Welcome!

KPQC Fall Virtual Conference:

Birth & Beyond: What Keeps You Up at Night?

A Conference Sponsored by:

KPQC
Kansas Perinatal Quality Collaborative

Tuesday, October 22, 2024

Kansas Perinatal Quality Collaborative

Welcome!

Dr Nguyen, KPQC Advisory Board Chair

https://kansaspqc.org/oct-2024-fall-conference/

KPQC Fall Virtual Conference:

Birth & Beyond: What Keeps You Up at Night?

KPQC
Kansas Perinatal Quality Collaborative

October 22, 2024 • 9:00 a.m. to 12:00 p.m.

Join the Kansas Perinatal Quality Collaborative for this virtual, complimentary conference featuring clinical and health policy leaders. Engage in conversations and learnings to improve maternal outcomes and health equity.

Agenda

9:00 a.m.	**Rapid Response: Hot Topics in Kansas Birth & Newborn Care** KPQC Leadership Team
9:30 a.m.	**Sepsis: Before, During, & After Birth** **Angela Martin, MD, FACOG** Medical Director of Labor and Delivery, Obstetrics and Gynecology University of Kansas Health System
10:15 a.m.	**Session Q&A**
10:30 a.m.	**Reimagining Health Equity: Leveraging Data, Partnerships, and Innovation to Drive Excellent Care** **Emersen Frazier, MPH** Director of Health Equity and Policy Stormont Vail Health
11:15 a.m.	**Session Q&A**
11:30 a.m.	**Unveiling of next KPQC Safety Bundle**
12:00 p.m.	**Closing**

Register today for this virtual, complimentary conference!

Keynote Speakers

Angela Martin, MD, FACOG
Medical Director of Labor and Delivery, Obstetrics and Gynecology,
University of Kansas Health System

Dr. Angela Martin attended medical school at the University of Missouri-Columbia. She completed her residency in OBGYN at Emory University where she completed a fellowship in Maternal-Fetal Medicine. Dr. Martin joined the faculty at the University of Kansas in 2016. She is currently a Clinical Associate Professor of Maternal-Fetal Medicine. Since joining the faculty, she has won several teaching awards at KU, including the American College of Obstetrics and Gynecology National Faculty Award and an Excellence in Teaching Award from the Association of Professors of Gynecology and Obstetrics. She has enjoyed performing retrospective cohort projects on topics such as preterm birth, fetal growth restriction, and trial of labor after cesarean section. She is currently the vice chair of the hospital pharmacy and therapeutics committee and has been involved in the OB quality and patient safety committee. Most recently, she has enjoyed her role as the medical director of labor and delivery.

Emersen Frazier, MPH
Director of Health Equity and Policy, Stormont Vail Health

Emersen Frazier, MPH, has a strong commitment to community advocacy and policy development. Currently serving as the Director of Health Equity and Policy at Stormont Vail Health in Topeka, KS, Emersen has taken the lead in implementing data-driven initiatives to ensure equitable health outcomes for patient populations and fostering collaboration with state and federal policymakers. Emersen has contributed to various critical aspects of healthcare, including patient safety, population health, accreditation standards, and policy development. Emersen holds a Masters in Public Health from the University of South Carolina (Columbia, SC), concentrating on Health Services, Policy, and Management. There, she achieved summa cum laude honors and crafted a thesis on a Community Health Worker Health Equity Impact Program. Her BA in Political Science is from Claflin University (Orangeburg, SC), where she also earned her summa cum laude honors and valedictorian status.

Conference Information

Registration is free, and a Zoom link will be provided in advance of the conference. Attendees will receive slides and conference materials after the live session.

Register today for this virtual, complimentary conference!

https://kansaspqc.org/oct-2024-fall-conference/

KPQC KDHE Staff

Jill Nelson

Kari Smith

Terrah Stroda

Rapid Response: *Hot Topics* Fall 2024

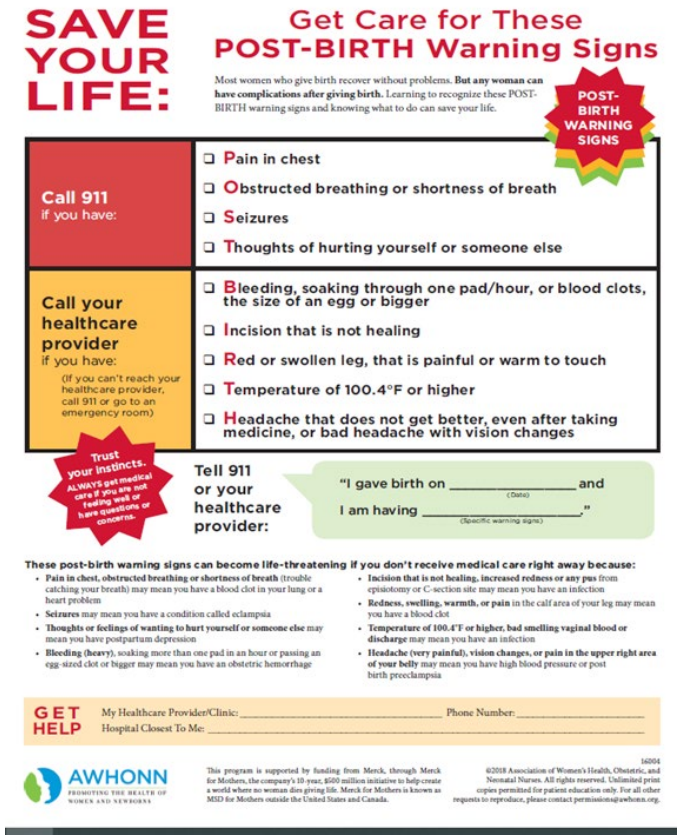
FTI is officially COMPLETED!!!!

We will continue to be the EPICENTER of Perinatal & Neonatal QI Work in **Kansas**

- Fourth Trimester Initiative
- NAS
- And on and on

Learning Forums are online with ALL FTI topics: https://kansaspqc.org/initiatives/fourth-trimester-initiative/fourth-trimester-learning-forum-meetings/

POSTBIRTH= Game.Changer.



SAVE YOUR LIFE:

Get Care for These POST-BIRTH Warning Signs

Most women who give birth recover without problems. **But any woman can have complications after giving birth.** Learning to recognize these POST-BIRTH warning signs and knowing what to do can save your life.

POST-BIRTH WARNING SIGNS

Call 911 if you have:

- ❑ Pain in chest
- ❑ Obstructed breathing or shortness of breath
- ❑ Seizures
- ❑ Thoughts of hurting yourself or someone else

Call your healthcare provider if you have:
(If you can't reach your healthcare provider, call 911 or go to an emergency room)

- ❑ Bleeding, soaking through one pad/hour, or blood clots, the size of an egg or bigger
- ❑ Incision that is not healing
- ❑ Red or swollen leg, that is painful or warm to touch
- ❑ Temperature of 100.4°F or higher
- ❑ Headache that does not get better, even after taking medicine, or bad headache with vision changes

Trust your instincts. ALWAYS get medical care if you are not feeling well or have questions or concerns.

Tell 911 or your healthcare provider:

"I gave birth on _____ (Date) and I am having _____ (Specific warning signs)."

These post-birth warning signs can become life-threatening if you don't receive medical care right away because:

- **Pain in chest, obstructed breathing or shortness of breath** (trouble catching your breath) may mean you have a blood clot in your lung or a heart problem
- **Seizures** may mean you have a condition called eclampsia
- **Thoughts or feelings of wanting to hurt yourself or someone else** may mean you have postpartum depression
- **Bleeding (heavy)**, soaking more than one pad in an hour or passing an egg-sized clot or bigger may mean you have an obstetric hemorrhage
- **Incision that is not healing, increased redness or any pus** from episiotomy or C-section site may mean you have an infection
- **Redness, swelling, warmth, or pain** in the calf area of your leg may mean you have a blood clot
- **Temperature of 100.4°F or higher, bad smelling vaginal blood or discharge** may mean you have an infection
- **Headache (very painful), vision changes, or pain in the upper right area of your belly** may mean you have high blood pressure or post birth preeclampsia

GET HELP My Healthcare Provider/Clinic: _____ Phone Number: _____
Hospital Closest To Me: _____

AWHONN PROMOTING THE HEALTH OF WOMEN AND NEWBORNS

This program is supported by funding from Merck, through Merck for Mothers, the company's 10-year, $500 million initiative to help create a world where no woman dies giving life. Merck for Mothers is known as MSD for Mothers outside the United States and Canada.

MARCH OF DIMES

FOURTH TRIMESTER INITIATIVE

Mom's Name:_____

Date of Delivery:_____ Vaginal Birth C-Section Birth

Complications in pregnancy: Asthma Diabetes Depression/Anxiety Hypertension Thyroid Disease

Other:_____

Medications at discharge:_____

Upcoming Appointments:

Date:_____ **Time:**_____ **With:**_____
Date:_____ **Time:**_____ **With:**_____
Date:_____ **Time:**_____ **With:**_____

What happens at a Postpartum Check?
https://www.marchofdimes.org/pregnancy/your-postpartum-checkups

Baby's Name:_____

Term Preterm _____weeks

Birth Weight:_____**Birth Length:**_____

Infant Feeding: Breast Milk Formula Both

Upcoming Appointments:

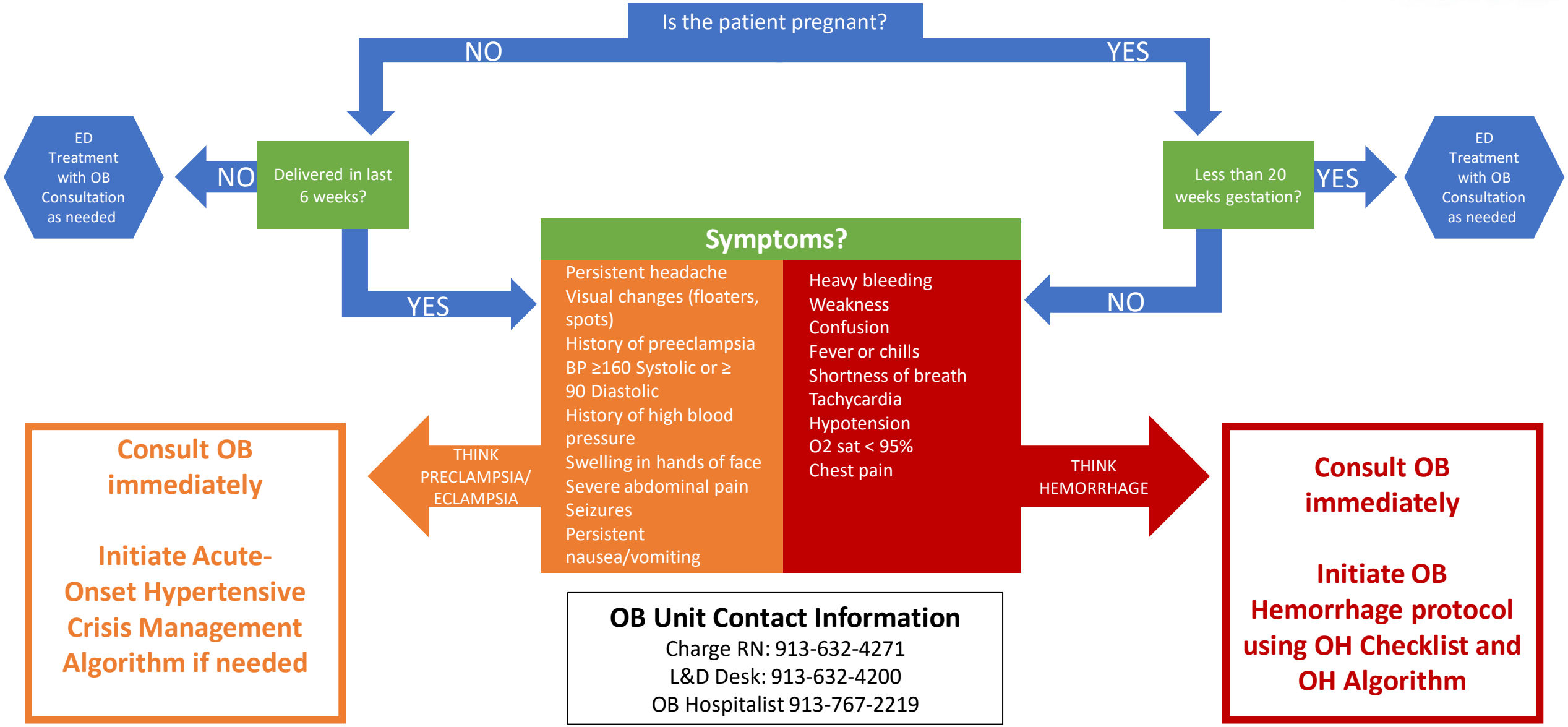
Date:_____ **Time:**_____ **With:**_____
Date:_____ **Time:**_____ **With:**_____

Created by: Delivering Change, Inc.

Recognition of Postpartum Emergent Conditions in the Emergency Department

AdventHealth Shawnee Mission

FOR ALL FEMALE PATIENTS PRESENTING TO THE ED AGE 12-50



OB Unit Contact Information

Charge RN: 913-632-4271
L&D Desk: 913-632-4200
OB Hospitalist 913-767-2219

Where we've been:
POSTPARTUM

FOURTH Trimester Initiative

Please join us to help make Kansas the best place to birth, be born, and to raise a family.

A review of Kansas maternal deaths has determined that the majority of deaths occur between the time immediately after birth and the end of the 1st year. We also know the year after birth has many physical and emotional changes for the mother, the baby, and the family. Together we created the **Fourth Trimester Initiative,** a cutting edge approach to study and improve the experience of our mothers and families in Kansas.

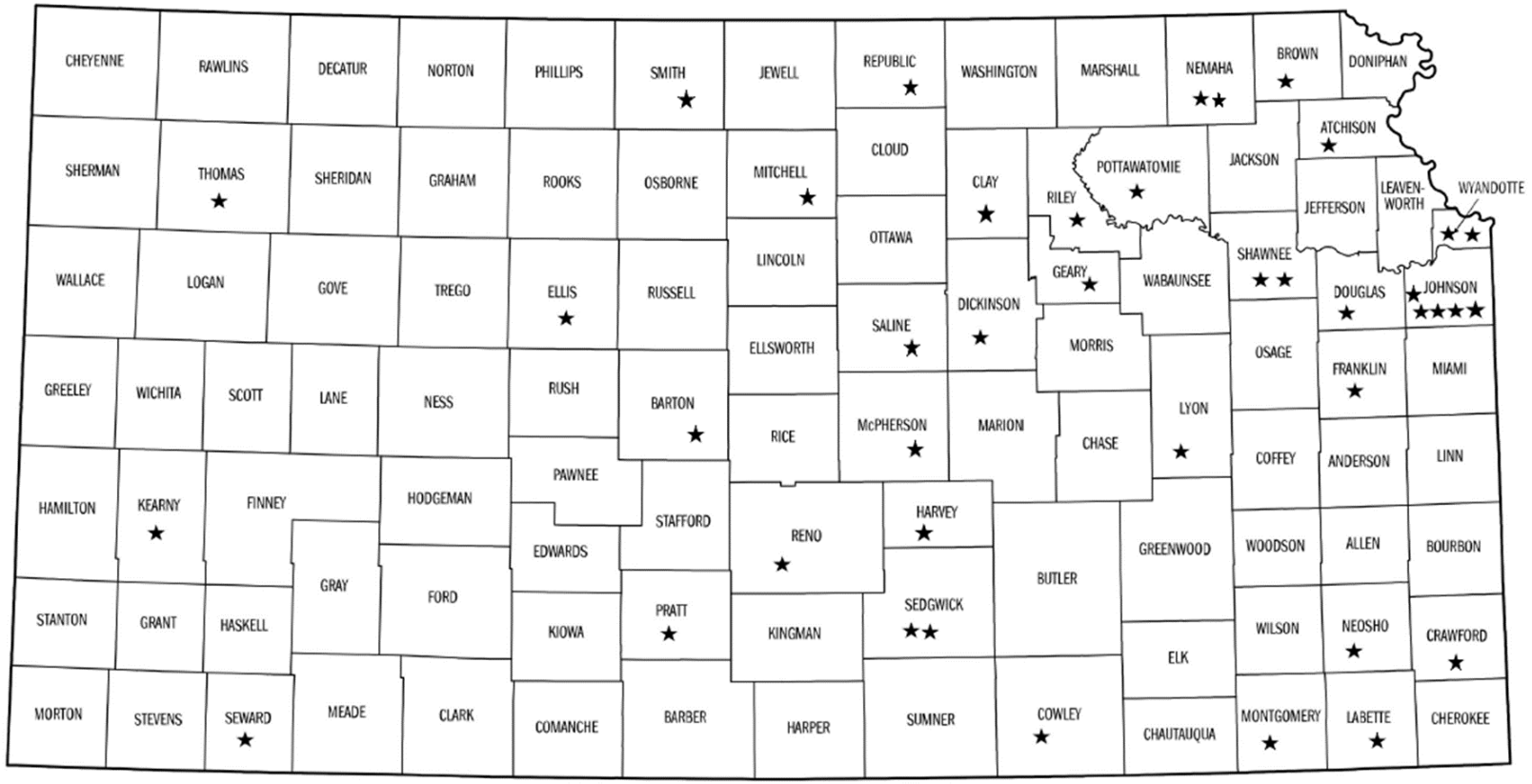
Through this work we will **engage and empower** patients, their families and support system, providers, and Kansas communities to **intentionally improve** maternal health outcomes with our collective, inspired effort.

Kansas “Fourth Trimester Initiative” = AIM “Postpartum Discharge Transition Bundle”

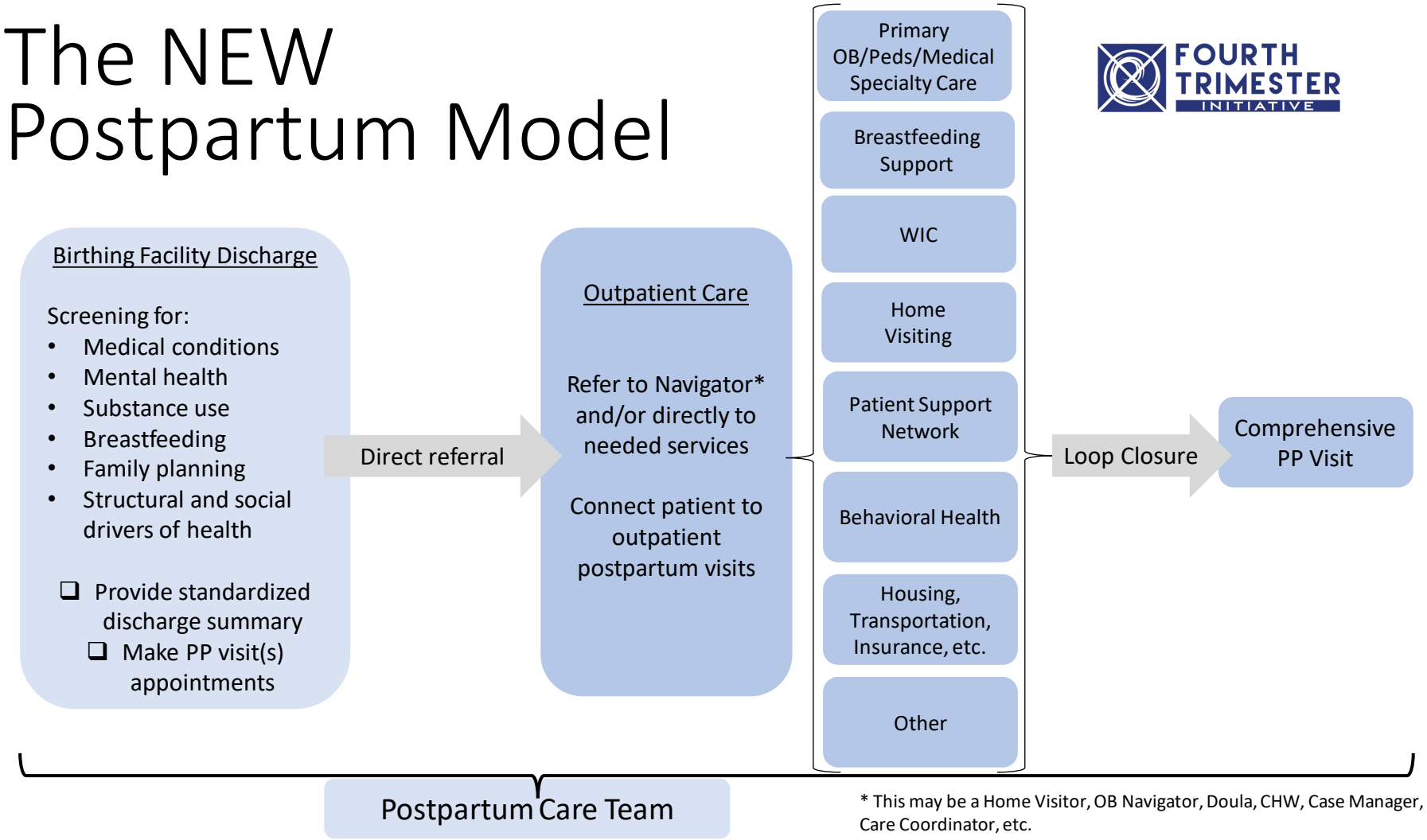
https://saferbirth.org/psbs/postpartum-discharge-transition/

FINAL *FTI Enrolled Sites*

41 Total Sites Enrolled
3 are Inactive Sites
93% of KS Births impacted by FTI



The NEW Postpartum Model



* This may be a Home Visitor, OB Navigator, Doula, CHW, Case Manager, Care Coordinator, etc.

Coming January 2025!

- Final numbers for POSTBIRTH ☺
- Maternal Mental Health screenings/referrals- whew!
- OB/ED Triage- did it really happen?!
- PP Visit Scheduling- how long did the big hospitals hold out?

BUT TODAY…

Before we LAUNCH our next Bundle, today let’s work through a few important and lingering KS issues

We. Heard. You.

Survey. KS Data. Conversations. Social Media.

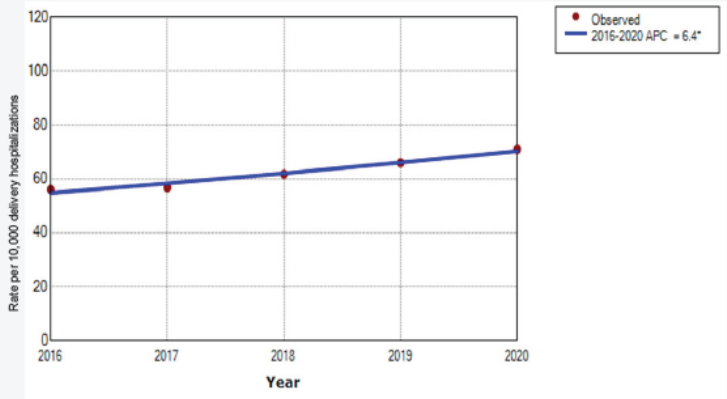
KS Severe Maternal Morbidity data

According to American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine:

Severe maternal morbidity can be thought of as unintended outcomes of the process of labor and delivery that result in significant short-term or long-term consequences to a woman's health. Severe maternal morbidity is associated with a high rate of preventability, similar to that of maternal mortality. It also can be considered a near miss for maternal mortality because without identification and treatment, in some cases, these conditions would lead to maternal death. Identifying severe morbidity is, therefore, important for preventing such injuries that lead to mortality and for highlighting opportunities to avoid repeat injuries.[1]

Severe maternal morbidity (SMM) occurs **nearly 100 times more frequently than maternal death.** Because they are closely related, investigation of SMM can provide valuable/critical insights into underlying/ contributing causes of maternal death.[2]

From 2016 to 2020, of the **164,049 delivery hospitalizations of Kansas residents, 1,019 deliveries with one or more severe maternal morbidities were identified**, representing a rate of 62.1 per 10,000 delivery hospitalizations. This translates to about 1 in 161 women who delivered a baby experienced SMM.



^ Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.
Source: Kansas Department of Health and Environment, Kansas hospital discharge data (resident)

Figure 1:

Shows trends in SMM in Kansas from 2016 to 2020. **The SMM rate significantly increased by 6.4% per year** (95% confidence interval: 4.2%, 8.7%).

Chart Title: *Trends in delivery hospitalizations involving severe maternal morbidity, Kansas, 2016-2020*
Source: *Kansas Department of Health and Environment, Kansas hospital discharge data (resident)*

Today's 1st Topic: SEPSIS!

Per 10,000 delivery hospitalizations, respectively, the top five most common indicators of SMM were:

14.8	13.1	12.2	11.0	9.1
Disseminated intravascular coagulation	Acute renal failure	Acute respiratory distress syndrome	Sepsis	Hysterectomy

Dr. Angela Martin

Dr. Angela Martin went to the University of Missouri-Columbia for medical school. She completed her residency in OBGYN at Emory University and stayed there for her fellowship in Maternal-Fetal Medicine. Dr. Martin Joined faculty at the University of Kansas in 2016. She is currently a Clinical Associate Professor of Maternal-Fetal Medicine. Since joining faculty, she has won several teaching awards at KU including the American College of Obstetrics and Gynecology National Faculty Award and an Excellence in Teaching Award from the Association of Professors of Gynecology and Obstetrics. She has enjoyed performing retrospective cohort projects in topics such as preterm birth, fetal growth restriction, and trial of labor after cesarean section. She is currently the vice chair of the hospital pharmacy and therapeutics committee and has been involved in the OB quality and patient safety committee. Most recently she has enjoyed her role as the medical director of labor and delivery.

THE UNIVERSITY OF KANSAS HEALTH SYSTEM

Sepsis:
Before, During, and After Birth

Angela Martin, MD, FACOG
Associate Clinical Professor
Maternal-Fetal Medicine
Medical Director, Labor and Delivery

Objectives

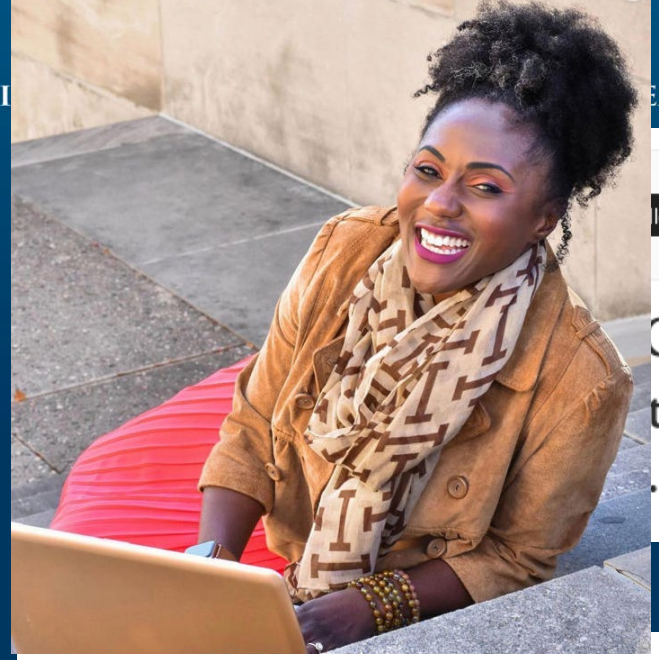
- Scope of the problem
- Etiology & Pathophysiology
- Definition
- Screening & Diagnosis
- Treatment
- Outcomes
- Prevention

Scope of the Sepsis Problem

- Sepsis occurs in ~ 0.04% of deliveries
- Infection/Sepsis has been one of the top 2 leading cause of maternal death in USA (2017-2020)
- 4th leading causes of pregnancy-related death and maternal morbidity in KS (2018 - 2022)

Centers for Disease Control and Prevention. Pregnancy Mortality Surveillance System. https://www.cdc.gov/maternal-mortality/php/pregnancy-mortality-surveillance/index.html.

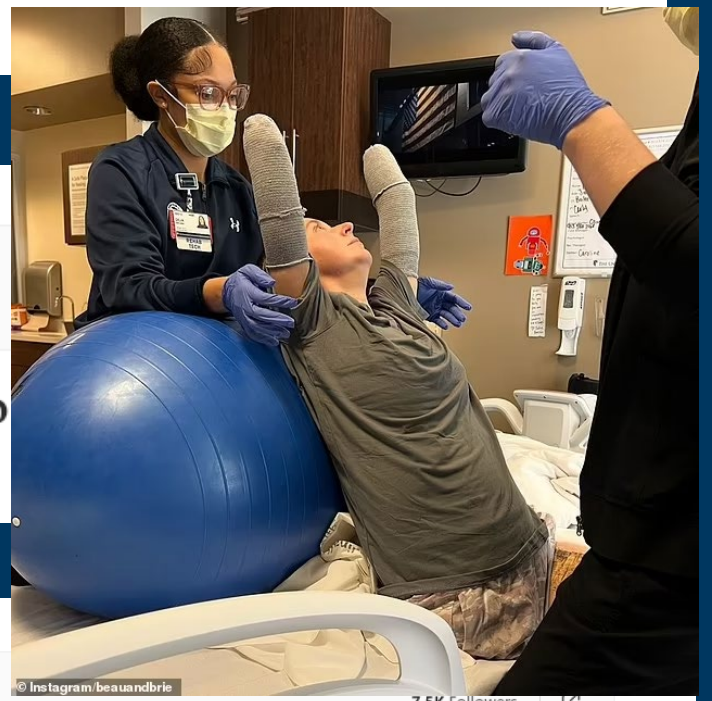
Kansas Hospital Discharge Data; CDC SMM indicators and corresponding ICD codes - https://www.cdc.gov/maternal-infant-health/php/severe-maternal-morbidity/icd.html.



low 80K Followers

Chiefs cheerleader Krystal Anderson dies from th

• 6mo • 4 min read



Daily Mail + Follow

Kansas mom, 35, loses arms and legs in childbirth due to

Story by Isabelle Stanley For Dailymail.Com • 3mo • 3 min read

W Wichita + Follow 7.5K Followers

City family in need of help after mom dies days after giving

nah King • 9h • 3 min read

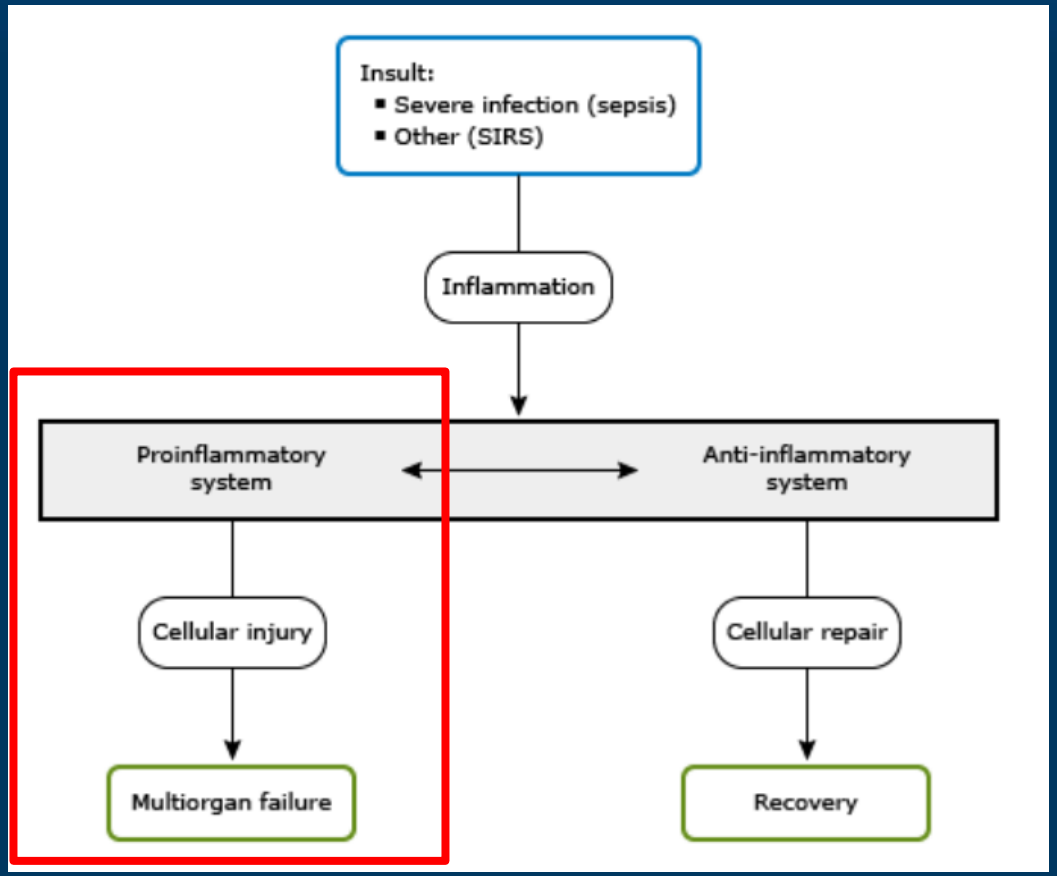
Pathophysiology

- Dysregulated host response to infection
- The inflammatory response that ensues leads to multiple organ dysfunction

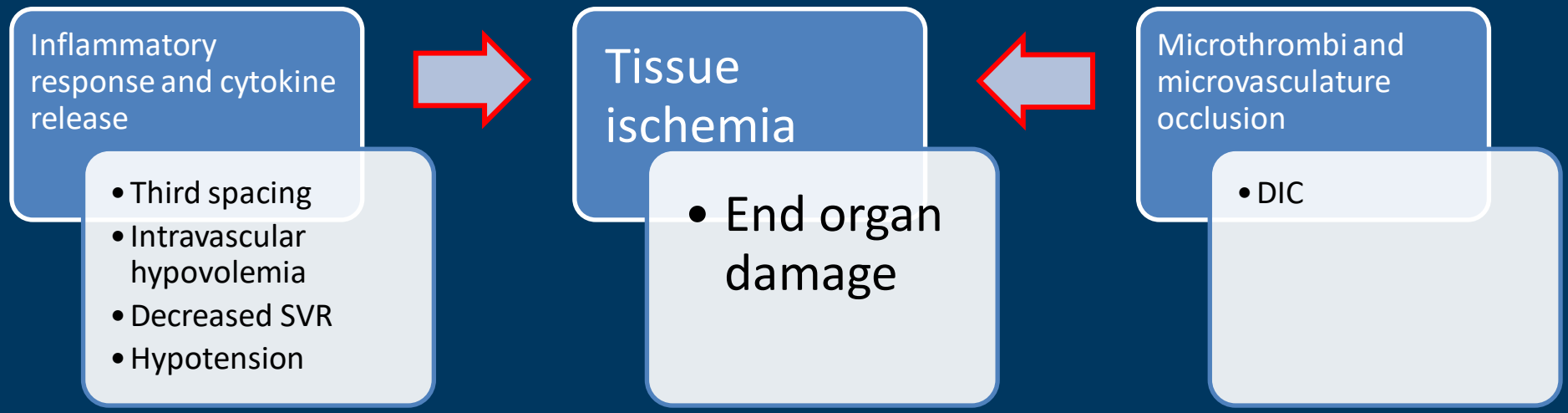
Pathophysiology

- Normal response to infection:
  - Immune cells bind to pathogen and signals host inflammatory response
  - This process is highly regulated by a mixture of pro-inflammatory and anti-inflammatory mediators secreted
  - If the mediators balance each other, the initial infectious insult is overcome, homeostasis will be restored.
  - End result = tissue repair and healing

Pathophysiology



Pathophysiology



Pathophysiology

TABLE 2
Organ damage caused by sepsis

System	Description of damage
Central nervous system	Altered mental status
Cardiovascular system	Hypotension from vasodilation and third-spacing; myocardial dysfunction
Pulmonary system	ARDS
Gastrointestinal system	Paralytic ileus
Hepatic system	Hepatic failure or abnormal transaminases
Urinary system	Oliguria or acute kidney injury
Hematologic system	Thrombocytopenia or disseminated intravascular coagulopathy
Endocrine system	Adrenal dysfunction and increased insulin resistance

ARDS, acute respiratory distress syndrome.

Society for Maternal-Fetal Medicine. Maternal sepsis. Am J Obstet Gynecol 2023.

Etiology

Antepartum	Intrapartum/ Immed. Postpartum	Post-discharge
Septic abortion	Chorioamnionitis/ intraamniotic infection	Pneumonia/influenza
Chorioamnionitis/ intraamniotic infection	Endometritis	Pyelonephritis
Pneumonia/ influenza	Pneumonia/influenza	Wound Infection/ Necrotizing Fasciitis
Pyelonephritis	Pyelonephritis	Mastitis
Appendicitis	Wound Infection/ Necrotizing Fasciitis	Cholecystitis

Etiology

- Most frequently organisms
  - Escherichia coli
  - Group A
  - Group B Streptococcus
  - Staphylococci, gram-negative and anaerobic bacteria, and many other organisms have been reported
  - 15% of maternal sepsis deaths were polymicrobial

Definition

- 2016 Surviving Sepsis Guidelines

- Sepsis:
  - Life threatening organ dysfunction caused by a dysregulated host response to infection

Screening

- Pregnancy Physiologic Changes
  - Increased heart rate, 5-10 bpm
  - Decreased blood pressure, 5-10 mmHG
  - Increased white blood cell count, 9-15,000/L normal
  - Increased lactic acid levels in labor to ≥ 2 mmol/L

THE UNIV

Scre

10/24/2024

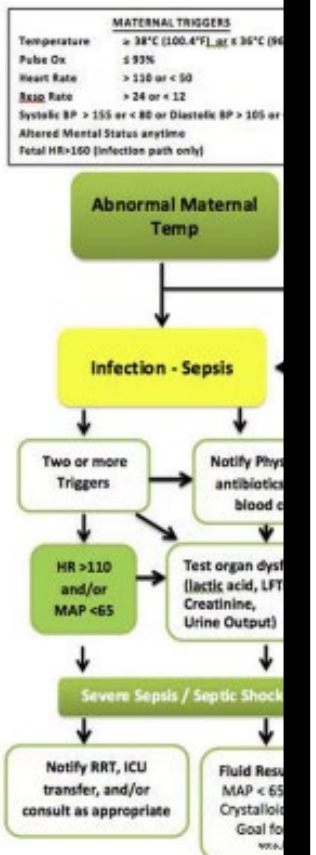
Original R

OBSTETRICS

Use of Materna
maternal morbi

Laurence E. Shields, MD; S
Barbara Pelletreau, RN, M

FIGURE
Flow diagram for mate



CMQCC Maternal Sepsis Evaluation Flow Chart

Suspected Infection

Routine Vital Signs / WBC Screening

Step 1: Initial Sepsis Screen
- Oral temp < 36°C (96.8°F) or > 38°C (100.4°F)
- Heart rate > 110 beats per minute
- Respiratory rate > 24 breaths per min
- WBCs > 15,000/mm³ *or* < 4,000/mm³ *or* > 10% bands

Positive if any 2 of 4 criteria met

Action: If suspected infection, start source-directed antibiotics and 1-2 L of IV fluids; increase monitoring and surveillance. Move to confirmation evaluation.

NOTE: A MAP < 65 mm Hg (persistent after 30ml/kg fluid load) in setting of infection directly defines SEPTIC SHOCK

Step 2: Confirmation of Sepsis Evaluation
- Respiratory: New need for mechanical ventilation *or* PaO2/FiO2 < 300
- Coagulation: Platelets < 100 x 10⁹/L ***or*** INR > 1.5 *or* PTT > 60 secs
- Liver: Bilirubin > 2 mg/dL
- Cardiovascular: SBP < 85 mm Hg *or* MAP < 65 mm Hg ***or*** > 40 mm Hg decrease in SBP (after fluids)
- Renal: Creatinine ≥ 1.2 mg/dL ***or*** doubling of creatinine *or* urine output < 0.5 ml/kg/hr x 2 hrs
- Mental Status: Agitated, confused, ***or*** unresponsive
- Lactic Acid: > 2 mmol/L in absence of labor

Confirmed if 1 or more criteria met

All Criteria NEGATIVE

Action: This group remains at high risk for sepsis and requires close supervision and reevaluation.

≥ 1 Criterion POSITIVE defines **SEPSIS**

Action: Start source-directed antibiotics, broad spectrum antibiotics if source unclear; increase fluids to 30 ml/kg within 3 hours; collect blood cultures if not already obtained, maintain close surveillance, e.g. RRT, and repeat lactate. Escalate care as needed.

Elevated lactate **ONLY** in *Labor*

Action: At a minimum, maintain close surveillance; consider additional fluids to reduce lactic acid level; repeat lactate. (See Discussion of the Role of Lactic Acid in the Peripartum Period In the toolkit for more detail.)

MAP < 65 mm Hg (with confirmation) defines SEPTIC SHOCK

Action: As above for Sepsis, admit to ICU. If hypotension persists after 30 ml/kg fluid load, assess hemodynamic status and consider vasopressor use.

www.AJOG.org

ntify risk of

nna L. Anderson, MD

ange		
	+3	+4
33.9	30-31.9	<30
90		<70
		≤5
	85-89%	<85%
.9		<1

ns (MOEWS)-TUKH

Screening During Delivery Admission

	Sepsis with end organ damage NO chorioamnionitis		Sepsis with end organ damage WITH chorioamnionitis	
Screening Tool	**False Positive**	**Sensitivity**	**False Positive**	**Sensitivity**
CMQCC	9.2%	96.9%	60.2%	93.7%
SIRS	23.9%	98.7%	86.6%	99.2%
MEWC	43.9%	98.2%	92.3%	97.9%
UKOSS	11.6%	96.1%	67.5%	95.0%
MEWT	19.8%	90.8%	45.7%	87.4%

Main, Elliott K. et al. Performance Characteristics of Sepsis Screening Tools During Delivery Admissions. Obstetrics & Gynecology 143(3):p 326-335, March 2024.

Screening Antepartum/Postpartum

- Antepartum
  - < 20 weeks, a non–pregnancy-adjusted sepsis screening tool has improved predictive capability
  - After 20 weeks, pregnancy adjusted screening tools had highest sensitivity and lowest false positive

- Postpartum
  - < 72 hours from delivery pregnancy adjusted screening tools have highest sensitivity and lowest false positive
  - After 72 hours from delivery, no advantage to pregnancy-adjusted tools

Bauer, M. et al. Performance Characteristics of Sepsis Screening Tools During Antepartum and Postpartum Admissions. Obstetrics & Gynecology, 143 (3), 336-345. March 2024.

CMQCC 2-Step Screening

- Step 1: Initial Screen
  - Oral Temperature < 36C (96.8F) or ≥ 38.4C (100.4F)
  - HR > 100 bpm
  - RR >24 breaths per minute
  - WBC >15,000/L, or < 4,000/L, or > 10% immature neutrophils (bands)

- If ≥ 2 → Step 2
  - Confirmation of End Organ Injury (EOI) at the bedside
    - Clinical evaluation
    - Laboratory assessment

CMQCC 2-Step Screening

- Sepsis screen positive, what should I do...
- **Order labs**
  - CBC with differential
  - Coags (INR, PTT, fibrinogen)
  - CMP
  - Blood gas
  - Lactic acid
  - Blood culture
  - Urine culture
- **Go see the patient**

KEY CLINICAL PEARL #1

- 2 abnormal vital signs and/or leukocytosis should prompt
  - More lab work
  - Bedside evaluation

CMQCC 2-Step Screening

- Step 2: Laboratory and Bedside Evaluation
- Only 1 needed to diagnose sepsis

- **Clinical Criteria**
  - CNS: confused, agitated, altered, unresponsive
  - Hypoxia: new O2 requirement, O2 Sat < 92%
  - Renal: Oliguria < 60 mL in 2 hrs

- **Laboratory Criteria**
- Platelets < 100 x 10^9/L
- Bilirubin > 2 mg/dL
- Creatinine > 1.1 mg/dL or doubling
- Lactic acid > 2 mmol/L or > 4 during labor*

*do not collect in 2nd stage or within 1 hour of delivery

CMQCC Management

- Sepsis Diagnosis
  - 2 abnormal vital signs or WBC and
  - ≥ 1 clinical or laboratory criteria = SEPSIS

NOW WHAT?

Sepsis Management

- Take Action!
  - Antibiotics
  - IVF
  - Monitor
  - Escalate care

KEY CLINICAL PEARL #2

- Early diagnosis and prompt treatment will reduce morbidity and mortality

Management – Antibiotics

- 2020 study of 82 sepsis-related mortality

- Mortality rate
  - 8.3% if antibiotics received within 1 hour
  - 20% if antibiotics received after 1 hour of diagnosis

Bauer ME, et al. Risk Factors, Etiologies, and Screening Tools for Sepsis in Pregnant Women: A Multicenter Case-Control Study. Anesth Analg. 2019 Dec;129(6):1613-1620.

Management – Antibiotics

TABLE 4
Proposed broad-spectrum empiric antibiotic coverage in sepsis complicating pregnancy

Source infection	Recommended antibiotics
Community-acquired pneumonia	Cefotaxime, ceftriaxone, ertapenem, or ampicillin plus azithromycin, clarithromycin, or erythromycin.[55]
Hospital-acquired pneumonia	Low-risk patients may be treated with ceftriaxone, ampicillin-sulbactam, ertapenem, meropenem, imipenem, or cefepime. Patients at high risk of mortality may need double coverage for *Pseudomonas* (beta lactam plus an aminoglycoside or a quinolone) and MRSA coverage with vancomycin or linezolid.[56,57]
Chorioamnionitis	Ampicillin plus gentamicin.[58] Add anaerobic coverage with clindamycin or metronidazole if cesarean delivery required.
Endomyometritis	Ampicillin, gentamicin, and metronidazole (or clindamycin). Alternatively, may use cefotaxime or ceftriaxone plus metronidazole.[59]
Urinary tract infections	Gentamicin with ampicillin Alternatively, may use monotherapy with a carbapenem or piperacillin-tazobactam.[60]
Abdominal infections	Ceftriaxone, cefotaxime, ceftazidime, or cefepime plus metronidazole.[61] Complicated cases may require monotherapy with a carbapenem or piperacillin-tazobactam.
Skin and soft tissues (necrotizing)	Vancomycin plus piperacillin-tazobactam.[62] If group A *Streptococcus* or *Clostridium perfringens* are present, use penicillin G plus clindamycin.

MRSA, methicillin-resistant Staphylococcus aureus.

Society for Maternal-Fetal Medicine. Maternal sepsis. Am J Obstet Gynecol 2023.

Management – Antibiotics

- Group A Streptococcus, GAS (Streptococcus Pyogenes)
  - Can lead to necrotizing fasciitis and/or toxic shock syndrome
  - Treatment = surgical management plus antibiotics
    - High dose penicillin plus clindamycin
    - Vancomycin or daptomycin if PCN allergy or suspect Staphylococcus toxic shock syndrome

Diagnose necrotizing fasciitis clinically in the presence of fever, pain out of proportion to exam, crepitus, bullae, erythema, and rapid progression of findings. Prompt surgical management (with tissue pathology) confirms the diagnosis. Early debridement is critical.

Management – Antibiotics

TABLE 9. Proposed Empiric Antibiotic Coverage for Patients with Sepsis of Unknown Source (with End Organ Injury) or Septic Shock

Antibiotic Choices *Empiric coverage for sepsis of unknown source or for septic shock should include at least one antibiotic for Gram-negative and anaerobic coverage **PLUS** one for Gram-positive coverage*	**Duration**
Gram-negative plus anaerobic coverage Piperacillin/tazobactam 3.375 g IV q8h (extended infusion) or 4.5 g IV q6h **OR** Meropenem 1 g IV q8h (if recent hospitalization or concern for MDRO organisms) **OR** Cefepime 1-2g IV q8h plus metronidazole 500 mg IV q8h **OR** Aztreonam 2 g IV q8h (for women with severe penicillin allergy) Plus metronidazole 500 mg IV q8h **OR** Aztreonam 2g IV q8h plus clindamycin 900 mg IV q8h **PLUS** **Gram-positive coverage** Vancomycin 15-20 mg/kg q8h-q12h (goal trough 15-20 mcg/mL) **OR** Linezolid 600 mg IV/PO q12h (for women with severe vancomycin allergy)	7-10 days is adequate for most infections

Management – IVF

- Optimize circulating volume and improve cardiac output (blood pressure) and tissue perfusion
- **Initial resuscitation includes at least 30 mL/kg of intravenous crystalloid fluid within 3 hours (2-3 L)**
- Following initial fluid resuscitation, additional fluids should be guided by frequent reassessment of hemodynamic status

KEY CLINICAL PEARL #3

- Timely antibiotic administration and IVF resuscitation are essential first steps in treatment

Management – IVF/Vasopressors

- Septic shock:
  - Persistent hypotension requiring vasopressors to maintain MAP of 65 mm Hg and a serum lactate level >2 mmol/L despite adequate volume resuscitation

Management – Vasopressors

Agent	Comment
Vasopressor	**Norepinephrine** is fist line Consider if MAP < 65 mmHg after IVF resuscitation
Inotrope	**Dobutamine** recommended for myocardial dysfunction or hypoperfusion despite IVF resuscitation and vasopressors

Management – Monitoring

Monitoring	Time Frame	Other Considerations
Fetal monitoring	Continuous	
Pulse Oximetry and HR	Continuous	Until vital signs normalize
BP and MAP	Q 30 minutes	Until lactate < 2, then q 3 hours
Temperature	Q 30 minutes	Until lactate < 2, then q 3 hours
Urine output	Q 1 hour	Foley catheter
Mental Status	Continuous	Notify physician if combativeness, confusion, disorientation

Management – Escalation of Care

Consider Transfer to Higher Level of Care
Need for vasopressors
Persistent hypoxia, SpO2 < 92% on RA
Altered mental status (combativeness, confusion, disorientation, unresponsiveness)
Higher level NICU required if delivery indicated

Management – Delivery?

- Sepsis is *not* an immediate indication for delivery
- Correcting maternal hemodynamics and acidosis often improves fetal status
- The timing of delivery in a septic pregnant woman should be individualized
  - Consider EGA
  - Cesarean delivery is usually reserved for routine obstetric indications after the patient is stabilized

Management – Other Considerations

- Corticosteroids for fetal lung maturity are not contraindicated
- In patients with sepsis or septic shock, strongly consider avoiding neuraxial procedures
  - Cardiovascular effects of a neuraxial block technique may cause further detriment with high potential for maternal (and fetal) morbidity and mortality
- DVT prevention
- Avoid hyperglycemia (glucose > 180 mg/dL)

Outcomes

- Mortality rate ~ 1-8% overall; 12-28% in septic shock
- Miscarriage, stillbirth, PTB rates increased
- Common morbidities in adult survivors of sepsis:
  - Organ dysfunction
  - Infertility
  - Amputations
  - Depression and anxiety
  - Insomnia
  - Panic attacks and nightmares
  - Disabling muscle and joint pains
  - Decreased cognitive function

Outcomes

- Arrange appropriate follow-up
  - With OB provider within 1 week
  - Occupational/physical therapy
  - Speech therapy
  - Mental health services

Guide for Post-Discharge Care After a Severe Maternal Event

Follow-Up Visits Arranged

- ❑ Follow up within 1-2 weeks of hospital discharge with obstetric care provider (OB)
- ❑ Identify key contact for immediate care and support as needed
- ❑ Arrange follow-up with primary care provider (PCP) or specialist(s) as appropriate
  - Many patients will need ongoing care up to 1 year to assess on going needs (especially mental health)
- ❑ Send Discharge Summary/Summary of Hospital Course to OB, PCP, and specialists
- ❑ Give Summary of Hospital Course to patient (see CMQCC Sepsis Toolkit for example)

Referrals (in-hospital or as outpatients)

- ❑ All patients with a Severe Maternal Event should have a referral to postpartum support group(s), either general or diagnosis specific (see resource list)
- ❑ Social Work—Medicaid or disability enrollment and transportation support as needed
- ❑ Lactation Consult—For support or suppression after major maternal illness or loss
- ❑ All patients with critical illness/ICU admission (for example: intubated, experiencing weakness) should have the following outpatient referrals placed on discharge[1]
  - Occupational Therapy and Physical Therapy
  - Speech/Swallow evaluation (usually done post-extubation refer if ongoing difficulties)

Specialized Postpartum Care (beyond standard services)

- Note: Postpartum visits for complications may be billed outside of the global Obstetric fee.[2]
- ❑ Serial mental health assessments recommended for one year. Patients can experience continuing or new symptoms over the course of a year. There may be overlap between PTSD symptoms, trauma-related postpartum depression, postpartum anxiety and ICU-related trauma; additionally, cognitive challenges (sleep, memory and concentration disorders) may complicate/compound the postpartum mental health course. Examples of validated tools are provided below. All 3 areas are important to evaluate.
  - **Depression**
    PHQ-9[3] (Patient Health Questionnaire, a 9-question depression assessment)
    EPDS (Edinburgh Postnatal Depression Scale, a 10-question assessment)
  - **Anxiety**
    GAD-7[3] (Generalized Anxiety Disorder 7-item assessment)
  - **Post-Traumatic Stress Disorder (PTSD)**
    PCL-5 [4](PTSD Checklist for DSM-5, a 20-item assessment of PTSD symptoms)
- ❑ Contraception needs, in the context of medical conditions[5]
- ❑ Mobilize a support system of family, community social services and/or Doula services

---

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[4] Arora IH, Woscoboinik GG, Mokhtar S, et al. Establishing the validity of a diagnostic questionnaire for childbirth-related posttraumatic stress disorder. Am J Obstet Gynecol. 2023;0(0). doi:10.1016/j.ajog.2023.11.1229
[5] CDC Summary Chart of Medical Eligibility Criteria for Contraceptive Use (2024). https://www.cdc.gov/contraception/media/pdfs/2024/07/us-mec-summary-chart-color-508.pdf

CMQCC Stanford Medicine MI-AIM

Outcomes

- Patient debriefs may reduce anxiety, depression, PTSD

Guide For Pre-Discharge Care Discussion (aka Patient Debrief) After a Severe Maternal Event

- **Purpose**: to review what happened, answer questions, and plan on-going care with the patient and whoever the patient chooses to invite.
- **This document** is an informal checklist to help guide the discussion. The discussion would ideally include a senior physician and a nurse known to the patient, and a social worker. Known faces are important for support and starting the process of healing and closure.
- **Timing** should be after the patient is fully aware and near to discharge. This is not to replace earlier shorter care updates provided to the patient and family.

Step 1: Assess Patient Understanding

- ❑ "Now that you have had a few days to process, can you recap in your own words what you understand about what you experienced." "In a moment we will go through your story in detail."
  - Do not stop the patient to correct information
- ❑ "What are your biggest concerns about what happened?

Step 2: Provide an overarching description of the condition

- ❑ Define (in lay terms) the condition that they experienced, including how common
- ❑ Briefly review risk factors and in general the diagnosis and treatment approaches

Step 3: What happened with this specific patient

- ❑ Review in lay terms, how the patient presented and how the diagnosis was made
- ❑ What specific consultations and treatments were made
- ❑ How the patient responded to the treatments
- ❑ If and why they were transferred to a higher level of care (such as an ICU) and what happened there
- ❑ What has happened in the recovery phase
- ❑ Provide the summary document of the key elements of the diagnosis and care for her to share with her follow-up providers (see CMQCC Sepsis Toolkit for an example)
- ❑ Stress that this was not her fault

Step 4: Pause for questions

- ❑ "I have just given you a lot of information
  What questions do you have? What are your concerns going forward?"

Step 5: Review what to expect next

- ❑ Review plans for discharge, including who and when to see for follow up (ideal to identify an "anchor" provider)
  - The Discharge Follow-up Checklist is very useful
  - Early follow-up is almost always required
- ❑ Discuss return precautions and "what to watch for", involving the patient's family and/or those who may be helping support them
  - Emphasize the need for support from providers, family, and others
- ❑ Broadly review how this event may affect future health and future pregnancies, if relevant
- ❑ Emphasize the importance of continuing discussions
- ❑ Give opportunity for more questions

CMQCC California Maternal Quality Care Collaborative

Stanford MEDICINE Dunlevie Maternal-Fetal Medicine Center for Discovery, Innovation and Clinical Impact

MiAIM MICHIGAN ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

Prevention

- Recent study found 63% of sepsis deaths were likely preventable

- Leading causes of preventable death
  - **Delay in seeking care**
  - **Delay in diagnosis** and appropriate treatment
    - Inadequate antibiotic coverage
  - Delay in the escalation of care

KEY CLINICAL PEARL #4

- To reduce maternal morbidity and mortality
  - Educate all patients on alarming warning signs
  - Educate providers on when to encourage prompt evaluation

SAVE YOUR LIFE:

Get Care for These POST-BIRTH Warning Signs

Most women who give birth recover without problems. **But any woman can have complications after giving birth.** Learning to recognize these POST-BIRTH warning signs and knowing what to do can save your life.

POST-BIRTH WARNING SIGNS

Call 911 if you have:

- ❑ **P**ain in chest
- ❑ **O**bstructed breathing or shortness of breath
- ❑ **S**eizures
- ❑ **T**houghts of hurting yourself or someone else

Call your healthcare provider if you have:

(If you can't reach your healthcare provider, call 911 or go to an emergency room)

- ❑ **B**leeding, soaking through one pad/hour, or blood clots, the size of an egg or bigger
- ❑ **I**ncision that is not healing
- ❑ **R**ed or swollen leg, that is painful or warm to touch
- ❑ **T**emperature of 100.4°F or higher
- ❑ **H**eadache that does not get better, even after taking medicine, or bad headache with vision changes

Trust your instincts. ALWAYS get medical care if you are not feeling well or have questions or concerns.

Tell 911 or your healthcare provider:

"I gave birth on _____ (Date) and I am having _____ (Specific warning signs)."

These post-birth warning signs can become life-threatening if you don't receive medical care right away because:

- **Pain in chest, obstructed breathing or shortness of breath** (trouble catching your breath) may mean you have a blood clot in your lung or a heart problem
- **Seizures** may mean you have a condition called eclampsia
- **Thoughts or feelings of wanting to hurt yourself or someone else** may mean you have postpartum depression
- **Bleeding (heavy)**, soaking more than one pad in an hour or passing an egg-sized clot or bigger may mean you have an obstetric hemorrhage
- **Incision that is not healing, increased redness or any pus** from episiotomy or C-section site may mean you have an infection
- **Redness, swelling, warmth, or pain** in the calf area of your leg may mean you have a blood clot
- **Temperature of 100.4°F or higher, bad smelling vaginal blood or discharge** may mean you have an infection
- **Headache (very painful), vision changes, or pain in the upper right area of your belly** may mean you have high blood pressure or post birth preeclampsia

GET HELP

My Healthcare Provider/Clinic: _____ Phone Number: _____

Hospital Closest To Me: _____

AWHONN
PROMOTING THE HEALTH OF WOMEN AND NEWBORNS

This program is supported by funding from Merck, through Merck for Mothers, the company's 10-year, $500 million initiative to help create a world where no woman dies giving life. Merck for Mothers is known as MSD for Mothers outside the United States and Canada.

16004

URGENT MATERNAL WARNING SIGNS

Headache that won't go away or gets worse over time

Dizziness or fainting

Thoughts about hurting yourself or your baby

Changes in your vision

Fever

Trouble breathing

Chest pain or fast-beating heart

Severe belly pain that doesn't go away

Severe nausea and throwing up (not like morning sickness)

Baby's movements stopping or slowing

Vaginal bleeding or fluid leaking *during* pregnancy

Vaginal bleeding or fluid leaking *after* pregnancy

Swelling, redness, or pain of your leg

Extreme swelling of your hands or face

Overwhelming tiredness

If you have any of these symptoms during or after pregnancy, contact your health care provider and get help right away.

If you can't reach your provider, go to the emergency room. Remember to say that you're pregnant or have been pregnant within the last year.

Learn more: https://saferbirth.org/aim-resources/aim-cornerstones/urgent-maternal-warning- signs/

Take a photo to learn more

V5 September 2022

AIM

Pregnant now or within the last year?

Get medical care right away if you experience any of the following symptoms:

Headache that won't go away or gets worse over time

Dizziness or fainting

Changes in your vision

Fever of 100.4°F or higher

Extreme swelling of your hands or face

Thoughts of harming yourself or your baby

Trouble breathing

Chest pain or fast beating heart

Severe nausea and throwing up

Severe belly pain that doesn't go away

Baby's movement stopping or slowing during pregnancy

Severe swelling, redness or pain of your leg or arm

Vaginal bleeding or fluid leaking *during* pregnancy

Heavy vaginal bleeding or discharge *after* pregnancy

Overwhelming tiredness

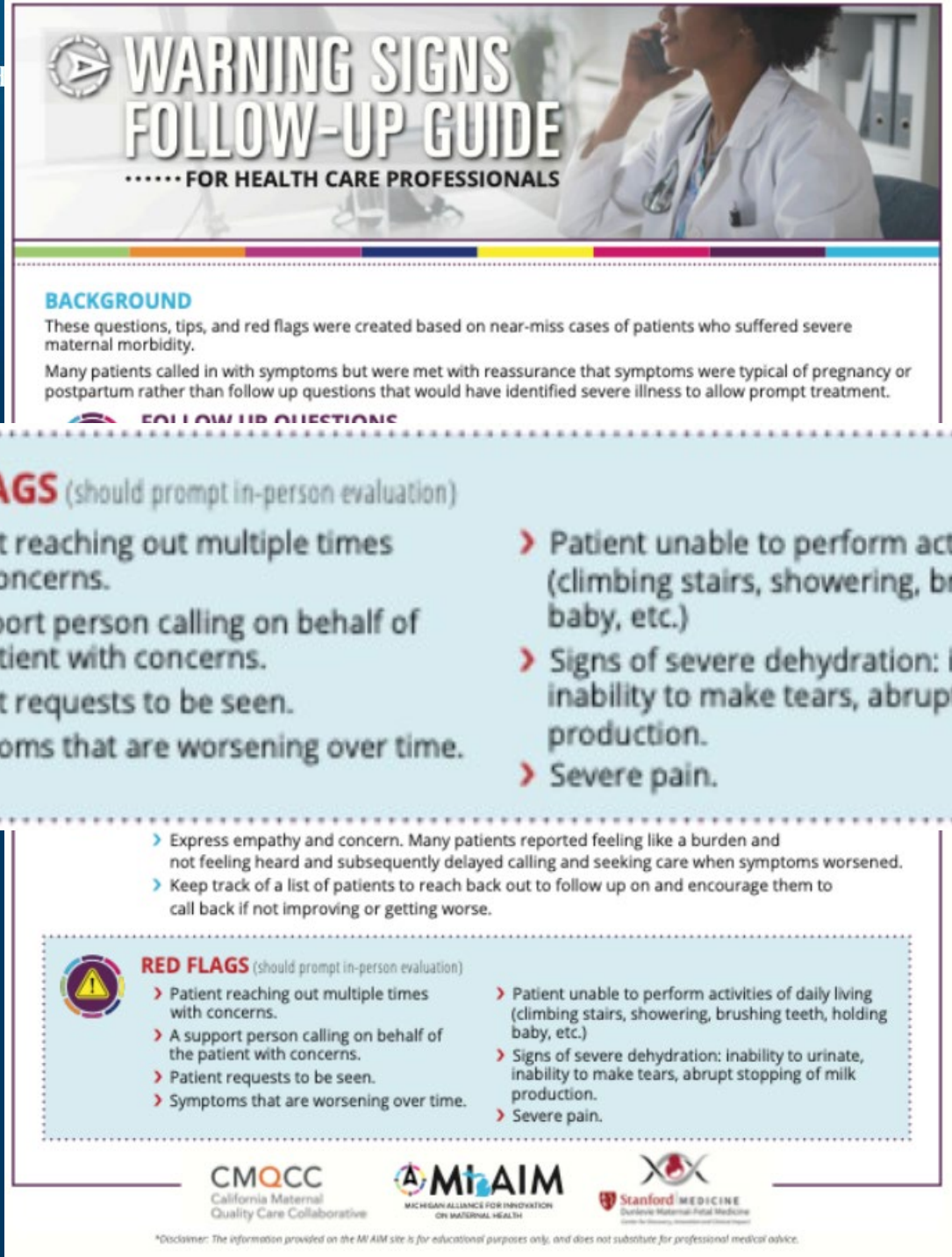
These could be signs of very serious complications. If you can't reach a healthcare provider, go to the emergency room. Be sure to tell them you are pregnant or were pregnant within the last year.

Learn more at
cdc.gov/HearHer

CDC

HEAR
HEAR HER CONCERNS

This list of urgent maternal warning signs was developed by the Council on Patient Safety in Women's Health Care.



WARNING SIGNS FOLLOW-UP GUIDE

FOR HEALTH CARE PROFESSIONALS

BACKGROUND

These questions, tips, and red flags were created based on near-miss cases of patients who suffered severe maternal morbidity.

Many patients called in with symptoms but were met with reassurance that symptoms were typical of pregnancy or postpartum rather than follow up questions that would have identified severe illness to allow prompt treatment.

RED FLAGS (should prompt in-person evaluation)

- Patient reaching out multiple times with concerns.
- A support person calling on behalf of the patient with concerns.
- Patient requests to be seen.
- Symptoms that are worsening over time.
- Patient unable to perform activities of daily living (climbing stairs, showering, brushing teeth, holding baby, etc.)
- Signs of severe dehydration: inability to urinate, inability to make tears, abrupt stopping of milk production.
- Severe pain.

- Express empathy and concern. Many patients reported feeling like a burden and not feeling heard and subsequently delayed calling and seeking care when symptoms worsened.
- Keep track of a list of patients to reach back out to follow up on and encourage them to call back if not improving or getting worse.

RED FLAGS (should prompt in-person evaluation)
- Patient reaching out multiple times with concerns.
- A support person calling on behalf of the patient with concerns.
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- Severe pain.

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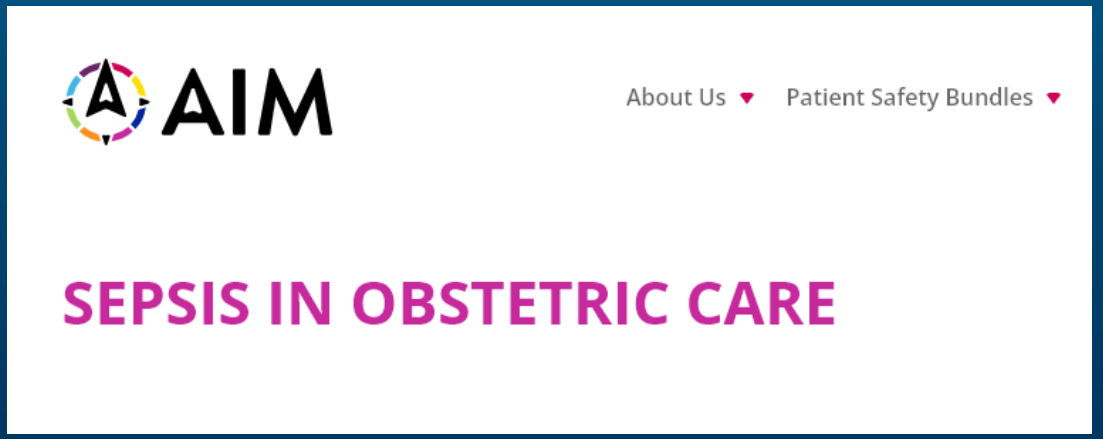
MiAIM Michigan Alliance for Innovation on Maternal Health

Stanford Medicine Dunlevie Maternal-Fetal Medicine

*Disclaimer: The information provided on the MI AIM site is for educational purposes only, and does not substitute for professional medical advice.

Prevention



- Patient Safety Bundles/Toolkits
  - Screening tools
  - Protocols
  - Order sets
- Identify and review all sepsis cases
- Address obstetric racism

CMQCC
California Maternal Quality Care Collaborative

KPQC
Kansas Perinatal Quality Collaborative

Summary

- Sepsis is rare, but deadly if not diagnosed and treated in a timely manner
- If patients have abnormal vitals and WBCs, order labs and perform bedside exam
- Start broad spectrum antibiotics and IVF ASAP
- Monitor and escalate care if necessary
- Perform a patient debrief before discharge
- Discharge education should include warning signs
- Encourage patients to go to the hospital if they call in with red flags

References

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- Fourth Trimester Initiative Resources - Kansas Perinatal Quality Collaborative (kansaspqc.org)

Birth Equity

We cannot continue to “treat everyone the same”

Emersen Frazier Freeman

Emersen Frazier, MPH has a strong commitment to community advocacy and policy development. Currently serving as the Director of Health Equity and Policy at Stormont Vail Health in Topeka, KS, Emersen has taken the lead in implementing data-driven initiatives to ensure equitable health outcomes for patient populations and fostering collaboration with state and federal policymakers. Emersen has contributed to various critical aspects of healthcare, including patient safety, population health, accreditation standards, and policy development. Educationally, Emersen holds an MPH from the University of South Carolina (Columbia, SC), concentrating on Health Services, Policy, and Management. There, she achieved Summa Cum Laude honors and crafted a thesis on a Community Health Worker Health Equity Impact Program. Her BA in Political Science from Claflin University (Orangeburg, SC) also earned her Summa Cum Laude honors and valedictorian status. Emersen is the soon to be wife of Zachary Freeman who hails from Aiken, SC and the daughter of Carl and Linessa Frazier who both reside in Topeka, KS.

Reimagining Health Equity:

Leveraging Data, Partnerships, and Innovation to Drive Excellent Care

By: Emersen Frazier Freeman, MPH
Director of Health Equity and Policy

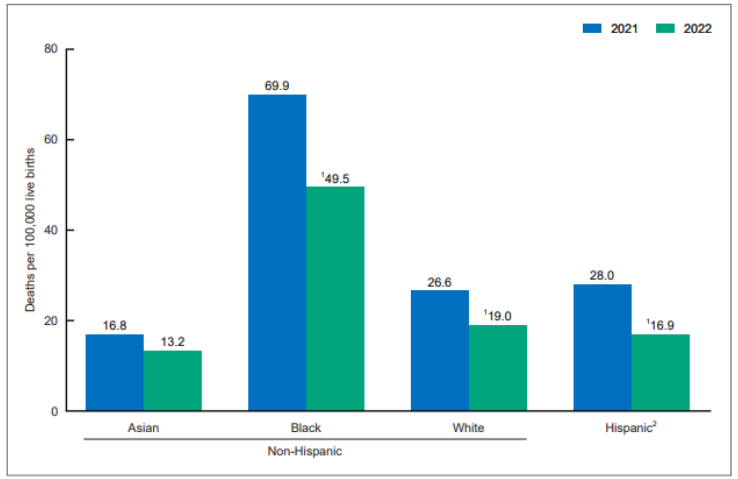
ABOUT ME

- Native Kansan
- Avid reader and lifelong learner
- Daughter, sister, aunt, friend and wife

THE WHAT: DATA

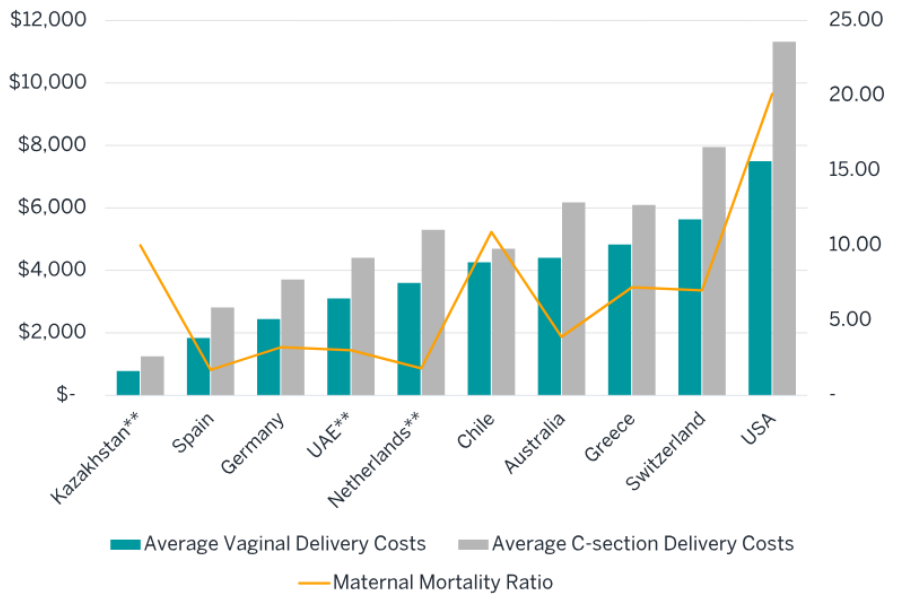
NCHS Health E-Stats May 2024

Figure 2. Maternal mortality rate, by race and Hispanic origin: United States, 2021 and 2022



¹Statistically significant decrease from previous year ($p < 0.05$).
²Hispanic people may be of any race.
NOTE: Race groups are single race.
SOURCE: National Center for Health Statistics, National Vital Statistics System, mortality data files.

Figure 1: 2019 maternity costs and maternal mortality ratios*



Sources: https://healthcostinstitute.org/hcci-research/international-comparisons-of-health-care-prices-2017-ifhp-survey, https://healthcostinstitute.org/images/pdfs/international_health_cost_comparison_report_2022.pdf, and https://ourworldindata.org/maternal-mortality.

** Reimbursed amounts include both plan-paid and patient cost sharing.*

*** UAE and Netherlands relied on 2017 costs, because 2019 costs were not available for this study. Kazakhstan used 2017 maternal mortality ratios because 2019 data was not available.*

Disaggregation
in Shawnee Kansas

Download Table

Disaggregation by racialized group	Value	Error Margin
Low Birthweight	8%	7-8%
Hispanic (all races)	8%	7-9%
Non-Hispanic Asian	8%	5-12%
Non-Hispanic Black	14%	12-16%
Non-Hispanic two or more races	9%	7-11%
Non-Hispanic White	7%	6-7%

2023 MARCH OF DIMES REPORT CARD FOR KANSAS

PRETERM BIRTH GRADE

D+

GRADE OF 10.4 PERCENT TO 10.7 PERCENT

Learn more

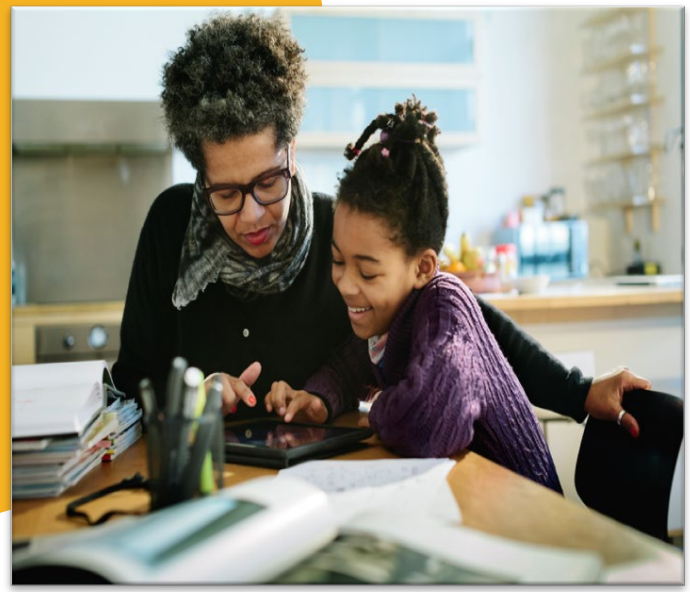
U.S. RATE **10.4**

KS RATE **10.5**

PRETERM BIRTH RATES BY COUNTIES AND CITY

County	Grade	Preterm Birth Rate	Change in rate from last year
Douglas	B-	9.1%	Improved
Johnson	C+	9.6%	Worsened
Leavenworth	D	10.8%	Improved
Sedgwick	D-	11.4%	Worsened
Shawnee	F	12.4%	Worsened
Wyandotte	F	11.6%	Worsened

BEYOND THE DATA



Real People. Real Families. Real Stories.

LET'S ADDRESS THE HARD STUFF:

HISTORY

IF WE KNOW:

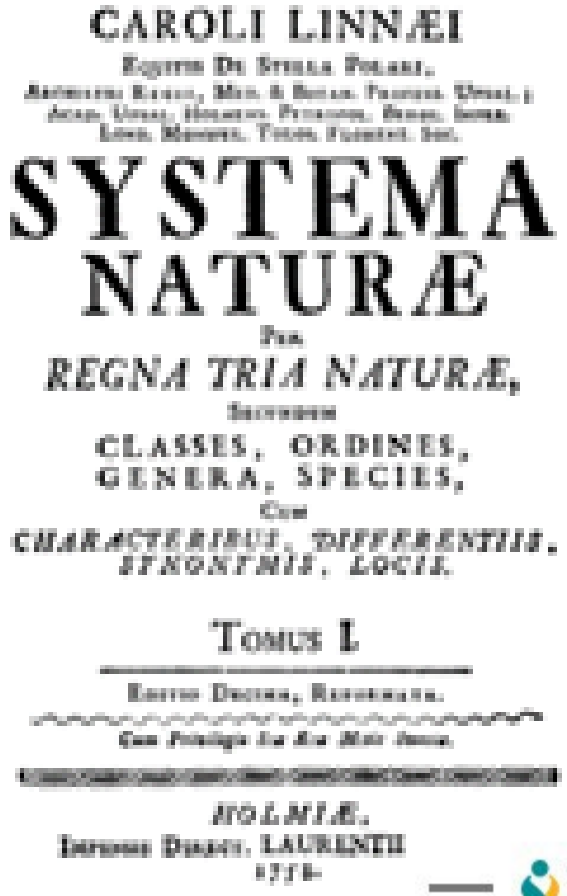
A. RACE IS A SOCIAL CONSTRUCT

B. THERE IS NO BIOLOGICAL BASIS TO RACE CATAGORIZATION

WHY DO WE SEE SUCH PROFOUND DISPARITIES IN HEALTH OUTCOMES?

History of Gynecologic and Obstetric Care in Medicine & the Impact of Racism on Pregnancy-Related Health

- The Origins of Race by Carolus Linnaeus, MD (1707-1778)
  - Swedish botanist, naturalist, physician
  - Established classification systems like the taxonomic concept of hierarchy (kingdom, phylum, class, order, family, genus, species)
    - First naturalist to include humans in the animal kingdom


CAROLI LINNÆI

SYSTEMA NATURÆ

REGNA TRIA NATURÆ,

CLASSES, ORDINES, GENERA, SPECIES,

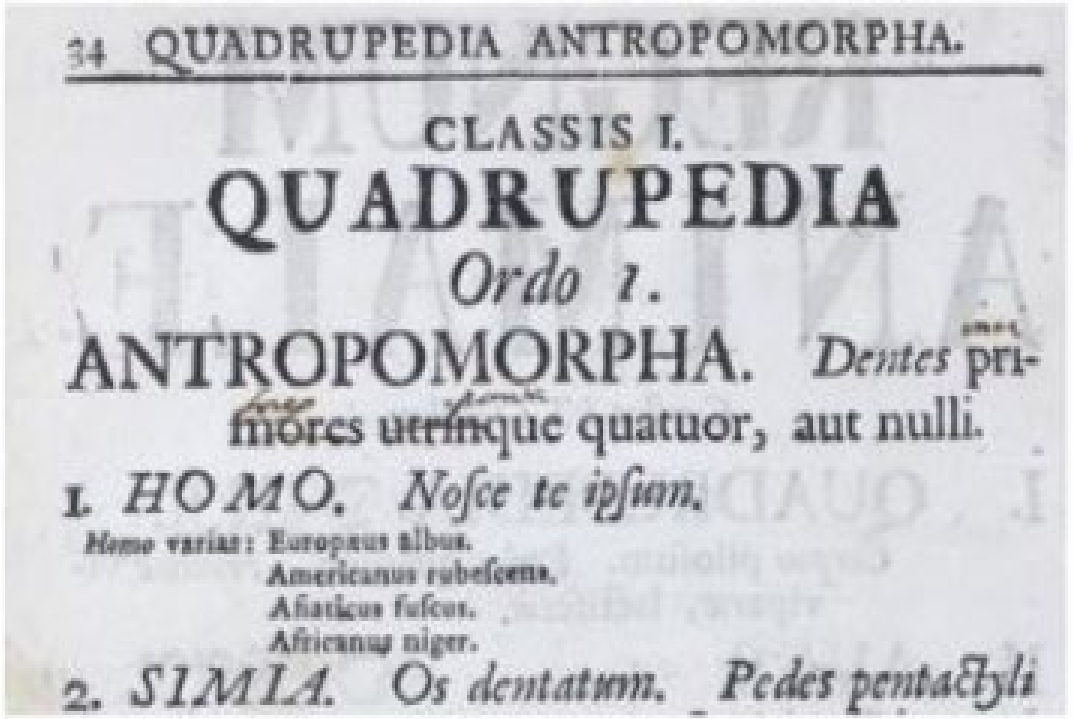
TOMUS I

HOLMIÆ.

Stormont Vail Health

History of Gynecologic and Obstetric Care in Medicine & the Impact of Racism on Pregnancy-Related Health

- The indoctrination of Scientific Racism. 1st edition, 1735
  - Originated “Homo variat” (human varieties) corresponding to the four known continents
    - Europaeus albus: “European white”
    - Americanus rubescens: “American reddish”
    - Asiaticus fuscus: “Asian tawny”
    - Africanus niger: “African black”


34 QUADRUPEDIA ANTROPOMORPHA.

CLASSIS I.

QUADRUPEDIA

Ordo 1.

ANTROPOMORPHA. Dentes primores utrinque quatuor, aut nulli.

1. HOMO. Nosce te ipsum.

Homo varias: Europæus albus.
Americanus rubescens.
Asiaticus fuscus.
Africanus niger.

2. SIMIA. Os dentatum. Pedes pentactyli

Quadrupeds in Systema naturae 2nd edition, 1740

History of Gynecologic and Obstetric Care in Medicine & the Impact of Racism on Pregnancy-Related Health

- 10th edition, 1758
  - Defined physical and moral attributes for each “variat”
  - Basis for scientific racism- the use of science to provide justification for racism
  - Implied that there were inherent, biological differences between races
  - Though not based on science, because of his influence, they were accepted as fact.
  - Justified the Atlantic slave trade and is also the foundation on which medicine considers racial difference today.

Variat	Skin Color, Temperament	Behavior	Governance
Europaeus albus	White, sanguine, muscular	Light, wise, inventor	Governed by rites
Americanus rubescens	Red, choleric and straight	Unyielding, cheerful, free	Governed by customary right
Asiaticus fuscus	Sallow, melancholic, stiff	Stern, haughty, greedy	Governed by opinions
Africanus niger	Black, phlegmatic, lazy	Sly, sluggish, neglectful	Governed by choice [caprice]

History of Gynecologic and Obstetric Care in Medicine & the Impact of Racism on Pregnancy-Related Health

550,000

Number of enslaved people in the U.S. in 1776

4,000,000

Number of enslaved people in the U.S. in 1860

Despite the federal outlawing of the Atlantic slave trade in 1808, slavery continued to grow exponentially into a $4 billion industry. How could this be?

This was due to the focus on the reproductive capacity of enslaved women living in America.

Stormont Vail Health

History of Gynecologic and Obstetric Care in Medicine & the Impact of Racism on Pregnancy-Related Health

- In order to explore the reproductive capacity of enslaved women, slaveowners allowed physicians to experiment on enslaved women. Some physicians were also slave owners and **would buy or lease enslaved people for medical experimentation.**
    - The discipline of obstetrics and **gynecology blossoms in response to the need to optimize the reproductive capacity** of enslaved women
- Partus sequitur ventrem- “That which is born follows the womb”
    - Enslaved women were property and **had no autonomy over their bodies nor that of their offspring.**
- Enslaved women where required to begin having children in late teens and would **have a child approximately every 2 years until her 40s.**

Stormont Vail Health

History of Gynecologic and Obstetric Care in Medicine & the Impact of Racism on Pregnancy-Related Health

- Father of Modern Gynecology- Dr. J. Marion Sims, MD, 1813-1883
  - Gained prominence after creating a surgery to correct a condition known as obstetric fistulas. A condition that renders typically young women less fertile and less productive among other disabilities.
  - Dr. Sims owned and leased enslaved people whom he experimented on and conducted over 30 surgeries on just one woman named Anarcha.
  - It is not hard to imagine how the effects of this mistreatment are evident today with the trust Black women/people have with physicians.

Sources: 1) Washington, HA. Medical apartheid: The dark history of medical experimentation on Black Americans from colonial times to the present. Harlem Moon; 2006.
2) J. Marion Sims, Gynecologic Surgeon from the 'History of Medicine.'" Artwork by Robert Thom. From the Collection of Michigan Medicine, University of Michigan. Available at: https://exchange.umma.umich.edu/resources/41241/view.

HEARST HEALTH

Stormont Vail Health

History of Gynecologic and Obstetric Care in Medicine & the Impact of Racism on Pregnancy-Related Health

- Stratified Reproduction: US Forced Sterilization 1909-1979
  - 32 US states passed laws authorizing sterilization of those "unfit" to reproduce
    - Poor white women (poverty prevention)
    - Mentally ill
    - Minoritized (Black, Native American, Latina)
  - Sterilizations were performed at the time of the other surgeries or procedures without knowledge (i.e. cesarean births, appendectomies, cholecystectomies).
  - Nearly half of the doctors in a 1972 study supported compulsory sterilization of welfare recipients
  - There were approximately 60,000 known state sponsored sterilizations preformed during the 20th century, without the knowledge of the patient. However, there were likely much more due to women not realizing they were sterilized or women not having an avenue to report sterilization.

Fannie Lou Hamer (1917-1977)

Stormont Vail Health

The Magnitude of the Problem

Effects in healthcare delivery

- Observational study in 2019 found that white medical students believed that Black patients had…
- Less sensitive nerve endings (up to 14%); Thicker skin (up to 40%); Blood that coagulates more quickly (up to 29%); Higher fertility (up to 15%); Age more slowly than whites
- Compared to white women, Hispanic and Black women had significantly greater odds of reporting a pain score of ≥ 5, but received significantly fewer inpatient morphine milligram equivalents/day (2019)

Effects in technology

- Pulse oximeters found to not be as effective on darker pigmented skin
- The risk posed by inaccurate readings typically results in patients being less likely to receive supplemental oxygen and life-saving treatment.
- During COVID-19 pandemic, as of January 2022, death rates were higher for Black (37.6 per 100,000), AIAN (34.8 per 100,000), and Hispanic people (30.0 per 100,000) compared with White people (23.5 per 100,000)

Effects in psychology

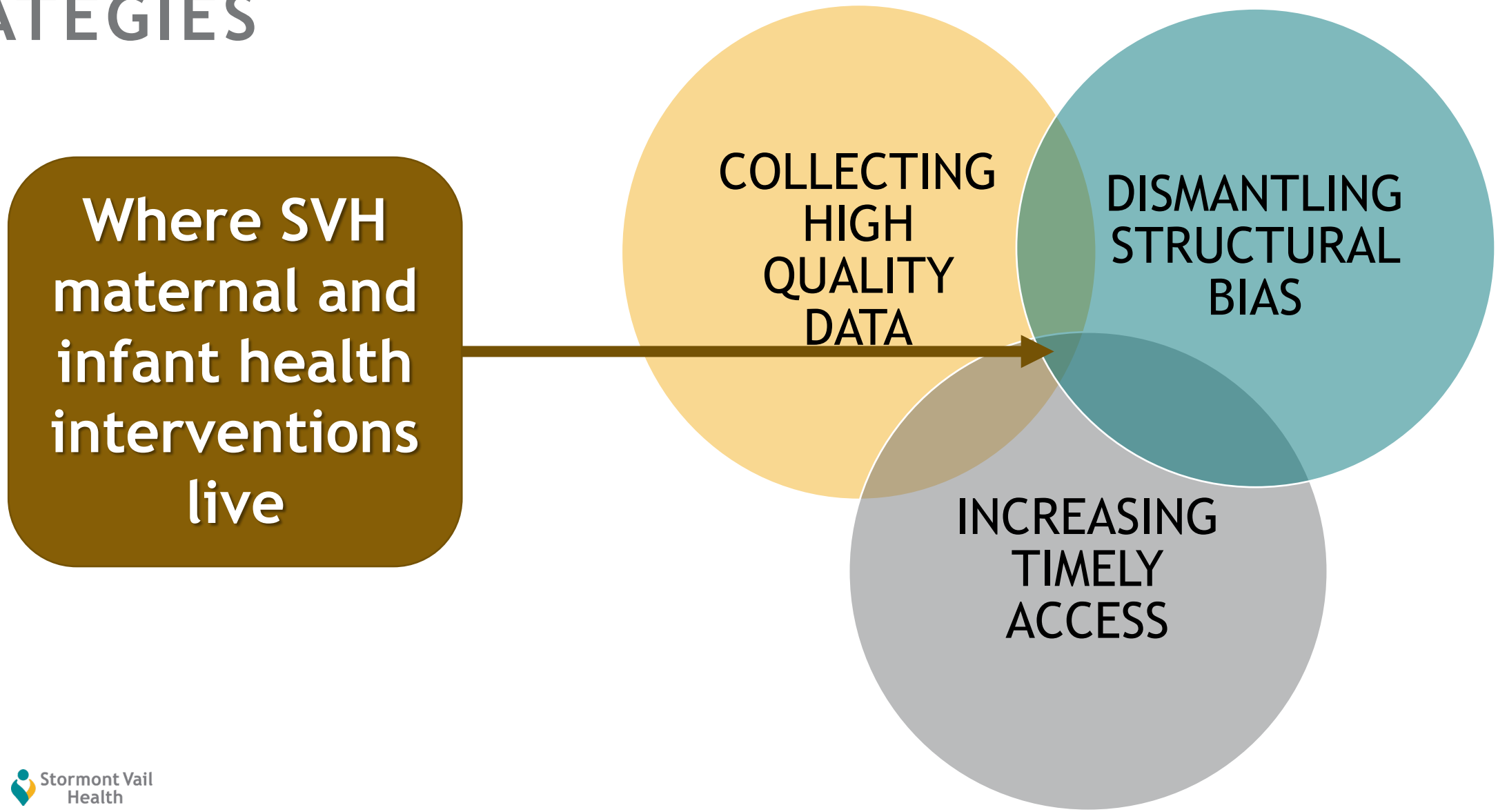
- Weathering hypothesis and allostatic load
- Black race was significantly associated with both high allostatic load and with 50% greater odds of adverse pregnancy outcomes and hypertensive disorders of pregnancy.
- Related to accelerated cellular aging in young through middle-aged women because of decreased telomerase activity and shortened telomeres, the stabilizing ends of chromosomes. (2015)

Effects on physiology

- Epigenetics
- Pregnancy related stress, environmental chemicals, early life exposure to nutritional and dietary deficiencies lead to these gene level changes and poor health outcomes.
- Some of these gene changes can be passed down through multiple generations, even if the initial exposure is removed. This is called trans generational inheritance.

NOW WHAT?

HOW WE PRIORITIZED OUR HEALTH EQUITY STRATEGIES

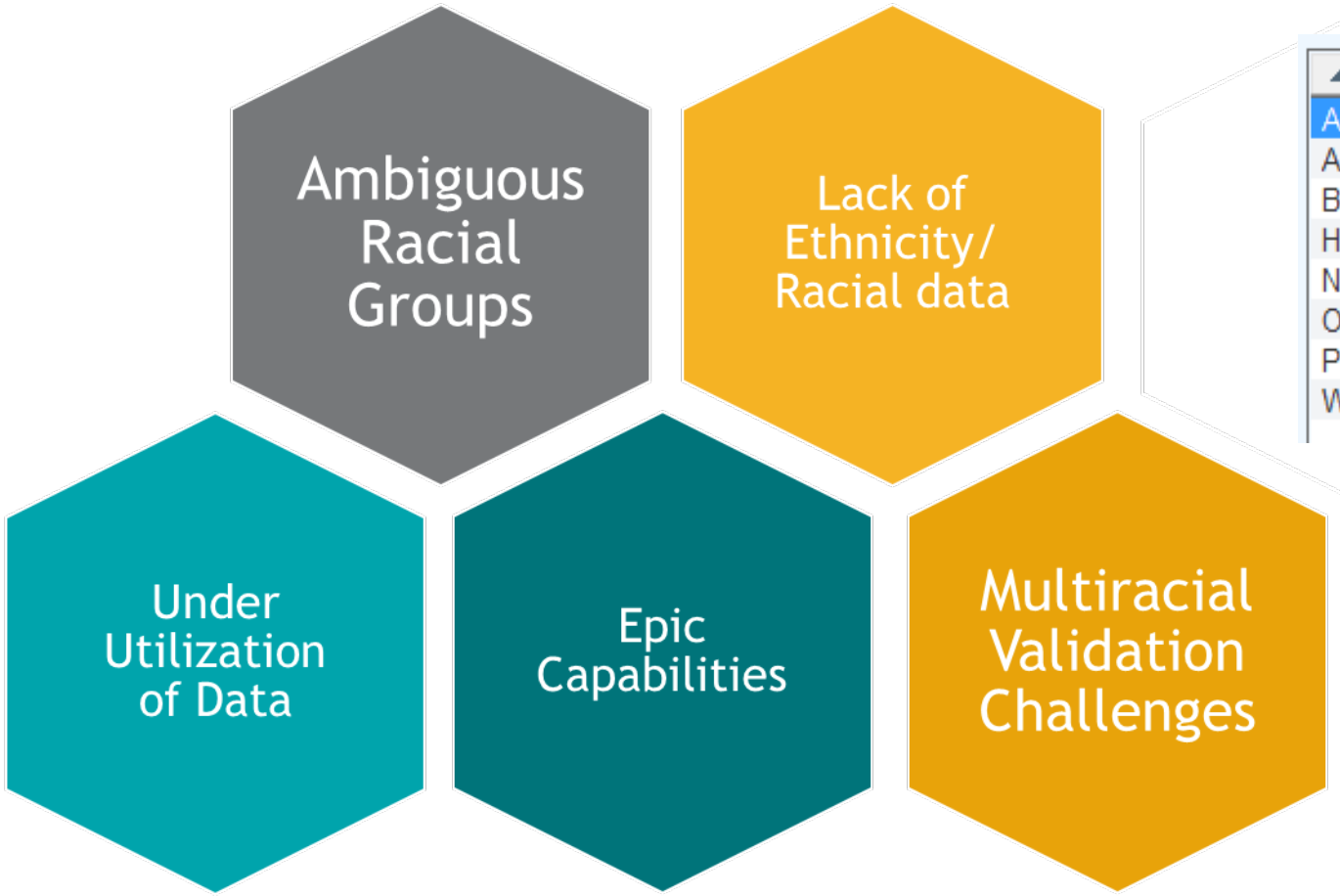


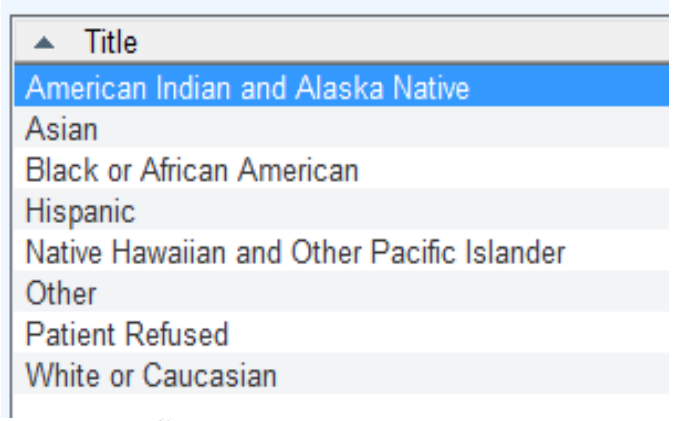
MARCH OF DIMES MATERNAL HEATHCARE COLLABORATIVE

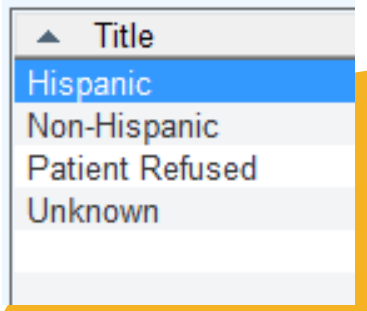
PROGRAM KEY COMPONENTS

- Create a culture of equity
- Utilize patient-reported race and ethnicity data to improve birth equity
- Center the patient in decision making
- Creates accountability to communities

PREVIOUS STATE: INTERFACE DESIGN





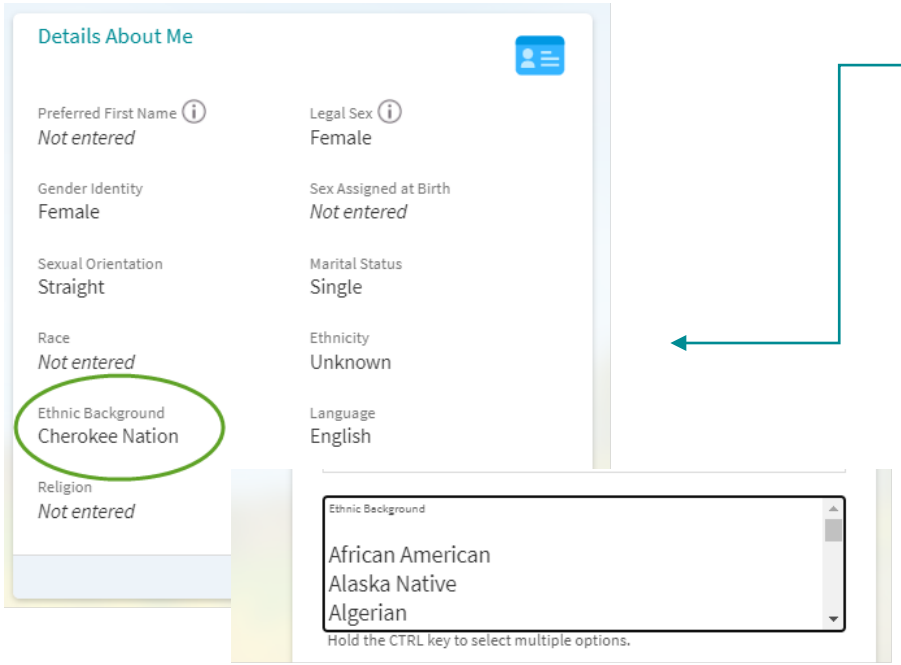


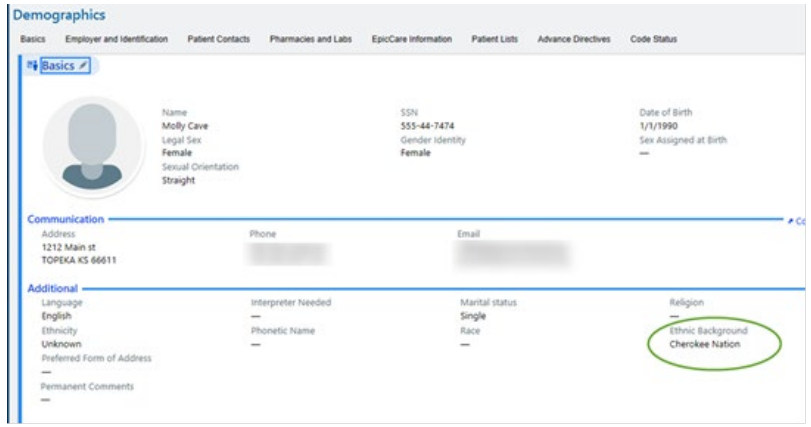
Other Why's:

- Best practice in health equity data collection
- Regulatory changes (CMS)
- Federal government changes to data collection pending (OMB)

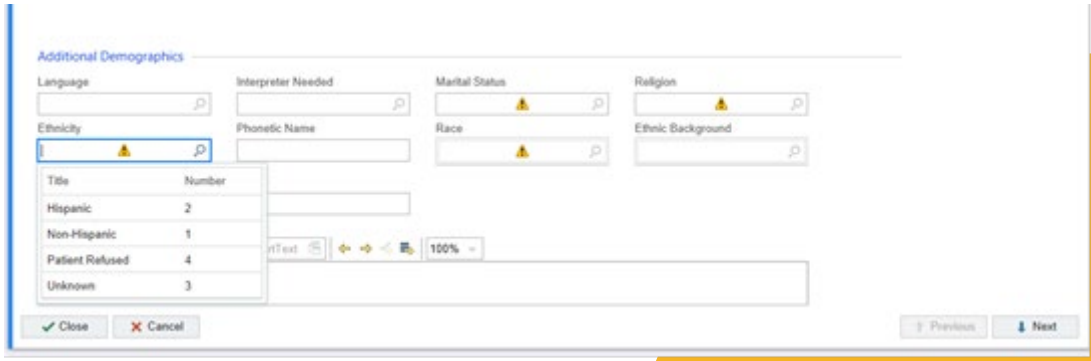
NEW INTERFACE DESIGN

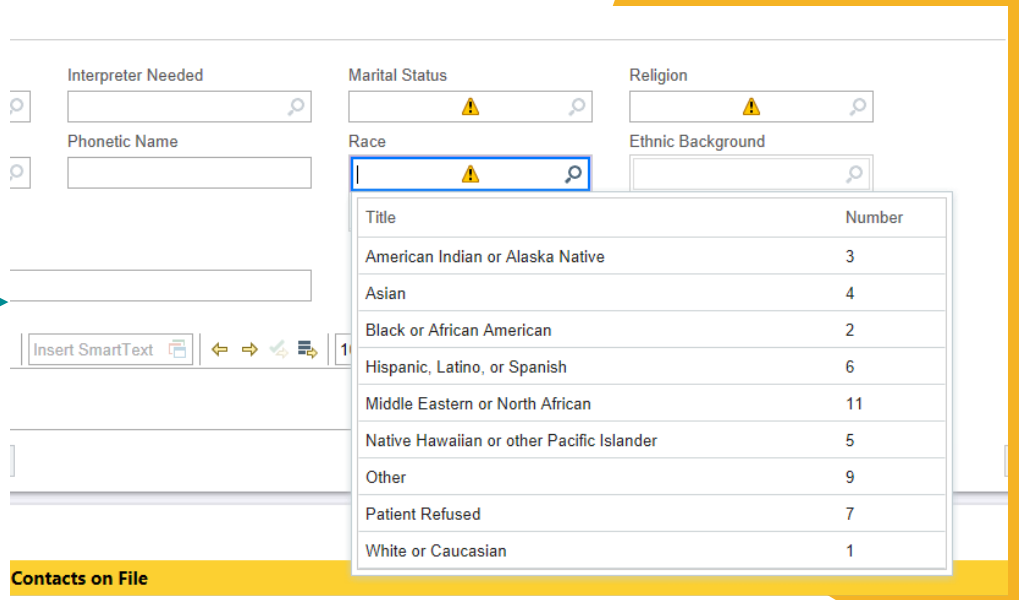
MyChart Interface





Epic Interface





Sample of Racial Group Definition List

Racial Group Option	Definition
American Indian/Alaska Native	A person having origins in any of the original peoples of North and South America (including Central America) and those who may maintain tribal affiliation or community attachment.
Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Chinese, Filipino, Asian Indian, Vietnamese, Korean, and Japanese. The category also includes groups such as Pakistani, Cambodian, Hmong, Thai, Bengali, Mien, etc.
Biracial/Multiracial	A person having origin from two or more racial groups based on biological parent race(s). **Note: Do not select a racial group that is isolated to further back than two generations ago** (biological grandparents) nor select a racial group that you are not apart of but is represented in extended family members (aunts, uncles, cousins, etc.) only.
Black/African American	The category "Black or African American" includes all individuals who identify with one or more nationalities or ethnic groups originating in any of the black racial groups of Africa. Examples of these groups include, but are not limited to, African American, Jamaican, Haitian, Nigerian, Ethiopian, and Somali. The category also includes groups such as Ghanaian, South African, Barbadian, Kenyan, Liberian, Bahamian, etc.
Hispanic/Latino	A person of the Spanish-language-speaking Latin America and Spain such as Cuban, Mexican, Puerto Rican, South or Central American persons, or other Spanish culture or origin, regardless of race. Latino- A person coming from Latin American countries and cultures, regardless of whether the person speaks Spanish.
Middle Eastern/North African	A person who identifies with one or more nationalities or ethnic groups originating in the Middle East or North Africa. Examples of these groups include, but are not limited to, Algerian, Bahraini, Egyptian, Emirati, Iranian, Iraqi, Israeli, Jordanian, Kuwaiti, Lebanese, Libyan, Moroccan, Omani, Palestinian, Qatari, Saudi Arabian, Syrian, Tunisian, Yemeni, Amazigh or Berber, Arab or Arabic,

List of Ethnic Backgrounds By Racial Group

Final Version:

- ☐ American Indian or Alaska Native
  - Alaska Native
  - Cherokee Nation
  - Iowa Tribe of Kansas and Nebraska
  - Kickapoo Tribe of Indians of the Kickapoo Reservation in Kansas
  - Prairie Band Potawatomi Nation
  - Sac & Fox Nation of Missouri (Kansas and Nebraska)
  - None
  - Other
  - Unknown
  - Declined
- ☐ Asian
  - Chinese
  - Filipino
  - Asian Indian
  - Vietnamese
  - Korean
  - Japanese
  - Other
  - Unknown
  - Declined
- ☐ Black or African American
  - African American
  - Jamaican
  - Haitian
  - Nigerian
  - Ethiopian
  - Somali
  - Other
  - Unknown
  - Declined
- ☐ Hispanic, Latino, or Spanish
  - Mexican or Mexican American
  - Puerto Rican
  - Cuban
  - Salvadoran
  - Dominican
  - Colombian
  - Other
  - Unknown
  - Declined
- ☐ Middle Eastern or North African
  - Lebanese
  - Iranian
  - Egyptian
  - Syrian
  - Moroccan
  - Algerian
  - Other
  - Unknown
  - Declined
- ☐ Native Hawaiian or other Pacific Islander
  - Native Hawaiian
  - Samoan
  - Chamorro
  - Tongan
  - Fijian
  - Marshallese
  - Other
  - Unknown
  - Declined
- ☐ White or Caucasian
  - German
  - Irish
  - English
  - Italian
  - Polish
  - French
  - Ukrainian
  - Other
  - Unknown
  - Declined

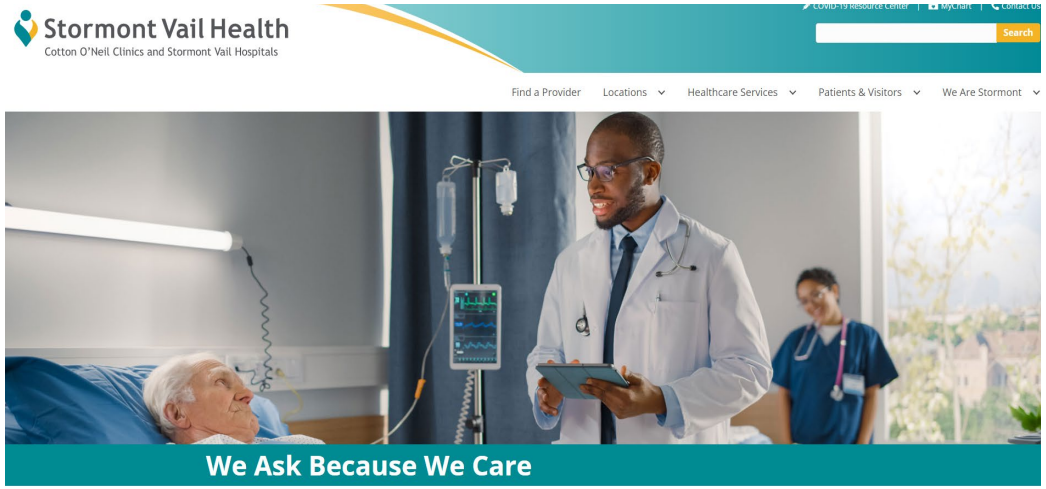
TRAINING: RESPONSE MATRIXES

"Are you saying that health inequities have happened at Stormont?"	We don't know, but we want to make sure that all our patients get the best care possible.
"Who looks at this?"	The only people who see this information are registration staff, administrators for the hospital, and the people involved in quality improvement.
"Are you trying to find out if I'm a US citizen?"	No. Definitely not!! Also, you should know that the confidentiality of what you say is protected by law, and we do not share this information with anyone.
“What will my information be used for?”	Information you give us on your race, ethnicity, and language will help us provide better services and programs to everyone. For example, with this information, we can provide health information in languages spoken by our patients and offer effective programs that can improve health.
“Who are you collecting this information from?”	We are collecting this information from all our patients.

Patient Response	Suggested Response
"I'm human."	Is that your way of saying that you do not want to answer the question? If so, I can just say that you didn't want to answer.
"It's none of your business."	I'll just put down that you didn't want to answer, which is fine.
"Why do you care? We're all human beings."	Well, many studies from around the country have shown that a patient's race and ethnicity can influence the treatment they receive. We want to make sure this doesn't happen here, so we use this information to check and make sure that everyone gets the best care possible. If we find a problem, we fix it.

Patient Response	Suggested Response
"I'm American."	Would you like to use an additional term, or would you like me to just put American?
"Can't you tell by looking at me?"	Well, usually I can. But sometimes I'm wrong, so we think it is better to let people tell us. I don't want to put in the wrong answer. I'm trained not to make any assumptions.
"I was born in Nigeria, but I've really lived here all my life. What should I say?"	That is really up to you. You can use any term you like. It is fine to say that you are Nigerian.

MARKETING CAMPAIGN



Frequently Asked Questions about We Ask Because We Care

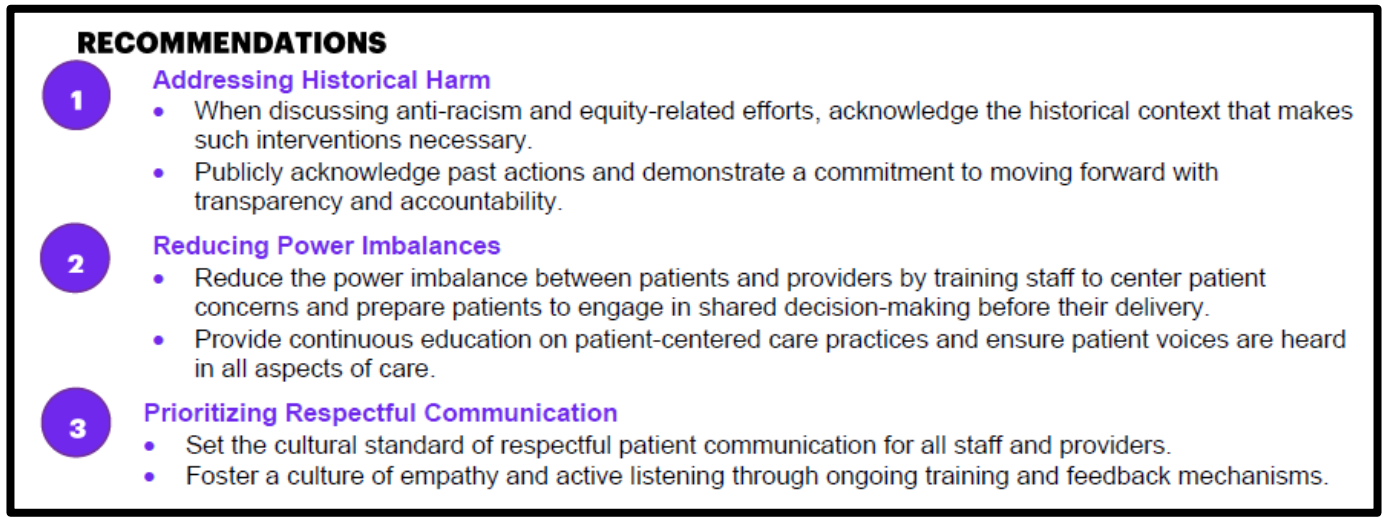
- What Is "We Ask Because We Care"?
- How do I update my information?
- What does We Ask Because We Care mean for you?
- Why does Stormont Vail ask about race and ethnicity? How are these relevant to patient care?
- Who asks these questions?
- Who will be able to access this information? Will Stormont Vail share it?
- How will Stormont Vail store this information?
- Are these questions mandatory?

Sources:

- American Hospital Association. (2020, December 17). Health Equity Snapshot: A Toolkit for Action. https://www.aha.org/system/files/media/file/2020/12/ihdhe_snapshot_survey_FINAL.pdf
- UChicago Medicine. (n.d.). We Ask Because We Care. https://www.uchicagomedicine.org/patients-visitors/patient-information/why-we-ask
- Stanford Medicine. (2023, January 26). *We Ask Because We Care*. Health Equity. https://med.stanford.edu/healthequity/WABWC.html

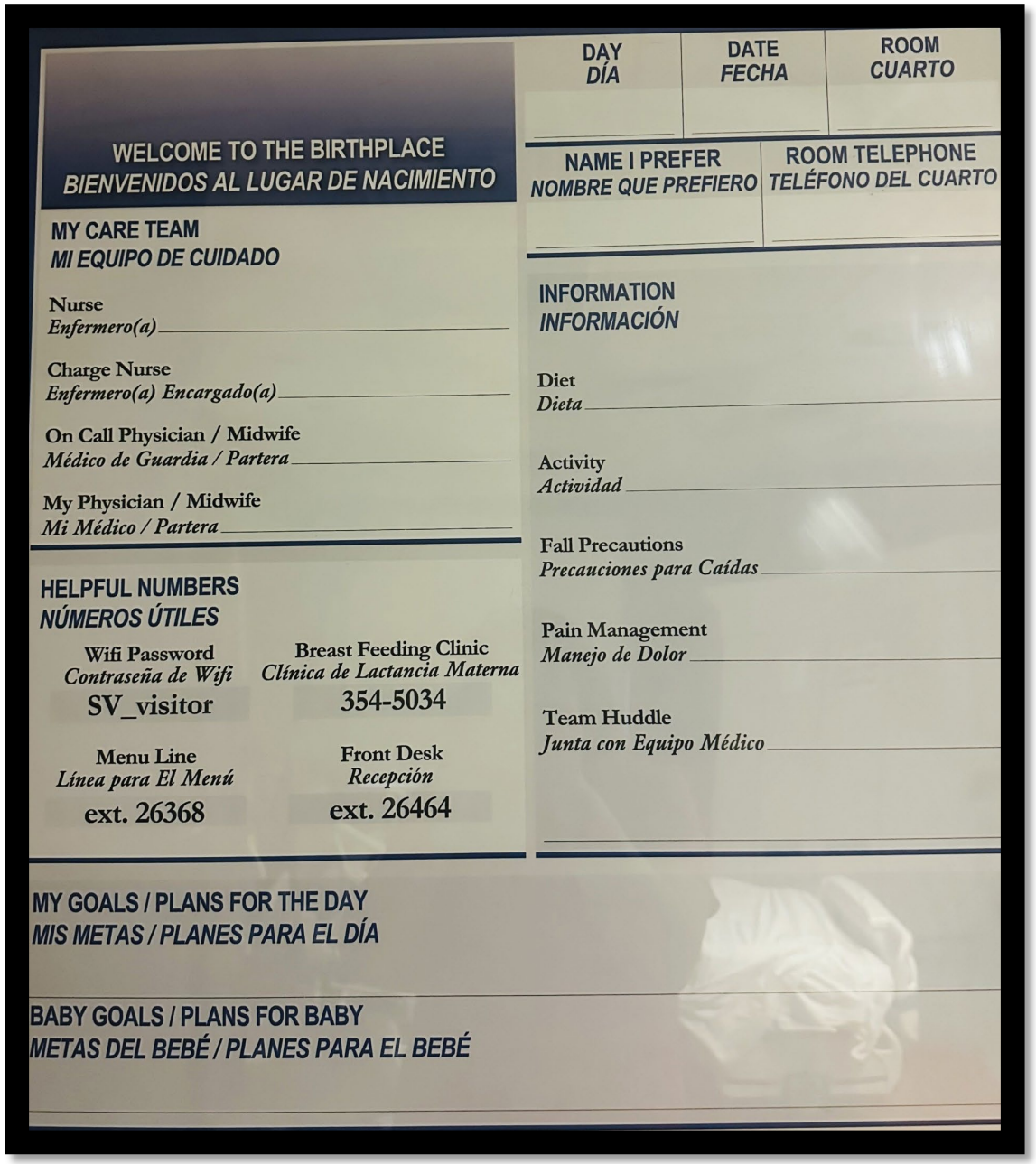
COMMUNITY ACCOUNTABILITY PANEL (CAP)

- Participants recruited and self selected to be a part of quarterly discussions with a third party organization.
- Discussion includes community members from around the area. Communities represented include Topeka, Manhattan, Lawrence, and Leawood. Discussion does not have to be hospital specific.
- Reports are created and distributed to hospital without identifiable information.

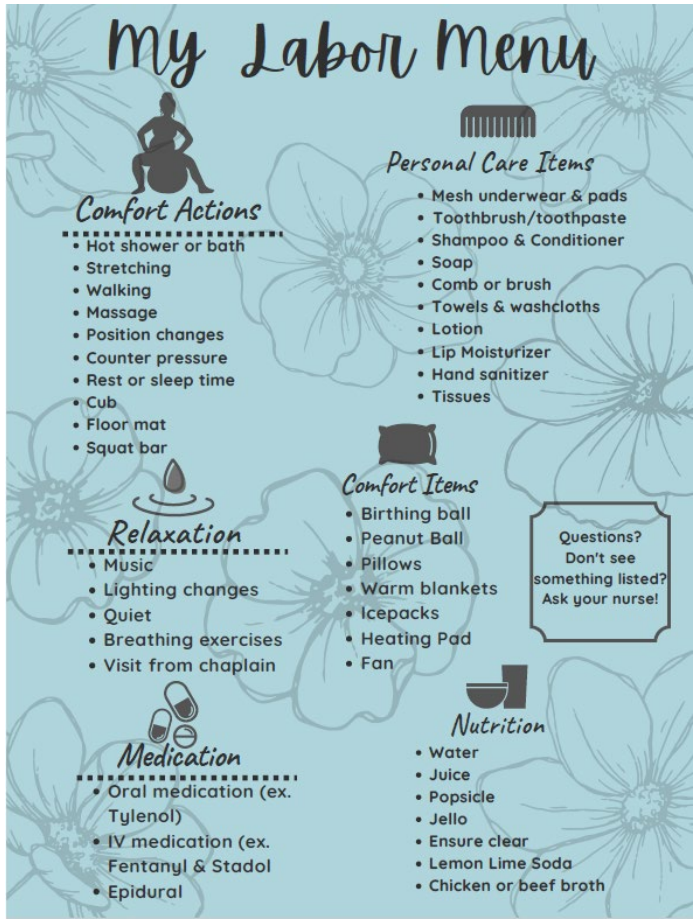


WHITE BOARD

- Visual Aid
- Patient can add to it
- Reference for all who come into the room



LABOR MENU EXAMPLE



My Support Team:

- Berta (Mom)
- Raquel (Doula)
- Brandan (FOB)

Preferences:

Me:

- Low lights
- Birth Playlist
- Room with Tub
- No epidural

Baby:

- Delayed cord clamping 2min
- Skin to skin
- All meds ok

Plan:

Me:

- Position changes
- IV pain meds

Baby:

- Wireless monitoring

Labor:

- No Pitocin
- Limited cervical exams

Early Labor — Active Labor — Pushing

Stormont Vail Health

ANTI-RACISM WORKGROUP GOALS

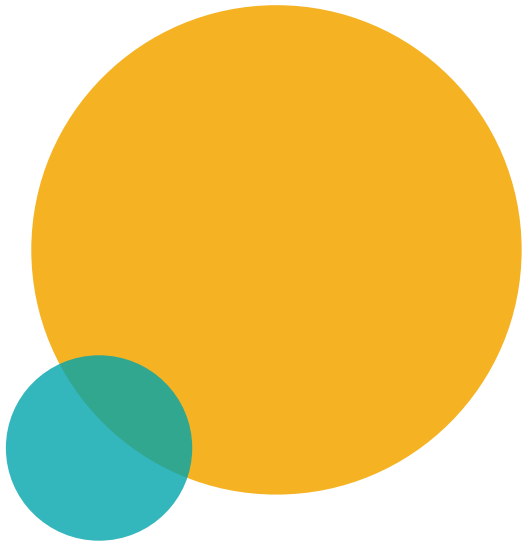
IDENTIFY AND CREATE NEW APPROACHES THAT DECREASE DISPARITIES

INCREASE UNITY AND COLLABORATION ACROSS STORMONT VAIL SYSTEM

EVALUATE OUR CURRENT STRUCTURE AND PRACTICES

CREATE LONGTERM AND SUSTAINABLE CHANGE

MARCH OF DIMES ACTION ITEMS



01

Develop an antiracism statement specific to the birthing person

02

Review OB department staff and hiring practices to ensure racial and ethnic diversity.

03

Review OB policies and procedures and revise to ensure the policies and procedures promote cultural humility and respect, including antiracism language where appropriate

04

Review OB patient and family educational materials for cultural appropriateness (representation, language, etc.)

DATA RESULTS

Nine months post go-live demographic data project

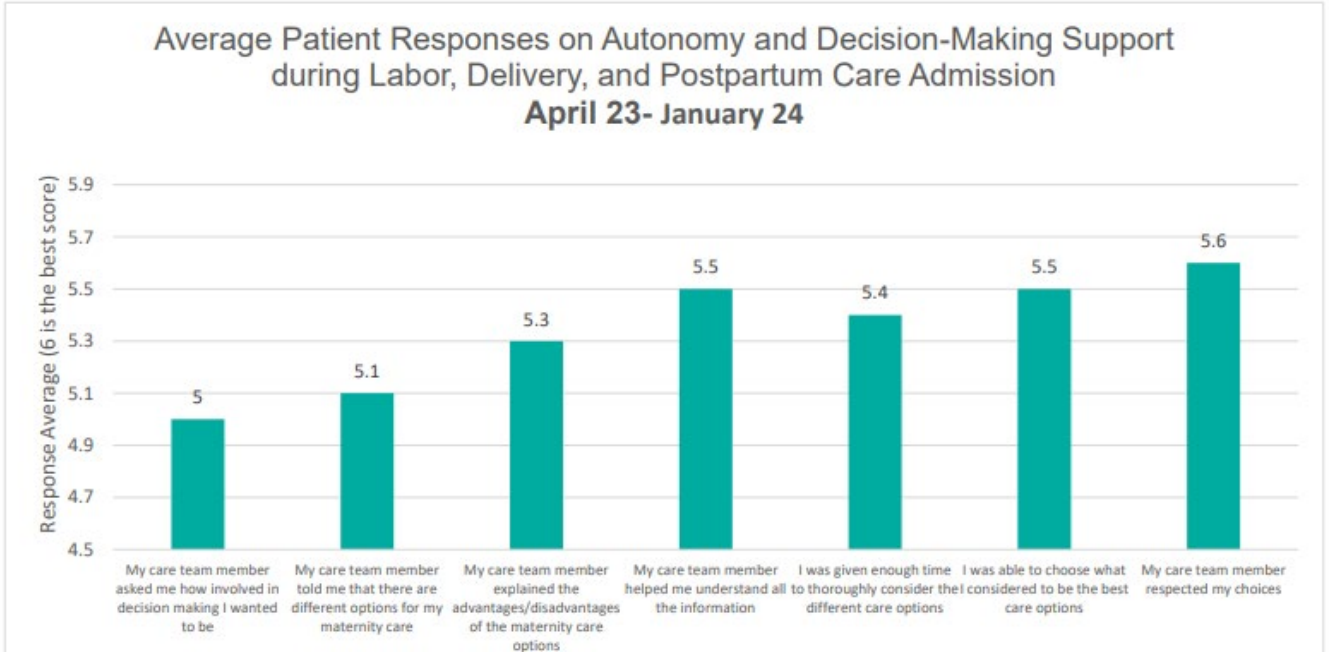
- 19% increase in updates to EMR demographic information
- 8.4% decrease in overall blank entry for race and ethnicity
- 3.9% decline in patients refusing to share ethnic background

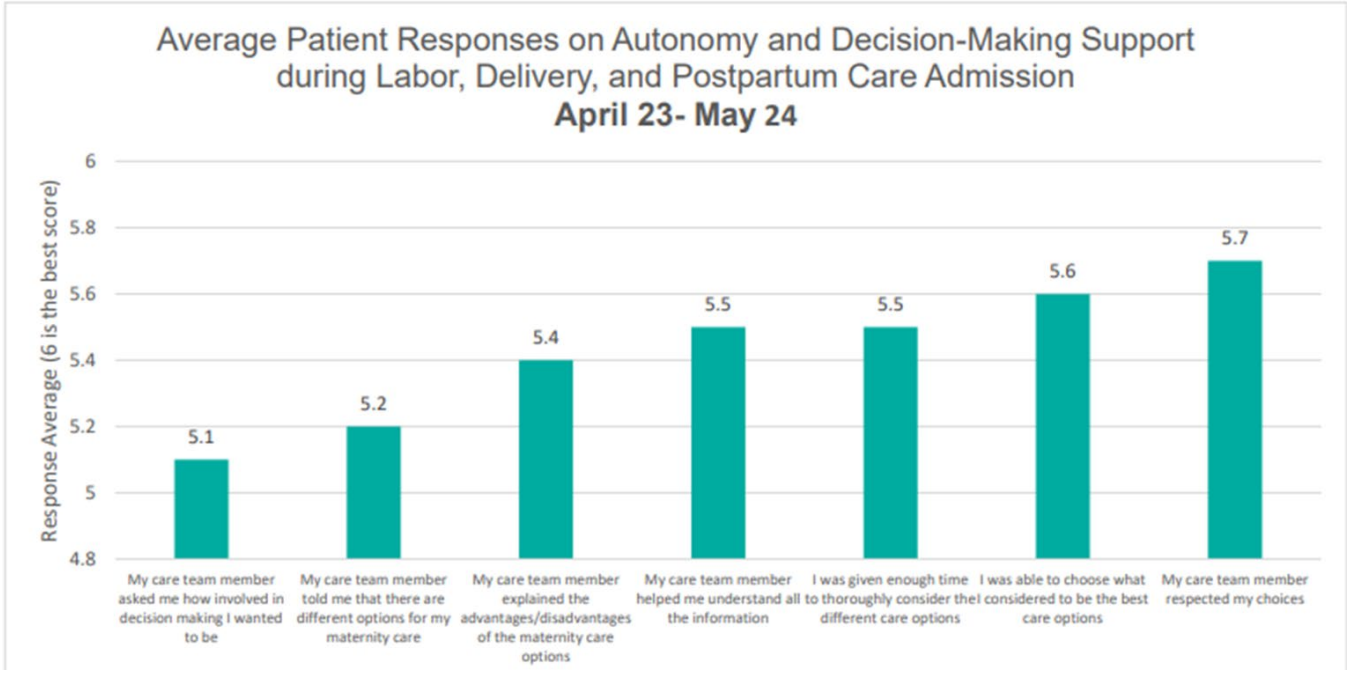
Four months post go-live maternal/child intervention

- Average disparity in Low Birth Weight declined by 52%
- Average disparity in first trimester appointment rate has declined by 32%
- Average disparity in 9 or more prenatal visits decreased by 29%

DATA RESULTS

We saw an overall improvement in patient experience scores over 5 months





CALL TO ACTION: START TODAY!

SAY THE HARD THINGS OUT LOUD. CONTEXT AND LANGUAGE MATTERS.

FIND WAYS TO GIVE POWER BACK TO PATIENTS AND COMMUNITY. HEAR THEM. RESPECT THEM.

FOCUS ON FINE TUNING DATA COLLECTION AND REPORTING

CREATE LONGTERM AND SUSTAINABLE CHANGE

LET'S STAY CONNECTED!

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Stormont Vail Health

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Emersen.Frazier@stormontvail.org

Work Phone:
(785) 354-6000 ext. 25805

THANK YOU

Stormont Vail Health

2025 KPQC Bundle Launch!

Where we're going: 1st, 2nd, 3rd AND FOURTH Trimester!

AND Peds, too!

AIM Bundle LAUNCH

KDHE Vital Statistics Natality Report 2022

Results

In 2022, Kansas birth outcome data revealed notable variations among different racial and ethnic groups. Out of a total of 23,569 births to White Non-Hispanic mothers in 2022, 4,209 (17.9%) were classified as poor outcomes (Table 1). Black Non-Hispanic mothers had a total of 2,191 births and 560 (25.6%) experienced poor outcomes. Low birth weight (<2,500 grams) births occurred more often for Black Non-Hispanic mothers (52.9%, Table 18) than for White Non-Hispanic (35.3%) or Hispanic mothers (40.8%). For Hispanic mothers of any race, the total number of births was 6,295 with 1,087 (17.3%) poor outcomes. For mothers where the race was unstated, a total of 96 births occurred and 19 (19.8%) had poor outcomes.

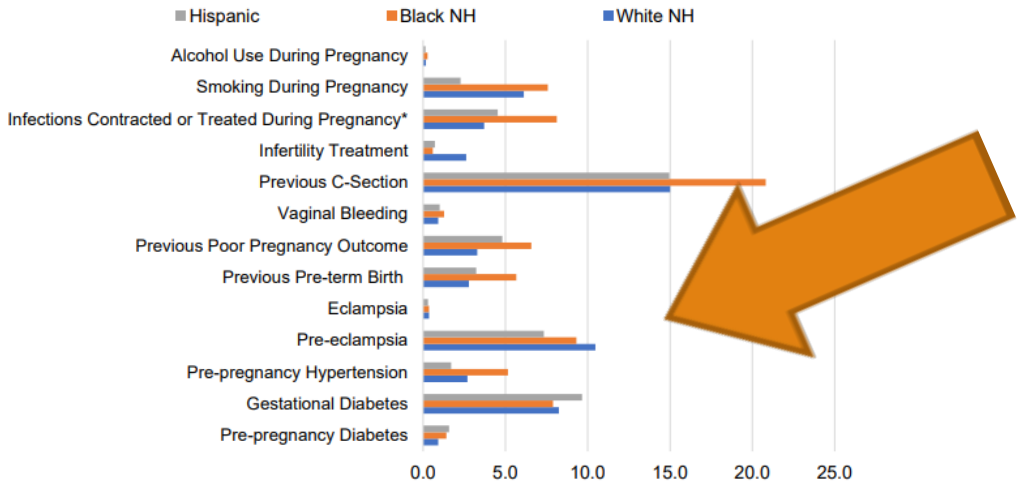
2

Regarding the adequacy of prenatal care, White non-Hispanic mothers had the highest percentage, receiving adequate or better prenatal care (86.8%, Table 11). Black non-Hispanic and Hispanic mothers experienced lower rates of adequate or better prenatal care than White Non-Hispanic mothers (69.0% and 68.6%, respectively). There is as similar pattern for singleton births with poor outcomes. Births with poor outcomes to White Non-Hispanics received adequate or adequate plus prenatal care at a higher rate than Black Non-Hispanic and Hispanic mothers experienced (86.6%, 69.7%, and 68.3%, respectively).

Higher WIC participation rates were observed among Hispanic mothers of any race (40.9%, Table 15) and Non-Hispanic Black mothers (33.7%), while White Non-Hispanic mothers had the lowest WIC participation rates (15.4%). Among singleton births with poor outcomes, WIC participation was similar for all race and ethnicity groups, except American Indian or Alaska Native mothers.

Black Non-Hispanic mothers, generally, experienced a higher rates of medical risk factors than White Non-Hispanic or Hispanic (any race) mothers. Births to Black Non-Hispanic mothers where there had been previous C-sections was 20.8 percent (Table 22), but only around 15 percent for White Non-Hispanic or Hispanic (any race) mothers. Black Non-Hispanic mothers also experienced higher rates of Infections Contracted or Treated During Pregnancy (8.1%) than White Non-Hispanic (3.7%) or Hispanic (any race) mothers (4.5%) (Figure A).

Figure A. Medical Risk Factors Rate for White, Black, and Hispanic 2022



*Infections include Gonorrhea, Syphilis, Herpes Simplex Virus, Chlamydia, HIV, Hepatitis B & Hepatitis C.

https://www.kdhe.ks.gov/DocumentCenter/View/40442/Natality-Report-by-Racial--Ethnic-Population-Groups-2022-PDF

KDHE Vital Statistics Natality Report 2022

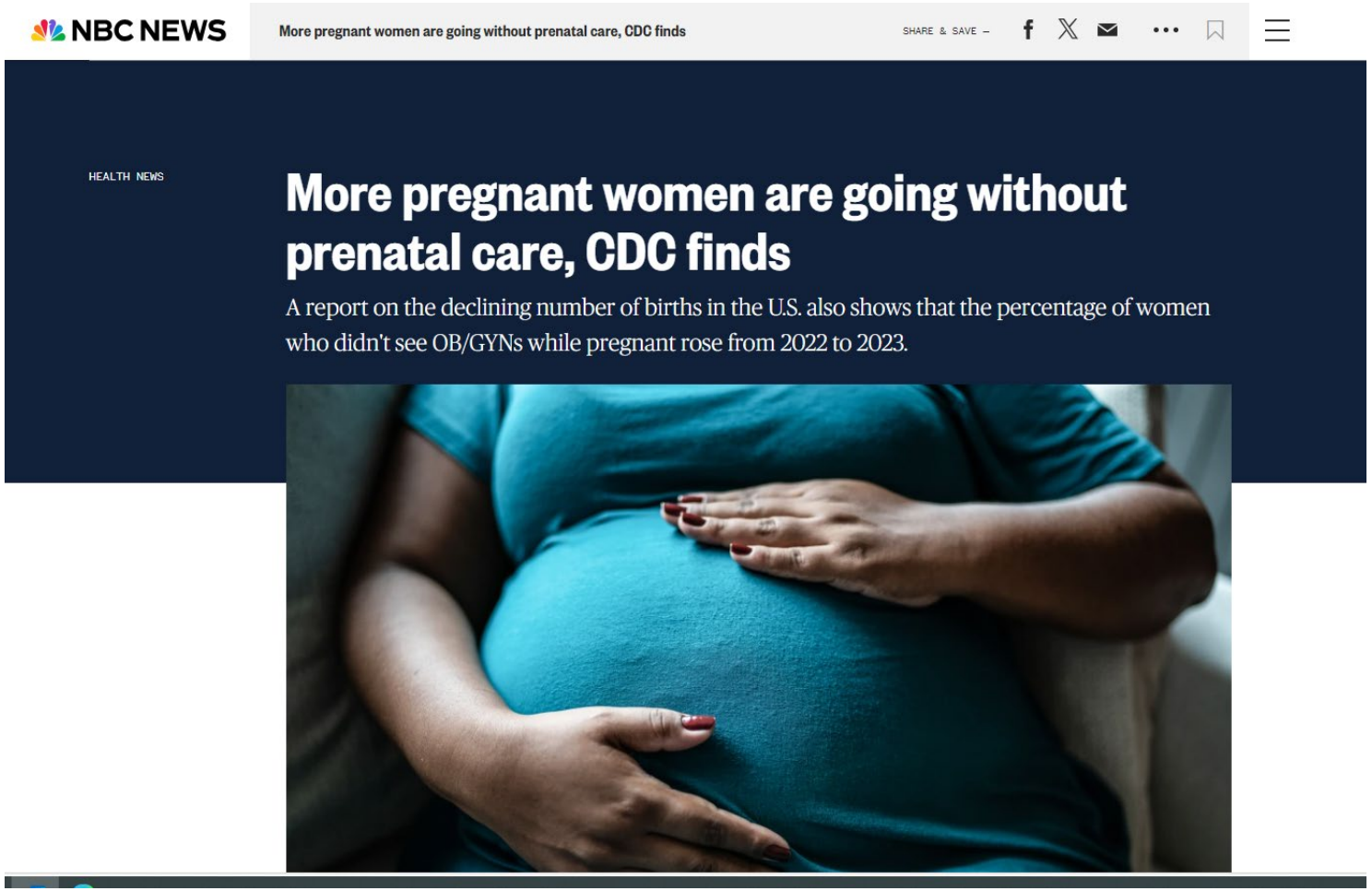
Table 22. Number of Births Where Reported Medical Risk Factors by Population Group, Kansas, 2022*

Medical Risk Factors†	Population Group															
	White NH		Black NH		American Indian Alaska Native NH		Asian-PI NH		Multi Race-Other NH		Hispanic-Any Race		n.s.‡		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Pre-pregnancy Diabetes	217	0.9	31	1.4	2	1.2	15	1.3	14	1.5	99	1.6	1	1.0	379	1.1
Gestational Diabetes	1,945	8.3	173	7.9	16	9.7	195	17.3	74	7.8	608	9.7	6	6.3	3,017	8.8
Pre-pregnancy Hypertension	636	2.7	113	5.2	6	3.6	23	2.0	26	2.7	107	1.7	3	3.1	914	2.7
Pre-eclampsia	2,467	10.5	204	9.3	20	12.1	83	7.4	80	8.4	462	7.3	3	3.1	3,319	9.7
Eclampsia	84	0.4	8	0.4	0	0.0	1	0.1	3	0.3	19	0.3	0	0.0	115	0.3
Previous Pre-term Birth	656	2.8	124	5.7	6	3.6	26	2.3	26	2.7	203	3.2	1	1.0	1,042	3.0
Previous Poor Pregnancy Outcome	776	3.3	144	6.6	12	7.3	56	5.0	23	2.4	303	4.8	1	1.0	1,315	3.8
Vaginal Bleeding	216	0.9	28	1.3	0	0.0	9	0.8	10	1.1	63	1.0	0	0.0	326	0.9
Previous C-Section	3,536	15.0	456	20.8	29	17.6	168	14.9	131	13.8	941	14.9	20	20.8	5,281	15.4
Infertility Treatment	618	2.6	13	0.6	2	1.2	47	4.2	11	1.2	45	0.7	3	3.1	739	2.1
Infections Contracted or Treated During Pregnancy§	874	3.7	178	8.1	13	7.9	40	3.6	76	8.0	285	4.5	4	4.2	1,470	4.3
Smoking During Pregnancy	1,442	6.1	166	7.6	23	13.9	10	0.9	89	9.4	143	2.3	0	0.0	1,873	5.4
Alcohol Use During Pregnancy	39	0.2	6	0.3	0	0.0	0	0.0	2	0.2	9	0.1	0	0.0	56	0.2
Total of Medical Risk Factors°	13,506	n/a¶	1,644	n/a¶	129	n/a¶	673	n/a¶	565	n/a¶	3,287	n/a¶	42	n/a¶	19,846	n/a¶
Total Births	23,569		2,191		165		1,124		949		6,295		96		34,389	

*Residence data
†More than one medical risk factor may have been reported for a birth. Therefore, actual number of births maybe lower than totals.
‡n.s. = not stated
§Infections include: Gonorrhea, Syphilis, Herpes Simplex Virus, Chlamydia, HIV, Hepatitis B & Hepatitis C
¶ n/a: Not Applicable
°The data provided only includes births with reported medical risk factors, each risk factor is counted individually. The total of birth with risk factor does not equal the total of births.

Less births, less prenatal care access

https://www.nbcnews.com/health/health-news/cdc-fewer-babies-born-2023-pregnant-women-missed-prenatal-care-rcna167149



This is the “WHY” for non-OB hospitals and non-OB departments. These women are showing up in the ED of your facility.

And the WINNER is...

AIM

ALLIANCE FOR INNOVATION
ON MATERNAL HEALTH

Severe Hypertension in Pregnancy Patient Safety Bundle (2022)

Why is this important?

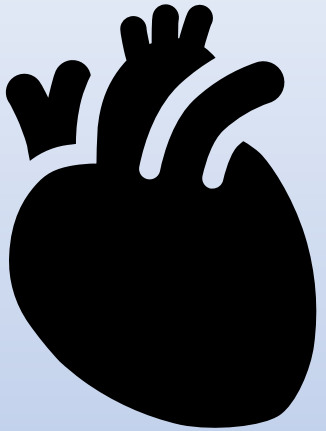
The US remains in a maternal mortality crisis. According to the latest data released by the Centers for Disease Control and Prevention (CDC), the 2018 pregnancy-related mortality ratio was 17.3 per 100,000 live births .[1] When disaggregated by race, the ratio of maternal death for non-Hispanic Black people (41.4 deaths for 100,000 live births) was three times the rate for non-Hispanic White people (13.7 deaths per 100,000) and three times that of Hispanic people (14.1 people per 100,000 live births).[1] Non-Hispanic American Indian and Alaska Native people also experienced pregnancy-related death ratios that were twice as high (26.4 per 100,000 live births) as those of non-Hispanic White people.[1]

Near-miss morbidity events or severe maternal morbidity (SMM) have increased nearly 200% from 1993 (49.5 per 10,000 delivery hospitalizations) to 2014 (144), with non-Hispanic Black people also experiencing higher rates of SMM.[1,2]

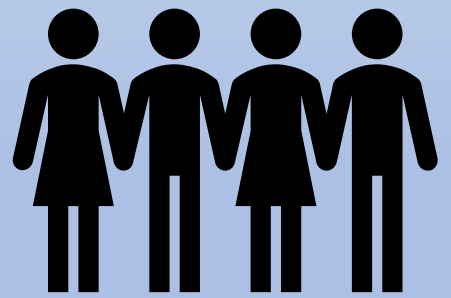
According to the CDC, the prevalence of hypertensive disorders in pregnancy affected at least 1 in 7 delivery hospitals during 2019 (1 in 5 for Black women and 1 in 6 for American Indian and Alaska Native women). The overall rate was an increase from about 13 percent in 2017 to 16 percent in 2019. During 2019, about one third of all deaths during a delivery hospitalization had a hypertensive disorder of pregnancy documented. Hypertension in pregnancy is a leading cause of preventable, pregnancy-related complications and death, with an estimated 60 percent of deaths related to severe hypertension being identified as preventable since 2005.[3–5] Indeed, there are many strategies to reduce hypertension-related deaths and complications.[6]

The goal of this change package is to aid teams implementing the AIM Severe Hypertension in Pregnancy Patient Safety Bundle by preparing them to recognize and respond to hypertension at all stages of care, and laying the foundation for respectful, equitable, and supportive care for all. It is imperative that the structural and process barriers to equitable care for Black birthing people be eliminated. Eliminating these structural and process barriers will require focus and resources. Thank you for joining the national efforts to work more effectively to end all hypertension-related preventable deaths and complications in pregnancy.

Let's Gooooo!

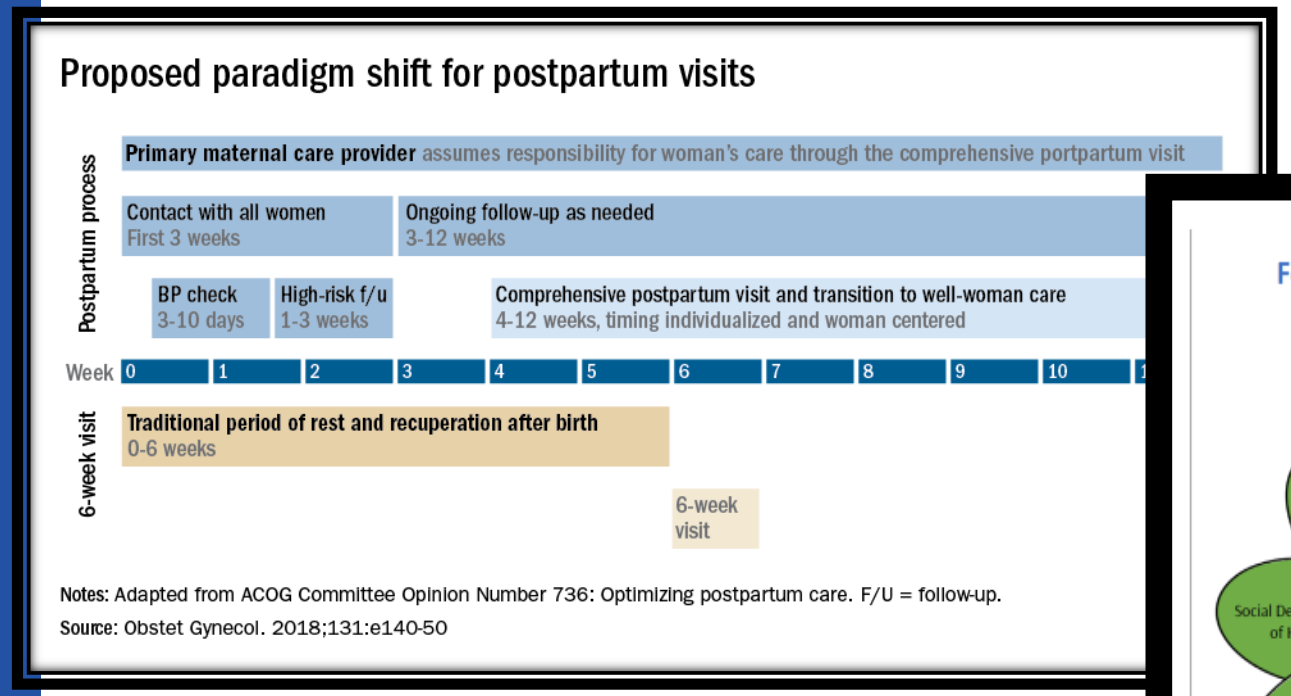


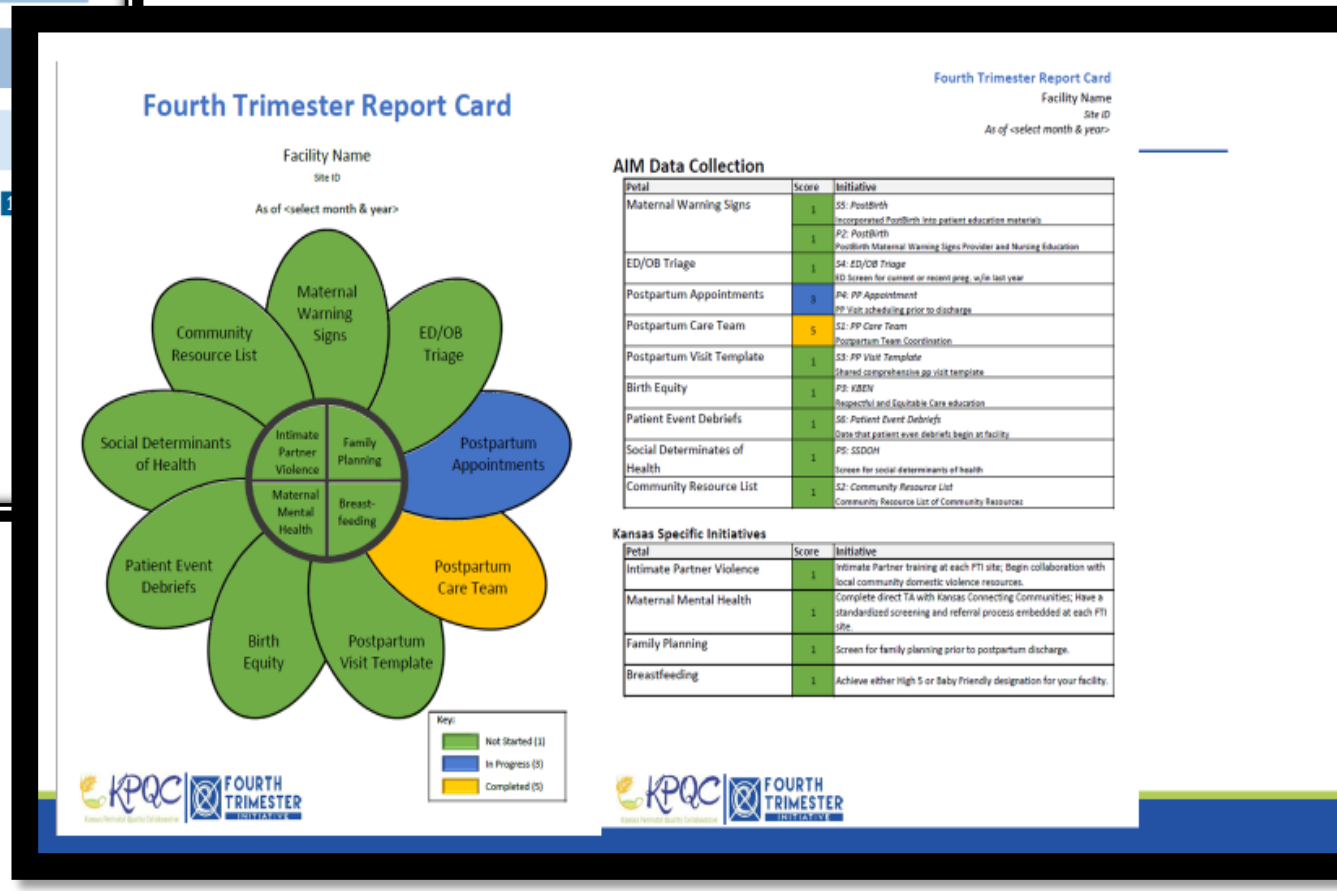
- ❑ LAUNCH
- ❑ Identify (accurately)
- ❑ Recognize (Education about diagnosis leads to immediate treatment)
- ❑ Respond (Best practice treatment modalities and related factors)



Initiative	Q1 2025	Q2 2025	Q3 2025	Q4 2025	2026
Launch Bundle (Readiness)	Launch Bundle Enrollment Data Collection Survey (Redcap)				
Identify (Recognition)		Staff: Education (POST BIRTH; ACOG algorithms) Patient: Education Community Organizations: Education *Data collection to continue			
Recognize and Respond			Staff: Finalize ACOG Protocols and Follow up appointments		
			Staff: Simulations (Inpatient ,EMS, Emergency Departments) *Data collection to continue		
			Patient: Follow up/Follow through Comprehensive Care Model; **Patient: Pumping Protocol, Non hypertensive initiatives		
			Community Outreach: KDHE/Local health departments Connect with facilities with Support Implementation of PP Visits; Home Visits/CHW/Doula/Navigation assigned		
***Reporting: Ongoing Data Collection**					EMS Education/Transfers; Pt Debriefs and Team

And CONTINUE FTI work! (Remember this…?)





Your homework

- **Watch the following & send out to staff/Admin/QI**
  https://vimeo.com/743542904\
- **Review your Obstetrical HTN Protocol/Bundle before January**

What happens next?

January 2025!

- FTI Champions receive Enrollment packets
  - If you do not have a Champion or you have a new Champion, email Kari or Terrah
- Enrollment packets
  - Facts Sheet
  - Baseline Data Collection (REDCap)
  - Bundle specific items

JOIN US:

January 28th, 2025 : January KPQC Learning Forum LINK

Have a cool name idea??

“Severe Hypertension in Pregnancy” Bundle

THANK YOU!

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