The Joint Commission
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Patient Safety Incident Reports Shed Light on Racial and Ethnic Disparities in Maternal Care

Maternal mortality in the United States is high, and women and birthing people of color experience higher rates of mortality and severe maternal morbidity (SMM). More than half of maternal deaths and cases of SMM are considered preventable.

A study featured in the January 2024 issue of *The Joint Commission Journal on Quality and Patient Safety (JQPS)* used patient safety incident reports to study systems issues contributing to adverse outcomes and racial/ethnic disparities in maternal care.

THE PROBLEM

Maternal mortality increased during the COVID-19 pandemic from 17.4 deaths per 100,000 live births in 2018 to 32.9 deaths in 2020, the highest rate of all high-income countries in the world.

Black, American Indian and Alaska Native women and birthing people were **two to three times more likely to die** from pregnancy-related causes than white women.

Maternal mortality and SMM are associated with **$350 million** in excess healthcare expenditures.

More than 80% of maternal deaths from 2017 to 2019 were preventable.

THE STUDY

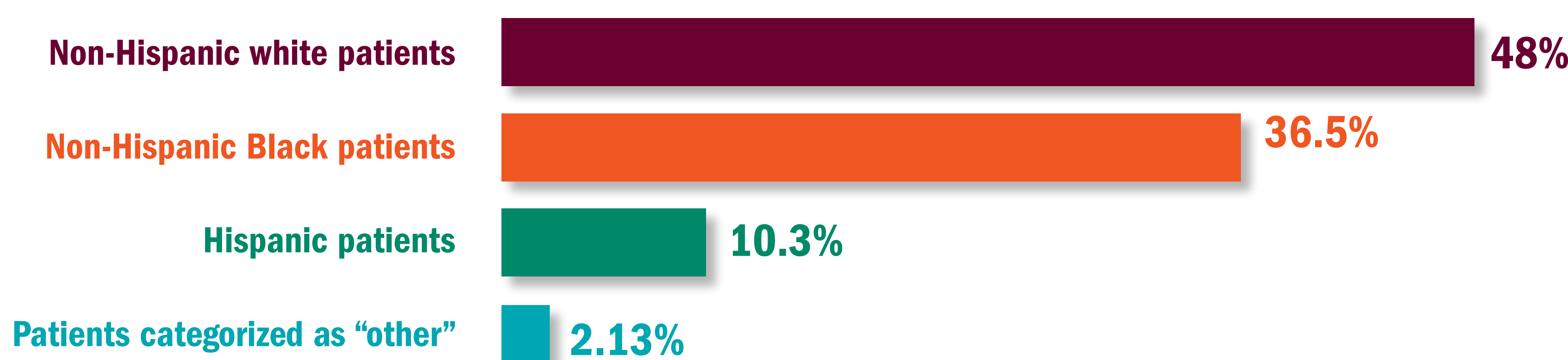
To gain a more nuanced understanding of which specific systems factors contribute to poor outcomes and disparities, the study authors analyzed two years of incident report (IR) data from the labor and delivery unit (L&D) and the antepartum and postpartum unit (A&P) of a large academic hospital.

To statistically evaluate differences, IRs were linked to demographic data using the patient's medical record number (MRN), and described by:

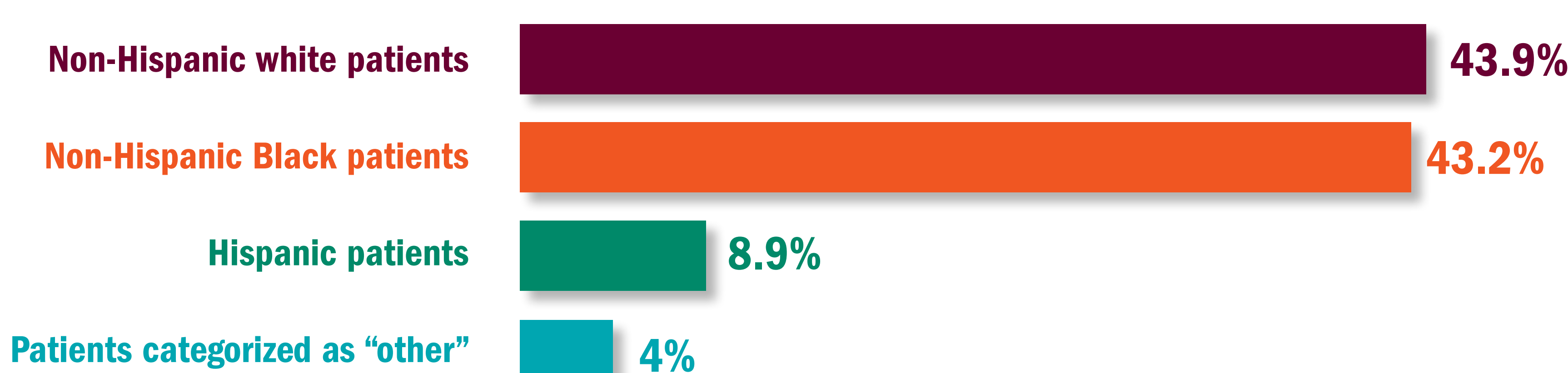
- Race/ethnicity
- Age group
- Method of delivery
- Other process variables

THE RESULTS

Birthing population (5,915 deliveries)



Reported incidents (528 IRs)



The odds of having a reported incident for non-Hispanic Black (NHB) patients were attenuated when controlling for cesarean section, indicating that cesarean delivery is a confounder for the association between race and reported incident.

5 event types accounted for 77.8% of the reported events

- Care coordination/communication
- Laboratory tests
- Medication-related
- Maternal (e.g., hemorrhage)
- Omission/errors in assessment, diagnosis or monitoring

NHB patients accounted for the majority of the following event types:

- Falls
- Complications of care
- Infrastructure failures
- Medical records/patient identification
- Transfusions

The study found that greater integration of patient safety and healthcare equity efforts in hospitals are needed to promptly identify and alleviate racial and ethnic disparities in maternal health outcomes. Although additional systems analysis is necessary, the authors offer recommendations to support safer, more equitable maternal care.

To learn more about this study, visit:
https://www.jointcommissionjournal.com/article/S1553-7250(23)00131-9/fulltext

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