

March 2026 KPQC Learning Forum

Statewide!

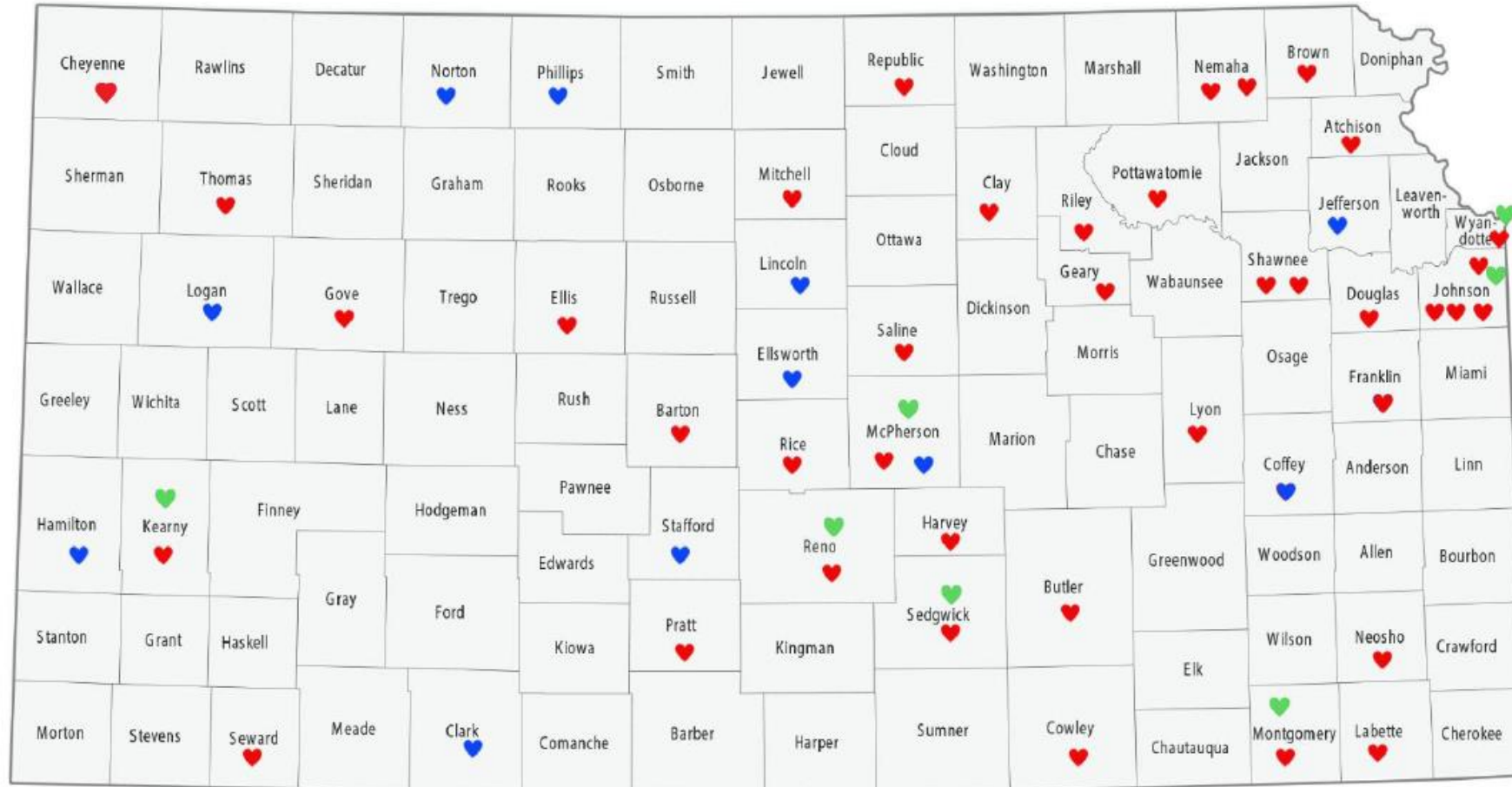


In the CHAT 😊




Name & Hospital/Agency



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

KPQC Spring Workday

May 1, 2026

Topeka, KS

One enrolled facility Champion per site
and a Plus-One

Link: <https://kansaspqc.kdhe.ks.gov/spring-conference-registration-2026/>

*Stronger Together for
Kansas Moms and Babies:*

Connecting Best Practices, Lived
Experiences, and Improved Outcomes



FRIDAY, MAY 1, 2026 | 9:00 a.m. – 4:00 p.m.

Keynote Speakers



Kourtney Bettinger, MD, MPH, FAAP

Dr. Bettinger is a general pediatrician and Associate Professor at the University of Kansas Medical Center who leads multiple state and international maternal and child health initiatives, particularly for immigrant, refugee and newborn populations.



Brandon Kennedy, MD, FAAP, FABPM

Dr. Kennedy is a Clinical Professor of Pediatrics at the University of Missouri-Kansas City, a pediatric hospitalist, and a clinical informatics specialist focused on improving patient safety through better electronic health record workflows.



Angela Martin, MD, FACOG

Dr. Martin is a Clinical Associate Professor of Maternal-Fetal Medicine at the University of Kansas, recognized with multiple national teaching awards. She founded the Pregnancy Heart Team, serves as vice chair of the hospital pharmacy and therapeutics committee, and is the medical director of labor and delivery.



Brianna Harris-Henderson

Brianna Harris-Henderson is a maternal health advocate and nonprofit leader who uses her lived experience with pregnancy-related heart conditions to educate, raise awareness, and champion better care and support for mothers.

Agenda

- 9:00 a.m.** Kickoff
- 9:15 a.m.** Hot Topics: Pediatric and Maternal Vaccines, Panel Discussion
Brandon Kennedy, MD, FAAP, FABPM
Kourtney Bettinger, MD, MPH, FAAP
Angela Martin, MD, FACOG
- 10:15 a.m.** The Untold Story: Peripartum Cardiomyopathy & Other Maternal Cardiac Risk Factors
Angela Martin, MD, FACOG
- 11:30 a.m.** Let's Talk: The Lived Experience of Peripartum Cardiomyopathy
Brianna Harris-Henderson, President and Founder of LetsTalkPPCM
- 12:00 p.m.** Lunch & Celebration of Success
KPQC Advisory Committee
- 1:00 p.m.** Enrolled Sites Workday: Breakout Sessions & Open Mic Discussion
- 4:00 p.m.** Day concludes



Register today!

Scan the QR code or follow the link [here](#) for more information.



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 LHM/T re-licensure. Kansas State Board of Nursing provider number: LT0258-1003.



MOM, DAD, & BABY

SATURDAY, APRIL 11 @ 10AM

Expo

Join us for a **FREE** community event built just for you!

Learn about doulas, midwives, health insurance, childcare, mental health, and resources to support your family!

Enjoy vendors, raffle prizes, free lunch, and free on-site childcare!



Register now!



Free childcare!

Sponsored by



KCKCC TECHNICAL EDUCATION CENTER

6565 STATE AVE,
KANSAS CITY, KS 66102

CONTACT US



@KSBirthEquity



tinyurl.com/ksbirthequity

KBEN

Kansas Birth
Equity Network



We're just **2 weeks** away from the 2026 Mom, Dad, and Baby Expo! 🎉

Be sure to **register** today and share with a friend to help us reach **100 registrations!**

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The event is **free**, **lunch will be provided**, and on-site **childcare** will be available. Whether you're a parent, community member, birthworker, healthcare professional, or simply interested in learning more, this event is for you!

Register: <https://tinyurl.com/BMHW26SignUp>

Vendor Sign-Up Form: <https://tinyurl.com/BMHW26Vendors>

Volunteer Sign-Up Form: <https://tinyurl.com/BMHW26Vol>

Childcare Sign-Up Form: <https://tinyurl.com/BMHW26Childcare>

More Information (Raffle sign-up, Marketing Toolkit, and more!): <https://linktr.ee/momdadbabyexpo26>

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Kansas Birth Equity Network

Email: kben@kumc.edu | Text Us: 913-363-3337

www.k-ben.org | [www.tinyurl.com/KSBirthEquity](https://tinyurl.com/KSBirthEquity)

Follow us on [Instagram](#) & [Facebook](#): @ksbirthequity

RAPID Response

When to Administer Anti-D Immune Globulin to Prevent Rh D Alloimmunization

The screenshot shows the ObG Project website interface. At the top left is the logo 'ObG PROJECT®' with the tagline 'Evidence-Based. Clearly Delivered.' Below the logo is a navigation menu with items: Alerts, OB, GYN, The Genome, Evidence Matters, L&D eBOOK, Primary Care, and More. A search icon and links for 'About Us' and 'Contact Us' are in the top right. A teal banner below the navigation reads 'Premium Content & Alerts. Start Free. Only \$9/month. Learn More'. The main content area features a sidebar on the left with a 'SECTIONS' menu listing various topics like Alerts, OB, Prenatal Testing & Ultrasound, etc. The main article content includes a 'CLINICAL ACTIONS:' section with a paragraph and three recommendation levels (A, B, and C), each with a bulleted list of clinical scenarios.

ObG PROJECT®
Evidence-Based. Clearly Delivered.

Alerts OB GYN The Genome Evidence Matters L&D eBOOK Primary Care More

Premium Content & Alerts. Start Free. Only \$9/month. [Learn More](#)

☆ 📄 PATIENT FRIENDLY Plain Text PATIENT FRIENDLY Quick Points

CLINICAL ACTIONS:

Rh D alloimmunization can be prevented with the administration of anti-D immune globulin. ACOG recommends administration of anti-D immune globulin to unsensitized Rh D-negative women as follows

Level A Recommendation (good and consistent science)

- 28 weeks (reduces risk from 2% to 0.2%)
- Within 72 hours of birth, if infant is Rh D positive and patient is not sensitized

Level B Recommendation (limited or inconsistent science)

- All invasive diagnostic procedures such as CVS and amniocentesis if fetus may be Rh D positive

Level C Recommendation (consensus/expert opinion)

ACOG language in (" ")

- External cephalic version, regardless of success ("indicated")
- Evacuation of suspected molar pregnancy ("reasonable to administer")
- Termination of pregnancy $\geq 12w0d$, either medical or surgical ("should be given")
- Ectopic pregnancy ("recommended")
- Antenatal hemorrhage >20 weeks gestation ("recommended")
- Abdominal trauma ("should be administered")

Rapid Response ASA therapy

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 aspirin is recommended in pregnant persons with certain risk factors, including elements of clinical history, laboratory, and examination. However, currently published checklists inadvertently overlooked and/or omitted several risk factors for all appropriate candidates. This statement presents updated checklists for preeclampsia risk-factor screening to guide recommendations for prophylactic low-dose aspirin.

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

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) or the patient-completed form (Figure 2). There is generally no advantage for a practice to use both forms. A decision should be made about the format of the checklist and the way it will be administered: either as a paper form to be filed in the patient chart, an electronic form to be filed in an electronic medical record, or a form to be used in a patient portal.

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 8-12 weeks' gestation and assessed categorically at thresholds (≥ 10 and ≥ 13) that are commonly used in clinical practice. The primary outcome was SMM at delivery hospitalization, and secondarily, SMM without transfusion. Relative risk regression using a modified Poisson model with robust error variance was used and adjusted for baseline age, insurance status, tobacco use, and residential Area Deprivation Index. In secondary analyses, we further adjusted for preexisting psychiatric diagnosis and psychotropic medication exposure in early pregnancy.

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 hypertensive disorders of pregnancy, preterm birth, and stillbirth. These findings suggest the need for initiatives designed to reduce the burden of mental health conditions during pregnancy. Severe maternal morbidity (SMM) includes a rare but potentially life-threatening complication of pregnancy, such as maternal intensive care unit admission and need for blood transfusion. The prevalence of SMM at delivery hospitalization is

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

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.

Rapid Response

Why 3 days, 7 days, 6 weeks...?

AJOG article:

[Society for Maternal-Fetal Medicine Special Statement: Checklist for postpartum discharge of women with hypertensive disorders - American Journal of Obstetrics & Gynecology](#)

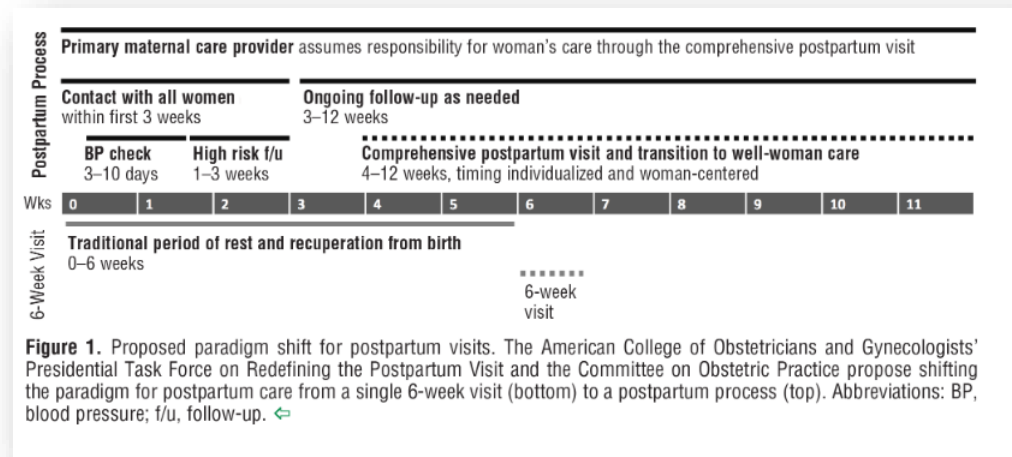
Postpartum exacerbations of hypertension and preeclampsia merit particular attention. Blood pressure usually decreases within 48 hours after delivery but increases again 3 to 6 days postpartum.⁶ Therefore, it is recommended that patients with hypertensive disorders monitor blood pressure at home until a visit at 7 to 10 days after delivery.⁶⁻⁸ A visit within 72 hours is recommended for women with severe hypertension.⁷ The American College of Obstetricians and Gynecologists (ACOG) Practice Bulletin on gestational hypertension and preeclampsia notes that most women who present with postpartum eclampsia or stroke had warning symptoms for hours or days before presentation.

ACOG Committee Opinion:

[Optimizing Postpartum Care | ACOG](#)

ACOG, MFM:

[Society for Maternal-Fetal Medicine Special Statement: Checklist for postpartum discharge of women with hypertensive disorders - American Journal of Obstetrics & Gynecology](#)



Checklist of additional considerations for postpartum patients with selected pregnancy complications or medical conditions

HELLP, hemolysis, elevated liver enzymes and low platelets; *PP*, postpartum.

Patient Safety and Quality Committee, Society for Maternal-Fetal Medicine. Postpartum visit checklists. Am J Obstet Gynecol 2022.

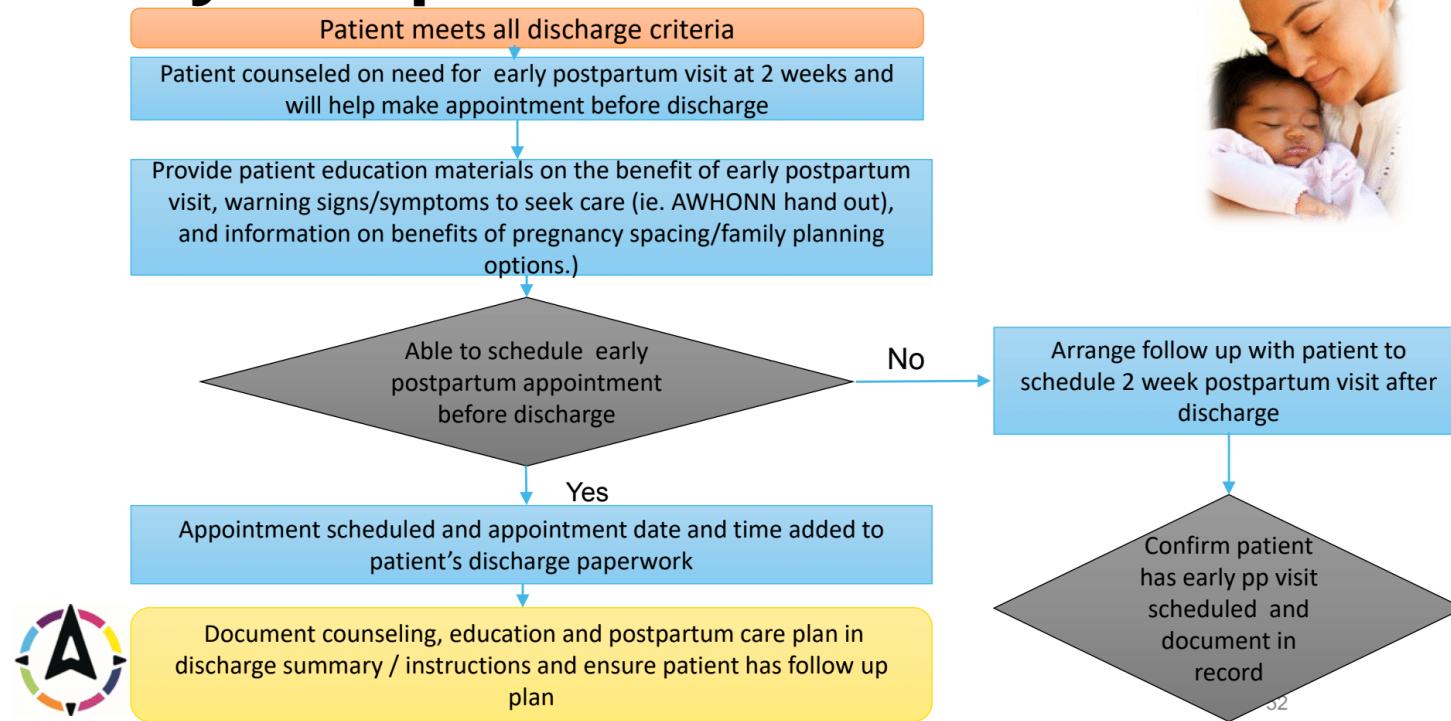
- a Hypertensive disorders: blood pressure evaluation within 7 to 10 days for any hypertensive disorder and within 72 hours for severe hypertension
- b Gestational diabetes mellitus: 75 g, 2-hour glucose tolerance test performed at 4 to 12 weeks PP
- c Cardiovascular disease: assessment within 7 to 14 days PP.

[Open table in a new tab ↗](#)

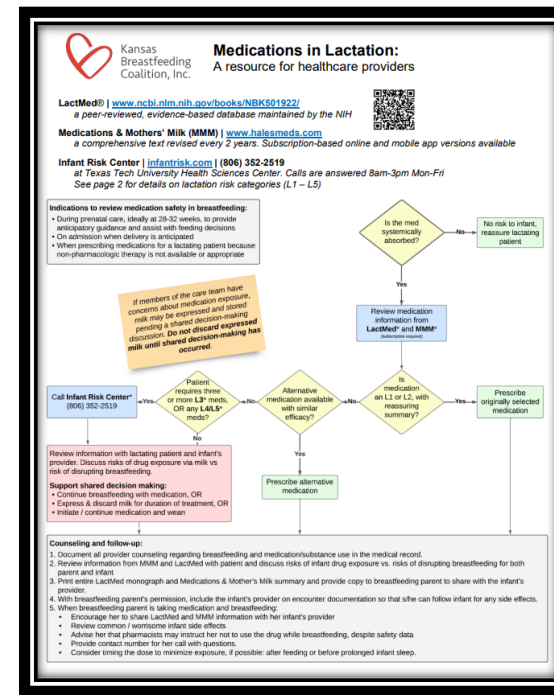
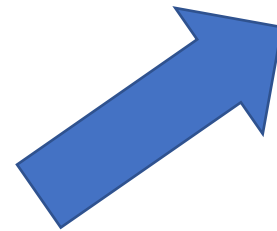
Draft your Process/Education Flow: PP

Scheduling Early PP Visit

Process Flow for Scheduling Early Postpartum Visit



Rapid Response Lactation & Meds



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!

Severe HTN Highlights!

kansaspqc.kdhe.ks.gov/initiatives/severe-hypertension-pregnancy-initiative/

Background

Kansas Department of Health and Environment (KDHE) has partnered with the Kansas Perinatal Quality Collaborative (KPQC) to launch maternal health quality initiatives aimed at decreasing maternal morbidity and mortality in our state. In October 2021, Kansas officially enrolled as an Alliance for Innovation on Maternal Health (AIM) state, implementing the Postpartum Discharge Transition patient safety bundle (known in Kansas as the Fourth Trimester Initiative).

According to 2016-2020 KS Maternal Mortality Review Committee data, cardiovascular



- Toolkits
- Kansas Cuff Project
- Provider Resources
- Other Helpful Links and Documents

Learn more about the SHTN Pregnancy

- About Severe Hypertension in Pregnancy Initiative
- Learning Forums

- Toolkits
 - Maternal Warning Signs Toolkit
 - Perinatal Hypertension Toolkit
 - AIM Severe Hypertension in PG Bundle
 - ACOG Severe Hypertension in Pregnancy Bundle
 - CMQCC Hypertension Toolkit
 - Suspected Preeclampsia Algorithm (PDF)
 - Preeclampsia Screening Tools (PDF)
 - Acute Treatment Algorithm (PDF)
 - Kansas Breastfeeding Coalition
 - Medications and Lactation Algorithm (PDF)
- Kansas Cuff Project
- Provider Resources
- Other Helpful Links and Documents



[Kansaspqc.kdhe.ks.gov](https://kansaspqc.kdhe.ks.gov)

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

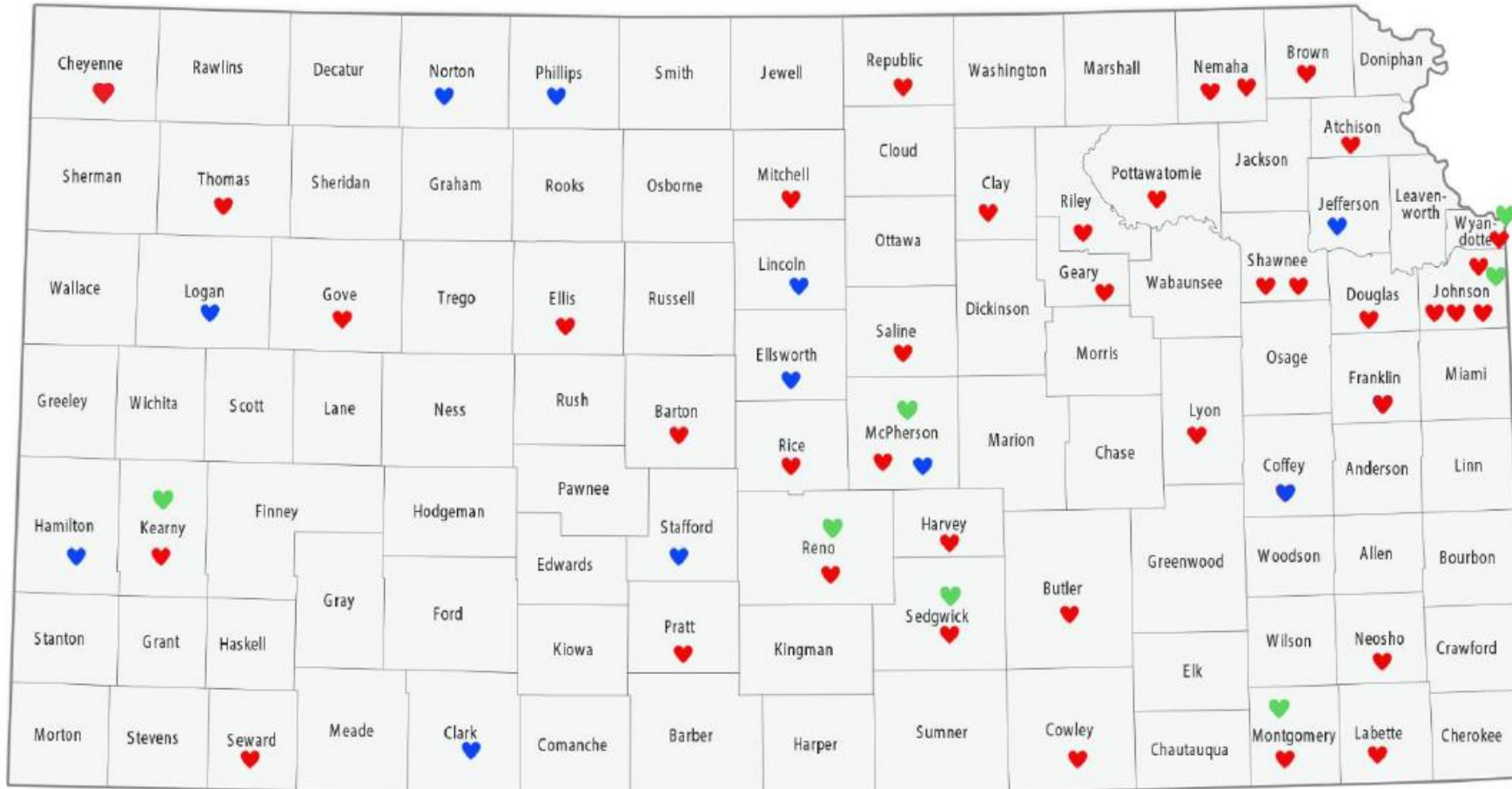
OB or ED Triage

Timely Treatment (<60 min)




Delivery or Antepartum Follow-Up

Outpatient Follow-Up (72 hours, 7 days)

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

Cuff Project: exciting updates!

UPDATE: How to order through YOUR office or hospital DME

Pilot Site Update!



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
- ~~Edgemark~~ Edgemark 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.



POSTBIRTH seats... the Re-Launch!

SAVE YOUR LIFE:

Get Care for These POST-BIRTH Warning Signs

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



<p>Call 911 if you have:</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Pain in chest <input type="checkbox"/> Obstructed breathing or shortness of breath <input type="checkbox"/> Seizures <input type="checkbox"/> Thoughts of hurting yourself or your baby
<p>Call your healthcare provider if you have:</p> <p style="font-size: x-small;">(If you can't reach your healthcare provider, call 911 or go to an emergency room)</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Bleeding, soaking through one pad/hour, or blood clots, the size of an egg or bigger <input type="checkbox"/> Incision that is not healing <input type="checkbox"/> Red or swollen leg, that is painful or warm to touch <input type="checkbox"/> Temperature of 100.4°F or higher <input type="checkbox"/> Headache that does not get better, even after taking medicine, or bad headache with vision changes



Tell 911 or your healthcare provider:

"I had a baby on _____ and
(Date)
I am having _____"
(Specific warning sign)

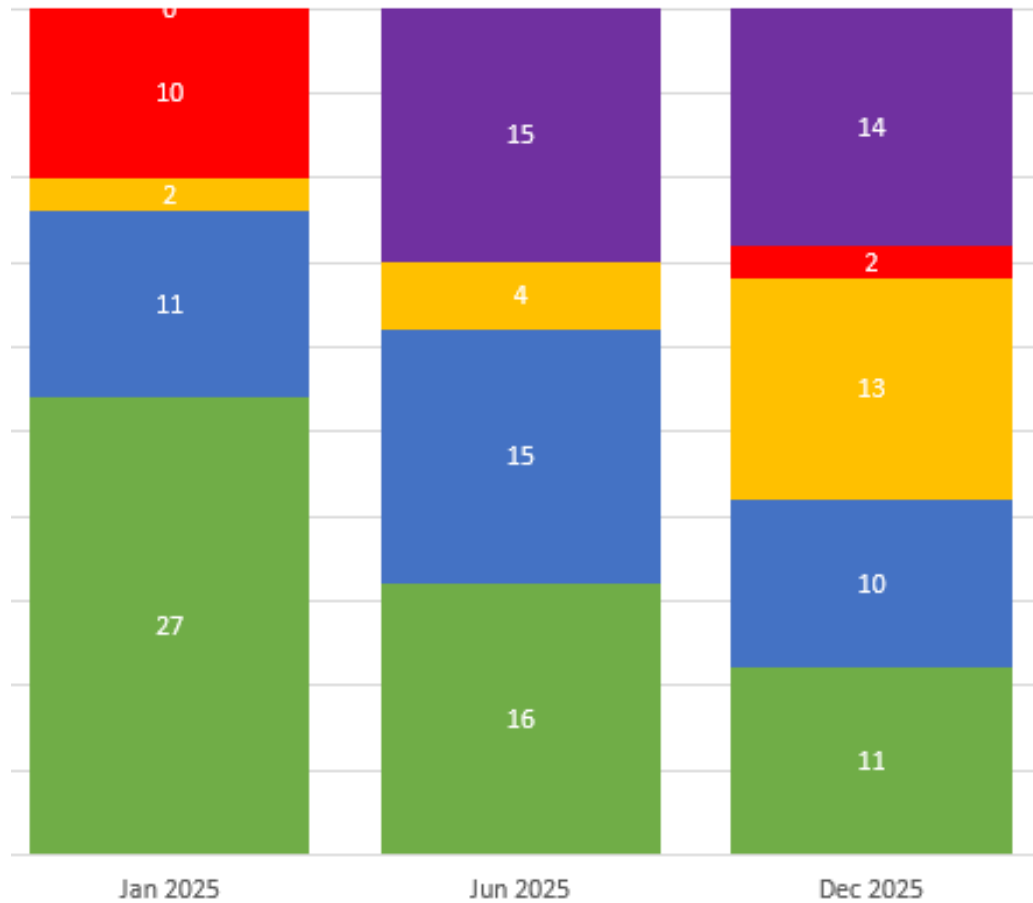
Breastfeeding/Pumping/Expression Protocols



Timely Treatment Transfer Case Studies



Timely Treatment



Percent of your patient population that received treatment within one hour.

Among the 34 hospitals

- 38% - were at 90% or greater
- 29% - between 10 to 89%
- 32% - were at 9% or below or didn't report data



■ Score 1

■ Score 3

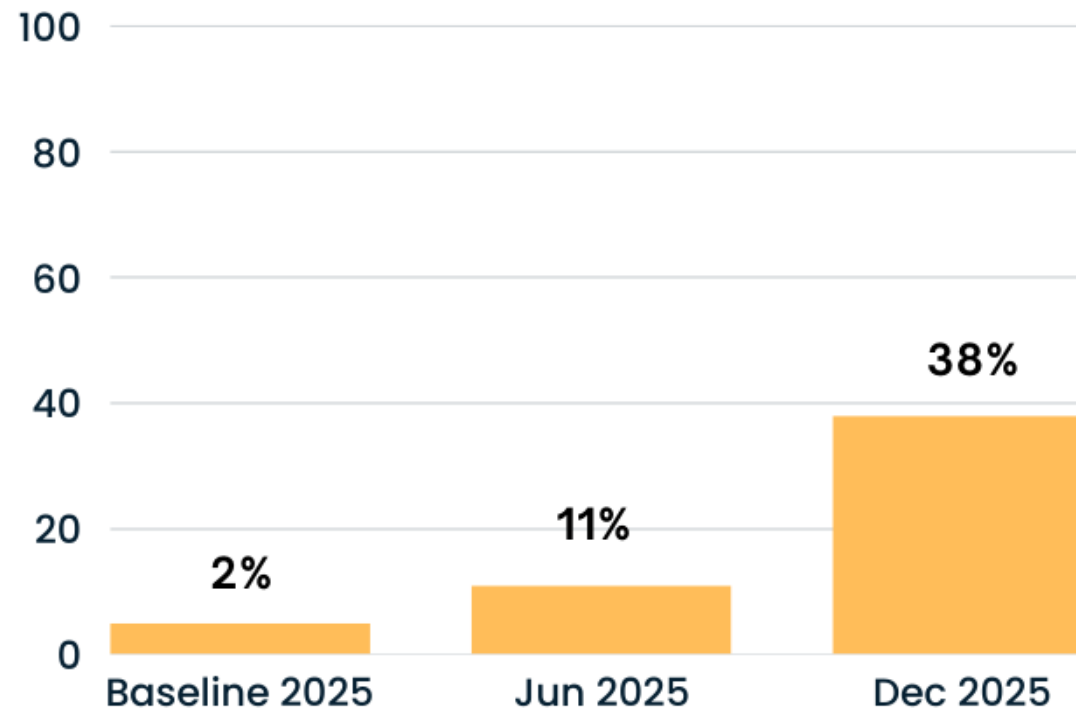
■ Score 5

■ Unknown

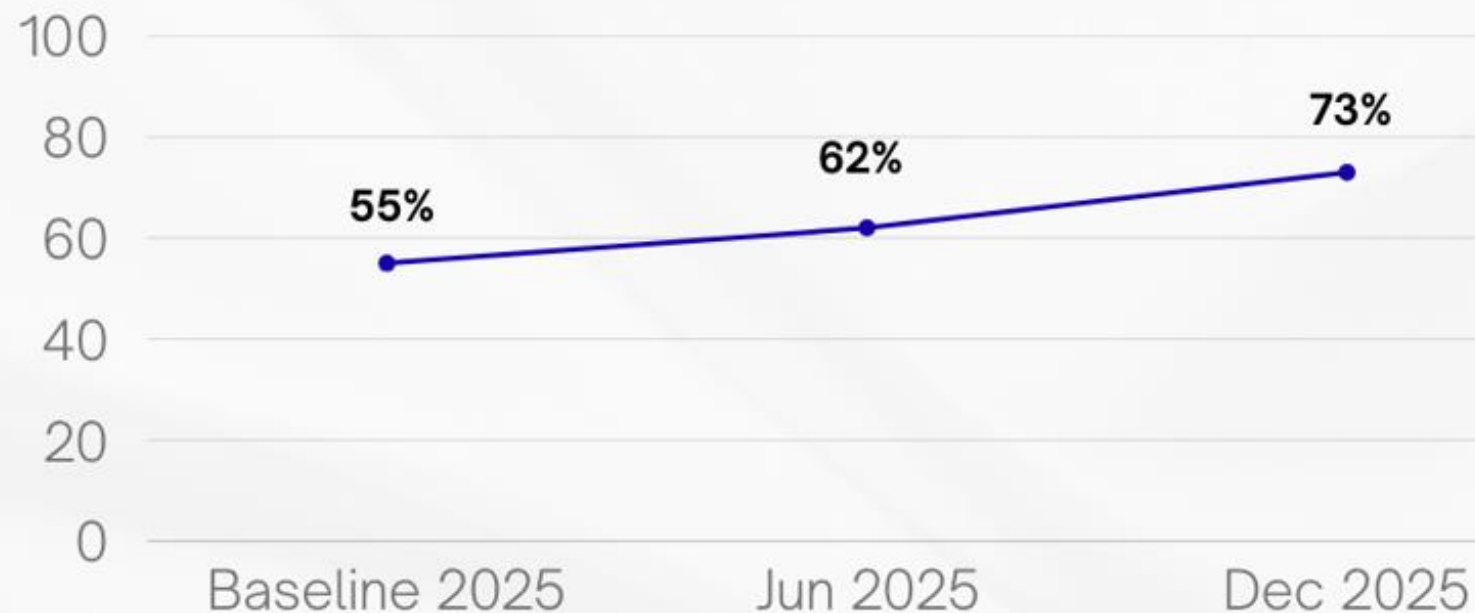
■ N/A

*N/A means no patient met criteria

Timely Treatment at 90% or Higher



Average Percent of Patients that were Treated within 60 Minutes



*Timely Treatment data was reported by 30 out of 39 facilities.

*Based on 30 reporting hospitals 25 had patients that met the criteria.

Maternal Mental Health Needs/Protocols

KANSAS CONNECTING COMMUNITIES



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



**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.

Connect with us!



1-800-332-6262



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.

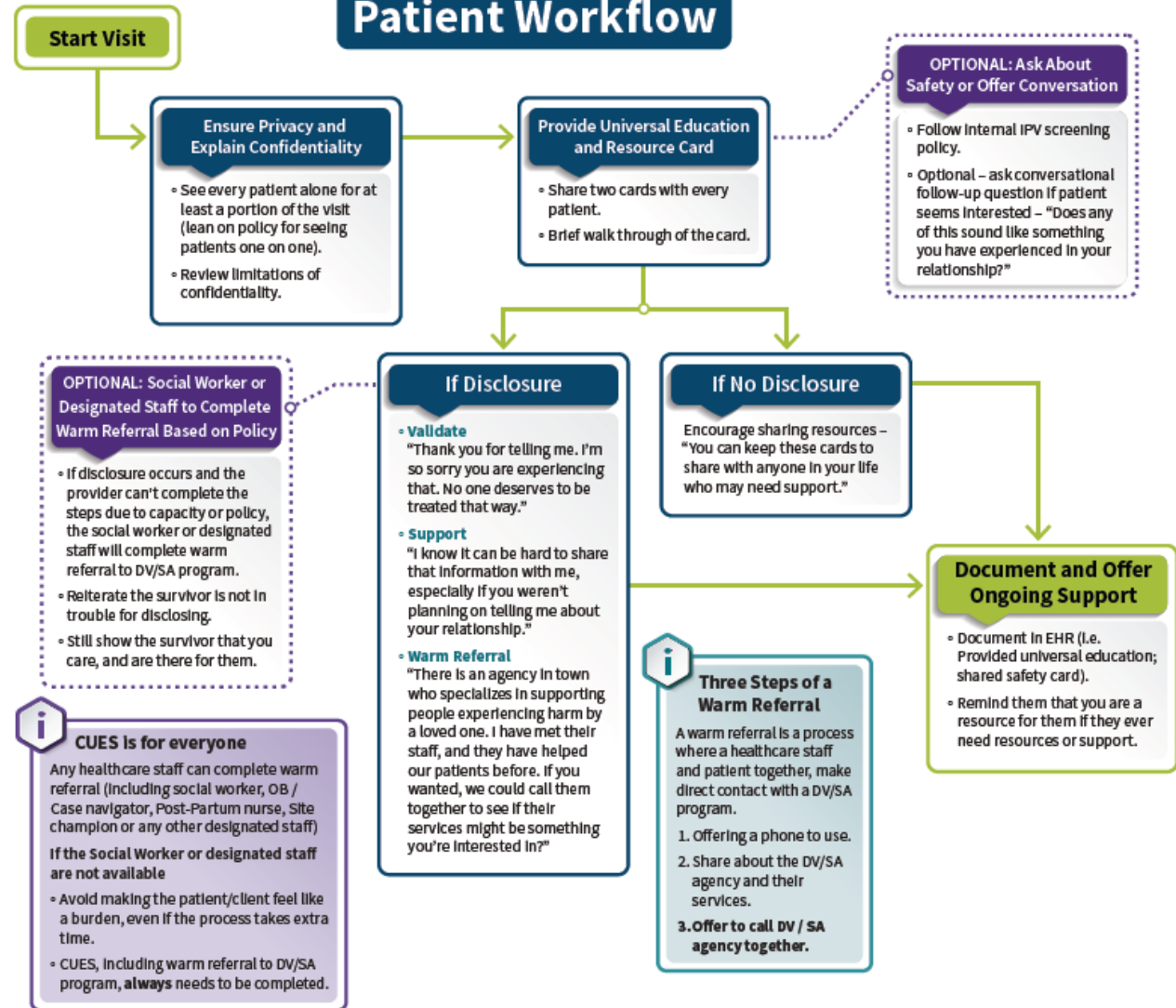
This agreement is made by and between _____ and _____ to promote health and safety outcomes for patients/clients who have experienced domestic/sexual violence. The purpose of this work is to strengthen collaboration between staff from both entities and promote bidirectional warm referrals for patients/clients 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.



Patient Workflow



IPV updates: Best practice model McPherson! Jacquie!

- The staff screen all patients on admission as they take them to the restroom to assist in changing clothes and review instructions for obtaining a UA. It gives us the best opportunity to ask those questions. If there is a positive screen, that is brought to the attention of me or the House Supervisor. At this time, we have no formal referral resource list, BUT we are working on the following process which works well with our IPV screening.
- Facility wide, we are beginning the process of screening all patients for any possible victims of Human Trafficking. All hospital staff are completing education on Human Trafficking. We are implementing a “gray folder” which will include a checklist of what to do if we have someone disclose they are being trafficked. The folder will also contain the cards that Hannah presented at CUES training. The gray folder will mean nothing to the patient or their partner. In fact, they may not even see it. It’s more of a clue word so that if we have a victim, I can call another department (think radiology or lab) and let them know we have a patient who needs the gray folder. That triggers the response for that department to alert the House Supervisor of the situation. We will then create a reason for the patient to need to leave the unit (ultrasound, CT, x ray, labs) where the support person cannot accompany the patient. This, in theory, will get the patient to a safe spot to determine a plan (if they want us to disclose to law enforcement, etc.). On OB, we are lucky in that we are a locked unit. If we have any idea or we get a phone call about the gray folder being needed, we can get the patient behind our locked doors while asking the partner to remain in the waiting room outside the unit while we get the patient “settled”.
- While the IPV victim may not be the same as a human trafficking victim, the process can be very much the same. Get the patient to a safe place or remove the support person, determine what the patient wants, and work with law enforcement or other agencies to determine a resolution. It’s hard to imagine someone not wanting help in either situation but staff will need to be ready for that to happen because it will. No matter what, in any of these situations, we will try to provide the CUES card so they have something. The ER is also creating a pen where the resource will be inside that pen but it looks just like a pen.

2026 KPQC Meeting Dates

KPQC Spring Workday

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

KPQC Learning Forums

- 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 TBD
- 10/27/26 TBD
- 11/24/26 12:00-1:00 (virtual):
<https://us02web.zoom.us/meeting/register/tZAkfuqhqTgqH9f7RnFy6H0Nph0CaKqXNT4N>

Next Learning Forum

All of KPQC! June 2026 TMaH Grant and how it works for KANSAS

