

Planned care provider for newborn: _____

Who is your labor support team? (partner, doula, friends, or relatives who will be present):

_____

_____

_____

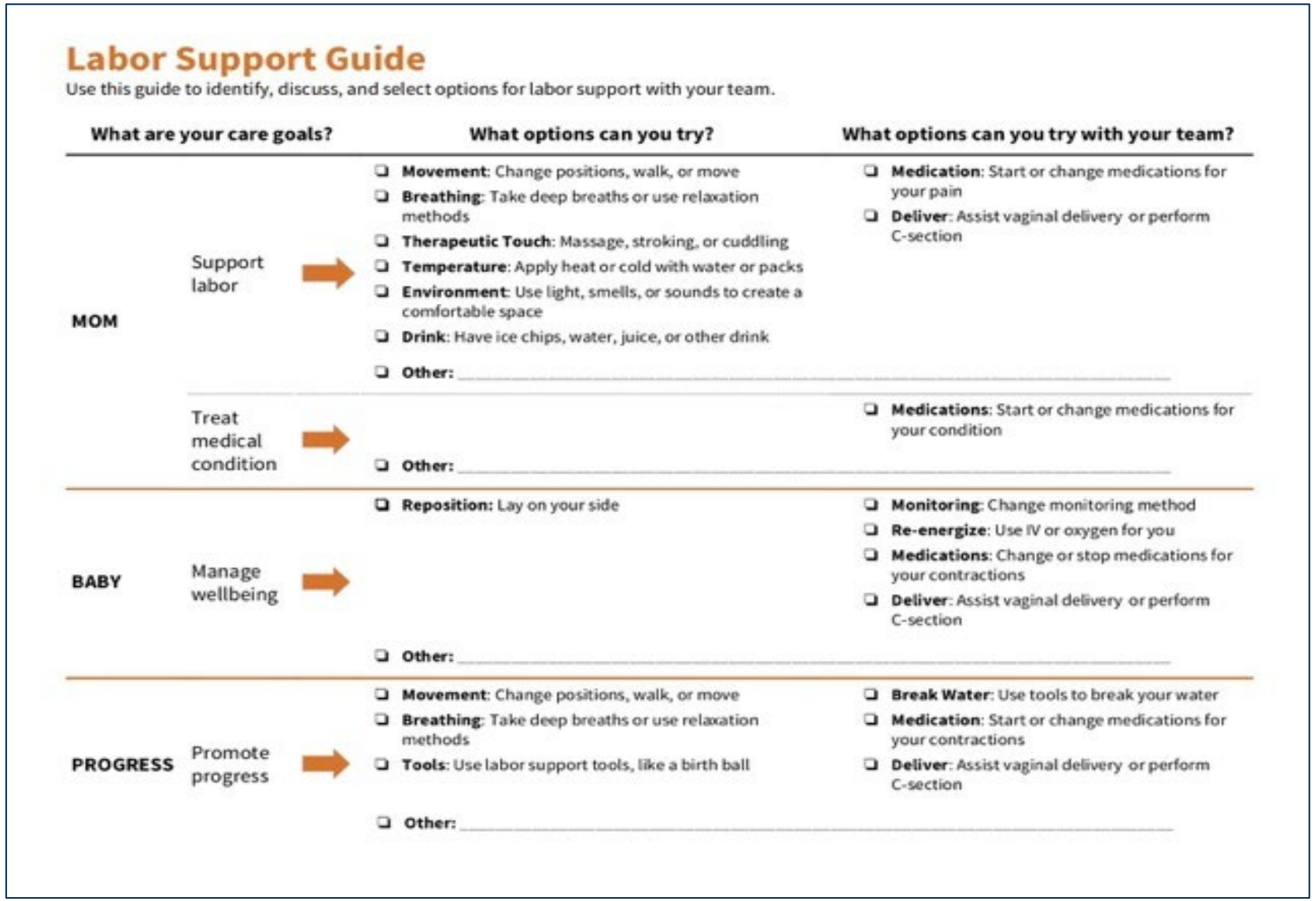
Questions to ask during prenatal care visits

We hope that this document helps you to start a conversation with your care provider during prenatal care visits. As you consider these questions, it is important to remember that while you may want less monitoring and intervention, you may need more intensive monitoring and intervention for medical reasons. While you might have other questions, here are some topics to discuss with your care provider:

- When to be admitted to the hospital
- Who will be your support person in labor
- How to better cope with labor contractions

Source: OBI Resources and Tools

Discussion & Decision Aids

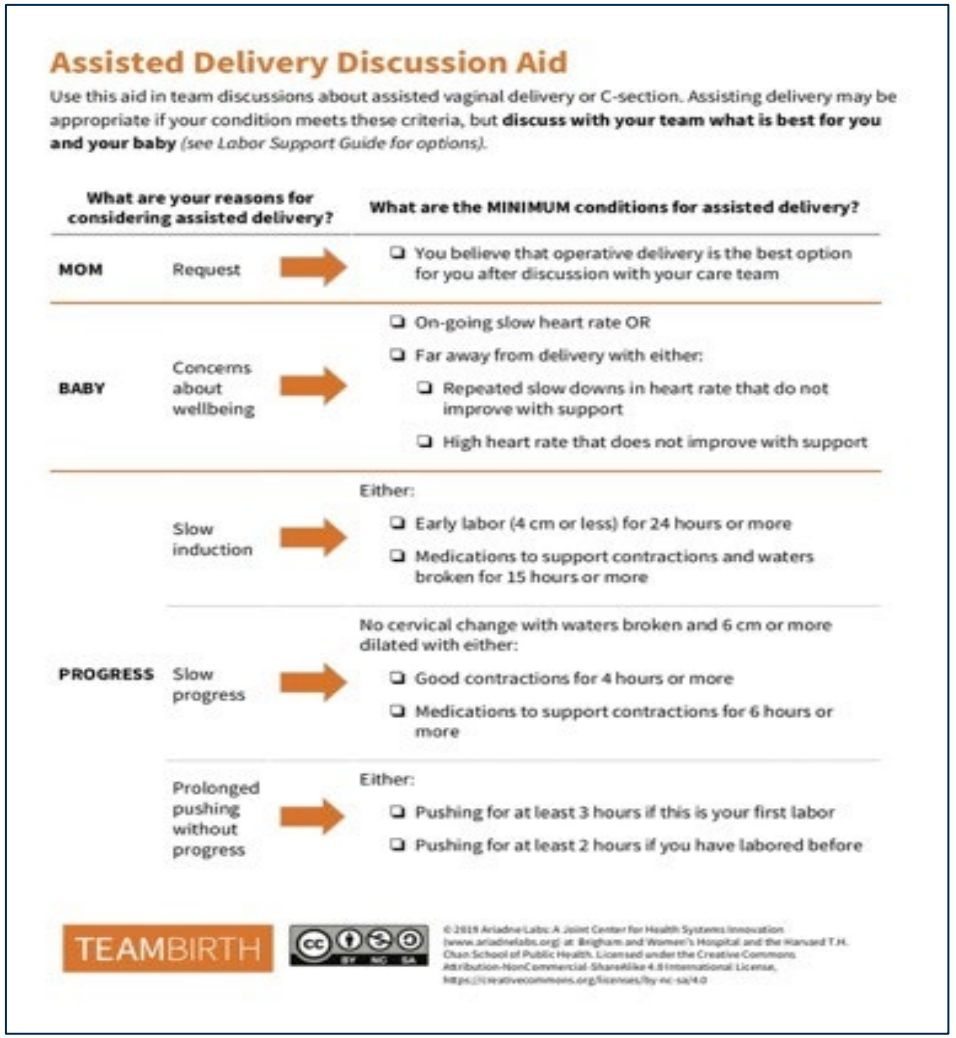


Labor Support Guide

Use this guide to identify, discuss, and select options for labor support with your team.

What are your care goals?		What options can you try?	What options can you try with your team?
MOM	Support labor →	❑ **Movement**: Change positions, walk, or move ❑ **Breathing**: Take deep breaths or use relaxation methods ❑ **Therapeutic Touch**: Massage, stroking, or cuddling ❑ **Temperature**: Apply heat or cold with water or packs ❑ **Environment**: Use light, smells, or sounds to create a comfortable space ❑ **Drink**: Have ice chips, water, juice, or other drink ❑ **Other:** _____	❑ **Medication**: Start or change medications for your pain ❑ **Deliver**: Assist vaginal delivery or perform C-section
	Treat medical condition →	❑ **Other:** _____	❑ **Medications**: Start or change medications for your condition
BABY	Manage wellbeing →	❑ **Reposition:** Lay on your side ❑ **Other:** _____	❑ **Monitoring**: Change monitoring method ❑ **Re-energize**: Use IV or oxygen for you ❑ **Medications**: Change or stop medications for your contractions ❑ **Deliver**: Assist vaginal delivery or perform C-section
PROGRESS	Promote progress →	❑ **Movement**: Change positions, walk, or move ❑ **Breathing**: Take deep breaths or use relaxation methods ❑ **Tools**: Use labor support tools, like a birth ball ❑ **Other:** _____	❑ **Break Water**: Use tools to break your water ❑ **Medication**: Start or change medications for your contractions ❑ **Deliver**: Assist vaginal delivery or perform C-section

Discussion & Decision Aids



Assisted Delivery Discussion Aid

Use this aid in team discussions about assisted vaginal delivery or C-section. Assisting delivery may be appropriate if your condition meets these criteria, but **discuss with your team what is best for you and your baby** *(see Labor Support Guide for options).*

What are your reasons for considering assisted delivery?		What are the MINIMUM conditions for assisted delivery?
MOM	Request →	❑ You believe that operative delivery is the best option for you after discussion with your care team
BABY	Concerns about wellbeing →	❑ On-going slow heart rate OR ❑ Far away from delivery with either: ❑ Repeated slow downs in heart rate that do not improve with support ❑ High heart rate that does not improve with support
PROGRESS	Slow induction →	Either: ❑ Early labor (4 cm or less) for 24 hours or more ❑ Medications to support contractions and waters broken for 15 hours or more
	Slow progress →	No cervical change with waters broken and 6 cm or more dilated with either: ❑ Good contractions for 4 hours or more ❑ Medications to support contractions for 6 hours or more
	Prolonged pushing without progress →	Either: ❑ Pushing for at least 3 hours if this is your first labor ❑ Pushing for at least 2 hours if you have labored before

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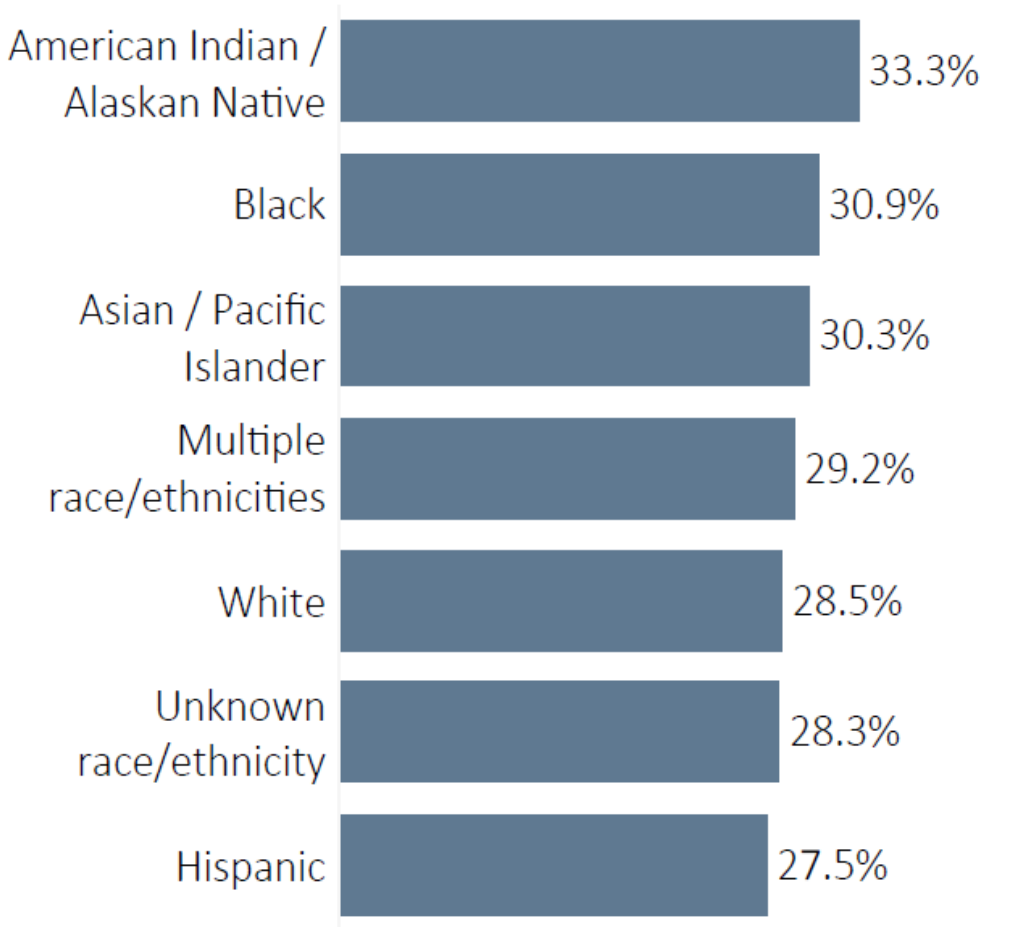
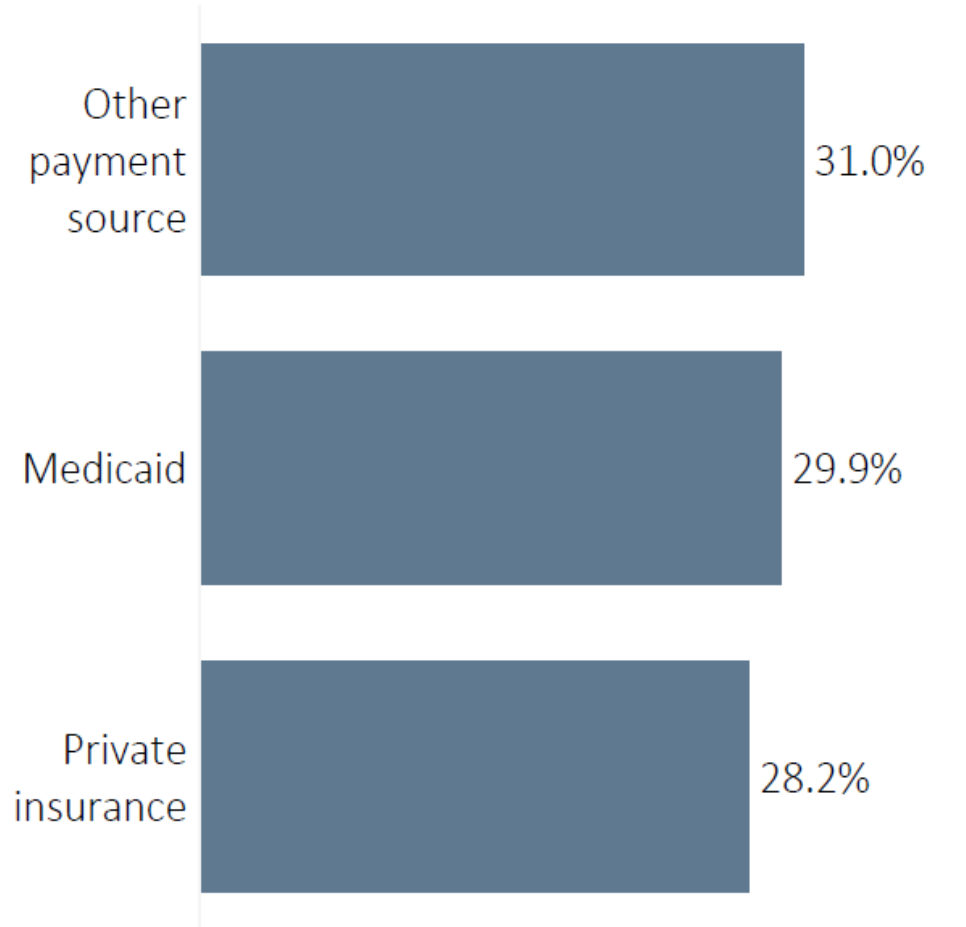
Collaborative-wide measures - Patient-centered huddles (2022 cases only)

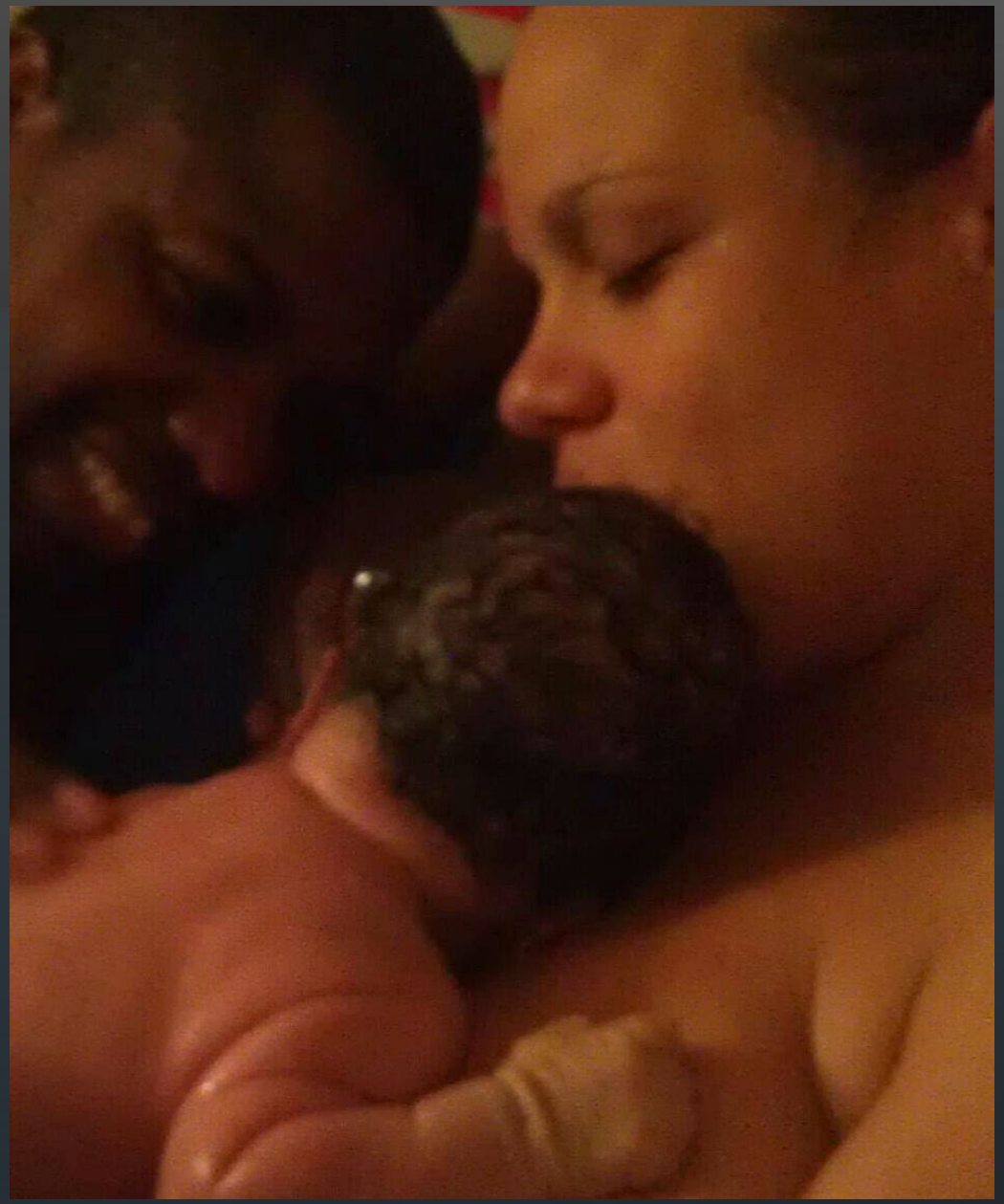
The proportion of births with a patient-centered huddles varies 5.8% by race/ethnicity across the collaborative (p = 0.661).*



The proportion of births with a patient-centered huddles varies 2.8% by race/ethnicity across the collaborative (p = 0.142).*



*Chisq



Patient Voices Are Essential for QI & Health Equity

- Patient-centeredness and equity are essential, but relatively under-addressed components of healthcare quality
- Collecting PREMs and PROs provides a standardized way of incorporating patient perspectives into QI activities
- QI efforts are likely needed to improve patient-centeredness and equity (The Giving Voice to Mothers Study)
- PREMs and PROs provide the 360-approach to evaluating QI initiatives

https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-019-0729-2

Patient Reported Experiences

MADM

The Mothers Autonomy in Decision Making scale (MADM) is a scale developed to assess women's experiences with maternity care.

MOR

The Mothers on Respect index (MOR) is a scale developed to assess the nature of respectful patient-provider interactions and their impact on a person's sense of comfort, behavior, and perceptions of racism or discrimination.

- Collect Demographic data with survey (Race/Ethnicity, income, education, etc.)
- Pilot testing 2022
- Use of QR Code and Email outreach

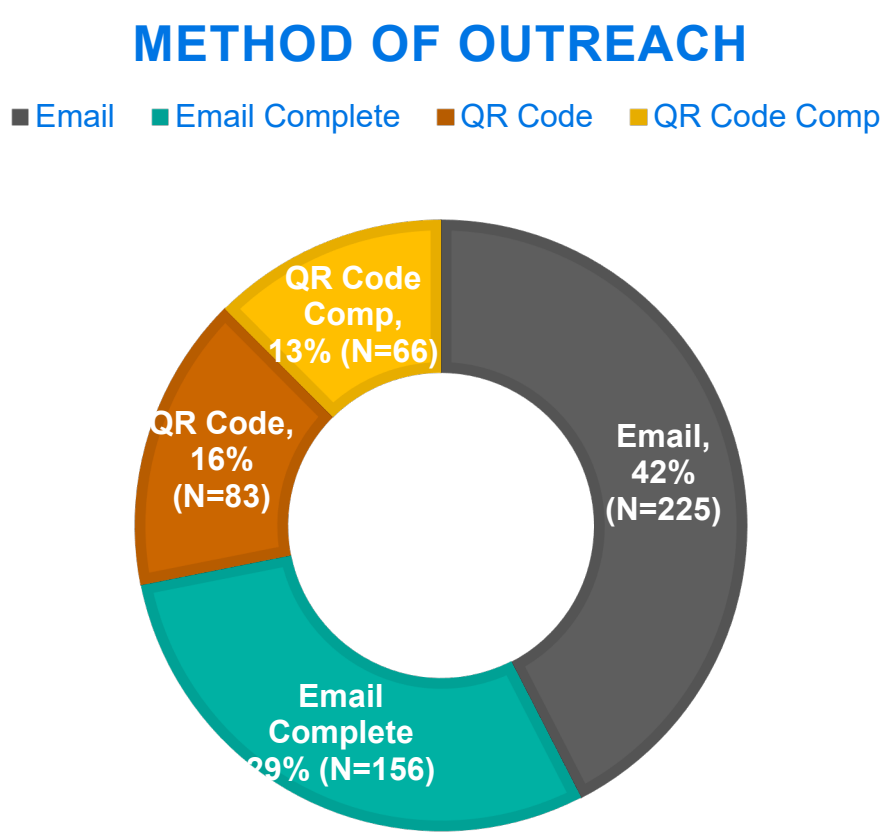
Mothers Autonomy in Decision Making Scale

Please tell us about your discussions with your clinical team during your recent labor and birth experience.

Questions:

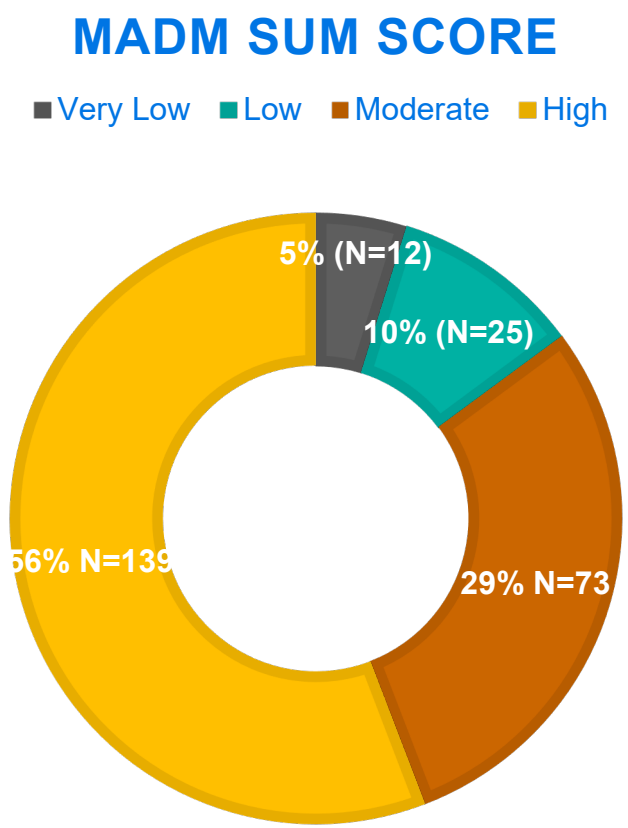
- My clinical team asked me how involved in decision-making I wanted to be.
- My clinical team told me that there are different options for my maternity care.
- My clinical team explained the advantages and disadvantages of maternity care options.
- My clinical team helped me understand all the information.
- I was given enough time to thoroughly consider the different maternity care options.
- I was able to choose what I considered to be the best care options.
- My clinical team respected my choices.

Method for Seeking PREMS Responses



- Total of 308 complete responses
- Response rate 15%
- QR Code had low uptake
- All surveys completed in English
- Initiating vs completing 27% loss
- Continuing to evaluate:
  - Incentives for completion
  - Adjustment to order of questions
  - Presentation of the survey

Pilot Outcome of PREMS survey



- MADM Sum Score – Level of Autonomy in Decision Making
- 7 question survey
- Higher scores indicate more opportunities to take an active role and lead decisions
- Overall 86% felt they had a moderate or high level of autonomy in decision making
- Indicator of respectful maternity care

OBI Patient Voices: Aims

Conduct patient survey data collection, analysis, performance feedback, and sharing of best practices

Develop and disseminate QI resources

Optimize patient experiences, improve health outcomes, and dismantle birth inequities

Components of the Survey

- Email Invitation with Survey Link
  - Opportunity to opt-out
  - Compensation for completion of the survey

- Specific Survey Components
  - Mothers Autonomy in Decision Making (MADM) scale
  - Pain Management After Childbirth
  - Financial Strain
  - Demographics
  - Option to have follow up

Coordination and Synergies between Perinatal Quality Improvement Initiatives

Widest Range of Stakeholders, AIM Reports, Responsive to Local Needs, Aligns with State Health Priorities	• PQC
Specific Bundles, Statewide Programing with Data, National Priorities combined with State Needs	• AIM
Hospital Based, Specific to NTSV CS, Future Expansion, AIM Collaboration, Introduction of PREMS, Statewide Infrastructure	• OBI
Quality Priorities, Infrastructure Resources, Multiple Resources from Each Program to Support Work,	• Sites

https://www.michigan.gov/mdhhs/keep-mi-healthy/maternal-and-infant-health/miheip

The CATCH Pilot:

BCR Birthing Cultural Rigor

Community-led **A**ccountability and **T**ransformation
in **C**are experiences and **H**ospital culture

PREM-OB Scale™ Michigan

Join the movement to #EndObstetricRacism!

- Complete The Patient Reported Experience Measure of OBstetric racism© (The PREM-OB Scale™ Suite).
- The PREM-OB Scale™ Suite shows how the hospital team cared for you, your baby, and your support team.
- We will share results with participants, partners, and the public.

WHO CAN PARTICIPATE?

- Black or African-American people age 18 and older,
- who gave birth on or after January 1, 2021,
- in **a birthing hospital located within Genessee, Ingham, Kalamazoo, Kent, Macomb, Oakland, Washtenaw, and Wayne counties.**

SIGN UP:

redcap.link/CATCHPilot

PARTICIPANTS WILL BE ASKED TO COMPLETE THREE STEPS:

1. online screening
2. video call verification
3. online survey (survey will take approximately one hour)

Complete all three steps by October 31, 2023 and get a $50 electronic gift card.

Questions? info@birthingculturalrigor.org

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To the Future: Creating the Village

starting from the beginning

Thank You!

Questions?

kanelow@umich.edu

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