March 2023 LEARNING FORUM

Rapid Response:
*Welcome, **Kari Smith!***

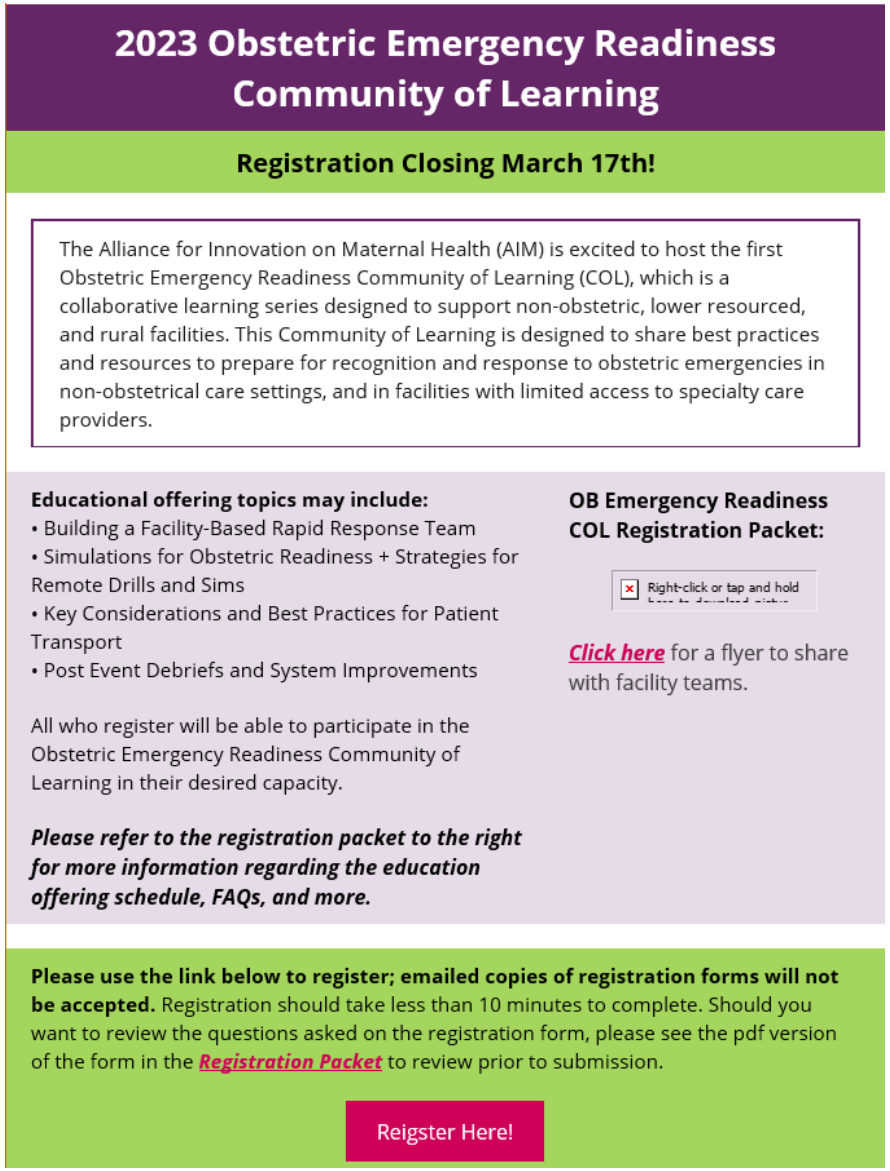
KPQC Kansas Perinatal Quality Collaborative | FOURTH TRIMESTER INITIATIVE

RAPID RESPONSE: Feedback?

February FTI Learning Forum-

Mandated Reporting and Perinatal Substance Use

RAPID RESPONSE: Learning Opportunity



2023 Obstetric Emergency Readiness Community of Learning

Registration Closing March 17th!

The Alliance for Innovation on Maternal Health (AIM) is excited to host the first Obstetric Emergency Readiness Community of Learning (COL), which is a collaborative learning series designed to support non-obstetric, lower resourced, and rural facilities. This Community of Learning is designed to share best practices and resources to prepare for recognition and response to obstetric emergencies in non-obstetrical care settings, and in facilities with limited access to specialty care providers.

Educational offering topics may include:

- Building a Facility-Based Rapid Response Team
- Simulations for Obstetric Readiness + Strategies for Remote Drills and Sims
- Key Considerations and Best Practices for Patient Transport
- Post Event Debriefs and System Improvements

All who register will be able to participate in the Obstetric Emergency Readiness Community of Learning in their desired capacity.

Please refer to the registration packet to the right for more information regarding the education offering schedule, FAQs, and more.

OB Emergency Readiness COL Registration Packet:

Right-click or tap and hold

Click here for a flyer to share with facility teams.

Please use the link below to register; emailed copies of registration forms will not be accepted. Registration should take less than 10 minutes to complete. Should you want to review the questions asked on the registration form, please see the pdf version of the form in the ***Registration Packet*** to review prior to submission.

Reigster Here!

Prevent Child Abuse Kansas

Kansas Children's Service League
Stronger families start here.

KANSAS CONNECTING COMMUNITIES

KANSAS MATERNAL & CHILD HEALTH

Kansas Department of Health and Environment

Important Dates:

Next Learning Forum: April 25, 2023

Speaker: Dr. Kourtney Bettinger

Topic: Hot Topics in Kansas:

Neonatal Care

Kansas Perinatal Quality Collaborative

Spring Conference

Save the Date

May 23 2023

General KPQC Membership (virtual)

9:00-12:00

FTI Champions (in-person)

9:00-4:00

Sunflower Foundation, Topeka, KS

KPQC
Kansas Perinatal Quality Collaborative

FOURTH TRIMESTER INITIATIVE

KPQC

Kansas Perinatal Quality Collaborative

The women speak: Birth & Death data and what it means to FTI

2020 DATA (KDHE OFFICE VITAL STATISTICS)

Live Births: **34,368**

Stillbirths: 169

Total Births: **34,537**

3,645 abortions

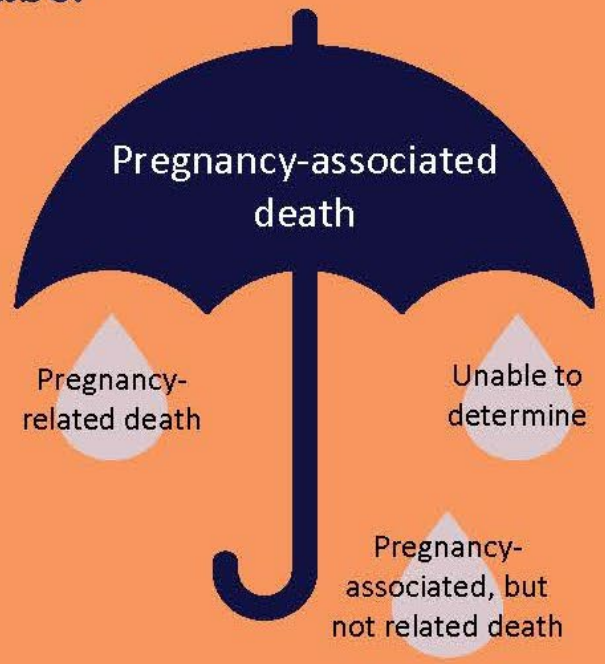
5 maternal deaths (7 in 2019)

*Deaths related to or aggravated by pregnancy, but due to accidental or incidental causes, and occurring within 42 days of the end of a pregnancy (follows the World Health Organization (WHO) definition).

Pregnancy-Associated Death

A pregnancy-associated death refers to the death of a woman while pregnant or anytime within one year of pregnancy regardless of cause.[1]

- **Pregnancy-related death.** The death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.
- **Pregnancy-associated, but not-related death.** The death of a woman during pregnancy or within one year of the end of pregnancy from a cause that is not related to pregnancy.
- **Pregnancy-associated but unable to determine pregnancy relatedness.** The death of a woman while pregnant or within one year of pregnancy, due to a cause that could not be determined to be pregnancy-related or not pregnancy-related.



Centers for Disease Control and Prevention. Division of Reproductive Health. Building U.S. Capacity to Review and Prevent Maternal Deaths Program. Maternal Mortality Review Committee Decisions Form v20. October 13, 2020. https://reviewtoaction.org/content/maternal-mortality-review-committee-decisions-form.

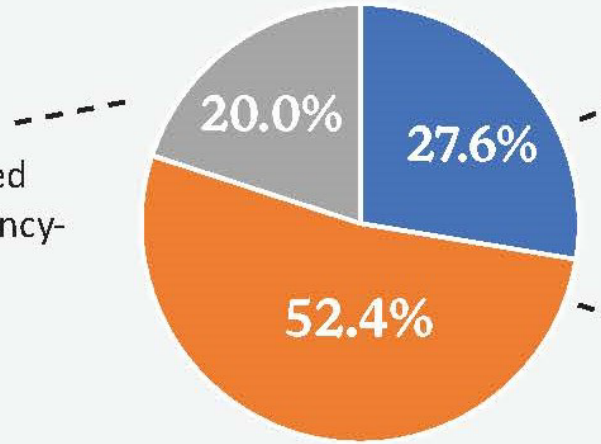
The Role of the MMRC

	CDC – National Center for Health Statistics (NCHS)	CDC – Pregnancy Mortality Surveillance System (PMSS)	Maternal Mortality Review Committees
Data Source	Death certificates	Death certificates linked to fetal death and birth certificates	Death certificates linked to **fetal death and birth certificates, medical records, social service records, autopsy, informant interviews…**
Time Frame	During pregnancy – 42 days	During pregnancy – 365 days	During pregnancy – 365 days
Source of Classification	ICD-10 codes	Medical epidemiologists (PMSS-MM)	**Multidisciplinary committees**
Purpose	Show national trends and provide a basis for international comparison	Analyze clinical factors associated with deaths, publish information that may lead to prevention strategies	**Understand medical and non-medical contributors to deaths, prioritize interventions that effectively reduce maternal deaths**

Sourced from: St Pierre A, Zaharatos J., Goodman D, Callaghan W.M., Challenges and opportunities in identifying, reviewing, and preventing maternal deaths. Obstetrics & Gynecology, 2018. 131(1): p. 138-142.

Pregnancy-Associated deaths KMMRC Determinations Kansas, 2016-2020

(Preliminary Data, Subject To Change)



21 deaths were pregnancy-associated but unable to determine the pregnancy-relatedness

29 deaths were pregnancy-related

55 deaths were pregnancy associated but not related

More than half (52.4%) of all pregnancy-associated deaths occurred after 42 days postpartum

Pregnancy Associated Deaths Kansas, 2016-2020

(Preliminary Data, Subject to Change)

Source: Kansas Maternal Mortality Review Committee

56 deaths per every 100,000 live births occurred in Kansas.

From 2016 to 2020, there were **105 pregnancy-associated deaths**, which translated to a pregnancy-associated mortality ratio (PAMR) of **56 deaths per every 100,000 live births occurred in Kansas.**

Most pregnancy-associated deaths occurred among:

Women with a **high school education or less** were **nearly three times** as likely to die within one year of pregnancy as women who had more than a high school education.

Women on **Medicaid during pregnancy or for delivery** were **nearly four times** as likely to die within one year of pregnancy as women with private insurance.

Unmarried women were **nearly four times** as likely to die within one year of pregnancy as married women.

Disparities in pregnancy-associated deaths:

Non-White minority women were **nearly twice** as likely to die within a year of pregnancy as non-Hispanic White women.

Women who did not enter prenatal care during the first trimester were **more than twice** as likely to die within one year of pregnancy as women who entered prenatal care during the first trimester.

Women who resided in ZIP Codes with the lowest median household income (quartile 1, poorest) were **more than twice** as likely to die within one year of pregnancy as women who lived in the highest median household income (quartile 4, wealthiest).

Pregnancy-associated deaths can happen to women of any race and ethnicity. However, in Kansas from 2016 to 2020, most of racial and ethnic minority women were disproportionately affected (Figures 1). Figure 1 shows that the percent of deaths that occurred among **non-Hispanic Black women (18.1%) and women of other races (10.5%) far exceed their representation** among the population of women giving birth (7.1%, 6.8%, respectively) in Kansas.

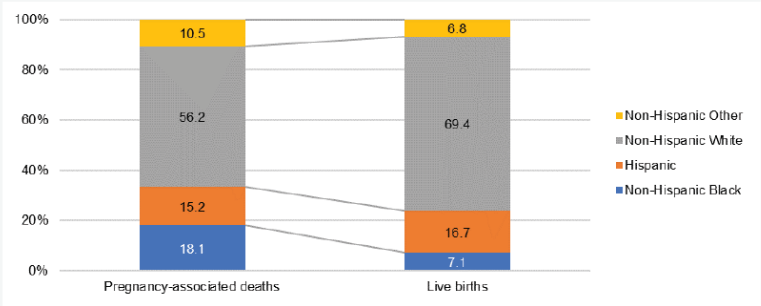


Figure 1

Chart Title: *Percent of Pregnancy-associated deaths and live births by race and ethnicity, Kansas, 2016-2020*

Source: *Kansas Maternal Mortality Review Committee; Kansas Department of Health and Environment, birth data (occurrence)*

Pregnancy Associated deaths Causes of death; Kansas, 2016-2020

(Preliminary Data, Subject To Change)

- **Nearly half (49 deaths, 46.7%) were related to medical causes of death, such as cardiovascular conditions, embolism-thrombotic (non-cerebral), infection, or hypertensive disorders of pregnancy.**

- Nearly one-third (29 deaths, 27.6%) were caused by homicide, suicide, mental health conditions, or unintentional poisoning/overdose.

- The remainder were caused by motor vehicle crash, fire or burn accidents, and unknown (27 deaths, 25.7%).

PREGNANCY ASSOCIATED DEATHS
KANSAS, 2016-2020 (Preliminary Data, Subject To Change)

KMMRC determinations on circumstances surrounding death were:

Obesity
contributed to 23.8%

***Discrimination**
contributed to 7.4%
*All deaths reviewed after May 29, 2020

Mental Health Conditions
contributed to 22.9%

Substance Use Disorder
contributed to 26.7%

- Obesity contributed to about **one in four deaths** (25 deaths, 23.8%).
- Discrimination contributed to about **one in 14 deaths** (4 deaths, 7.4%).
- Mental Health Conditions contributed to about **one in four deaths** (24 deaths, 22.9%).
- Substance Use Disorder contributed to about **one in four deaths** (28 deaths, 26.7%).

PREGNANCY RELATED DEATHS KANSAS, 2016-2020 (Preliminary Data, Subject To Change)

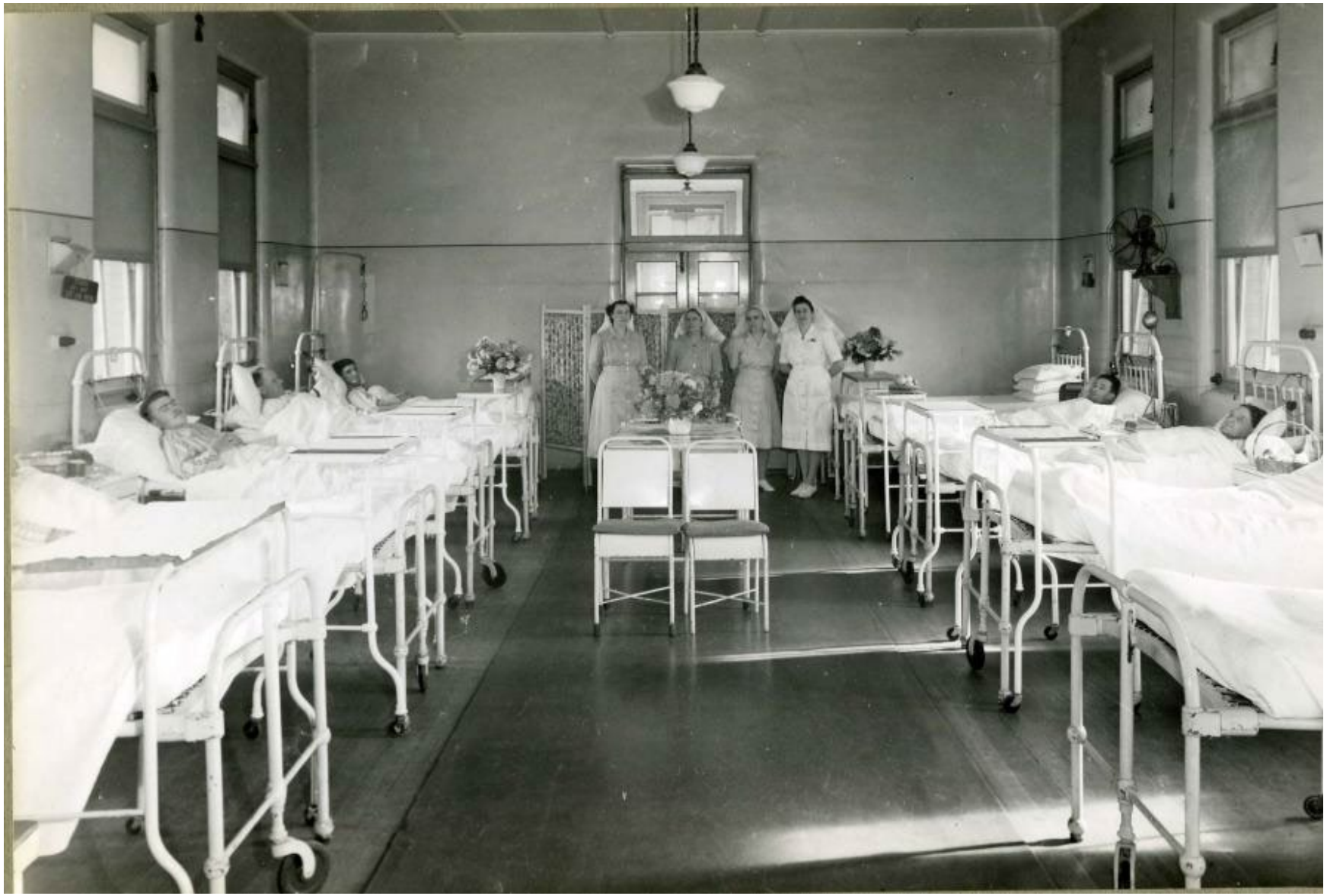
The leading causes of death were (in order):

Cardiovascular conditions

Hypertensive disorders

Embolism

Infection



Covid related fallouts set us back BIG!

Oct 2022 CDC Report

United States Government Accountability Office

Report to Congressional Addressees

October 2022

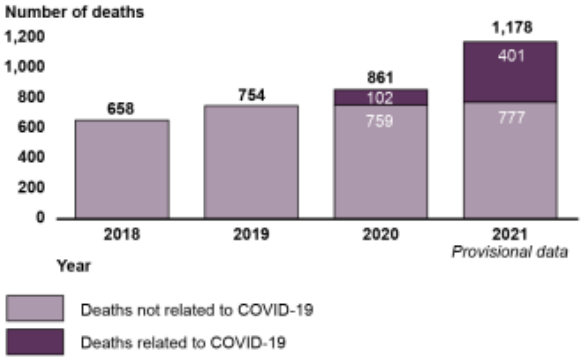
MATERNAL HEALTH

Outcomes Worsened and Disparities Persisted During the Pandemic

What GAO Found

Each year in the U.S., hundreds of women die from complications related to pregnancy and childbirth—known as maternal death. GAO's analysis of Centers for Disease Control and Prevention (CDC) data shows that maternal deaths increased during the COVID-19 pandemic. Further, the data show that COVID-19 was a contributing factor in one quarter of all maternal deaths in 2020 and 2021 combined.

Maternal Deaths, 2018 through 2021



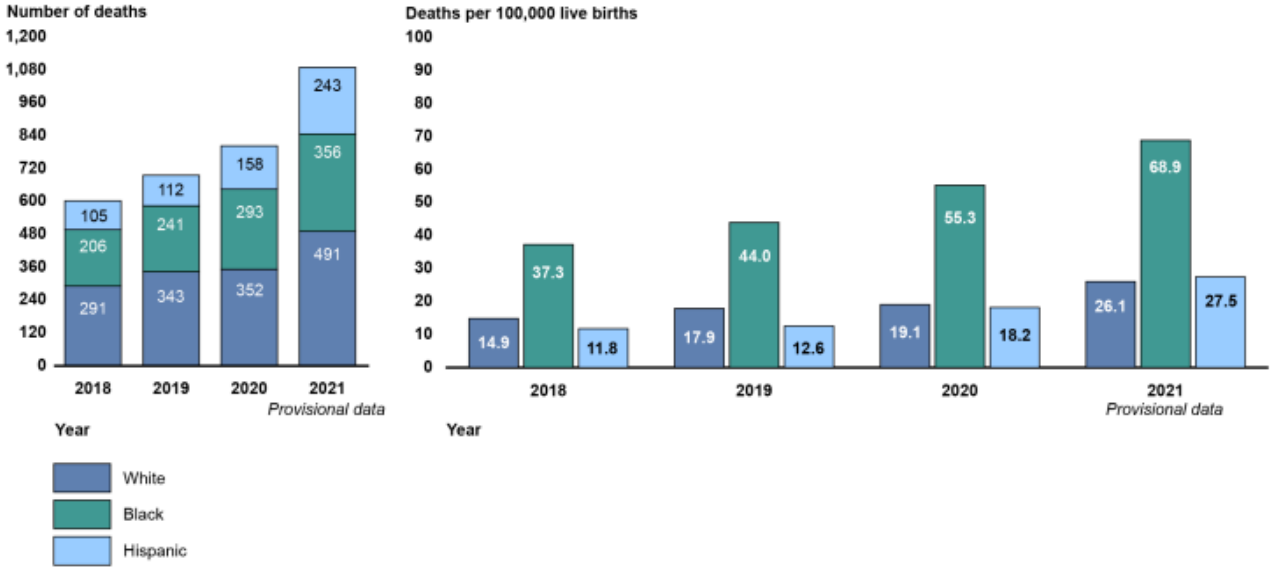
Source: GAO analysis of Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS) data. | GAO-23-105871

CDC data also show racial and ethnic disparities in the rate of maternal deaths per 100,000 live births per year. For example:

- The maternal death rate for Black or African-American (not Hispanic or Latina) women was 44.0 per 100,000 live births in 2019, then increased to 55.3 in 2020, and 68.9 in 2021. In contrast, White (not Hispanic or Latina) women had death rates of 17.9, 19.1, and 26.1, respectively.
- The maternal death rate for Hispanic or Latina women was lower (12.6) compared with White (not Hispanic or Latina) women (17.9) in 2019, but increased significantly during the pandemic in 2020 (18.2) and 2021 (27.5).

Disparities in other adverse outcomes, such as preterm and low birthweight births, persisted for Black or African-American (not Hispanic or Latina) women, according to GAO analysis of CDC data.

Figure 1: Number and Rate of Maternal Deaths by Race and Ethnicity, 2018 through 2021

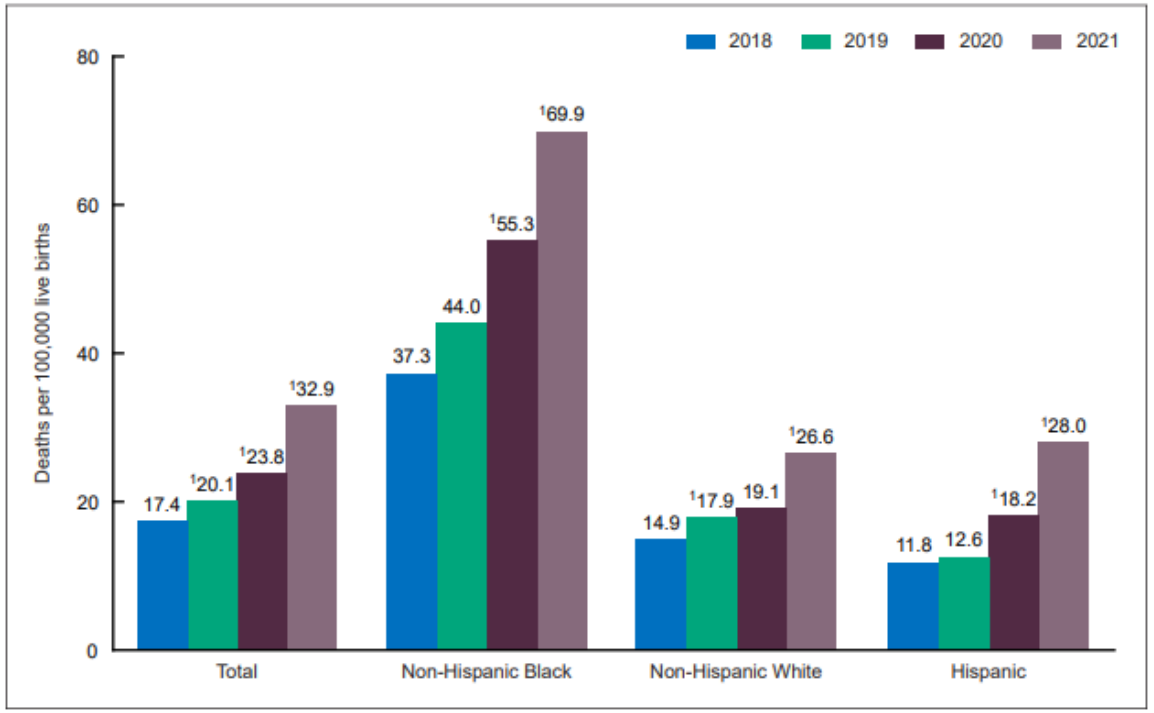


Source: GAO analysis of Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS) data. | GAO-23-105871

Maternal Mortality Rates in U.S., 2021

NCHS Health E-Stats March 2023

Figure 1. Maternal mortality rates, by race and Hispanic origin: United States, 2018–2021



†Statistically significant increase from previous year ($p < 0.05$).
NOTE: Race groups are single race.
SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

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"…stillbirths and maternal mortality are shockingly high in the United States compared with other similarly developed nations, and that Black women are paying the highest price."

Federal Study Calls U.S. Stillbirth Rate "Unacceptably High" and Recommends Action

A National Institutes of Health report decried stillbirths as a "major public health concern" and said the nation needed to do more to address the problem through research and prevention.

Amanda Duffy traces a cast of the hand of her daughter, Reese, who was stillborn. Jenn Ackerman, special to ProPublica

by Duaa Eldeib

March 23, 5 a.m. EDT

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Additional COVID-19 set-backs

Prenatal Care visits decreased as did postpartum visits

Struggle with increased childcare demands

Healthcare infrastructure was strained

Women more vulnerable to loss of income during pandemic

Increase in maternal anxiety and depression

Domestic violence spiked

Total % of preterm births increased

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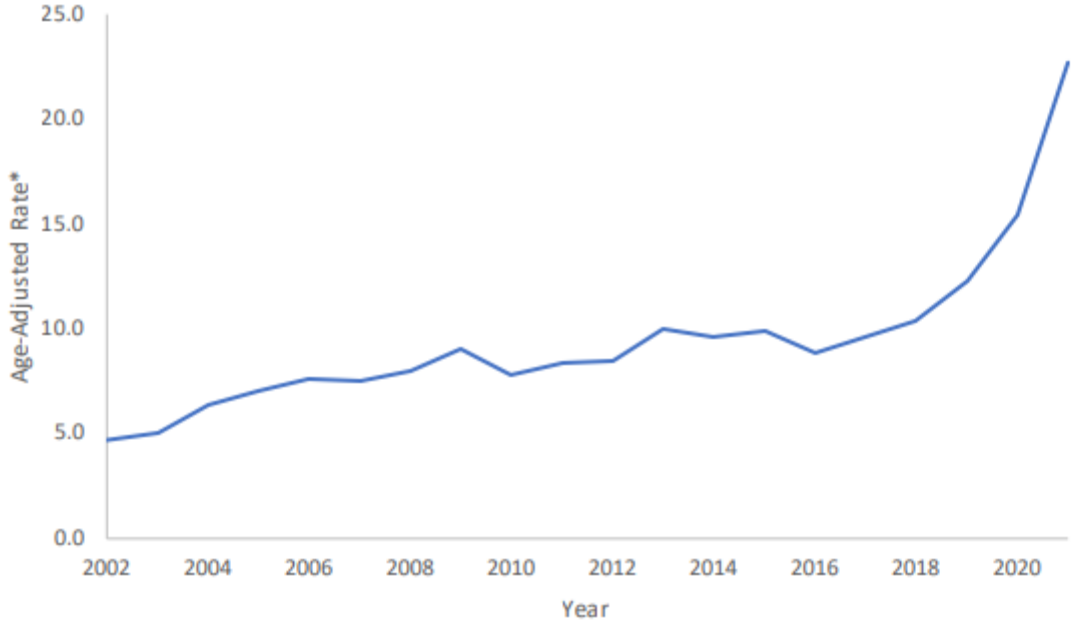
Drug Related Deaths in Kansas

- Four-Fold Increase from 2002-2021
  - In 2002- 168 drug related KS deaths
  - In 2021- 679 drug related KS deaths.
  - Increase from 4.7/100,00 to 22.7/100,000
  - Excludes cases where drugs were used for suicide or homicide.

Figure 1. Deaths of unintentional or undetermined intent with drugs as underlying cause, by year of death and age-adjusted death rate, Kansas residents 2002-2021



* per 100,000 U.S. 2000 Standard Population

FOURTH TRIMESTER INITIATIVE

Let’s Talk about Nursing!

- April 2022, a published workforce analysis found RN workforce decreased >100,000 from 2020-2021.
  - Most were under the age of 35
- Over the past five years, RNs in step down, emergency services, behavioral health and telemetry were most with a cumulative turnover rate between 101.3% and 111.4%.
  - "Essentially, every five years, these departments will turn over their entire RN staff.”

Let’s Talk about Nursing, cont.…

- **COVID worsened insufficient staffing, raised the stress level of nurses, impacted job satisfaction, leading many nurses to leave the profession.**
- 29% of nurses across all license types considering leaving in 2021, compared with 11% in 2020.
- Higher pay was the most influential motivation to stay, followed by better support for work-life balance and more reasonable workload.

- March 2022, COVID-19 Impact Assessment Survey found 52% of nurses are considering leaving their current position
  - primarily to insufficient staffing, work negatively affecting health and well-being, and inability to deliver quality care.
  - 60% of acute care nurses report feeling burnt out, and 75% report feeling stressed, frustrated, and exhausted.

- How Do We Improve Patient Outcomes Without Nursing?


DO
MORE
WITH
LESS

2022 - 2023
KPQC Fourth Trimester Initiative
Champion Timeline

FTI Project	Start	Finish	Sept '22	Oct '22	Nov '22	Dec '22	Jan '23	Feb '23	Mar '23	Apr '23
POSTBIRTH Training	Current	Dec 2022								
KBEN Training	Current	October 2022								
Maternal Mental Health TA	Current	Ongoing thru 2023								
PP Appointment Prior to Discharge	Current	Ongoing thru 2023								
AIM Data Entry	Nov 2022	Ongoing thru April 2023								
PP Care Team/PP Referrals/Community Resource List	Sept 2022	December 2022								
Breastfeeding: High 5 & Baby Friendly	Current	Ongoing thru 2023								
Reproductive Family Planning	Oct 2022	Ongoing thru 2023								
ED/EMS Triage Policy	Current	Ongoing thru 2023								
SSDOH Screening & Referral to CRL	TBD		TBD							
Implicit Bias Training	TBD		TBD							
Standardized Discharge Summary	TBD		TBD							

The NEW Postpartum Model

Educate

Screen

Refer

- In every patient, in every birth setting, in every protocol:
  - ❑ **Maternal Warning Signs**
    1. POSTBIRTH Education & Recognition
    2. Identify Medical Red Flags prior to discharge, PP Appt
  - ❑ **Maternal Mental Health**
  - ❑ **PP Appointment(s)** prior to discharge
    - ❑ Standard DC Summary
  - ❑ **Breastfeeding**
    - High 5 for Mom & Baby, Baby Friendly
  - ❑ **Family Planning**
  - ❑ **SSDOH**
  - ❑ **Birth Equity**
  - ❑ **PP Care Team**
    - Patient as center of Team
    - Navigation available
  - ❑ Pt debriefs for Adverse Outcome Events
  - ❑ ED/EMS Triage (Universal question, POST-BIRTH, ACOG Algorithms)
  - ❑ Link Up! (KPCCs, MCH, Outpatient clinics, etc.)

ACOG Postpartum Bundle

AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

Postpartum Discharge Transition Bundle

Readiness — Every Unit

Develop and maintain a set of referral resources and communication pathways between obstetric providers, community-based organizations, and state and public health agencies to enhance services and supports for pregnant and postpartum families.*

Establish a multidisciplinary care team to design coordinated clinical pathways for patient discharge and a standardized discharge summary form to give to all postpartum patients prior to discharge.

Response — Every Event

Provide patient education prior to discharge that includes life-threatening postpartum complications and early warning signs, including mental health conditions, in addition to individual patient-specific conditions, risks, and how to seek care.*

Provide each postpartum patient with a standardized discharge summary form that details key information from pregnancy and birth.*

Conduct a comprehensive postpartum visit.*

FOURTH TRIMESTER INITIATIVE

U3-FINAL_AIM_Bundle_PPDT.pdf (saferbirth.org)

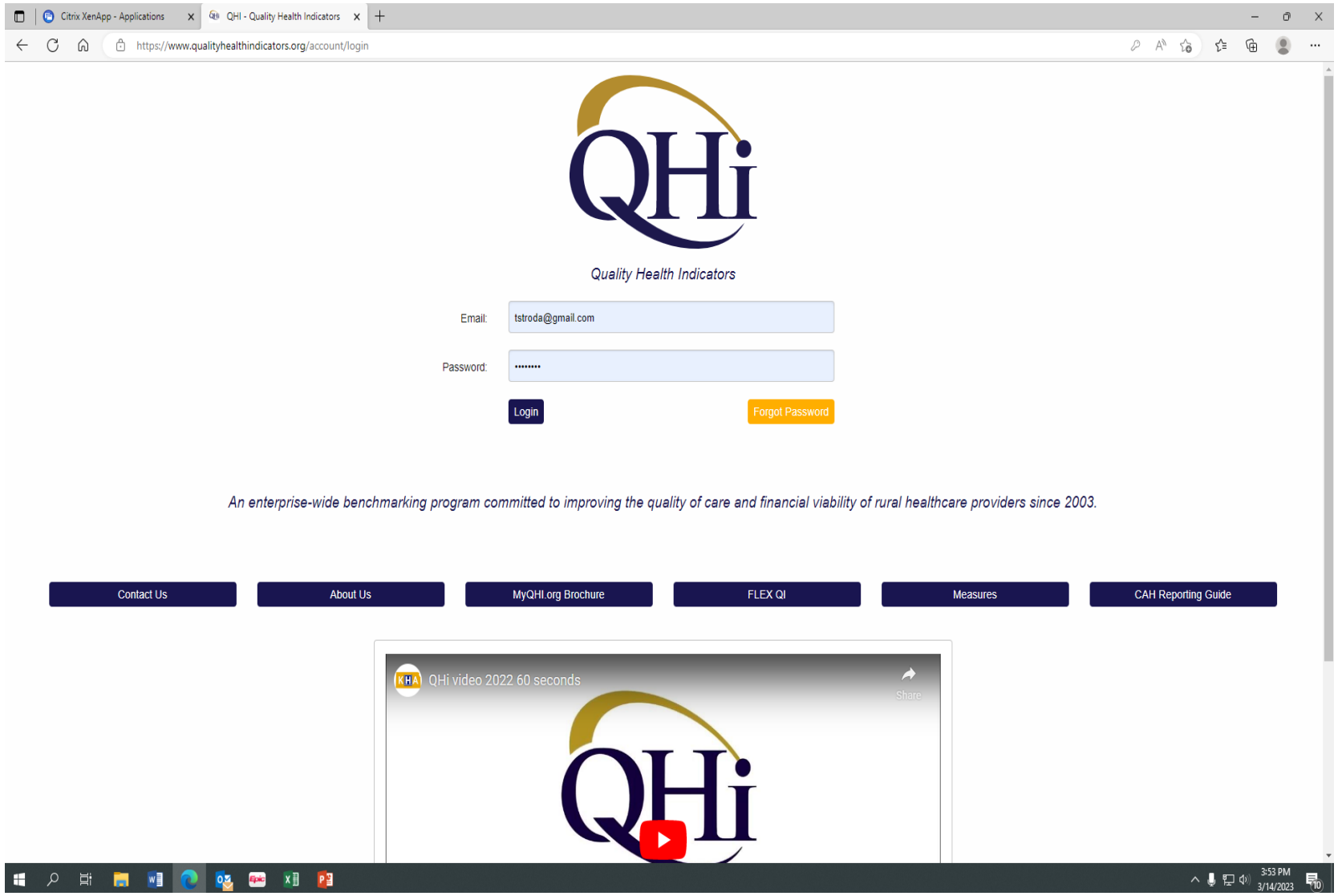
Hospitals will need to submit the following items MONTHLY:

1- Number of maternal discharges after live birth
    a. NOTE: goal is to provide data disaggregated by race
2- Number of patients discharged that have been:
    a. Given education and discharge materials on POSTBIRTH (Magnet, Mom Card, etc)
    b. Screened for Social Determinants of Health
    c. Provided a Postpartum Appointment prior to discharge
3- Number of educational offerings done each month that are related to FTI work

    For example: POSTBIRTH or KBEN trainings, Learning Forums, General Meetings/Conferences, Hospital Trainings/Simulations, Perinatal community meetings and trainings

4- Number of agencies or hospital units involved in those trainings referenced in #3
5- When the Emergency Dept in your facility begins to incorporate a screening question for current or future PG in each triage of female patients of childbearing age
6- TBD: Birth Equity Training, PP Visit Template sharing with outpatient clinics, Patient Debriefs after adverse outcome

Postpartum Discharge Transition
Bundle-In Development


Citrix XenApp - Applications
QHI - Quality Health Indicators
https://www.qualityhealthindicators.org/account/login
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Quality Health Indicators
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tstroda@gmail.com
Password:
Login
Forgot Password
An enterprise-wide benchmarking program committed to improving the quality of care and financial viability of rural healthcare providers since 2003.
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Measures
CAH Reporting Guide
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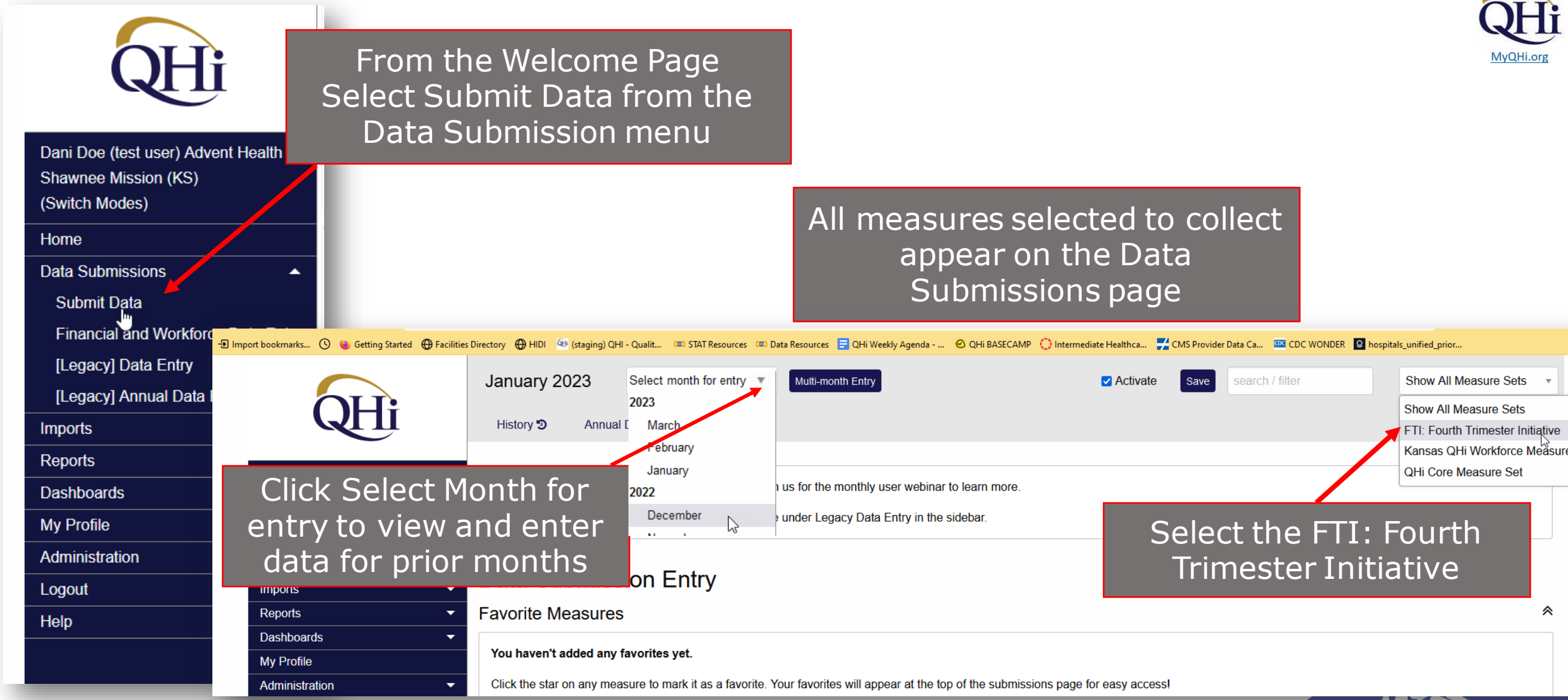
3/14/2023

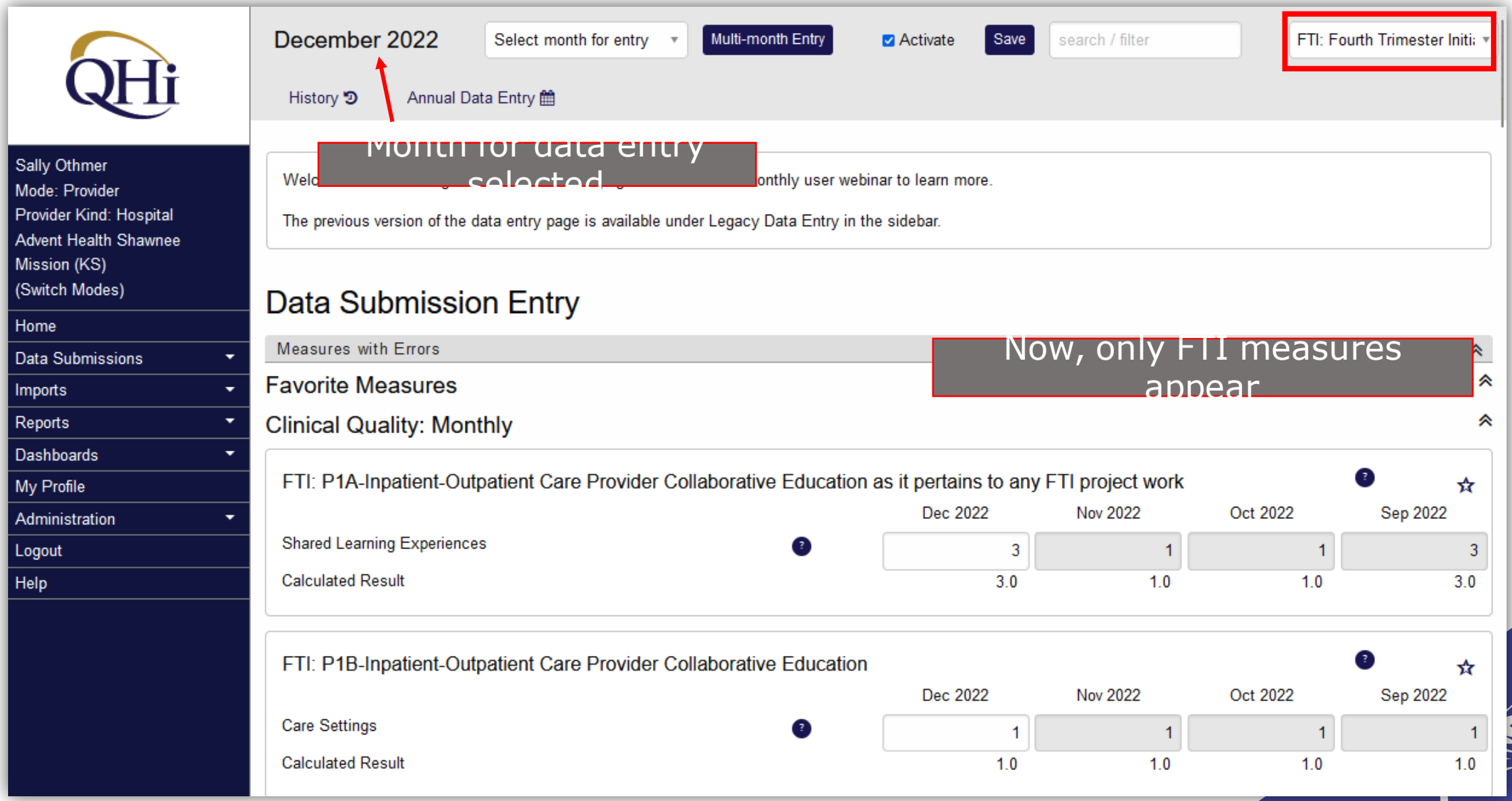
From the Welcome Page Select Submit Data from the Data Submission menu

All measures selected to collect appear on the Data Submissions page



Click Select Month for entry to view and enter data for prior months

Select the FTI: Fourth Trimester Initiative



https://www.qualityhealthindicators.org/account/login