

KPQC Learning Forum

September 2025



ATTENTION

Enrolled Hospitals!

Let us know your name, hospital & EHR system in the chat

Agenda for Today's LF

SHTN Bundle Update

Rapid Response: info, articles & website

October KPQC Conference & other events

KEYNOTE speakers: Kansas Breastfeeding Coalition members!

SHTN Bundle updates



Important Dates & Events

ALL Kansas Perinatal Quality Collaborative members:

1. October 28th Virtual Fall Conference

SHTN Bundle sites (Champions, OB Providers, Staff):

1. “Bridges to Wellness” Webinar training series:

Session 1: October 14th

Session 2: October 21st

2. Data webinar “office hours”

Date: TBD

3. In-person CHAMPION Workdays (9am-1pm)

“West” November 18th Hays Medical Center

“East” December 2nd Lawrence Memorial Hospital

**Registration information to come!*



KPQC FALL CONFERENCE

VIRTUAL ONLY

October 28, 2025 8:00-12:00



2025 Fall Conference Agenda

9:00-9:30

Welcome and introductions
(KPQC Team)

9:30-11:00

Session 1: OB Emergencies & Transport
(Heather Scruton, RNC-OB and Heather Morgan, MD)

11:00-11:30

Session 2: Hot Topics in OB: 2025
(Tara Chettiar, MD, FACOG)

11:30-12:00

Session 3: Preterm babies in 2025,
what's the big deal?
(Jenny Espy, ARNP, NNP-BC)



KPQC Health Improvement Partners is approved as a provider of continuing nursing education by the Kansas State Board of Nursing. This course offering is pending approval for RN, LPN, or LMT/NT re-licensure. Kansas State Board of Nursing provider: LT0256-1009.

Meeting link:

[KPQC Fall 2025 Conference Registration - Kansas Perinatal Quality Collaborative](#)





BRIDGES TO WELLNESS

CONNECTING MENTAL HEALTH, SUBSTANCE USE & INTIMATE PARTNER VIOLENCE IN PERINATAL CARE

A free, two-part webinar training series for KPQC-enrolled hospitals. All staff and providers are encouraged to attend. The sessions will address perinatal mood disorders, substance use disorder, and intimate partner violence, with practical tools for implementation and follow-up technical assistance as needed.

REGISTER NOW

SESSION 1

Maternal Mental Health and Substance Use Disorder In the Inpatient Setting

Kansas Connecting Communities (KCC) Team
Date: October 14, 2025
Time: 12:00 – 1:00 PM

SESSION 2

Intimate Partner Violence in the Perinatal Setting: CUES Training

MAVIS Team
Date: October 21, 2025
Time: 12:00 – 1:00 PM



KU
THE UNIVERSITY OF KANSAS
Center for Public Partnerships and Research

KANSAS CONNECTING COMMUNITIES
A collaborative network of health and behavioral professionals

CKF
ADDICTION TREATMENT
HELP | HOPE | HEALING

KPQC
Kansas Perinatal Quality Collaborative

KANSAS COALITION
against sexual & domestic violence

MAVIS PROJECT

Mental Health Consultation & Resource Network
Empowering clinicians. Growing patient care.
A Kansas Department of Health and Senior Services Program

Meeting link:

[Meeting Registration - Zoom](#)

SHTN Bundle Update

SHTN Protocols

*Send protocols to Kari (even if NOT completed, or “in process”)

POSTBIRTH seats coming available

*magnets- Sent out!

	Policy received	Policy Reviewed and sent back
Advent Health Shawnee Mission		
AdventHealth South Overland Park		
Amberwell Hiawatha Community Hospital	Yes	Yes
Ascension Via Christi Manhattan		
Amberwell Atchison		
Citizens Medical Center	Yes	Yes
Clay County Medical Center		
Coffey County Hospital		
Coffeyville Regional Medical Center		
Community Healthcare System	Yes	Yes
Gove Regional Medical Center		
Hays Medical Center ("HaysMed")	Yes	Yes
Hospital District #1 of Rice County		
Hutchinson Regional Medical Center	Yes	
Kearny County Hospital	Yes	
Labette Health		
Lawrence Memorial Hospital	Yes	Yes
McPherson County		
Mitchell County Hospital Health System		
Nemaha Valley Community Hospital		
Neosho Memorial Regional Medical Center	Yes	Yes
Newman Regional Health		
Newton Medical Center		
Overland Park Regional		
Pratt Regional Medical Center	Yes	Yes
Republic County Hospital		
Sabetha Community Hospital		
Salina Regional Health Center		
Southwest Medical Center		
Stormont Vail Health	Yes	Yes
Stormont Vail Health Flinthills		
Susan B Allen Memorial Hospital		
University of Kansas Health System- Great Bend		
University of Kansas Health System- Olathe		
University of Kansas Health System- St. Francis		
University of Kansas Health System-KC	Yes	Yes
Wesley Medical Center		
William Newton Hospital		

SHTN Bundle Update: Data!

Data!

We need data from



Facility

Advent Health Shawnee Mission
AdventHealth South Overland Park
Ascension Via Christi Manhattan
Atchison Hospital Association dba Amberwell Atchison
Coffey County Hospital
Coffeyville Regional Medical Center
Hospital District #1 of Rice County
Kearny County Hospital
Overland Park Regional
Republic County Hospital
Salina Regional Health Center
Southwest Medical Center
Stormont Vail Health Flinthills
Susan B Allen Memorial Hospital
University of Kansas Health System- Great Bend
University of Kansas Health System- Olathe
Wesley Medical Center
William Newton Hospital

Webinar “Office Hours” planned: watch your email for details

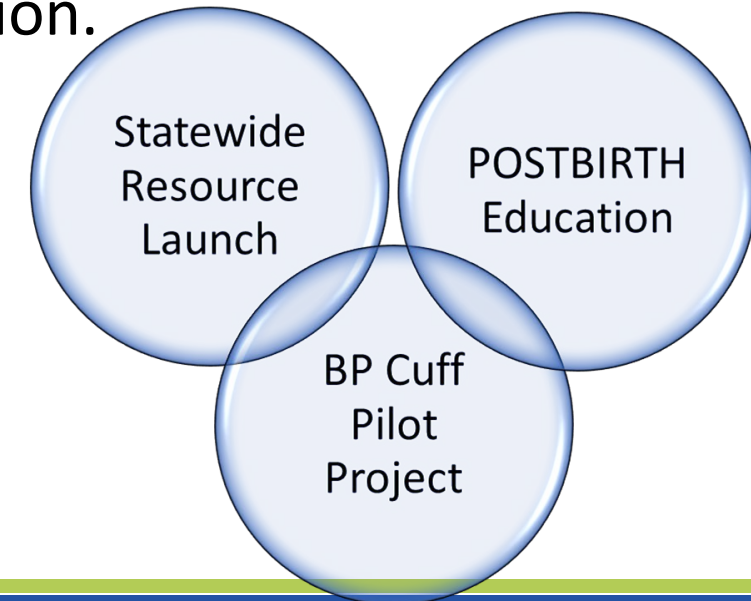
Direct TA available!

Michelle Black (SHTN Data): michelle.black@ks.gov

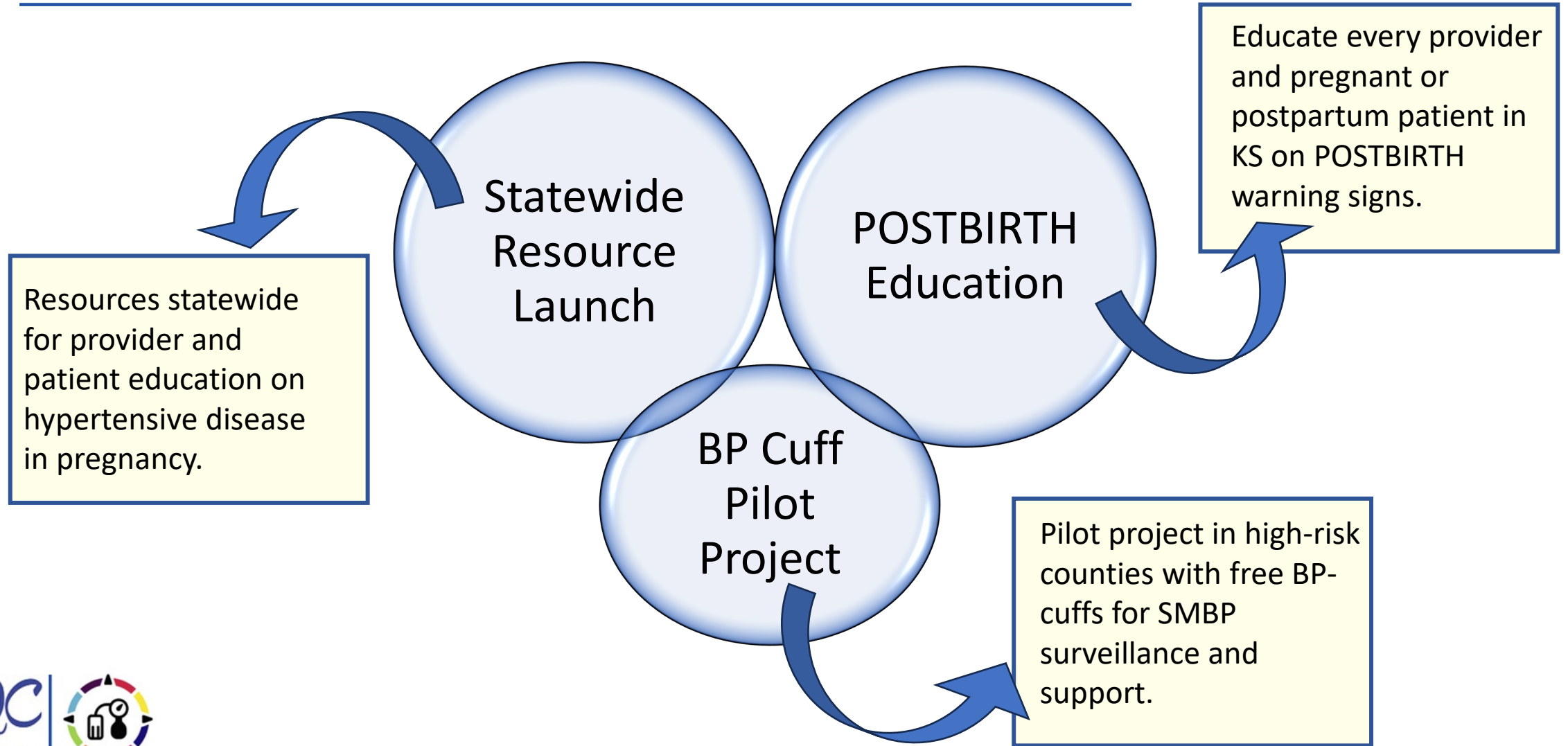
Finally, LAUNCHED!!!

Kansas Cuff Project, a three- tiered plan to:

1. Educate statewide on POSTBIRTH maternal warning signs
2. Launch a pilot project in eight high-risk Kansas counties that will provide free BP cuffs to provider-identified patients **respond by Oct 7th!
3. Launch statewide help for providers to order BP cuffs covered through various payors, working to eliminate barriers to rapid distribution.



Kansas Cuff Project Launch



SHTN Bundle Update: Resources

KPQC Website:

<https://kansaspqc.kdhe.ks.gov/resources/severe-hypertension-initiative-resources/#toggle-id-4>

KDHE Website:

<https://www.kdhe.ks.gov/2350/Perinatal-Hypertension-Toolkit>

Provider resources & articles (sent!)

<https://www.acog.org/community/districts-and-sections/district-ii/programs-and-resources/safe-motherhood-initiative/severe-hypertension>

https://www.xmncx.gov/z550/perinatal-hypertension-toolkit

Create a Website Account - Manage notification subscriptions, save form progress and more.

Kansas
Department of Health
and Environment

Division of
Public Health

How Do I...

Disease & Injury PreventionCommunity HealthPersonal & Family Health

Pregnancy Complications and Increased Risk of Heart Disease - English (PDF) | Spanish (PDF)

Heart Health After Pregnancy - English (PDF) | Spanish (PDF)

Preeclampsia and Increased Risk of Heart Disease - English (PDF) | Spanish (PDF)

Educational Videos

- Patient Education Video on Home Blood Pressure Monitoring
- How to Find the Correct Size Blood Pressure Cuff Video

Guidance DocumentsRelated Research

Guidance Documents

The American College of Obstetricians and Gynecologists (ACOG) Practice Bulletins and Committee Opinions

- Gestational Hypertension and Preeclampsia
- Low-Dose Aspirin Use During Pregnancy English (PDF)
- Optimizing Postpartum Care English (PDF)

U.S. Preventive Services Task Force (USPSTF) Bulletins and Recommendation Statements

- Recommendation on Screening for Hypertensive Disorders of Pregnancy
- Recommendation on Aspirin Use to Prevent Preeclampsia and Related Morbidity and Mortality

KPOC KPHN Provider Resource List 2023 - Excel


File Home Insert Page Layout Formulas Data Review View Help

Clipboard Font Alignment Number Styles Cells Editing

Project Resources

A	B	C	D	E	F
PROJECT	Resources				
1 Kansas AIM Safety Bundle: Severe HTN in PG	Severe Hypertension in Pregnancy ACOG				
2	Severe Hypertension in Pregnancy Initiative Facts Sheet				
3	Severe Hypertension ACOG				
4	*Includes algorithms & protocols for all Hypertensive Diseases of Pregnancy				
5	Artificial Intelligence in Clinical Decision Support Systems: Opportunities and Challenges				
6	The assessment of blood pressure in pregnant women: pitfalls and novel approaches - Published				
7	Educating Patients - Preeclampsia Foundation resource				
8	Maternal Warning Signs Patient Education Toolkit-Binder-Final.pdf				
9	**Training & Resources Contact Karl Smith, KPQC				
10	HEAR HER Campaign HEAR HER Campaign CDC				
11	Kansas Birth Equity Network				
12	Patient Delivered after Adverse Outcome & Birth Equity Training				
13	For training contact: Terrah Stroda, KPQC				
14	Intimate Partner Violence ACOG				
15	Maternal Mental Health (Provider Consult Line, training, resources)				
16	Maternal Mental Health Training, Contact Terrah Stroda, KPQC				
17	For training contact: Karl Smith, KPQC				
18	About The Cuff app				
19	Home Blood Pressure Monitoring: The Cuff Project				
20	OB Simulations				
21	Training statewide, Contact: Karl Smith, KPQC				
22	Other important HTN-related articles				
23	ACOG: SHRN and long term implications				
24	Long Term Cardiovascular Risk in Women With Hypertension During Pregnancy - Published				
25	ACOG: Low dose Aspirin in Pregnancy				
26	Low-Dose Aspirin Use During Pregnancy ACOG				
27	PP visit schedule				
28	Varieties State LACOG Committee Op 786 Optimizing Postpartum Care.pdf				
29	Varieties State LACOG Consensus Bundle on PP Basics 1-21.pdf				
30	Primary Cesarean prevention				
31	Quality Improvement Strategies for Safe Reduction of Primary Cesarean Births ACOG				
32	HTN in PG protocols				
33	Severe Hypertension ACOG				
34	OB Emergency Training: Severe HTN				
35	ACOG Committee Opinion No. 787 Emergent Therapy for Acute-Onset, Severe Hypertension During Pregnancy and the Postpartum Period - Published				
36	Female age 15-50 years present to ED Trauma				
37	Integrating Trauma-Informed Care Into Maternity Care Practice: Conceptual and Practical Issues - Sperlrich - 2017 - Journal of Midwifery & Women's Health - Wiley Online Library				
38	Trauma Informed Care				
39	New AMA policies recognize race as a social, not biological, construct Social construction of race AMA				
40	AMA implicit bias				
41	RHDE Annual Reports 2023 (include state births, morbidity, mortality)				
42	RHDE Vital stats 2023 KS Prenatal Care report				
43	Varieties State LACOG Annual Summary 2023.pdf				

Sheet1



About Programs Membership Community Donate

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— Safe Motherhood Initiative — Severe Hypertension

Programs and Resources

- Let's Connect Podcast
- Medical Education
- Reentering Obstetrical–Gynecologists into Practice
- Safe Motherhood Initiative

Subscribe to the District II Newsletter

Severe Hypertension in Pregnancy Bundle

Slide Deck	Algorithm: Labetalol	Algorithm: Hydralazine	Algorithm: Oral Nifedipine
Checklist: Hypertensive Emergency	Checklist: Eclampsia	Checklist: ED Postpartum Preeclampsia	



KPQC: Rapid Response

September 2025





Maternal, Infant and Immunization Health Symposium 2025

8:30 a.m.–3:45 p.m., Friday, October 3, 2025

HaysMed, Hadley Rooms, 2220 Canterbury Drive, Hays, KS 67601

Joint providership with HaysMed and The University of Kansas Medical Center Continuing Education and Professional Development and Area Health Education Center-West.

Program overview

This program is designed to improve the care of maternal patients including, but not limited to, updates in regulation and guidelines for immunizations, immunization compliance, paternal support, hypertension in pre and post pregnancy and postnatal collapse and SIDS.

Objectives

Following this program, the participants can be expected to:

- Address the misinformation on immunizations.
- Explore the difficulties that providers are experiencing in immunization compliance.
- Discuss the importance of paternal support through pregnancy, labor and postpartum.
- Identify the new guidelines in hypertensive care for pregnancy and post-partum.
- Explore updates in sudden unexpected postnatal collapse and sudden infant death syndrome.

For more information

785-623-5500
haysmed.eeds.com



Registration URL and QR Code

<https://www.eeds.com/live/327373>





About Us Patient Safety Bundles Resource Kits Research Events AIM Data

AIM OBSTETRIC EMERGENCY READINESS RESOURCE KIT



The AIM Obstetric Emergency Readiness Resource Kit is a collection of best practices to aid in readiness efforts to appropriately care for people experiencing obstetric emergencies in non-obstetric or lower-resources settings. This resource kit may particularly benefit those who do not typically provide obstetric services or encounter obstetric emergencies.

[Download the Full Resource Kit](#)

[Download the Full Resource Kit Without Survey](#)

Resource Kit Scope and Highlights

- ▶ This resource kit is not intended to be a response manual but rather provides background and resources for review, planning, prioritization, and adaptation to unique needs and clinical settings to support readiness efforts in advance of an obstetric emergency.
- ▶ This resource kit may particularly benefit Family Medicine and Emergency Medicine clinicians, nursing administrators, and other leaders in clinical settings that may not routinely encounter an obstetric emergency.
- ▶ Because high-quality care is not possible without equitable care, centering equity in quality improvement and implementation of elements of this resource kit is crucial to address inequities that lead to disparities in health outcomes.

DOWNLOAD BY SECTION OR TOPIC

Individual sections of AIM's Obstetric Emergency Readiness Resource Kit are available for download below.

Table of Contents	Introduction & Resource Kit Keys	Readiness
Section highlights: <ul style="list-style-type: none">▶ An overview of contents of the resource kit	Section highlights: <ul style="list-style-type: none">▶ The background and purpose.	Section highlights: <ul style="list-style-type: none">▶ Building rapid response teams

Rapid Response

AIM: OB Emergency Readiness Resource Kit

<https://saferbirth.org/aim-obstetric-emergency-readiness-resource-kit/>

Recognition & Prevention

Section highlights:

- ▶ Pregnancy screening
- ▶ Triage of pregnant and postpartum people
- ▶ Screening for other risk factors and comorbid conditions

Response – General

Section highlights:

- ▶ Routine births in non-obstetric settings
- ▶ Perimortem Cesarean delivery

Response – Obstetric Hemorrhage

Section highlights:

- ▶ Critical signs and symptoms
- ▶ Response and clinical keys
- ▶ Practice resources

Response – Perinatal Mental Health Conditions

Section highlights:

- ▶ Screening
- ▶ Response and clinical keys
- ▶ Practice resources

Response – Severe Hypertension in Pregnancy

Section highlights:

- ▶ Critical signs and symptoms
- ▶ Response and clinical keys
- ▶ Practice resources

Response – Sepsis in Obstetric Care

Section highlights:

- ▶ Critical signs and symptoms
- ▶ Response and clinical keys
- ▶ Practice resources

Response – Care for Pregnant & Postpartum People with Substance Use Disorder

Section highlights:

- ▶ Screening
- ▶ Response and clinical keys
- ▶ Practice resources

Response – Cardiac Conditions in Obstetric Care

Section highlights:

- ▶ Critical signs and symptoms
- ▶ Response and clinical keys
- ▶ Practice resources

Reporting & Systems Learning

Section highlights:

- ▶ Huddles, debriefs, and action planning
- ▶ Multidisciplinary reviews of obstetric care and emergencies

Respectful, Equitable, & Supportive Care

Section highlights:

- ▶ Communications and shared decision-making strategies

APPENDICES & OTHER RESOURCES

Appendix A

Section highlights:

- ▶ Condition- and event-specific equipment and medications for care of obstetric patients in the Emergency Department

Appendix B

Section highlights:

- ▶ Example supplies list for an obstetric hemorrhage cart, bag, or box

Resource

Section highlights:

- ▶ Example obstetric hemorrhage documentation flowsheet for inclusion in a hemorrhage cart, bag, or box

Resource

Section highlights:

- ▶ Printable facility example hemorrhage cart supply list

Resource

Section highlights:

- ▶ ACOG Obstetric Emergency Algorithms for Emergency Departments
- ▶ Pregnancy Status Sign

Resource

Section highlights:

- ▶ Cardiac Disease in Pregnancy and Postpartum Algorithm for Care in Emergency Departments

Resource

Section highlights:

- ▶ Eclampsia Algorithm
- ▶ Acute Hypertension in Pregnancy & Postpartum Algorithm

Resource: Obstetric Simulation Scenarios for the Emergency Department

Section highlights:

- ▶ Six scenarios
- ▶ Can be used in any level of fidelity simulation

Resource: Obstetric Emergency Readiness Measurement Strategy

Section highlights:

- ▶ Measures to support data-driven quality improvement in non-obstetric settings.



AAP-Immunization-Schedule.pdf

Table 1 Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

These recommendations must be read with the **Notes** that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the outlined purple bars (Table 2). To determine minimum intervals between doses, see the catch-up schedule (Table 2).

Vaccine and other immunizing agents	Birth	1 mos	2 mos	4 mos	6 mos	8 mos	9 mos	12 mos	15 mos	18 mos	19–23 mos	2–3 yrs	4–6 yrs	7–10 yrs	11–12 yrs	13–15 yrs	16 yrs	17–18 yrs
Respiratory syncytial virus (RSV-mAb [nirsevimab, clesrovimab])	1 dose during RSV season depending on maternal RSV vaccination status (See Notes)				1 dose during RSV season (See Notes)													
Hepatitis B (HepB)	1 st dose	2 nd dose						3 rd dose										
Rotavirus (RV): RV1 (2-dose series), RVS (3-dose series)			1 st dose	2 nd dose	See Notes													
Diphtheria, tetanus, and acellular pertussis (DTaP <7 yrs)			1 st dose	2 nd dose	3 rd dose				4 th dose				5 th dose					
Haemophilus influenzae type b (Hib)			1 st dose	2 nd dose	See Notes			3 rd or 4 th dose (See Notes)										
Pneumococcal conjugate (PCV15, PCV20)			1 st dose	2 nd dose	3 rd dose			4 th dose										
Inactivated poliovirus (IPV)			1 st dose	2 nd dose				3 rd dose					4 th dose					See Notes
COVID-19 (1vCOV-mRNA, 1vCOV-aPS)								1 or more doses of 2025–2026 vaccine (See Notes)					1 dose of 2025–2026 vaccine (See Notes)					
Influenza								1 or 2 doses annually (See Notes)								1 dose annually (See Notes)		
Measles, mumps, and rubella (MMR)						See Notes		1 st dose					2 nd dose					
Varicella (VAR)								1 st dose					2 nd dose					
Hepatitis A (HepA)						See Notes			2-dose series (See Notes)									
Tetanus, diphtheria, and acellular pertussis (Tdap ≥7 yrs)															1 st dose			
Human papillomavirus (HPV)															2-dose series		See Notes	
Meningococcal (MenACWY-CRM ≥2 mos, MenACWY-TT ≥2 years)																1 st dose	2 nd dose	
Meningococcal B (MenB-4C, MenB-FHbp)																		See Notes
Respiratory syncytial virus vaccine (RSV [Abrysvo])																		Seasonal administration during pregnancy if not previously vaccinated
Dengue (DEN4CYD: 9–16 yrs)																		Seropositive in areas with endemic dengue (See Notes)
Mpox																		

Range of recommended ages for all children

Range of recommended ages for catch-up vaccination

Range of recommended ages for certain high-risk groups or populations

Recommended vaccination for those who desire protection

Recommended vaccination based on shared clinical decision-making

Rapid Response

AAP Vaccine Update: 2025

The Scientific Experts Say:

SCIENCE IS CLEAR:
there is no link between
acetaminophen use during
pregnancy and autism in children.

High-quality studies confirm
acetaminophen's safety for use
during pregnancy.

**Pregnant patients can continue to
rely on this trusted medicine for
managing pain and fever.**

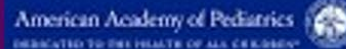


In response to today's
White House press
conference announcement,
SMFM reiterates its
recommendation advising
both physicians and
patients that
acetaminophen is an
appropriate medication to
treat pain and fever during
pregnancy.



AAP remains committed to
publishing evidence-based
vaccine recommendations
based on a careful review of
the most recent data.

Our schedule is based on how
vaccines support children's
immune systems, so they can
stay healthy and thriving.



As experts in high-risk pregnancies,
SMFM and its members are alarmed
by the recent unsubstantiated and
inaccurate claims made by FDA
panelists concerning maternal
depression and the use of SSRI
antidepressants during pregnancy.

SMFM strongly supports the use of
SSRIs to treat depression during
pregnancy.



Rapid Response

SHTN treatment article

Oral antihypertensive treatment during pregnancy: a systematic review and network meta-analysis



Rosalie J. Hup, MD; Johanna A. A. Damen, MSc, PhD; Jonne Terstappen, MD; Mirthe J. Klein Haneveld, MD, MA; Fieke Terstappen, MD, PhD; Laura A. Magee, MD, MSc; A. Titia Lely, MD, PhD; Martine Depmann, MD, PhD

OBJECTIVE: Considering safety and effectiveness of oral antihypertensive agents when treating hypertensive disorders of pregnancy, no preference can be stated between the 3 agents currently available. Therefore, this systematic review and network meta-analysis aims to determine the effects of antenatal treatment with methyldopa, labetalol, or nifedipine for hypertensive disorders of pregnancy regarding maternal or fetal/neonatal morbidity and mortality.

DATA SOURCES: On August 25, 2023, an electronic search in PubMed/Medline, Embase, and CENTRAL was performed.

STUDY ELIGIBILITY CRITERIA: Randomized controlled trials reporting on perinatal outcomes in hypertensive pregnancies treated with oral antihypertensive agents of interest (methyldopa, labetalol, or nifedipine) or placebo/no treatment were identified.

STUDY APPRAISAL AND SYNTHESIS METHODS: Quality assessment was performed using the Cochrane Risk of Bias tool for randomized controlled trials and trustworthiness was assessed with the Trustworthiness in RAndomised Controlled Trials Checklist. Data on our predefined outcomes were extracted and relative risks were calculated in network estimates if possible.

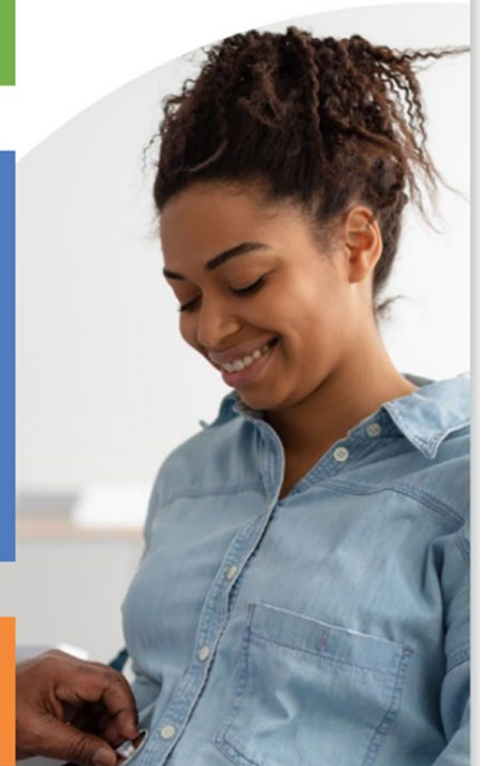
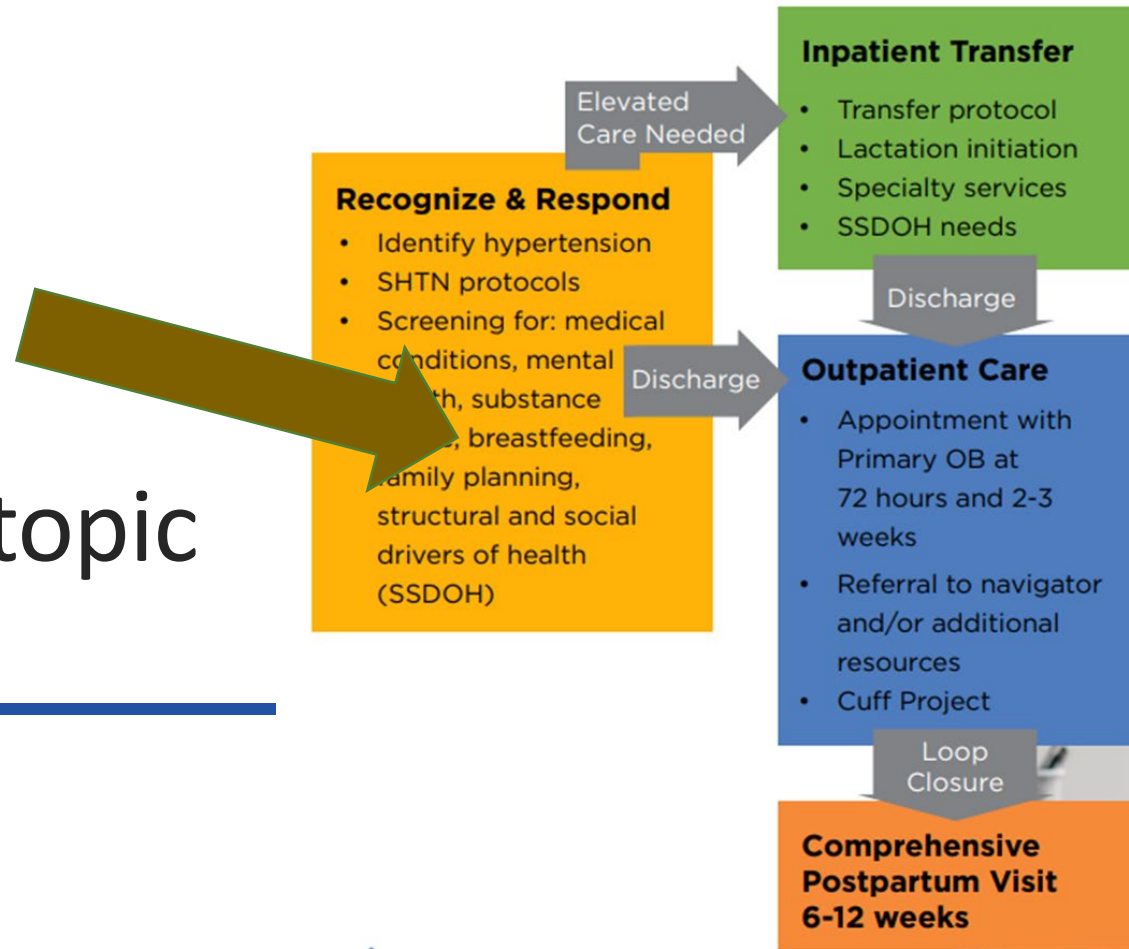
RESULTS: Twenty three trials (3989 women) were included in our network meta-analysis with an overall low-to-moderate quality. Compared to placebo/no treatment, labetalol and methyldopa significantly reduced the incidence of severe hypertension (including 8 studies, relative risk 0.20 [95% confidence interval 0.09–0.48] and 0.44 [0.20–0.99], respectively). In the network meta-analysis, labetalol vs nifedipine was associated with a reduction in preeclampsia (relative risk, 0.50 [0.28–0.87]; 15 studies) and preterm birth (relative risk, 0.68 [0.52–0.90]; 14 studies). No significant differences could be detected for any of the other outcomes of interest.

CONCLUSION: When comparing the oral antihypertensive agents currently available head-to-head, no significant differences in the primary outcome, severe hypertension, could be detected as well as on most of the secondary outcomes of interest. Considering the preference of labetalol over nifedipine regarding the outcomes preeclampsia and preterm birth, a modest favor for labetalol could be stated. Included studies however were of low overall quality warranting caution when interpreting results.

Key words: antihypertensive medication, blood pressure, hypertension, hypertensive disorders of pregnancy, network meta-analysis



KPQC: Today's topic



Breastfeeding, Expressing, Pumping PROTOCOL

Send to Kari! Kari Smith
kari.smith@kansaspqc.org



Stormont Vail Topeka
HaysMed
AdventHealth South Overland Park
UKHS St Francis

Michelle Finn, MS, IBCLC, PMH-C



Michelle is an International Board Certified Lactation Consultant and certified in perinatal mental health. She began supporting breastfeeding families as an accredited La Leche League Leader in 2006 and earned her IBCLC in 2011. Michelle has more than 10 years' experience working in the hospital setting to ensure care practices align with the best evidence.

Michelle currently serves as lactation team lead at the University of Kansas Health System, supporting new parents, educating maternal-child nursing staff and providers, coordinating the human milk depot and collaborating with a team to sustain the facility's High 5 Premier recognition. Her undergraduate degree is in communications and public relations, and she holds a master's in management from Baker University.

Michelle is a past board chair of the Kansas Breastfeeding Coalition and remains involved in the coalition's efforts to create the structural changes needed for new parents to meet their feeding goals. She is a youthful empty-nester, and enjoys music, podcasts, cooking and spending time with her amazing husband and family.

Dana Deters, RN, BSN, IBCLC, CPST

Dana is a Washburn University graduate. She has worked as a critical access hospital nurse for over 20 years at the Nemaha Valley Community Hospital in Seneca. Since she has worked there, she has cared for patients ranging from newborn to elderly. For over 18 years she has been the OB Supervisor as well.

Dana is an International Board-Certified Lactation Consultant and Child Passenger Seat Technician. She helps moms through the entire pregnancy, ranging from childbirth classes, to delivery, to follow up care in the Breastfeeding Clinic. She is also active in the Kansas Breastfeeding Coalition and is the current Hospital Section Chair.



Dana Deters

NEMAHA VALLEY COMMUNITY
HOSPITAL

RN, BSN, IBCLC, CPST, OB Supervisor,
CART Nurse Auditor

KANSAS BREASTFEEDING COALITION
Hospital Section Leader

Cara Gerhardt, RN, IBCLC



Cara Gerhardt is a registered nurse and International Board-Certified Lactation Consultant. She is the coordinator for High 5 for Mom and Baby, a program that provides resources, recognition, and support to help hospitals and birth centers improve health outcomes for breastfeeding families by promoting ten evidence-based practices that increase breastfeeding success.

**Supporting
Lactation**
in the context of
**Perinatal
Hypertension**

Kansas Perinatal Quality Collaborative September Learning Forum

Michelle Finn, MS, IBCLC, PMH-C
The University of Kansas Health System

Dana Deters, RN, BSN, IBCLC
Nemaha Valley Community Hospital

Cara Gerhardt, BSN, RN, IBCLC
High 5 for Mom & Baby



Kansas
Breastfeeding
Coalition, Inc.

OVERVIEW

- Importance of breastfeeding for birthing parent and infant, including unique protections for the hypertensive patient
- Evidence-based approaches for supporting the establishment of breastfeeding in patients experiencing hypertensive disorders of pregnancy (HDP)
- Best practices related to antenatal counseling, skin-to-skin, milk expression, storage and handling, medication compatibility, rooming in as well as considerations for the readmitted breastfeeding patient
- Policy and staff education ideas to support lactation in hospital settings
- Applied learning through 3 case studies



INCLUSIVITY

Wherever possible, we've used gender-neutral language in this presentation as the practices described here apply to all birthing individuals.

Gendered terms such as “mother” and “breast” may be used as they align with the language used in the literature we cite and in the guidance from our professional organizations (AAP, ACOG, ABM).

We recognize the diversity of family types and understand such terms may not represent the circumstances or norms of all families. We encourage meaningful conversations with families – especially those with unique circumstances – to ensure a clear understanding of each family's specific wishes, feeding goals and preferred identifiers.



THE BROAD IMPACT OF LACTATION ON MATERNAL HEALTH

BREASTFEEDING
= A METABOLIC
RESET

Endocrine

- Decreased Risk of:
 - T2DM
 - Metabolic Syndrome
 - HbA1c Levels
 - Postpartum Diabetes

Cancer

- Decreased Risk of:
 - Breast Cancer
 - Ovarian Cancer
 - Endometrial Cancer

Long-term Health

- Decreased Risk of:
 - Lifetime Cardiovascular Disease
 - Future heart failure
- Increase of Longevity

Metabolism

- Decrease of:
 - LDL Cholesterol
 - Triglycerides
- Increase of:
 - HDL Cholesterol
 - Lipid Mobilization

Cardiovascular

- Decreased risk of:
 - Hypertension
 - Coronary Artery Disease
 - Myocardial infarction
 - Atherosclerosis

Vascular and Hormonal

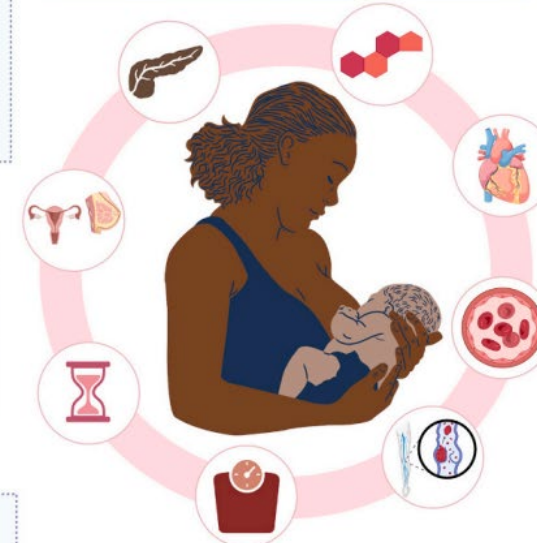
- Increase of Oxytocin Levels
- Decrease of:
 - Inflammatory markers
 - Cortisol/stress response
 - Endothelial dysfunction

Hematologic

- Decreased Risk of:
 - Postpartum Hemorrhage
 - Venous thromboembolism

Weight and Body

- Decrease of:
 - Postpartum Weight
 - Visceral Fat
 - Long-term Obesity Risk
- Increase of Caloric Burning



...AND ON
INFANT HEALTH

BREASTFEEDING
=
BIOLOGICALLY
NORMATIVE
FEEDING

AAP (2022)

Dose-Response Benefits of Breastfeeding for the Breastfed Infant

Condition	% Lower Risk ^a	Length of Breastfeeding	Comments
Otitis media ¹	23	Any	—
Otitis media ¹	50	≥3 or 6 mo	Exclusive breastfeeding
Recurrent otitis media ²	77	Exclusive BF ≥6 mo ^b	Compared with breastfeeding 4 to <6 mo ^b
Upper respiratory tract infection ³	63	>6 mo	Exclusive breastfeeding
Lower respiratory tract infection ¹	72	≥4 mo	Exclusive breastfeeding
Lower respiratory tract infection ²	77	Exclusive BF ≥6 mo ^b	Compared with breastfeeding 4 to <6 mo ^b
Asthma ¹	40	≥3 mo	Atopic family history
Asthma ¹	26	≥3 mo	No atopic family history
RSV bronchiolitis ⁴	74	>4 mo	—
Necrotizing enterocolitis ⁵	77	NICU stay	Preterm infants; exclusive human milk
Atopic dermatitis ⁶	27	>3 mo	Exclusive breastfeeding; negative family history
Atopic dermatitis ⁶	42	>3 mo	Exclusive breastfeeding; positive family history
Gastroenteritis ^{1,7}	64	Any	—
Inflammatory bowel disease ⁸	31	Any	—
Obesity ¹	24	Any	—
Celiac disease ⁷	52	>2 mo	Gluten exposure when breastfeeding
Type 1 diabetes ^{1,10}	30	>3 mo	Exclusive breastfeeding
Type 2 diabetes ^{1,11}	40	Any	—
Acute lymphocytic leukemia ^{1,12}	20	>6 mo	—
Acute myelogenous leukemia ^{1,13}	15	>6 mo	—
SIDS ¹	36	Any >1 mo	—

^a % lower risk refers to lower risk while BF compared with feeding commercial infant formula or referent group specified.

^b Referent group is exclusive BF ≥6 months.

HDP & BREASTFEEDING: SCOPE & IMPACT

HDPs affect 16% of pregnancies nationwide but are much more common among Black and Indigenous parents who also face some of the steepest disparities in lactation support.

Beyond peripartum mortality risks, HDP exposure is associated with adverse long-term cardiometabolic outcomes among women and their children.

Breastfeeding is associated with lower long-term risk of maternal cardiometabolic disease, preeclampsia, and both maternal and infant all-cause mortality.

A dose-dependent association has been observed, with longer breastfeeding durations associated with lower cardiometabolic risk for both infants and women, with potential for augmented cardiovascular benefit among those with HDP compared with those without.

COMMON LACTATION CHALLENGES FOR THIS POPULATION

Delayed secretory activation common with preterm birth, cesarean, use of magnesium sulfate, separation of the dyad for medical intervention

Those with HDP often have comorbidities that are associated with delayed transition to mature milk and/or lower milk supply -- such as obesity or insulin resistance

Lack of supportive hospital practice, lack of timely referrals to skilled lactation care and/or misinformation about medication compatibility



BEST PRACTICE:

Antenatal Counseling

- Explore patient's feeding goals, discuss the importance of breastfeeding and dispel any myths/misconceptions.
- Encourage participation in a prenatal breastfeeding class and/or support group. ksbreastfeeding.org/local-resource-directory
- Discuss indications for early induction and possibility for baby to require NICU admission / transfer for higher level of care
- Teach antenatal hand expression for those at higher risk of separation or C-section firstdroplets.com
- Discuss option of pasteurized donor human milk (PDHM) if available
- Provide Rx for a breast pump and resources on how to obtain via insurance if available.

Handout: KanCare Breast Pump Coverage and Access -
<https://ksbreastfeeding.org/wp-content/uploads/2025/02/KanCare-BREAST-PUMP-info-02-2025.pdf>



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ANTENATAL EXPRESSION

- Antenatal hand expression – once or twice a day
- In most cases pregnant people may begin around 37 weeks with OB ok
- Collect in small (3-5 ml) syringes and label with date/time expressed and freeze
- Care team to ensure colostrum remains *frozen* until baby is born
- Once thawed should be used within 24 hours

BEST
PRACTICE:

Skin to Skin &
Responsive
Feeding

Early & Often

- Start skin-to-skin (STS) immediately. Regardless of feeding method, stable newborns are immediately placed prone on the birthing parent's bare chest after birth. Thoroughly dried and the couplet is covered with a warm blanket.
- Following a vaginal birth, STS begins immediately, unless there is a documented medical reasons for a delay.
- Following a cesarean birth, STS begins when safe and feasible. Minimally, STS begins in the recovery room when the birthing parent is responsive and alert, unless there is a documented medical reason for a delay.
- The initial period of STS continues uninterrupted for at least 1 hour and through the completion of the first breastfeeding (at least one hour if not breastfeeding.)
- If parent is on continuous infusion (e.g., mag), evaluate alertness and fall-risk. Continuous monitoring of couplet during early skin to skin in the transition period.



IMPORTANCE OF IMMEDIATE SKIN-TO-SKIN

- Releases a cascade of hormones in both parent and infant, especially oxytocin
- First hour is a time-sensitive period for unlocking and programming infant and maternal behaviors
- Many physical benefits for infant – promotes GI motility, stabilizes blood glucose levels, supports thermal stability, colonizes infant with parent's flora
- Enhances PP uterine contractions reducing risk of hemorrhage
- Breastfeeding infants are 3 times more likely to remain exclusively breastfed by time of discharge if they have at least a full hour of immediate skin to skin after delivery.





REMINDERS FOR SKIN-TO-SKIN

- Skin-to-skin is wonderful for both parents, however baby should remain skin-to-skin with the birthing parent in the first hour, unless there are complications.
- Routine cares should be done on parent's chest, or delayed until after the first feeding and at least an hour of skin-to-skin (weight, meds, etc.)
- Great time to educate on cue-based feeding
- The average infant takes 52 mins to find the breast by themselves
- Assist with/support the first breastfeeding



SAFETY AND SKIN-TO-SKIN CARE

- Can you see baby's face?
- Are baby's nose and mouth uncovered?
- Is baby in the "sniffing" position?
- Is baby's neck straight, not bent?
- Is baby chest-to-chest with baby's shoulders flat against the birthing parent?
- Are baby's legs flexed?
- Are parent and baby positioned a little upright, not flat?
- Is baby's back covered with a blanket?

BEST
PRACTICE:

Support Safe
Rooming-in

- Magnesium sulfate may cause maternal sedation.
- Rooming-in can be encouraged even for high-risk couples and it must be **actively supported and continuously reassessed**.



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SAFE ROOMING-IN

- **Risk Assessment:** maternal sedation / fatigue, mobility limits, infant stability
- **Environment & Staffing:** scan of the room (lower bed, raise bedrails), consider support system
- **Parent Education:** safe sleep, skin-to-skin safety, pressing call-light for help before ambulating
- **Monitoring for drowsiness/fall risk:** hourly rounding, document maternal/infant safety, continuous observe for early feedings
- **Collaboration & Escalation:** temporary separation only if safety compromised



**BEST
PRACTICE:**

Early Initiation
of Milk
Expression

- When skin to skin and direct attachment is not possible, hand expression and/or pumping in the first hours is critical for establishment of milk supply.
- Jane Morton, Stanford – med.stanford.edu/newborns/
- Combining hand expression with pumping to boost yield

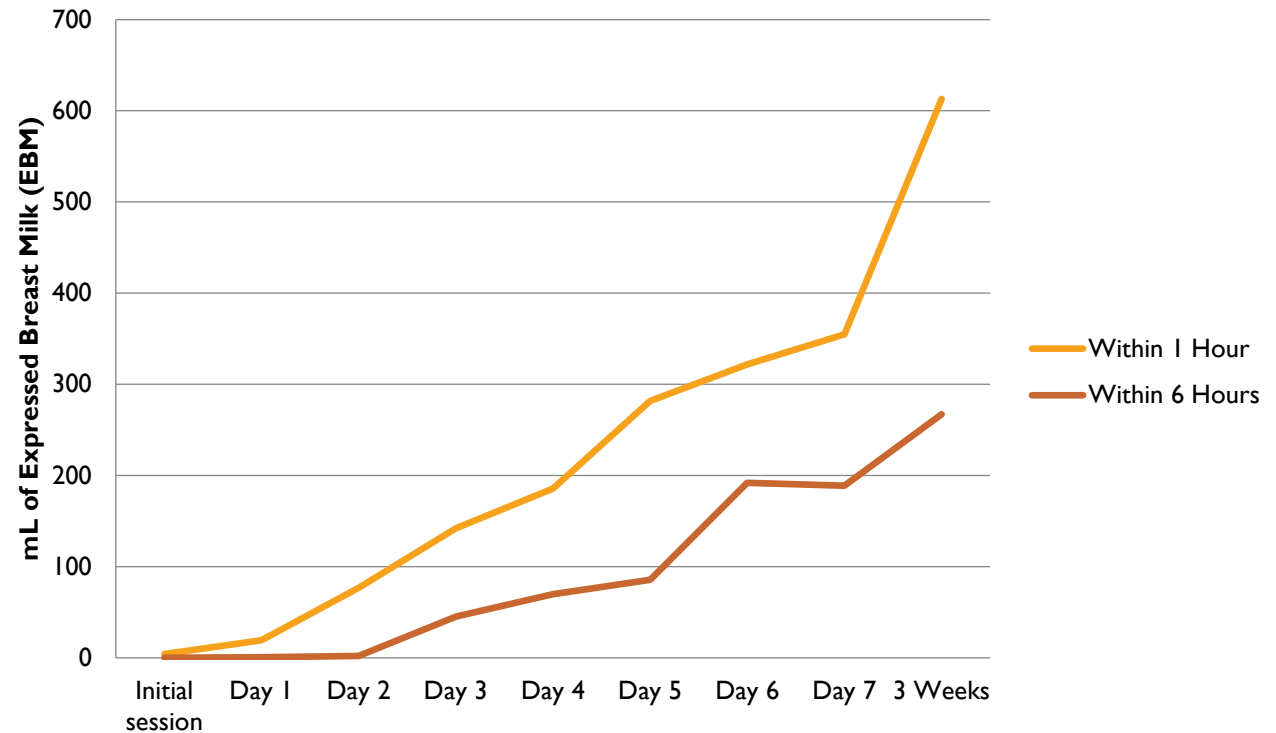
TIMING MATTERS

Parker, et al (2012) compared milk volumes of two groups of mothers with VLBW infants (a RCT) who initiated milk expression

- within 1 hour, or
- between 1 and 6 hours

Group that initiated milk expression within 1 hour had the strongest association with higher volumes and decreased time to secretory activation (onset of mature milk)

Expressed Milk Volumes Based on Time of First Expression



To obtain colostrum
when needed if baby
unable to feed directly
at the breast

Boosts maternal self-
efficacy

Reduces need for
other supplements

Can be used to
maintain or increase
milk supply

More effective than
pumping alone in
obtaining volume in
the first few days of life

Can be used to relieve
engorgement

Expressed drops can
be used to entice a
babe to breast

Some prefer the feel
or convenience of
hand expression over
pumping

WHY HAND EXPRESSION?



The Neptune Fountain
Bologna, Italy



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MILK EXPRESSION ROUTINE & EQUIPMENT CONSIDERATIONS

- Initiate milk expression (hand expression and/or pumping) within 1–2 hours if infant unable to feed or any separation is required (NICU admit)
- Use of a multi-user, double electric pump. Pumps vary greatly in quality and efficacy.
- Aim for 8+ sessions per 24 hrs., approx. 15 mins
- Encourage expressing at baby's bedside and skin-to-skin whenever possible
- Studies show hand expression + electric pumping increases milk production vs pump alone (Morton)

Types of Breast Pumps



Multi-User

Single or Double Electric

Portable



Wearable

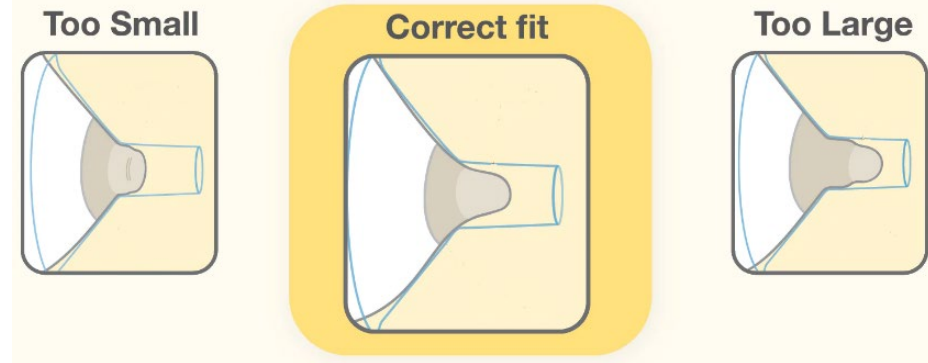
Manual

Silicone Collector



FLANGE FIT & PUMP KIT HYGIENE

- Flange fit matters. After pumping, breasts should feel softer all over. Pumping should not be painful!
- Use mild dish soap and warm water, hand wash pump parts in a wash basin after each use. Do not wash parts directly in the sink because germs in the sink may contaminate the items. The long tubing generally does not need to be washed.
- Steam sanitize pump parts once per day.
- If your facility has a NICU, consider implementing a loaner pump program to ensure access to a high quality, multi-user pump for those who are pump-dependent



MILK STORAGE, HANDLING & TRANSPORT

Guidelines may vary slightly in different settings (NICU, home, childcare settings) – consider your own facilities policies and the evidence behind them

- Room temp ($\leq 77^{\circ}\text{F}$): up to 4 hours
- Insulated cooler w/ “blue ice” packs: up to 24 hrs.
- Fridge ($\leq 40^{\circ}\text{F}$): up to 4 days
- Freezer (0°F): 6–12 months

Label with patient name, DOB, date/time expressed

Milk should be treated as food — not a biohazard!

Provide patient with storage containers, labels, and transport instructions prior to discharge

Best Practice for Expressing, Storing, and Handling Human Milk

IN HOSPITALS, HOMES, AND
CHILD CARE SETTINGS

Fifth Edition

Edited by
Rebecca Mannel and Sarah Taylor

HUMAN
MILK BANKING
ASSOCIATION OF NORTH AMERICA

**BEST
PRACTICE:**

**Consider How
to Best Support
Readmitted
Patients**

- Identify lactating patients upon admission to the hospital.
- Support and provide resources to the lactating patient to encourage continued lactation.
- Coordinate care to support in a case-appropriate way: continued breastfeeding, temporary interruption, or discontinuation of lactation in a way that avoids harm.



MODEL POLICY FOR A READMITTED LACTATING PATIENT

- Much like we do for pregnancy status, consider assessing all female patients of childbearing age on lactation status on admission and ensure it is clearly documented.
- Consider referral to lactation if available.
- Ensure your facility has multi-user electric pumps & storage bottles available. Support the patient in feeding infant directly at the breast if infant able to be in hospital with the patient. Or expressing milk at approximately the same schedule as before admission.
- Ensure milk storage options are available and coordinate with pharmacy to identify medications that are compatible with breastfeeding.



CONSIDERATIONS FOR PRE/POST PROCEDURE

- If patient is having a procedure, they should be encouraged to express milk or breastfeed before the procedure.
- After procedure, and as soon as the patient is alert and able, they should be encouraged to express milk or breastfeed.
- If the lactating patient is unconscious, preparations should be made to have a knowledgeable person assist with milk expression.
- If surgical skin prep is indicated, choose chlorhexidine over iodine, and avoid applying it to the breasts if possible. Wash surgical skin prep from the breast area, if necessary, at the conclusion of the procedure.

BEST PRACTICE:

Evidence-Informed Decision Making on Medications

- Most antihypertensives are compatible with breastfeeding and the use of milk.
- Use evidence-based references like LactMed, Hale's *Medications & Mother's Milk* book, Infant Risk Center
- Avoid *Physicians' Desk Reference* or relying on package inserts, Google/AI.
- Coordinate with pharmacy and/or prescribing providers to include preferred agents and alternatives
- Consider adding a weblink to LactMed from your EHR



Common medications

Magnesium sulfate - L1.

Unlikely that the amount of magnesium in milk would be clinically relevant.

Labetalol (Normodyne) - L2.

Levels reported in infant have been low, but it is dose related. RID 0.2-0.6%

Hydralazine (Alphapress) - L2.

Milk levels far less than the pediatric dose.

Lactation Risk Categories (Hale)

L1 – Compatible

L2 – Probably Compatible

L3 – Presumed Compatible

L4 – Potentially Hazardous

L5 – Hazardous

Nifedipine (Procardia) - L2.

The amount of nifedipine intake in infant would be very low (less than 1.8% of the pediatric dose) and thus poses little risk to an infant.

Diuretics - usually L2 meds.

Rarely may reduce milk supply; avoid high-dose thiazides if possible.

Common meds, cont

Carboprost (Hemabate) - L3.

Not likely to penetrate milk in clinically relevant amounts.

Tranexamic acid (TXA) - L3.

Excreted in human milk minimally. Present in the mother's milk at a concentration of about one-hundredth of the corresponding maternal serum concentration.

Methergine - L2.

Short-term use (<5 days) is not problematic. Prolonged use may negatively affect milk production.

Misoprostol (Cytotec) - L2.

At peak concentration 1 hour after dose, authors estimate that the infant would receive less than 0.5% of the maternal dose. Rapidly eliminated and levels in milk are exceedingly low.

Lactation Risk Categories (Hale)

L1 – Compatible

L2 – Probably Compatible

L3 – Presumed Compatible

L4 – Potentially Hazardous

L5 – Hazardous

Pitocin - L2.

Minimal oral absorption, very short half-life (3-5 mins)

Oxycodone - L3.

Doses greater than 40mg/day are discouraged in opiate naïve breastfeeding mothers.

KEY RESOURCES & REFERENCES

- KBC's [Medications in Lactation algorithm](#) (new revision coming soon!)
- NIH's [LactMed Database](#)
- [Medications & Mother's Milk, by Hale & Krutsch](#) (published every 2 years)
- [Infant Risk Center](#) at Texas Tech University (806)352-2519 8am-3pm M-F
- CDC's [Milk Storage & Handling guidance](#)
- HMBANA's [Best Practice for Expressing, Storing and Handling Human Milk in Hospitals, Homes and Childcare Settings](#) (2024)
- ABM Protocols www.bfmed.org/protocols
- COBA's [Model Hospital Policy for Readmitted Lactating Patient](#)



EDUCATION NEEDS



Breastfeeding 101 & 201 Courses

- Consider staff education needs to support lactating patients. Staff who are not consistently caring for lactating parents (or are in a facility where lactation services are not available) must receive basic education on supporting the lactating patient.
- This education should include the following topics at a minimum:
 - Importance of breastfeeding, need for support to sustain
 - Process of milk production
 - Signs and treatment of engorgement, mastitis, nipple damage
 - Breast pump use
 - Milk storage guidelines
 - Lactation support and referral sources

APPLIED LEARNING THROUGH CASE STUDIES



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#1: GESTATIONAL HYPERTENSION

- **Vignette:** 29yo G1 with gestational HTN, term vaginal birth, goal of exclusive breastfeeding
- **Interventions:** Antenatal counseling and education; Immediate skin-to-skin and rooming-in; Hand expression and spoon-feeding colostrum; Assessment of feedings at least q shift; Referral to outpatient lactation if available
- **Outcome:** Exclusively breastfeeding at discharge and through 6 weeks



#2: SEVERE PREECLAMPSIA ON MGSO₄, C-SECTION, NICU ADMISSION

- **Vignette:** 34yo G2 with severe preeclampsia, emergency C-section, term infant to NICU for respiratory support
- **Interventions:** Hand expression initiated in PACU within 30 min and expression with hospital-provided multi-user pump once transferred to PP unit; Partner offered skin-to-skin in NICU once baby stable; Maternal meds were reviewed and use of EBM supported in the NICU; Parents consented to PDHM as a bridge.
- **Outcome:** Infant transitioned to room air after 24 hours and was supported in initiating breastfeeding along with NG feeds. Transferred to nursery level of care after 36 hours and roomed in with parents. Onset of mature milk by day 3. Couplet discharged home together on day 5.



#3: CHRONIC HTN – PP READMIT

- **Vignette:** 38yo P3 with chronic HTN admitted to non-birthing facility on day 8 PP for management of postpartum BP
- **Interventions:** Nursing team provided hospital multi-user breast pump and offered education, including a plan to label and store milk; Pharmacy consulted to optimize meds compatible with lactation (mag, switch from atenolol to nifedipine); Nursing team coordinated with the FOB and offered a crib; FOB supported in bringing infant to patient for breastfeeding and stayed to provide safe care for infant.
- **Outcome:** Milk supply sustained through consistent milk expression; Dyad was reunited and successfully reestablished breastfeeding. Continued breastfeeding at 6 months.

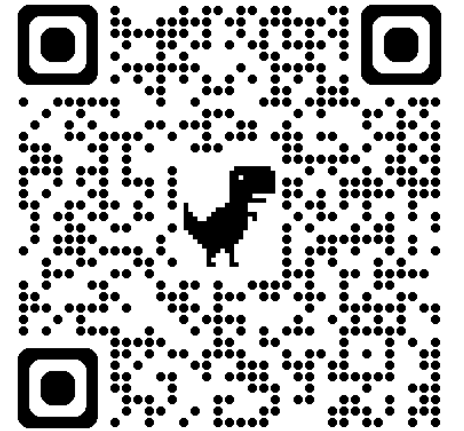


TECHNICAL ASSISTANCE & SUPPORT



www.high5kansas.org

- Breastfeeding Policy Checklist
- Skills Fair Kit
- High 5 for Mom and Baby Recognition Application
- Parent Resources
- Marketing Materials



TECHNICAL ASSISTANCE & SUPPORT



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KBC's Local Resource Directory



Join KBC's Hospital Section

Kansas 2025 Breastfeeding Conference

Oct 16th & 17th

Drury Plaza Hotel in Wichita



It's not too late! Register today!



ksbreastfeeding.org/breastfeeding-conference

Thank you for your time today!



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Open access images from the USBC's Landscape of
Breastfeeding Support usbreastfeeding.org

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Upcoming trainings and events for KPQC Champions:

- 10/3/25: [HaysMed Maternal, Infant and Immunization Health Symposium](#)
- 10/14/25: [Bridges to Wellness, Session One](#) (only need to register once for both sessions)
- 10/21/25: [Bridges to Wellness, Session Two](#) (only need to register once for both sessions)
- 10/28/25: [KPQC Fall Conference](#)
- 11/18/25: [KPQC Champion In-Person Workday \(WEST\) in Hays](#) (only attend one – EAST or WEST)
- 11/25/25: [KPQC Monthly Learning Forum](#) (only need to register once for ALL Learning Forums)
- 12/2/25: [KPQC Champion In-Person Workday \(EAST\) in Lawrence](#) (only attend one – EAST or WEST)

Upcoming:

October 28, 2025 - Fall Conference (virtual)

November 25, 2025 - Learning Forum

December – No Learning Forum

