




SMFM SPECIAL STATEMENT

Society for Maternal-Fetal Medicine Special Statement: How to incorporate health equity into quality improvement and patient safety efforts

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Abstract

Optimizing health outcomes among historically marginalized racial and ethnic communities, especially in obstetrics, has tremendous potential to improve the lives of not only patients and their families but also future generations. Understanding potential drivers of health inequities in obstetrics is critical to eliminating them. This Special Statement delivers a comprehensive, action-driven framework that builds on the recommendations in Society for Maternal-Fetal Medicine Consult Series #62: Best Practices in Equitable Care Delivery—Addressing Systemic Racism and Other Social Determinants of Health as Causes of Obstetrical Disparities. We provide strategies to integrate the evaluation of social drivers of health and health disparities into quality and safety case reviews, thereby advancing equity as a fundamental dimension of healthcare excellence. We demonstrate how to incorporate a health equity lens into patient safety events, specifically severe maternal morbidity case reviews and root cause analyses. Through an enhanced case review process that considers health and healthcare inequities as potential contributing factors, hospital quality improvement efforts can target upstream contributors to health outcomes so that adverse outcomes around the time of delivery may be averted.

KEYWORDS

cognitive bias, health equity, implicit bias, linguistic bias, quality improvement and patient safety, root cause analysis, severe maternal morbidity, social drivers of health

1 | INTRODUCTION**1.1 | Hypothetical case**

Your hospital quality improvement and patient safety (QIPS) committee is reviewing a case that was identified

for patient safety event analysis because of the following severe maternal morbidity (SMM) diagnostic criteria:

1. Eclampsia
2. An unplanned intensive care unit (ICU) admission
3. Hospital readmission

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The case notes are as follows:

Jane Doe (JD) is a 21-year-old G1 [primigravida] non-Hispanic Black woman with no significant medical problems who presented at 38 3/7 weeks of gestation with severe headache, abdominal pain, and vaginal bleeding. Her cervical exam was 4/80/−1 [4 cm dilated, 80% effaced, −1 station], and she was admitted to labor and delivery, where she progressed to 7/90/0 [7 cm dilated, 90% effacement, 0 station] 4 h later. She subsequently underwent an emergent cesarean delivery for fetal bradycardia, and placental abruption was identified. During the cesarean delivery, she had an eclamptic seizure. She was discharged home on postoperative Day 4 and then presented 1 week later with severe headache, slurred speech, and persistent severe hypertension. She was ultimately diagnosed with a stroke and admitted to the ICU for treatment.

1.2 | Why is achieving health equity important?

Achieving health equity in all sectors, but especially maternal care, is a national health priority. Minoritized pregnant people are more likely to die from childbirth and are at higher risk of SMM [1]. The maternal mortality rate in the United States is among the highest of developed nations, and the overwhelming majority of deaths (87%) are preventable [2]. The reasons for this are complex and multifactorial, but structural racism and implicit bias play a significant role [3, 4]. Social drivers of health (SDOH), defined as the “conditions in the environments where people are born, live, learn, work, play, worship, and age” [5], are a consequence of discriminatory policies for low-income individuals and persons of color and are strong predictors of adverse pregnancy outcomes [1, 6]. Addressing healthcare gaps that impact the most marginalized groups will undoubtedly improve care for all.

Recognizing the importance of achieving health equity, regulatory agencies, including the Centers for Medicare & Medicaid Services (CMS) and the Joint Commission, have incentivized prioritizing health equity through hospital reimbursement [4, 7]. Additionally, new requirements incorporating screening for SDOH to reduce healthcare disparities are tied to hospital accreditation programs [4, 7]. It is important to note that the terms *social determinants of health* and *social/nonmedical drivers of health* have been used interchangeably. The American College of Physicians explained that the term *drivers* is preferred over *determinants* because it emphasizes that “these factors are changeable drivers that can be influenced rather than fixed determinants that are immutable” [8], and CMS has adopted the term [5]. The Joint Commission refers to these factors as *health-related social needs* to emphasize

that they are a proximate cause of poor health outcomes for individual patients, as opposed to SDOH, which is used to describe populations. This document uses the term SDOH throughout, although we recognize the nuances of these different terms.

In this Special Statement, we provide an action-oriented framework to patient safety event analysis that can be applied to mitigate maternal health disparities and their associated inequities at your institution. Building on the hypothetical case, we describe in detail the composition of an ideal QIPS committee, how to perform a standardized evaluation of the event, how to proactively identify health inequities at your institution, and how to target quality improvement (QI) efforts to reduce them. Leveraging the joint recommendations of the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine (SMFM) for the review of SMM events [9], we apply a structured framework established by the Alliance for Innovation on Maternal Health (AIM) to analyze the hypothetical case [10]. Through this process, we demonstrate how incorporating a health equity lens into case reviews can reveal systemic gaps and institutional-level opportunities for improvement. This approach not only facilitates a deeper understanding of individual and structural contributors to maternal outcomes but also informs targeted QI initiatives aimed at advancing maternal health equity.

2 | GETTING STARTED: HOW TO ESTABLISH A QIPS COMMITTEE THAT MONITORS AND EVALUATES FOR HEALTH DISPARITIES

2.1 | Committee membership and components of the QI process

Evaluating health disparities and their associated inequities must be at the center of any QIPS committee. The QIPS committee should, at a minimum, consist of a committee of clinicians who actively engage in maternal care, as well as social services and community representation, if possible (Figure 1); a method to track the results of a QI initiative; and a forum to engage with and inform the medical staff on the progress of that initiative. Gandhi et al.’s description of how to create an effective practice peer review process can be used to guide the development of an effective multidisciplinary QIPS program [11]. Lastly, it is important for any QIPS committee to educate the medical staff on lessons gleaned from case review. Opportunities to share information, such as patient safety conferences, grand rounds, and



FIGURE 1 Key members of a maternal health quality improvement and patient safety committee.

traditional maternal morbidity and mortality conferences, should be identified early on.

2.2 | How to identify cases for patient safety analysis

Like maternal mortality, SMM is increasing in the United States and is associated with a high rate of preventability [9]. SMM can be considered a near-miss for maternal mortality because, without proper identification and treatment, in some cases, these conditions would lead to maternal death. Identifying SMM is, therefore, important for preventing mortality. A core component of every QIPS program is a holistic, in-depth case review of specific clinical events, similar to reviews conducted by statewide maternal mortality review committees. The goal of case review should be to identify healthcare provider, facility, patient, and environmental factors that may have contributed to the adverse outcome so that QI opportunities can be developed and implemented (Figure 2) [12]. The updated AIM guidance on SMM review [10] includes a framework to assess respectful, equitable, and supportive care. The AIM guidance recommends that each case review assess the following:

- Contributing factors associated with SDOH
- Appropriate referral and follow-up for identified unmet social needs

- Instances of racism, discrimination, or implicit or explicit bias and how these may have impacted quality of care

The AIM website provides a collection of support tools to help institutions implement this framework, including an SMM review form, webinars on chart abstraction, lessons learned, and strategies to integrate equity considerations [10].

Reviews should focus on information gleaned from the electronic health record (EHR), along with discussion with the primary team members involved (physicians, residents, fellows, nurses, etc.), and should compare clinical actions to hospital-specific guidelines, policies, and procedures. Consider identifying one or two members of the committee to review the case by completing the AIM SMM review forms [13] and presenting standardized factors to the QIPS committee for discussion. If the committee is large enough, consider having both a physician or advanced practice provider reviewer and a nurse reviewer evaluate the case so that the committee hears from different perspectives. The committee should then discuss whether there was evidence of health inequity due to racism, particularly the potential for implicit bias. Findings of the case review, including any discovery of health inequities, must be discussed and reviewed thoroughly in various learning formats to reach key clinical stakeholders within your institution, including but not limited to traditional maternal morbidity and mortality conferences, grand rounds, root cause analyses (RCAs), and clinical debriefs.

3 | HOW TO CONDUCT THE PATIENT SAFETY EVENT ANALYSIS

3.1 | SDOH factors

To understand the impact of SDOH on maternal health outcomes, universal SDOH screening must be implemented during pregnancy and the postpartum period. Several SDOH screening tools exist and can be adapted to fit your institutional needs [3, 14, 15]. Screening must be implemented with caution, humility, and empathy to eradicate any perceived feelings of shame or judgment from the healthcare team when disclosing social needs [15]. In the absence of universal SDOH screening, chart review may identify SDOH barriers, particularly within social work consultation notes. The AIM SMM Factors Sheet [16] is a structured tool designed to support reviewers in examining the underlying contributors to SMM, with a focus on identifying clinical, systemic, and contextual influences on patient outcomes. Characteristics of SDOH that can impact a clinical outcome may include the following:

- Language barrier/limited English proficiency
- Cultural or religious differences
- Limited health literacy
- High social needs (e.g., people who are refugees, are unhoused, or have been involved with child protective services)
- Barriers to care (e.g., immigration status, lack of transportation, or lack of insurance)

Rather than initially asking whether specific factors directly contributed to the patient safety event, it may be more effective to begin by simply identifying whether these factors were present. This approach can help uncover recurring patterns across incidents without prematurely assigning causality. Additionally, integrating the reflective questions from the AIM SMM Review Form [13] into clinical event debriefing tools provides the team with a structured space to voice concerns. Such integration encourages deeper discussion, fosters collective insight, and supports the development of timely, actionable strategies for improvement.

3.2 | Bias and stigma factors

Importantly, the language used in the EHR can help elucidate whether negative bias has occurred [17]. Studies indicate that clinicians may be more likely to dismiss, ignore, or downplay the concerns of Black and female patients compared with White and male patients [18]. The phenomenon of clinicians disbelieving certain patients may be a manifestation of unconscious biases and stereotypes of women and minoritized people as lacking credibility [19]. Because these biases are typically unconscious and subtle, their potential impact on clinical care can be challenging to detect. Literature from the field of social psychology finds that attitudes can be reflected through people's language [20–23]. Thus, unconscious biases and stereotypes may reveal themselves in the language used to describe patients, including women and minoritized people, in clinical notes. A content analysis of 600 clinical notes revealed three linguistic features suggesting disbelief: (1) using quotation marks (e.g., had a “reaction” to the medication); (2) using judgment words that suggest

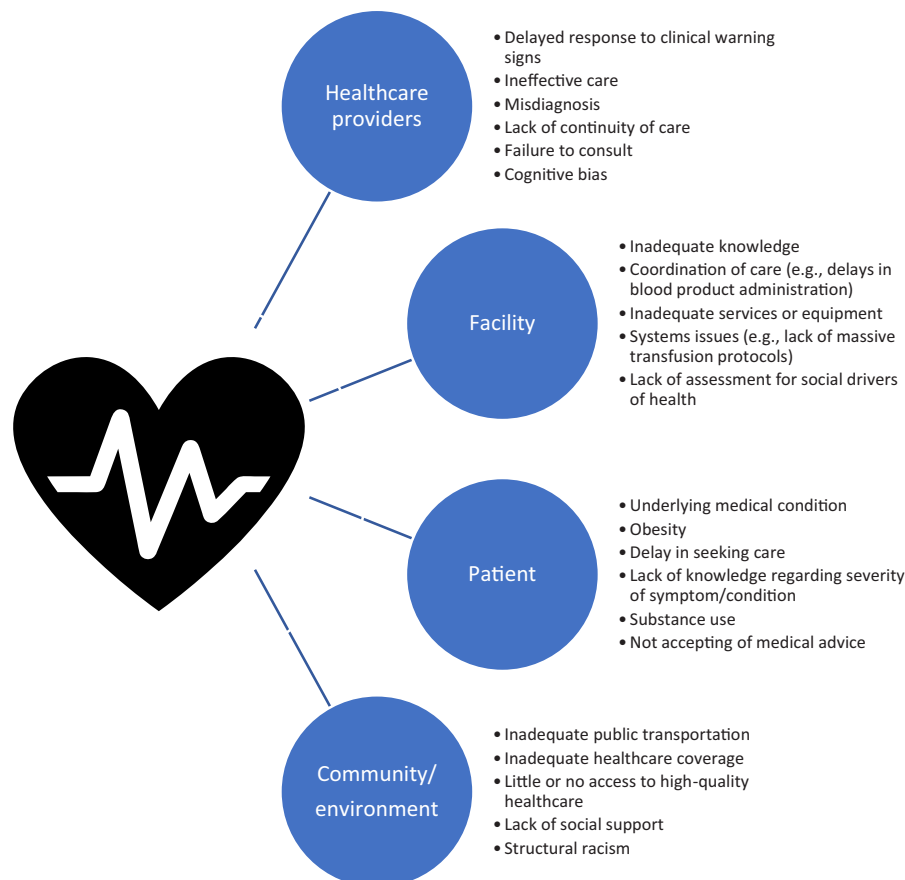


FIGURE 2 Contributing factors to maternal morbidity and mortality.

doubt (e.g., *claims* or *insists*); and (3) writing in evidentials, a sentence construction in which patients' symptoms or experiences are reported as hearsay. In the analysis, all three linguistic features appeared more often in the medical records of Black patients than White patients, and quotation marks were more likely to be used in notes for women than men [18]. In a 2018 randomized controlled vignette study that examined how language in the medical record of a hypothetical patient with sickle cell disease would impact care, the authors found that readers of stigmatizing versus neutral language had more negative attitudes toward the patient and opted to administer less analgesia, even though the clinical information was the same. This finding suggests that bias can be perpetuated through patient medical records and can influence clinician decision-making [24]. Evaluating for stigmatizing language such as *noncompliant* or *refused* can help provide insight into whether linguistic bias impacted the patient's outcome.

It is also important to assess for cognitive and implicit bias during each case review [25]. Cognitive bias is defined as an implicit systematic error in thinking, which can lead clinicians to make an erroneous judgment about a case. There are more than 180 types of cognitive bias [26]. Within events reported to the Joint Commission, cognitive biases have been identified as contributors to a number of sentinel events, including unintended retention of foreign objects (e.g., search satisficing), wrong-site surgeries (e.g., confirmation bias), patient falls (e.g., availability heuristic and ascertainment bias), and delays in treatment, particularly diagnostic errors that may result in a delay in treatment (e.g., anchoring, availability heuristic, framing effect, and premature closure). According to the literature, diagnostic errors are associated with 6%–17% of adverse events in hospitals, and 28% of diagnostic errors have been attributed to cognitive error [27]. The most common types of cognitive bias, their descriptions, and examples can be found in Table 1. Because linguistic and implicit biases are also described as unconscious acts, we group them as another form of cognitive bias.

The AIM SMM Factors worksheet integrates an assessment of health team member biases and racism, including an assessment of linguistic bias and stigmatizing language in the medical record [16]. When evidence of bias is identified in the medical record, engaging the involved clinician may not lead to acknowledgment unless the conversation is approached with intentionality and framed to invite reflection and introspection rather than provoke defensiveness. Creating space for open, nonjudgmental dialogue is essential to fostering awareness and accountability in clinical practice. One approach is for the case reviewer to pose the following questions to the involved clinician:

(1) Did you feel there was any discrimination or bias in the case? (2) How do you assess yourself for bias or discrimination? QI leaders may engage with their institutions' human resources staff to facilitate such conversations, as these discussions can be challenging.

3.3 | Condition-specific questions

The AIM SMM Review Form also includes condition-specific questions for various clinical conditions, including obstetrical hemorrhage, cardiac and cardiopulmonary conditions, and mental health conditions [28]. In this article, we use the AIM questions specific to respectful, equitable, and supportive care and hypertensive disorders of pregnancy to thoroughly dissect the hypothetical case from a health equity perspective.

3.4 | Root cause analysis

Using the AIM SMM forms, the initial step in analyzing a case involves determining the sequence of SMM, which functions as an RCA. Generally, RCAs are indicated for any sentinel event, defined by the Joint Commission as a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm) [29]. An RCA is a deliberate dissection of an error to get to the underlying source of an issue rather than stopping at superficial explanations [30]. RCAs are often used in QI efforts to identify the fundamental or deepest reasons for unwanted conditions or outcomes and use those findings to make changes to minimize recurrence [31]. RCAs can also be used to identify opportunities to reduce and eliminate health and healthcare inequities by applying an equity lens. Tools such as process-mapping, the five whys, and a cause-and-effect diagram (e.g., a fishbone diagram) are used to conduct an RCA.

The five whys approach involves asking and answering the question "why?" five times—or as many times as it takes to get to the root or end of the causal chain [32]. Figure 3 applies a health equity lens to the five whys methodology to determine the underlying root cause for JD's ICU admission in the hypothetical case. A fishbone diagram (described in detail in the SMFM primer on patient safety and healthcare quality for maternal-fetal medicine fellows [30]) is a cause-and-effect diagram in which the "head" of the fish represents the adverse event or error and the "bones" represent categories of contributing factors. A central line (spine) is drawn to

TABLE 1 Types and examples of cognitive biases [26, 27].

Type of bias	Definition	Example
Anchoring	Giving weight to and relying on initial information/impressions, and not adjusting from this (anchor) despite the availability of new information	Jumping to conclusions, which can lead to missed/delayed diagnoses
Ascertainment	Shaping decision-making based on prior expectations (e.g., stereotyping, gender bias)	Identifying some patients as “frequent flyers” with recurrent complaints, or, in the case of falls, describing a patient as one who “always uses the call bell,” predisposing staff to expect that behavior
Availability	Judging the likelihood of a diagnosis based on the ease with which examples can be retrieved (e.g., examples that are more familiar, common, recent, or memorable)	Diagnosing a patient based on frequently seen conditions such as the flu and failing to consider other diagnoses
Confirmation	Selectively noticing/seeking information that confirms opinion/impression versus seeking information that disconfirms; evidence in support of beliefs is given more weight, while evidence that refutes may not be noticed	Not noticing a warning label on medication or performing procedure on the incorrect site
Framing effect	The impact of how information is presented or how a question is framed	Describing potential outcomes in terms of the possibility that the patient might live or that they might die
Search satisficing/premature closure	Ceasing to look for findings/signals (e.g., disease processes, fracture, retained object) once a possible answer has been identified; accepting a diagnosis before considering all information and verifying the diagnosis	Failing to look for a second foreign object once an object has been identified and removed
Implicit	Attitudes and stereotypes that affect our understanding, actions, and decisions in an unconscious manner	Failing to consider a diagnosis because it is more common in patients of a certain ethnicity
Linguistic: quotation marks	Often used as an indication that the words are to be doubted	Documenting that “The patient had a ‘reaction’ to the medication.”
Linguistic: judgment words	Words convey a sense of doubt or negative judgment on the part of the clinician	Using words such as <i>adamant</i> , <i>apparently</i> , <i>claims</i> , <i>insists</i> , <i>states</i> , <i>abusive</i> , <i>combative</i> , <i>noncompliant</i> , <i>refuses</i>
Linguistic: evidentials	Sentence construction in which patients’ symptoms or experiences are reported as hearsay	Documenting that “The patient reports that the headache started yesterday.”

the left of the box in which the error is recorded. Possible categories when considering medical error include the five P’s: patients, providers, policies, processes, and place/equipment (Figure 4), but can change based on the error at hand. Figure 5 shows a fishbone diagram of the hypothetical case.

The organization Advancing Health Equity developed an RCA model specifically to understand the root causes of inequities [31]. The model not only offers practical guidance but also challenges organizations to engage deeply with equity-centered inquiry. Central to this pro-

cess is the imperative to ask: How might the root causes of the inequity be different when considered from the perspective of different aspects of identity, such as race, ethnicity, class, sexuality, or age? Moreover, how do these root causes evolve when viewed through the lived experiences of individuals who navigate multiple, intersecting forms of marginalization? These questions are essential for uncovering systemic patterns of exclusion that might otherwise remain invisible and for moving toward solutions that are truly just and inclusive.

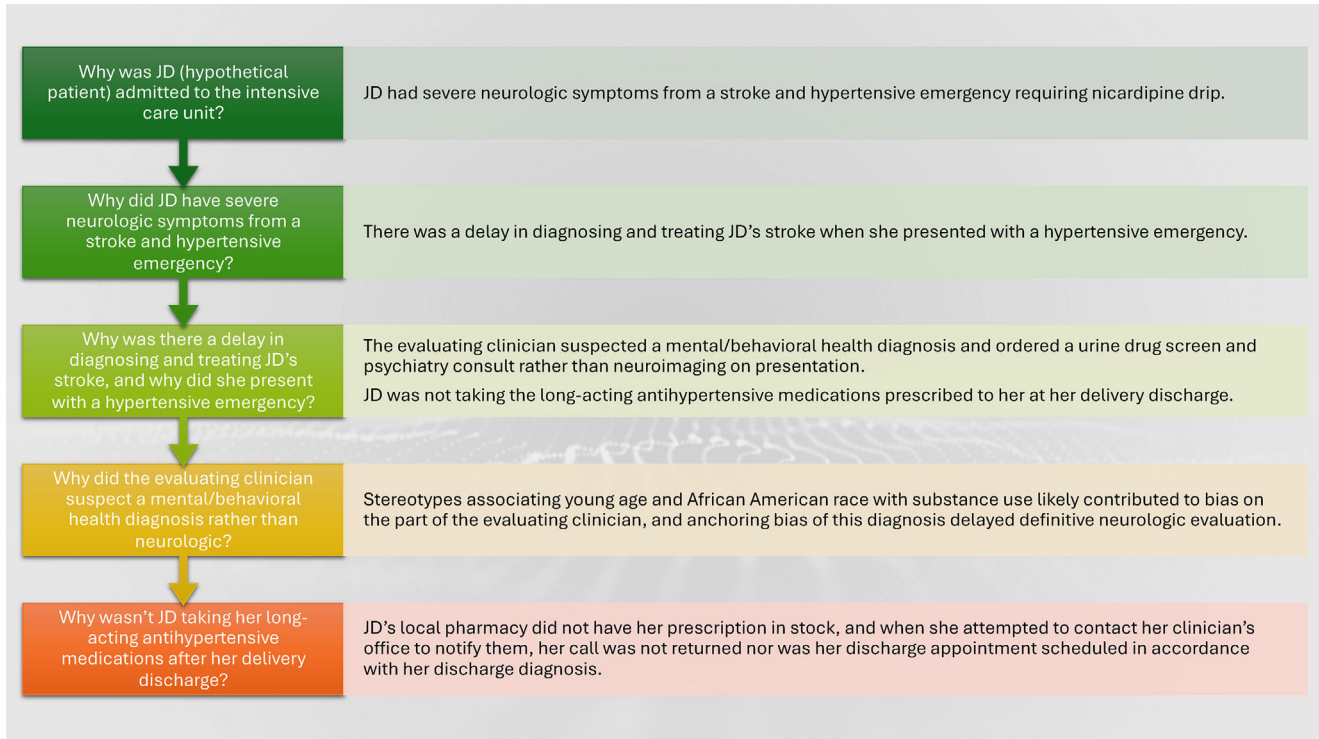


FIGURE 3 Five whys for the hypothetical case of intensive care unit admission.

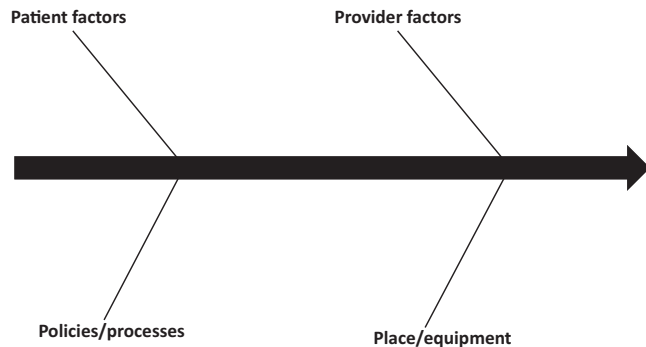


FIGURE 4 Example of a fishbone diagram.

4 | TYING IT ALL TOGETHER

As you review JD's chart, you note the following:

- JD had mildly elevated blood pressure in the prenatal period beginning at 34 weeks of gestation that was not acknowledged, and a preeclampsia workup was not performed.
- JD had severe hypertension during the intrapartum course that was attributed to pain. She did not undergo a workup for preeclampsia nor receive magnesium sulfate for seizure prophylaxis even though she met the criteria for preeclampsia with severe features.

- JD had severe abdominal pain upon presentation and was described as “refusing” treatment and “uncooperative” during provider and nursing assessments in triage. The initial focus on admission to labor and delivery was on providing an epidural for pain management. There was a lack of recognition that JD's abdominal pain and hypertension were signs and symptoms of preeclampsia with severe features and placental abruption.
- JD's elevated blood pressure (in the range of 150/100 mmHg) persisted postpartum, and oral antihypertensive medication was prescribed. She had a postpartum follow-up scheduled for 2 weeks after delivery. She did not receive a blood pressure cuff for home use. She was unable to fill her prescription for oral antihypertensives because the pharmacy did not have it in stock.
- There was a delay in care when JD re-presented because of the focus on obtaining a psychiatry consult and a urine drug screen in response to JD's slurred speech instead of immediately sending JD for neuroimaging.
- A social worker was consulted because of JD's “noncompliance.”

In the hypothetical case for JD, the SMM under review is the ICU admission. The sequence of morbidity-related events leading to the ICU admission began with

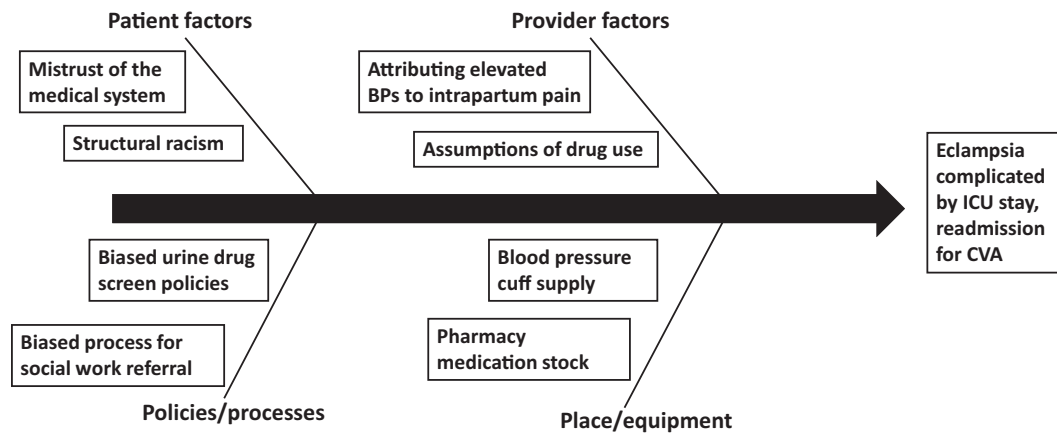


FIGURE 5 Fishbone diagram of the hypothetical case. BP, blood pressure; CVA, cerebrovascular accident; ICU, intensive care unit.

preeclampsia with severe features and barriers to health-care, which led to inadequately treated hypertension postpartum, which led to a stroke and hypertensive emergency that required ICU care. In reviewing the care surrounding JD's delivery and readmission, the AIM condition-specific questions on hypertensive disorders of pregnancy and respectful, equitable, and supportive care highlight care deviations and provide a better understanding of the root causes of JD's SMM [28]. Table 2 illustrates how the answers to the condition-specific questions [28] and their associations with the relevant AIM factor [16] can help identify opportunities for improvement in addressing cases such as JD's. Table 3 groups recommendations for QI efforts based on the identified factors [13].

Both anchoring and implicit bias may have played a role when JD presented with headache and slurred speech after delivery. The historically biased association of Black race and young age with substance use may have led the clinical team to assume that she was under the influence of substances rather than exhibiting stroke-like symptoms. Anchoring bias on the substance use as the etiology of her symptoms may have caused a significant delay in diagnosing the cerebrovascular accident, which is a known complication of severe hypertension.

In the hypothetical case, clinicians directly involved in JD's care may have recognized that cognitive or implicit bias influenced the clinical decision-making process. However, even when such insight exists, the absence of reporting systems that explicitly capture these concerns and the lack of a psychologically safe culture that encour-

ages their disclosure can allow critical safety threats to persist unaddressed. These drawbacks underscore the importance of incorporating health equity into all patient safety event analyses. We provide a rubric for incorporating health equity into patient safety analysis in Table 4, modeled after *Obstetrics & Gynecology's* rubric to center equity in research [36].

5 | CONCLUSION

Achieving health equity in maternal care requires a systematic approach using QIPS strategies to reduce maternal health disparities. Future work will describe other important aspects of achieving health equity through QI, including involving patient representatives or community advisory boards, creating a health equity dashboard, and applying QI methodologies to the ambulatory care setting.

In this article, we describe in detail how to construct a QIPS program centered on thorough case review within the departmental QIPS committee as well as the institutional RCA process. We provide several tools and the framework for embedding health equity into patient safety analysis and designing QI efforts to mitigate the identified health inequities. These tools and examples are provided to help any organization, regardless of available resources, get started. This action-oriented framework provides the tools necessary to design and implement an effective QIPS program with health equity at its foundation, thereby accelerating the momentum toward reducing maternal health disparities.

TABLE 2 Alliance for Innovation on Maternal Health severe maternal morbidity condition-specific questions and factors worksheet for the hypothetical case [16, 28].

Questions	Hypothetical case review findings	AIM SMM factors and case-specific rationale
Condition-specific questions: Hypertensive disorders of pregnancy		
Were the following recognized in an appropriate and timely manner?	1. Yes. 2. No. The patient had several episodes of unrecognized hypertension in the antepartum and intrapartum settings. Her severe hypertension intrapartum was incorrectly attributed to pain, and there was a focus on getting her an epidural rather than evaluating her for preeclampsia with severe features and treating with antihypertensive medications and magnesium sulfate.	<i>System factors—culture</i> <i>Team-based communication:</i> JD had multiple severe-range BP results during labor that were not communicated to the physicians and were not visible in the EHR because they had not been validated from the bedside vital sign monitor.
Did the following occur in an appropriate and timely manner, if applicable or needed?	1. No. JD had persistent severe hypertension for several hours and never received short-acting antihypertensive treatment. 2. No. JD satisfied the criteria for preeclampsia with severe features based on her intrapartum persistent severe hypertension; however, magnesium was not administered until after her eclamptic seizure. 3. No. The mid-range BP readings at every prenatal visit beginning at 34 weeks satisfied the diagnostic criteria for gestational hypertension. JD may have had preeclampsia with or without severe features. However, no laboratory workup for preeclampsia was performed. JD should have been delivered at 37 weeks for gestational hypertension, if not earlier. Earlier delivery may have avoided the presentation at 38 weeks with placental abruptio. 4. No. JD's misdiagnosis and lack of appropriate and timely treatment for preeclampsia with severe features resulted in an eclamptic seizure.	<i>System factors—process</i> <i>Delivery planning:</i> Delivery should have been planned for no later than 37 weeks based on satisfying diagnostic criteria for a hypertensive disorder of pregnancy at prenatal visits.
1. Treatment of persistent severe HTN within 60 min of the first severe-range BP reading		
2. Administration of magnesium sulfate		
3. Delivery at the appropriate GA in relation to the patient's hypertensive disease		
4. Monitoring for and management of complications related to patient's hypertensive disease or treatment		
If this was a postpartum HTN readmission, did the patient receive appropriate delivery discharge medications and follow-up based on their diagnosis and documented BP prior to initial discharge?	Discharge medications were appropriate; however, the medication was not available at the pharmacy. JD called the office to notify the provider and did not receive a response. The follow-up appointment was not scheduled appropriately based on the severity of the condition. If it had been scheduled within 3 days, there would have been an opportunity to assist JD with obtaining a BP cuff and her prescribed medications, possibly preventing readmission.	<i>System factors—process</i> <i>Discharge planning and process:</i> Inappropriate follow-up at 2 weeks in a patient with severe hypertension and eclampsia was documented. <i>Follow-up process:</i> If an appropriate follow-up had been scheduled within 3 days, it would have been discovered that the patient never received oral antihypertensive medication, which may have prevented the stroke. <i>Social and structural determinants of health</i> <i>Health barriers and barriers to healthcare access:</i> JD was unable to obtain a BP cuff because her insurance did not cover the full cost and the remaining out-of-pocket amount was cost-prohibitive. JD was unable to fill her prescription for long-acting antihypertensive medications because her local pharmacy did not have them in stock and she did not have transportation to a pharmacy that stocked them.

(Continues)

TABLE 2 (Continued)

Questions	Hypothetical case review findings	AIM SMM factors and case-specific rationale
Condition-specific questions: Respectful, equitable, and supportive care		
Was documentation in the patient's chart non-stigmatizing and respectful?	No. The H&P from the delivery admission described JD as "refusing" care and "uncooperative" with assessments. Additionally, documentation on the readmission H&P noted that JD was "noncompliant" with prescribed antihypertensive medication. However, once JD met with the social worker, it was recognized that she had barriers to filling that prescription.	<i>Health team member considerations—care team biases or racism</i> Availability bias, as the hypertension was falsely attributed to pain, with a focus on epidural placement rather than evaluation and management for preeclampsia. Anchoring bias, as the team's focus on substance use as the etiology of JD's symptoms likely caused a significant delay in diagnosing the cerebrovascular accident. Evidence of racism and implicit bias was found due to the assumption of substance use when the patient presented with signs and symptoms of a stroke.
Was there documentation of screening for social and structural determinants of health needs?	Yes, but only after social work consultation was requested for "noncompliance."	
Was there documentation of timely referral to identified needed resources and social supports?	No. The patient was not offered any social or emotional support for her traumatic birth.	
Was there documentation of a referral to social work and/or other support services after the event?	Yes, but only due to "noncompliance" upon readmission, not because of a recognized need for social or emotional support from the healthcare team after the events surrounding her delivery or her readmission.	

Note: Adapted from [16, 28].

Abbreviations: AIM, Alliance for Innovation on Maternal Health; BP, blood pressure; EHR, electronic health record; GA, gestational age; H&P, history and physical; HTN, hypertension; JD, Jane Doe (hypothetical patient); SMM, severe maternal morbidity.

TABLE 3 Recommendations to guide quality improvement efforts following patient safety event analysis.

Clinical factor	Recommendations for improvement
System	<ul style="list-style-type: none"> • Offer training on implicit bias and respectful care for all nurses and other providers, repeated annually. • Institute health equity rounds/case-based curriculum [33] to engage in discussions of how racism and implicit bias directly impact patient care. • Develop and implement a maternal early warning system to standardize recognition and response to abnormal vital signs and symptoms. • Develop and implement a guideline regarding diagnosis and management of hypertensive disorders of pregnancy and their associated complications, including timing of postpartum and post-discharge follow-up, based on severity of condition. • Implement a checklist for postpartum discharge of patients with hypertensive disorders of pregnancy [34]. • Develop simulation scenarios on recognition and response to hypertensive emergencies and their complications, such as stroke.
Provider	<ul style="list-style-type: none"> • Attend annual simulations developed by the system on recognition and response to hypertensive emergencies. • Develop and implement a process for scheduling timely postpartum follow-up appointments prior to discharging a postpartum patient with a hypertensive disorder of pregnancy. Consider innovative tools, such as mobile health options for recording and reporting blood pressures and telemedicine options for follow-up appointments.
Social and structural determinants of health	<ul style="list-style-type: none"> • Evaluate and address barriers to care prior to postpartum discharge, such as resources to fill/pick up prescriptions, including durable medical equipment (e.g., blood pressure cuff). • Consult social work provider prior to discharge to assist with identified health and healthcare barriers. • Partner with the hospital pharmacy to institute a program to eliminate barriers to obtaining prescribed long-acting medications from a local pharmacy after discharge.

Note: Adapted from [35].

TABLE 4 Health equity patient safety event analysis rubric.

Health equity questions		
Social drivers of health		
Were any of the following social drivers of health present in this case?	Language barrier/limited English proficiency	<input type="checkbox"/>
	Cultural or religious differences	<input type="checkbox"/>
	Limited health literacy	<input type="checkbox"/>
	Barriers to care (e.g., lack of transportation, immigration status, lack of insurance)	<input type="checkbox"/>
Bias and stigma factors		
Were any of the following types of stigmatizing language evident in the electronic health record?	Quotation marks, e.g., describing patient's "reaction" to medicine	<input type="checkbox"/>
	Judgment words that suggest doubt, e.g., patient <i>claims</i> or <i>insists</i>	<input type="checkbox"/>
	Stigmatizing language, e.g., the patient is <i>noncompliant</i> or the patient <i>refused</i>	<input type="checkbox"/>
Was there evidence of cognitive bias? ^a	Anchoring bias: Giving weight to the initial impression despite new information	<input type="checkbox"/>
	Ascertainment bias: Shaping decision-making based on prior expectations (e.g., stereotyping, gender bias)	<input type="checkbox"/>
	Availability bias: Judging the likelihood of a diagnosis based on the ease with which examples can be retrieved (more familiar, common, recent, memorable)	<input type="checkbox"/>

^aCommon types of bias are listed here. For a more detailed list, see Table 1.

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