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Expert Panel to Track Nurses' Effect on Maternal Morbidity and Mortality

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ABSTRACT

Rates of maternal morbidity and mortality in the United States have increased since 1990. Registered nurses are members of the health care work force who provide essential care to women during pregnancy, during birth, and after birth. Tools are needed to more effectively measure and track the effect of nursing care on maternal health outcomes. The Association of Women's Health, Obstetric and Neonatal Nurses and the Association of Maternal & Child Health Programs co-convened an expert panel to develop a set of tools for use by public health and clinical leaders to support this effort.

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Registered nurses represent the largest health care work force in the United States (U.S. Department of Health and Human Services, Health Resources and Services Administration, 2010) and provide essential care to the approximately four million women who give birth each year in the United States (Hamilton, Martin, Osterman, Curtin, & Mathews, 2015). Key responsibilities of nurses include ongoing assessments, implementation of tailored interventions based on these assessments, and team mobilization 24 hours per day to ensure optimum outcomes for women and newborns. However, the effect of nursing care provided to the women who give birth each year in the United States is not well understood. In fact, data about nursing care have been described by some experts as the "black box" of health care data; these experts stated that "differentiating nurses based on the delivery outcomes of women under their care may provide an important new lever to improve the quality of care during childbirth" (Edmonds, Hacker, Golen, & Shah, 2016, p. 4).

In the United States, the pregnancy-related mortality ratio rose from 10 deaths per 100,000 live births in 1990 to 17.8 deaths per 100,000 live births in 2011 to 15.9 deaths per 100,000 live births in 2012 (Centers for Disease Control and Prevention, 2016), which is more than double the 1978 rate of 7.2 deaths per 100,000 live births. In addition, researchers of U.S. maternal mortality trends found that the "raw, unadjusted data from all states regardless of whether they revised their death certificates resulted in a reported U.S. maternal mortality rate" of 21.5 per 100,000 live births in 2014 (MacDorman, Declercq, Cabral, & Morton, 2016, p. 450). Even more tragically, a significant racial disparity exists in the pregnancy-related mortality ratio: Black women have a more than 3 times greater pregnancy-related mortality risk than White women (Centers for Disease Control and Prevention, 2016). Furthermore, many of these deaths are preventable. For example, the North Carolina Pregnancy-Related Mortality Review Committee found that 40% of pregnancy-related deaths in their state between 1995 and 1999 were potentially preventable (Berg et al., 2005), and the Illinois Maternal Mortality Review found that 32.4% of all pregnancy-related deaths between 2002 and 2012 within their state were potentially preventable (Geller, Koch, Martin, Rosenberg, & Bigger, 2014). Preventability of pregnancy-related deaths differs by race: in North Carolina, 33% of deaths among White women were potentially preventable compared

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with 46% of deaths among Black women (Berg et al., 2005).

It is possible that characteristics of the health care setting contribute to these disparities. The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) assembled a team to lead a multiregion quality improvement initiative, and as part of the baseline data, the team examined the relationship between the patient population served and the presence of hospital preparedness elements to effectively respond to postpartum hemorrhage, a leading cause of pregnancy-related death. The team found that for every 10% increase in the total percentage of Black women who gave birth, there was a decrease of one element of hospital preparedness to respond to this obstetric emergency (Bingham, Scheich, Byfield, Wilson, & Bateman, 2016). Further, Howell, Egorova, Balbierz, Zeitlin, and Herbert (2016) found that in hospitals that served high and medium proportions of Black women, Black and White women overall had greater rates of severe maternal morbidity than women who gave birth in hospitals that served low percentages of Black women. In addition, Black women faired more poorly in all categories (Howell et al., 2016).

Given the significant role of nurses in the provision of perinatal care, a specific look at nursing care practices can elucidate opportunities to reduce pregnancy-related mortality in the United States. To address this national priority, in 2014 AWHONN and the Association of Maternal & Child Health Programs (AMCHP) co-convened an expert panel of nurses. The three broad objectives that guided the work of the expert panel were (a) to improve methods to track the ability of nurses to affect the rising trends in maternal mortality and morbidity in the United States; (b) to identify data collection opportunities for state-based maternal mortality review committees that will inform the development of effective strategies and tactics to improve the quality of care women receive before, during, and after pregnancy; and (c) to use the expert panel findings to activate and empower nurses, systems of care, and public health and health care provider partnerships to improve the quality and safety of patient care and reduce maternal mortality and morbidity.

Nurse leaders from across the nation and from varied disciplines, such as risk management, practice and regulation, quality improvement, and academia, were selected to participate in the expert panel. Leaders from the American College of Obstetricians and Gynecologists, the Centers for Disease Control and Prevention Division of Reproductive Health, the National Council of State Boards of Nursing, and the states of California and Illinois were invited guests and discussants at the in-person meeting. The four objectives for the in-person expert panel meeting were as follows: (a) to describe key nursing practices (independent and collaborative) that affect maternal outcomes, (b) to identify potential perinatal data elements on key nursing practices that can be abstracted from a medical record, (c) to identify opportunities to deploy questions or other data collection strategies as a part of state- and facility-based reviews to better characterize nurses' influence on maternal mortality and morbidity, and (d) to propose effective strategies and tactics to improve the quality of nursing care women receive before, during, and after pregnancy.

The meeting included learning panels on current practices in maternal mortality and morbidity surveillance and data collection initiatives related to performance, care quality, and safety at the facility, state, and national levels. After the learning panels, participants broke into small groups to respond to the meeting objectives. After 2 days of deliberation, the members of the expert panel established four workgroups: Nurse and Facility Interview, Clinical Reasoning and Judgment, Patient–Family Interaction and Education, and Communication. During the following year, the members of these workgroups conducted in-depth literature searches on their respective topics, clarified data elements that could be abstracted from a medical record, developed a supporting code book, and created resources and tools to be used by maternal death case abstractors. These data collection tools were designed to help abstractors glean critical nursing care process data from medical records in an effort to identify nursing care factors that could have contributed to the occurrence of a maternal death. The workgroups used two reference tools: Taxonomy of Error, Root Cause Analysis and Practice-Responsibility (TERCAP;

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