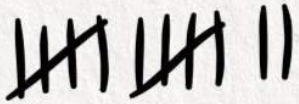
February 2026 KPQC Learning Forum

CHAMPS ONLY!

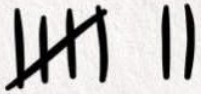
2026 Winter Olympics… a story of moms

Kansas Perinatal Quality Collaborative

Prenatal Visits



Infant Visits



Postpartum Visits

IT'S TIME TO CHANGE THE DYNAMIC IN HEALTHCARE FOR MOTHERS.

KPQC Enrolled Facility IN PERSON Spring Conference

May 1st, 2026

9:00-4:00

Sunflower Foundation, Topeka, KS

CHAMPION +1 Guest

“Stronger Together for Kansas Moms and Babies: Connecting Best Practices, Lived Experiences, and Improved Outcomes”

9:00 Kickoff

9:15 Hot Topics: Pediatric and Maternal Vaccines, Panel Discussion

10:15 The untold story: Peripartum Cardiomyopathy & other maternal cardiac risk factors

11:30 Let’s Talk: The Lived Experience of Peripartum Cardiomyopathy

12:00 Lunch & Celebration of Success

1:00 Enrolled Sites Workday

Group review of "hard topics"

- Case Studies
- Best practice
- Statewide challenges (open mic)

Round table sessions:

- SHTN Protocols
- Timely Treatment protocols/challenges
- OB-ED collaborations and challenges
- Breastfeeding: Hand expression/Pumping protocols
- Intimate Partner Violence
- Maternal Mental Health

Rapid Response
ASA therapy

Received: 4 December 2025 | Revised: 4 December 2025 | Accepted: 8 December 2025

DOI: 10.1002/pmf2.70212

PREGNANCY | Society for Maternal-Fetal Medicine

SMFM SPECIAL STATEMENT

Society for Maternal-Fetal Medicine Special Statement: Updated checklists for preeclampsia risk-factor screening to guide recommendations for prophylactic low-dose aspirin

Society for Maternal-Fetal Medicine (SMFM) | Jeny Ghartey | C. Andrew Combs |
SMFM Patient Safety and Quality Committee

Correspondence
The Society for Maternal-Fetal Medicine: Patient Safety and Quality Committee, PO Box 420016, Washington, DC 20042, USA.
Email: pubs@smfm.org

Replaces Society for Maternal-Fetal Medicine Special Statement: Checklists for preeclampsia risk-factor screening to guide recommendations for prophylactic low-dose aspirin, 2020.

Abstract

Prophylactic low-dose a
in pregnant persons wi
including elements of c
tory, and examination
published checklists int
vertently overlooked an
for all appropriate cand
lished an updated Reco
for whom aspirin proph
Medicine presents upda
also suggest steps for i
statement replaces the 2
Checklists for preeclan
prophylactic low-dose a

SMFM SPECIAL STATEMENT: CHECKLISTS FOR PREECLAMPSIA RISK-FACTOR SCREENING 3 of 7

Preeclampsia Risk Factors

High-Risk Factors *(Recommend prophylactic low-dose aspirin if any of these risk factors are present.)*

- ☐ Preeclampsia in previous pregnancy
- ☐ Multifetal pregnancy
- ☐ Chronic hypertension
- ☐ Diabetes (type 1 or type 2)
- ☐ Kidney disease
- ☐ Autoimmune disorder (e.g., systemic lupus erythematous, antiphospholipid syndrome)
- ☐ Combination of multiple moderate-risk factors

Moderate-Risk Factors *(Recommend prophylactic low-dose aspirin if more than one of these factors are present, and consider low-dose aspirin if patient has any of these factors. Consider low-dose aspirin if one of the factors indicated by an asterisk [*] is present, even if that is the only risk factor.)*

- ☐ Nulliparity
- ☐ Obesity (body mass index ≥ 30 kg/m²)
- ☐ Mother or sister had preeclampsia
- ☐ Black or African American race (self-identified, a proxy for racism as risk factor)*
- ☐ Lower income*
- ☐ Maternal age ≥ 35 years
- ☐ Personal history factors (e.g., low birthweight or small-for-gestational-age, previous adverse pregnancy outcome, > 10-year pregnancy interval)
- ☐ Pregnancy conceived by in vitro fertilization (IVF)

Provider Signature _____ Date_____

Version December 2025

FIGURE 1 Example checklist of preeclampsia risk factors suitable for completion by healthcare providers.

4 of 7 SMFM SPECIAL STATEMENT: CHECKLISTS FOR PREECLAMPSIA RISK-FACTOR SCREENIN

Preeclampsia Risk Factors

What is your height? _____ Usual weight before pregnancy?_____
Have you been told you have or had any of the following?

- ☐yes ☐no Preeclampsia ("toxemia") in a previous pregnancy
- ☐yes ☐no Twins or triplets in the current pregnancy
- ☐yes ☐no Hypertension (high blood pressure)
- ☐yes ☐no Diabetes (type 1 or type 2)
- ☐yes ☐no Kidney disease
- ☐yes ☐no Autoimmune disorder (lupus, rheumatoid arthritis, etc.)
- ☐yes ☐no Antiphospholipid or anticardiolipin syndrome

☐yes ☐no Did your mother or sister have preeclampsia ("toxemia") during a pregnancy?
☐yes ☐no Are you 35 years old or more?
☐yes ☐no Did you weigh less than 5½ pounds (2.5 kg) at birth?
☐yes ☐no Are you Black or African American?
☐yes ☐no Do you consider yourself or your family to have low income?
☐yes ☐no Did you have in vitro fertilization (IVF) for this pregnancy?
☐yes ☐no Will this be your first child?

If you have previous children:

- ☐yes ☐no Is your youngest child 10 years old or more?
- ☐yes ☐no Any previous child weighing less than 5½ pounds (2.5 kg) at birth?

☐yes ☐no Are you taking low-dose aspirin (81 mg daily)?

Signed by Patient_____ Date: _____

Office Use Only:
☐ BMI _____ (Initials_____) GA _____ wks
☐ Recommend ASA
☐ No Recommendation
☐ Already on ASA

Signed by Provider_____ Date_____

Version December 2025

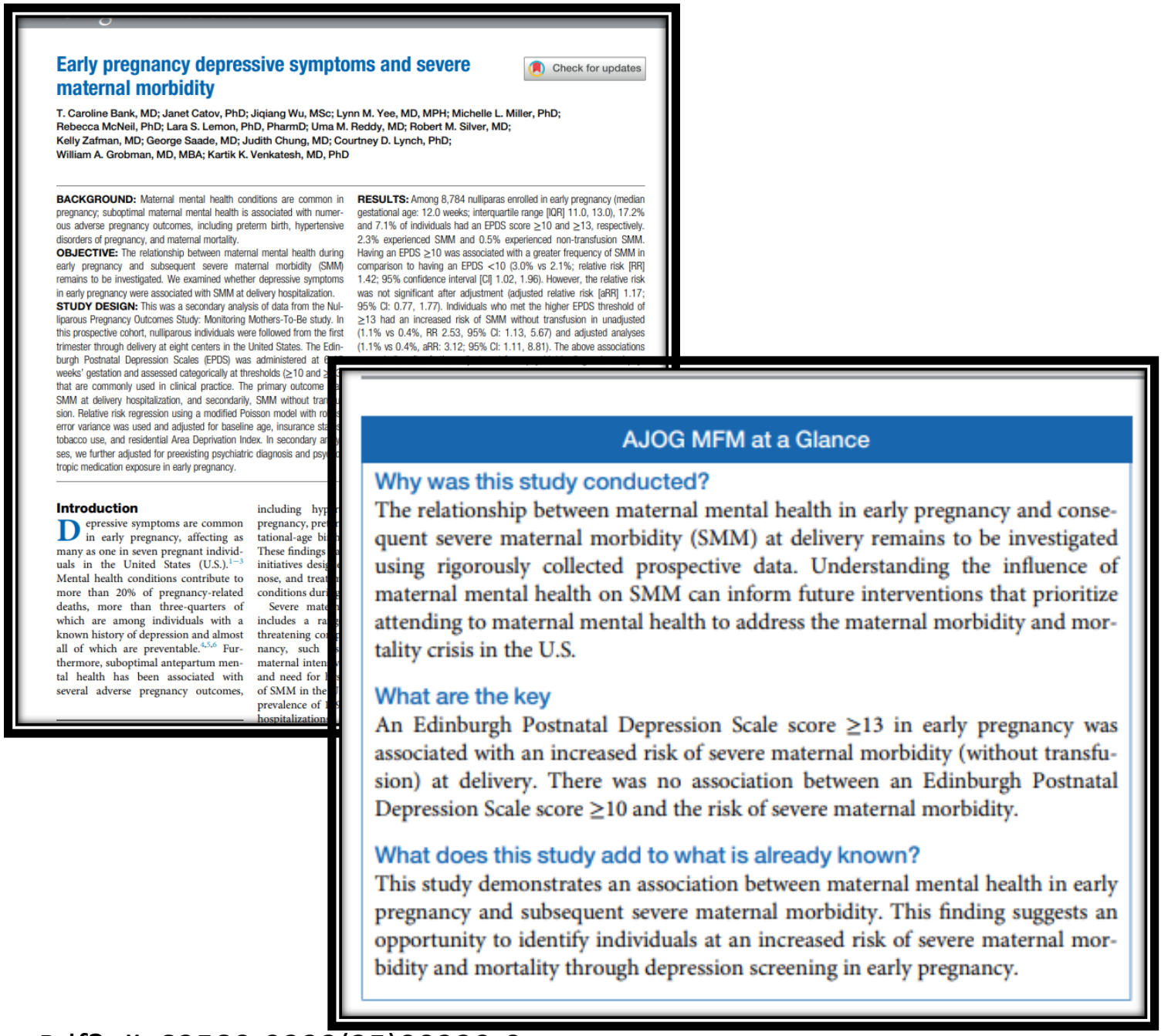
FIGURE 2 Example checklist of preeclampsia risk factors suitable for completion by patients.

with the checklist. Team meetings and individual interviews can be used to seek input from all personnel. Team goals should be to develop a timetable for implementation, identify and solve any barriers to implementation, monitor usage and effectiveness of the checklist, and develop a strategy for sustainability. Each practice will need to decide whether to use the provider-completed form (Figure 1) the patient-completed form (Figure 2). There is general no advantage for a practice to use both forms.

A decision should be made about the format of th checklist and the way it will be administered: either as paper form to be filed in the patient chart, an electron

https://obgyn.onlinelibrary.wiley.com/doi/10.1002/pmf2.70212?fbclid=IwRlRTSAP6AjJleHRuA2FlbQIxMQBzcnRjBmFwcF9pZAo2NjI4NTY4Mzc5AAE e0oqoJyMel27WBjyBjWQH46yIoofh1DuDOb488NE2mXH10QnHdclEVKa0KYM_aem_ly1WdJRLsVagJI-WBaq1uw__;!!NKQdatwUU9k7lA!TmRr-2kPnDWb0iZAmBYpKqRXo_UrLHWPLrA2vy-X7Tc5PJJwllBBhsF7FRR8Yh3BvaqUWNuFWuuWTQfNAHQIG8s$

Rapid Response
SMM tied to Perinatal Depression?



Early pregnancy depressive symptoms and severe maternal morbidity

Check for updates

T. Caroline Bank, MD; Janet Catov, PhD; Jiqiang Wu, MSc; Lynn M. Yee, MD, MPH; Michelle L. Miller, PhD; Rebecca McNeil, PhD; Lara S. Lemon, PhD, PharmD; Uma M. Reddy, MD; Robert M. Silver, MD; Kelly Zafman, MD; George Saade, MD; Judith Chung, MD; Courtney D. Lynch, PhD; William A. Grobman, MD, MBA; Kartik K. Venkatesh, MD, PhD

BACKGROUND: Maternal mental health conditions are common in pregnancy; suboptimal maternal mental health is associated with numerous adverse pregnancy outcomes, including preterm birth, hypertensive disorders of pregnancy, and maternal mortality.

OBJECTIVE: The relationship between maternal mental health during early pregnancy and subsequent severe maternal morbidity (SMM) remains to be investigated. We examined whether depressive symptoms in early pregnancy were associated with SMM at delivery hospitalization.

STUDY DESIGN: This was a secondary analysis of data from the Nulliparous Pregnancy Outcomes Study: Monitoring Mothers-To-Be study. In this prospective cohort, nulliparous individuals were followed from the first trimester through delivery at eight centers in the United States. The Edinburgh Postnatal Depression Scales (EPDS) was administered at 6 weeks' gestation and assessed categorically at thresholds (≥10 and ≥ that are commonly used in clinical practice. The primary outcome SMM at delivery hospitalization, and secondarily, SMM without tran sion. Relative risk regression using a modified Poisson model with ro error variance was used and adjusted for baseline age, insurance sta tobacco use, and residential Area Deprivation Index. In secondary an ses, we further adjusted for preexisting psychiatric diagnosis and psy tropic medication exposure in early pregnancy.

RESULTS: Among 8,784 nulliparas enrolled in early pregnancy (median gestational age: 12.0 weeks; interquartile range [IQR] 11.0, 13.0), 17.2% and 7.1% of individuals had an EPDS score ≥10 and ≥13, respectively. 2.3% experienced SMM and 0.5% experienced non-transfusion SMM. Having an EPDS ≥10 was associated with a greater frequency of SMM in comparison to having an EPDS <10 (3.0% vs 2.1%; relative risk [RR] 1.42; 95% confidence interval [CI] 1.02, 1.96). However, the relative risk was not significant after adjustment (adjusted relative risk [aRR] 1.17; 95% CI: 0.77, 1.77). Individuals who met the higher EPDS threshold of ≥13 had an increased risk of SMM without transfusion in unadjusted (1.1% vs 0.4%, RR 2.53, 95% CI: 1.13, 5.67) and adjusted analyses (1.1% vs 0.4%, aRR: 3.12; 95% CI: 1.11, 8.81). The above associations

Introduction

Depressive symptoms are common in early pregnancy, affecting as many as one in seven pregnant individuals in the United States (U.S.).[1–3] Mental health conditions contribute to more than 20% of pregnancy-related deaths, more than three-quarters of which are among individuals with a known history of depression and almost all of which are preventable.[4,5,6] Furthermore, suboptimal antepartum mental health has been associated with several adverse pregnancy outcomes, including hyp pregnancy, pre tational-age bi These findings initiatives desig nose, and treat conditions duri

Severe mate includes a ra threatening co nancy, such maternal inten and need for of SMM in the prevalence of hospitalization

AJOG MFM at a Glance

Why was this study conducted?

The relationship between maternal mental health in early pregnancy and consequent severe maternal morbidity (SMM) at delivery remains to be investigated using rigorously collected prospective data. Understanding the influence of maternal mental health on SMM can inform future interventions that prioritize attending to maternal mental health to address the maternal morbidity and mortality crisis in the U.S.

What are the key

An Edinburgh Postnatal Depression Scale score ≥13 in early pregnancy was associated with an increased risk of severe maternal morbidity (without transfusion) at delivery. There was no association between an Edinburgh Postnatal Depression Scale score ≥10 and the risk of severe maternal morbidity.

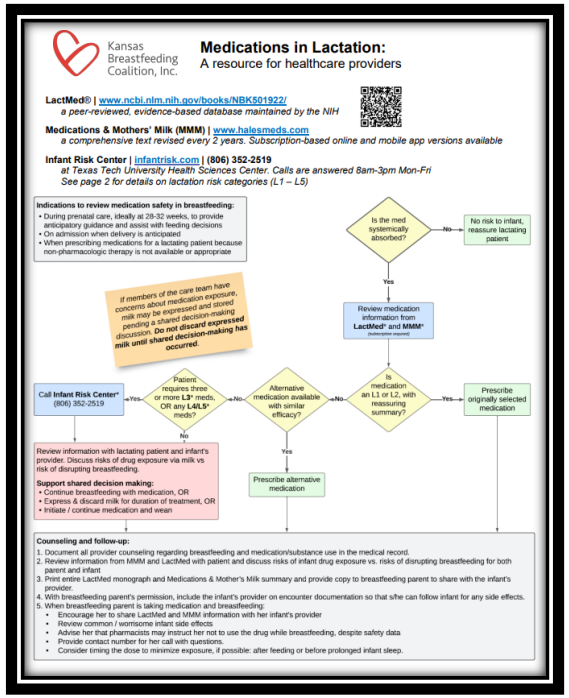
What does this study add to what is already known?

This study demonstrates an association between maternal mental health in early pregnancy and subsequent severe maternal morbidity. This finding suggests an opportunity to identify individuals at an increased risk of severe maternal morbidity and mortality through depression screening in early pregnancy.

https://www.ajogmfm.org/action/showPdf?pii=S2589-9333(25)00229-0

Rapid Response

Lactation & Meds



Kansas Breastfeeding Coalition, Inc.

Medications in Lactation:
A resource for healthcare providers

LactMed® | www.ncbi.nlm.nih.gov/books/NBK501922/
a peer-reviewed, evidence-based database maintained by the NIH

Medications & Mothers' Milk (MMM) | www.halesmeds.com
a comprehensive text revised every 2 years. Subscription-based online and mobile app versions available

Infant Risk Center | infantrisk.com | **(806) 352-2519**
at Texas Tech University Health Sciences Center. Calls are answered 8am-3pm Mon-Fri
See page 2 for details on lactation risk categories (L1 – L5)

Indications to review medication safety in breastfeeding:
- During prenatal care, ideally at 28-32 weeks, to provide anticipatory guidance and assist with feeding decisions
- On admission when delivery is anticipated
- When prescribing medications for a lactating patient because non-pharmacologic therapy is not available or appropriate

Is the med systemically absorbed? — No → No risk to infant, reassure lactating patient

Yes → Review medication information from **LactMed®** and **MMM®** (subscription required)

If members of the care team have concerns about medication exposure, milk may be expressed and stored pending a shared decision-making discussion. **Do not discard expressed milk until shared decision-making has occurred.**

Is medication an L1 or L2, with reassuring summary? — No → Alternative medication available with similar efficacy? — No → Patient requires three or more **L3*** meds, OR any **L4/L5*** meds? — Yes → Call **Infant Risk Center*** (806) 352-2519

Is medication an L1 or L2, with reassuring summary? — Yes → Prescribe originally selected medication

Alternative medication available with similar efficacy? — Yes → Prescribe alternative medication

Patient requires three or more **L3*** meds, OR any **L4/L5*** meds? — No

Review information with lactating patient and infant's provider. Discuss risks of drug exposure via milk vs risk of disrupting breastfeeding.

Support shared decision making:
- Continue breastfeeding with medication, OR
- Express & discard milk for duration of treatment, OR
- Initiate / continue medication and wean

Counseling and follow-up:
1. Document all provider counseling regarding breastfeeding and medication/substance use in the medical record.
2. Review information from MMM and LactMed with patient and discuss risks of infant drug exposure vs. risks of disrupting breastfeeding for both parent and infant
3. Print entire LactMed monograph and Medications & Mother's Milk summary and provide copy to breastfeeding parent to share with the infant's provider.
4. With breastfeeding parent's permission, include the infant's provider on encounter documentation so that s/he can follow infant for any side effects.
5. When breastfeeding parent is taking medication and breastfeeding:
   - Encourage her to share LactMed and MMM information with her infant's provider
   - Review common / worrisome infant side effects
   - Advise her that pharmacists may instruct her not to use the drug while breastfeeding, despite safety data
   - Provide contact number for her call with questions.
   - Consider timing the dose to minimize exposure, if possible: after feeding or before prolonged infant sleep.

Lactation + Meds= UPDATED

Medications-in-Lactation-REV-11.21.25.pdf

May 1 "In Person" teaser!

Pumping/Hand Expression Protocols

and

KCC + KBC= Lactation + SUD help!

Data collection

1- Email from Michelle Black with data survey to complete (below) was sent 1/14/2026
2- **Deadline for submission: Feb 4th**
3- COHORT! **Timely Treatment, Scheduling PP Blood Pressure Checks (both during admission and prior to admission)**
IF NEEDED: Large hospitals can pull out a % of charts that meet criteria, then report total numbers

i.e. 100 patients met criteria for Timely Treatment
Pull 10 charts, if 9 patients met protocol
Then report 90 (numerator, # treated within 1 hour)/100 (denominator, total eligible)

Dear Champions,

I hope you are doing well and having a great start to the new year—thank you for the incredible care you provide every day.

It's time to collect data for the **AIM Severe Hypertension in Pregnancy Safety Bundle**. Each facility is asked to complete and return the attached **fillable PDF form** with data from **July 1, 2025, to December 31, 2025**.

What's included in this email:

1. **Cheat Sheet** Attached:
   - A reference guide with descriptions for each data set
2. **Facility Report Card**
   - Visual of your facilities progress on bundle goals
3. **Fillable PDF Form** Attached:
   - Please complete the highlighted questions on your survey and return completed survey via email to the AIM Coordinator

What we need from you:

1. **Before the learning forum on January 27**
   - Review your facility's report card
   - Review the survey questions for your facility
   - Please come to the learning forum prepared with questions about data collection, as we will set aside dedicated time for Q&A to benefit the entire group
2. **Submit completed data by February 4th by email to the AIM coordinator**

If you have any questions or need help completing the form, please don't hesitate to reach out to me directly at Michelle.Black@ks.gov.

Thank you for your continued commitment to improving maternal health outcomes in **Making Kansas the Best Place to Give Birth, Be Born, and Raise a Family.**

KPQC
Kansas Perinatal Quality Collaborative

SHTN Data collection UPDATE

Those who have submitted Quarter 3 and 4 2025 Data

28/50

Advent Health Shawnee Mission
Amberwell Hiawatha
Cheyenne County Hospital
Citizens Medical Center
Coffeyville Regional Medical Center
Community Healthcare System
Gove Regional Medical Center
Hays Medical Center ("HaysMed")
Hutchinson Regional Medical Center
Kearny County Hospital
Labette Health
Lawrence Memorial Hospital

Mitchell County Hospital Health System
Nemaha Valley Community Hospital
Neosho Memorial Regional Medical Center
Newman Regional Health
NMC (Newton)
Pratt Regional Medical Center
Republic County Hospital
Salina Regional Health Center
Stormont Vail Health Flinthills
Stormont Vail Health Topeka
University of Kansas Health System- Olathe
University of Kansas Health System-KC

FW Huston Medical Center
Lincoln County Hospital
Logan County Health Services
Norton County Hospital

KPQC Kansas Perinatal Quality Collaborative

Reminder ☺

Severe HTN Bundle completion= December 2026

Please complete this survey to help determine which bundle topic would be most valuable to focus on next:

2026 Kansas Perinatal Quality Collaborative AIM Safety Bundle Survey – Fill out form

POSTBIRTH seats… the Re-Launch!

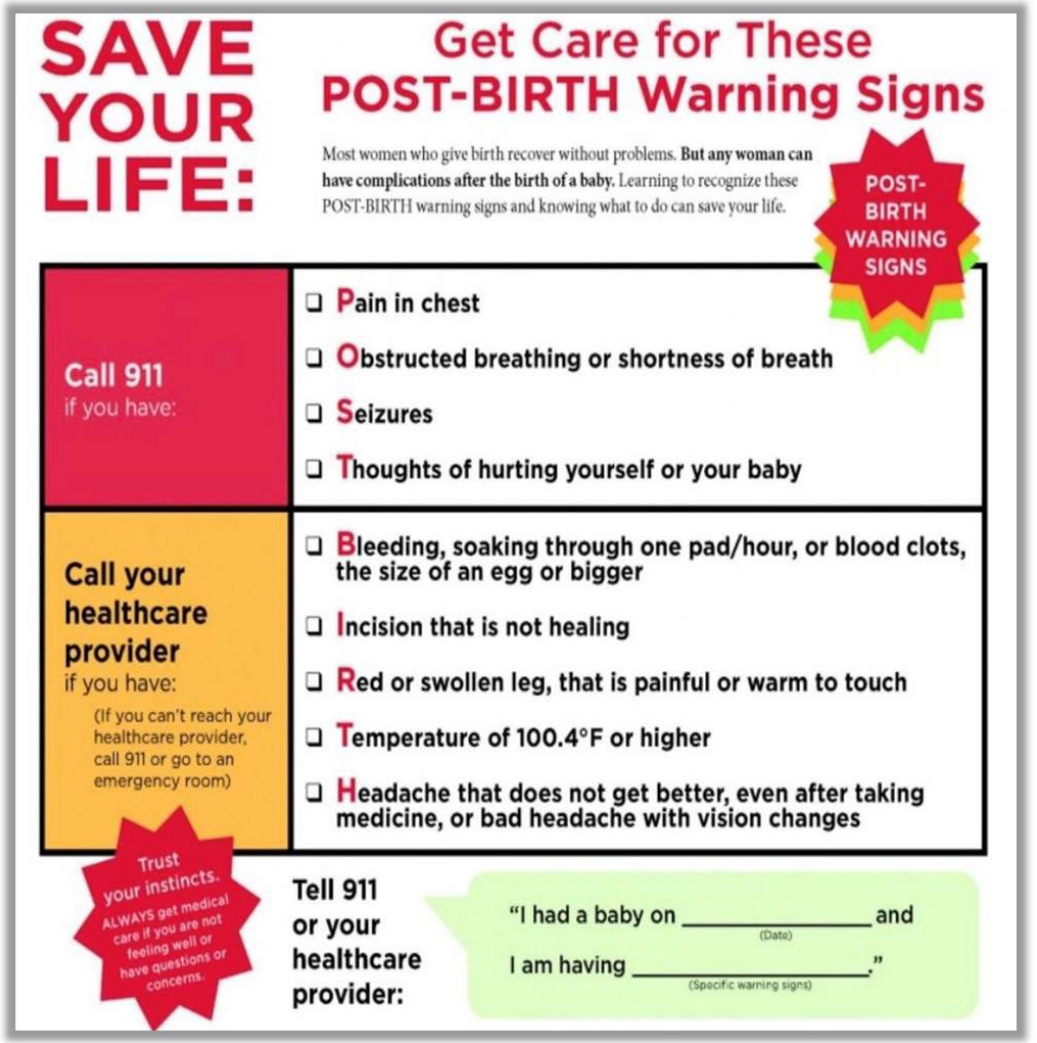
Email sent Jan 2026

Each of 50 hospitals will receive TWO or THREE free seats

Share with ED, EMS, Outpatient Clinics

- Completion: Summer 2026

- How do you plan to use YOUR seats?

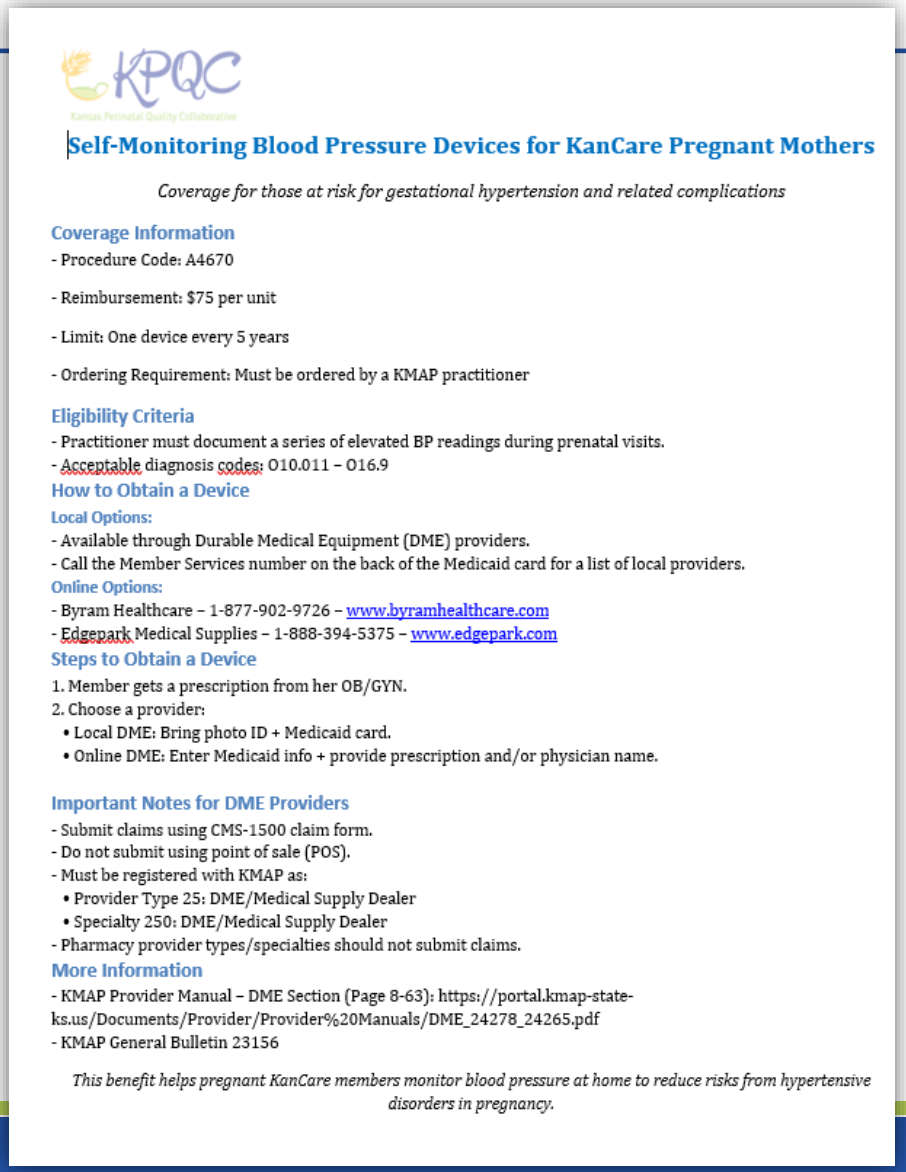


Kansas Perinatal Quality Collaborative

Cuff Project: exciting updates!

UPDATE: How to order through YOUR office or hospital DME

Pilot Site Update



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Self-Monitoring Blood Pressure Devices for KanCare Pregnant Mothers

Coverage for those at risk for gestational hypertension and related complications

Coverage Information

- Procedure Code: A4670
- Reimbursement: $75 per unit
- Limit: One device every 5 years
- Ordering Requirement: Must be ordered by a KMAP practitioner

Eligibility Criteria

- Practitioner must document a series of elevated BP readings during prenatal visits.
- Acceptable diagnosis codes: O10.011 – O16.9

How to Obtain a Device

Local Options:

- Available through Durable Medical Equipment (DME) providers.
- Call the Member Services number on the back of the Medicaid card for a list of local providers.

Online Options:

- Byram Healthcare – 1-877-902-9726 – www.byramhealthcare.com
- Edgepark Medical Supplies – 1-888-394-5375 – www.edgepark.com

Steps to Obtain a Device

1. Member gets a prescription from her OB/GYN.
2. Choose a provider:
   - Local DME: Bring photo ID + Medicaid card.
   - Online DME: Enter Medicaid info + provide prescription and/or physician name.

Important Notes for DME Providers

- Submit claims using CMS-1500 claim form.
- Do not submit using point of sale (POS).
- Must be registered with KMAP as:
  - Provider Type 25: DME/Medical Supply Dealer
  - Specialty 250: DME/Medical Supply Dealer
- Pharmacy provider types/specialties should not submit claims.

More Information

- KMAP Provider Manual – DME Section (Page 8-63): https://portal.kmap-state-ks.us/Documents/Provider/Provider%20Manuals/DME_24278_24265.pdf
- KMAP General Bulletin 23156

This benefit helps pregnant KanCare members monitor blood pressure at home to reduce risks from hypertensive disorders in pregnancy.

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Kansas SHTN Cuff Project
Improved Identification to Treatment

Access to Early and Consistent OB Care

Prevention (ASA daily)

Education: POSTBIRTH

Identification of Need for Home BP monitoring

Home Blood Pressure Monitoring

Education: Home BP Protocol, POSTBIRTH, and Follow-Up

Increased Maternal/Fetal Surveillance

Health Related Social Needs: screenings and referrals

OB Navigation

OB or ED Triage

Timely Treatment (<60 min)

Delivery or Antepartum Follow-Up

Outpatient Follow-Up (72 hours, 7 days)

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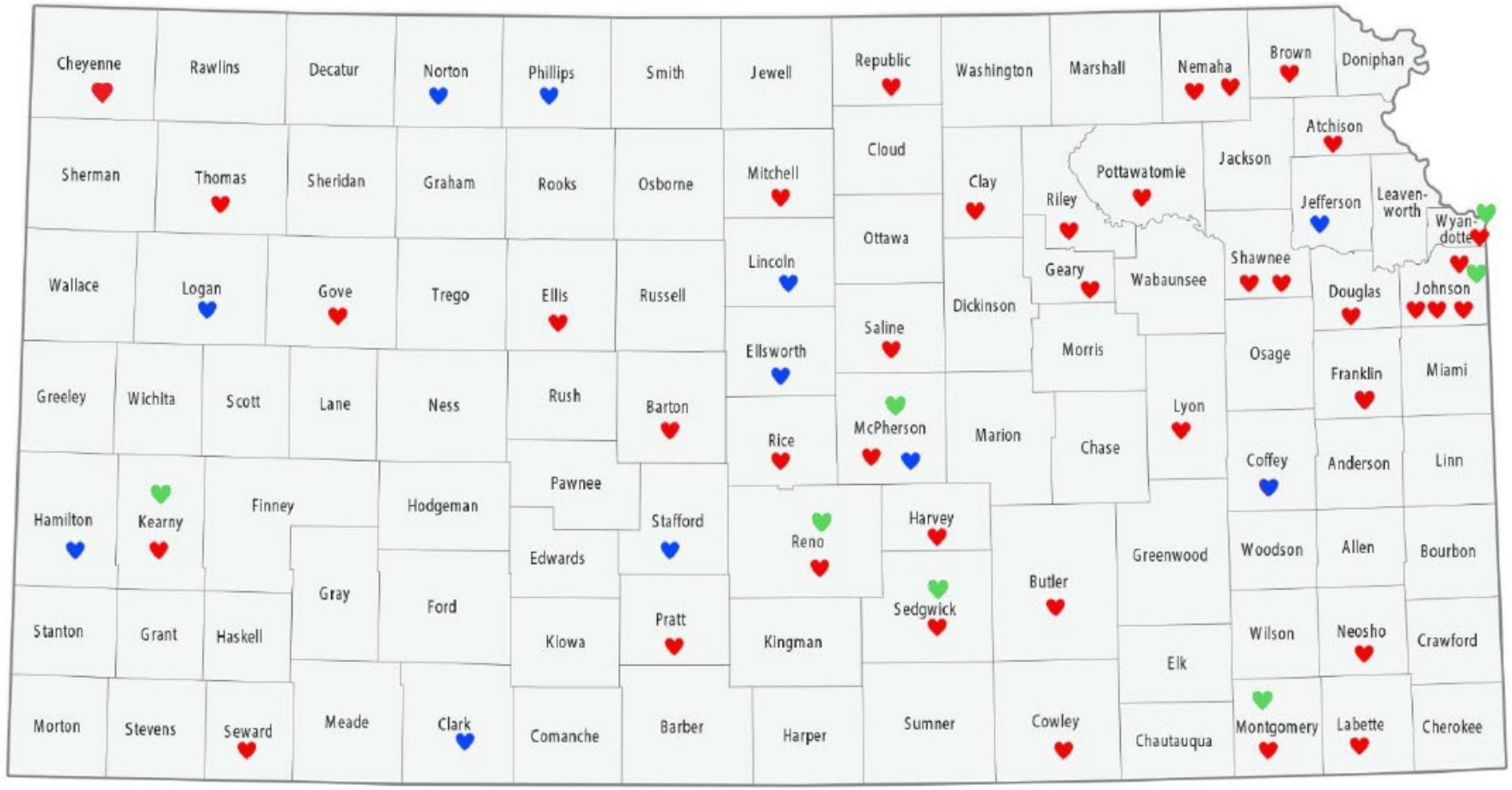
KPQC Severe Hypertension in Pregnancy



39 Birthing Facilities, 11 Non-Birthing Facilities, 7 Cuff Pilot Project Sites

Green hearts are locations participating in the Cuff Pilot Project

Red hearts are birthing facilities enrolled in the AIM Severe Hypertension Safety Bundle

Blue hearts are non-birthing facilities enrolled in the AIM Severe Hypertension Safety Bundle

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Breastfeeding/Pumping/Expression Protocols

Send to Kari Smith for review ASAP

NOTE: It may be embedded in “admission of postpartum patient”

KPQC
Kansas Perinatal Quality Collaborative

Submitted

AdventHealth Shawnee Mission
Amberwell Hiawatha
Citizens Medical Center
Clay County Medical Center
Community Healthcare System
Kerney County Hospital
KU Olathe
KU St. Francis
Labette Health
Lawrence Memorial Hospital

Mitchelle County Hospital
Nemaha Valley Community Hospital
Newman Regional
Newton Medical Center
Pratt Regional Medical Center
Sabetha Community Hospital
Stormont Vail Health Flint Hills
Stormont Vail Health Topeka

Send to Kari Smith for review ASAP

NOTE: It may be embedded in “admission of postpartum patient”

KPQC
Kansas Perinatal Quality Collaborative

Maternal Mental Health Needs/Protocols

KANSAS
CONNECTING
COMMUNITIES

KPQC
Kansas Perinatal Quality Collaborative

KANSAS CONNECTING COMMUNITIES

We are Kansas' perinatal psychiatric access program.

We empower physicians, clinicians, and other care professionals to identify, refer, and treat perinatal behavioral health conditions.

We provide consultation, care coordination support, training, and implementation support.

Kansas Connecting Communities is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $3,750,000 with 10% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.

Mental Health Consultation & Resource Network

1-800-332-6262

Mental Health Consultation & Resource Network

Empowering clinicians. Elevating patient care.

A Kansas Department of Health and Environment Program

KSKidsMAP Pediatric Mental Health

KANSAS CONNECTING COMMUNITIES

Kansas Connecting Communities and KSKidsMAP are supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of awards totaling $6,106,944 with 30% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.

Office Hours

KCC Technical Assistance

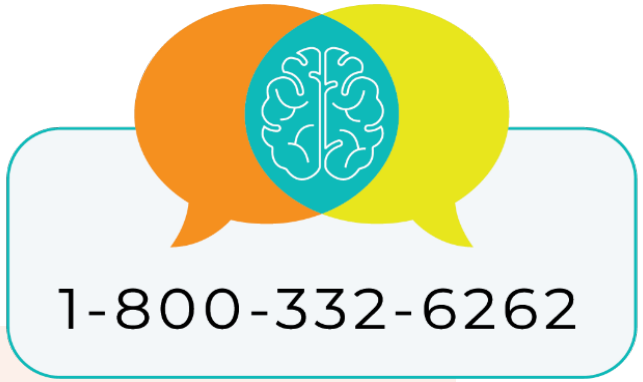
Does your team ever feel like…

- There aren’t enough resources or referral options for pregnant and postpartum patients
- You can’t seem to get your patients an appointment fast enough
- You aren’t sure what to try next

Receive **practical, solutions-focused, 1:1 support** virtually, every other Monday, 12:00-1:00 PM CST

Scan the QR code to register for the series and join as you can!

Connect with us!



1-800-332-6262

kcc@kumc.edu

kansasmch.org/kcc

bit.ly/MCHRNform

Scan the QR code to download our contact card!

Intimate Partner Violence

COMMUNITY PARTNERSHIP AGREEMENT

This agreement may be changed to best fit each Healthcare Facility and Domestic Violence/Sexual Assault Agency (DV/SA) Agency. Both parties must be a part of the agreement, this is not just a referral policy. Outcomes of survivors have shown to be improved by warm hand-offs and strong relationships between parties. This agreement does not negate the entities different requirements for patient/client confidentiality, each have different grant and federal requirements that still must be followed.

Please contact Maggie Clevenger at Kansas Coalition against Sexual and Domestic Violence (KCSDV) mclevenger@kcsdv.org if you need help with implementation, contacting the DV/SA Agency, the Healthcare Facility or have any questions.

This agreement is made by and between _____ and _____ to promote health and safety outcomes for patients/clients who have experienced domestic/sexual violence. The purpose of this work is to strengthen collaboration between staff from both entities and promote bidirectional warm referrals for patients/clients and staff. In addition, this agreement will support implementation of the CUES (Confidentiality, Universal Education and Empowerment, Support) framework.

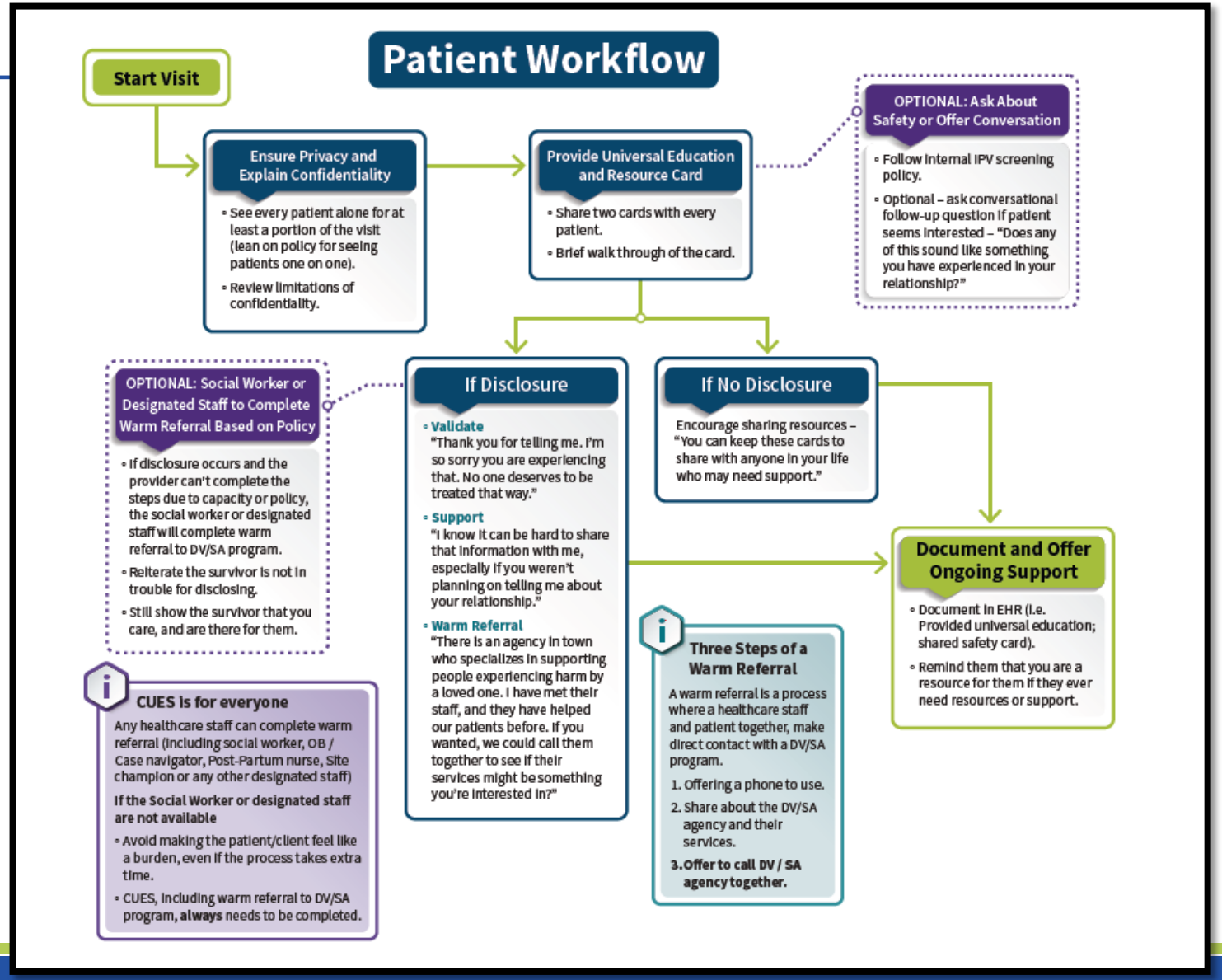
The parties above and designated agents have signed this document and agree that:

1. Representatives of _____ and _____ will meet each other in-person or via video/phone at least once at the inception of this collaboration to understand the services currently provided by their respective programs and to discuss needs, goals and next steps.
2. Representatives of _____ and _____ will continue to meet , at minimum annually between _____ and _____ to review and discuss the goals and outcomes of the agreement.
3. _____ will provide the following resources: brochures or other materials regarding DV/SA services available to patients/clients.
4. _____ will continue using CUES framework of universal education to further collaborate with DV/SA programs and enhance support for patients/clients.
5. _____ and _____ will offer warm referrals for patients/clients. Both will provide each party with updated information, brochures, bidirectional training and updates on available services needed to maintain effective collaboration.

KANSAS COALITION against sexual & domestic violence

MAVIS PROJECT Maternal Anti-Violence Innovation & Sharing

Kansas Department of Health and Environment



Transfer Protocol

Send in!

Here's what we are looking for:

1- Identification of need

2- Acceptance from accepting facility

3- Transfer of care policy, including documentation of timeliness

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SHTN Protocols

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Kansas Perinatal Quality Collaborative

Timely Treatment

NOTE: Criteria!
160/110 on two readings 15 min apart THEN patient qualifies for timely treatment protocol

Update?

Successes?

Questions?

SHTN Policy and Procedure

Facilities that need to submit SHTN policies

- Advent Health South Overland Park
- Ascension Via Christi Manhattan
- Amberwell Atchison
- Coffey County Hospital
- Coffeyville Regional Medical Center
- Hospital District #1 of Rice County
- Overland Park Regional
- Republic County Hospital
- Salina Regional Health Center
- Southwest Medical Center
- Susan B Allen Memorial Hospital
- Wesley Medical Center
- William Newton Hospital

***Non-birthing facilities**, please submit your unit policies.

SHTN
PP Blood pressure appointments

How's it going??

Percent of your pt population with treatable BPs
PreE, or Eclampsia on CURRENT admission
had a scheduled appt at 3 days

2026 KPQC Meeting Dates

KPQC Spring Conference

- *5/1/26 – 9:00-4:00 (in-person for **enrolled facilities** @ Sunflower)*

KPQC Learning Forums

- 3/24/26 12:00-1:00 (virtual): https://us02web.zoom.us/meeting/register/tZAkfuqhqTgqH9f7RnFy6H0Nph0CaKqXNT4N
- 6/23/26 12:00-1:00 (virtual): https://us02web.zoom.us/meeting/register/tZAkfuqhqTgqH9f7RnFy6H0Nph0CaKqXNT4N
- 8/25/26 12:00-1:00 (virtual): https://us02web.zoom.us/meeting/register/tZAkfuqhqTgqH9f7RnFy6H0Nph0CaKqXNT4N
- 9/22/26 12:00-1:00 TBD
- 10/27/26 12:00-1:00 TBD
- 11/24/26 12:00-1:00 (virtual): https://us02web.zoom.us/meeting/register/tZAkfuqhqTgqH9f7RnFy6H0Nph0CaKqXNT4N

Next Learning Forum

All of KPQC! March 2026