Welcome!

Maternal Mortality:
Who's at the Table of Change?

A Conference Sponsored Collaboratively by:

KPQC
Kansas Perinatal Quality Collaborative

AWHONN
KANSAS
PROMOTING THE HEALTH OF WOMEN AND NEWBORNS

Friday, October 20, 2023

KPQC

Kansas Perinatal Quality Collaborative

KPQC & KDHE

Jill Nelson, **KDHE** Maternal & Perinatal Initiatives Consultant
Terrah Stroda, **KPQC** Maternal QI Co-Coordinator
Kari Smith, **KPQC** Maternal QI Co-Coordinator

Jill Nelson

Jill Nelson is the Maternal and Perinatal Initiatives Consultant in the Bureau of Family Health at KDHE. In this role, she coordinates and oversees the Kansas Maternal Mortality Review Committee (KMMRC) and the Kansas Perinatal Quality Collaborative (KPQC). Jill joined KDHE after 8 years at the local level where she helped to build and lead *Delivering Change: Healthy Families-Healthy Communities,* a Kansas perinatal community collaborative, in Junction City/Geary County. A SIDS parent, Jill holds a deep passion and interest in improving the health of mothers, infants and families in the state of Kansas. Jill has a bachelor's degree from Kansas State University. She and her husband, David, are parents to Isabelle, Kael, Emmalynne, and the late Luke Nelson.

Terrah Stroda, CNM

Terrah Stroda is a full scope Certified Nurse Midwife in practice at Stormont Vail Flinthills in Junction City, KS, now in her twentieth year of full scope maternal health services. In 2010, as part of a community collaborative response to the adverse maternal outcomes found there, she became the co-founder & Medical Director of Delivering Change: Healthy Families-Healthy Communities. Delivering Change was able to cut infant mortality in half in under five years, by significantly impacting maternal health care in that region.

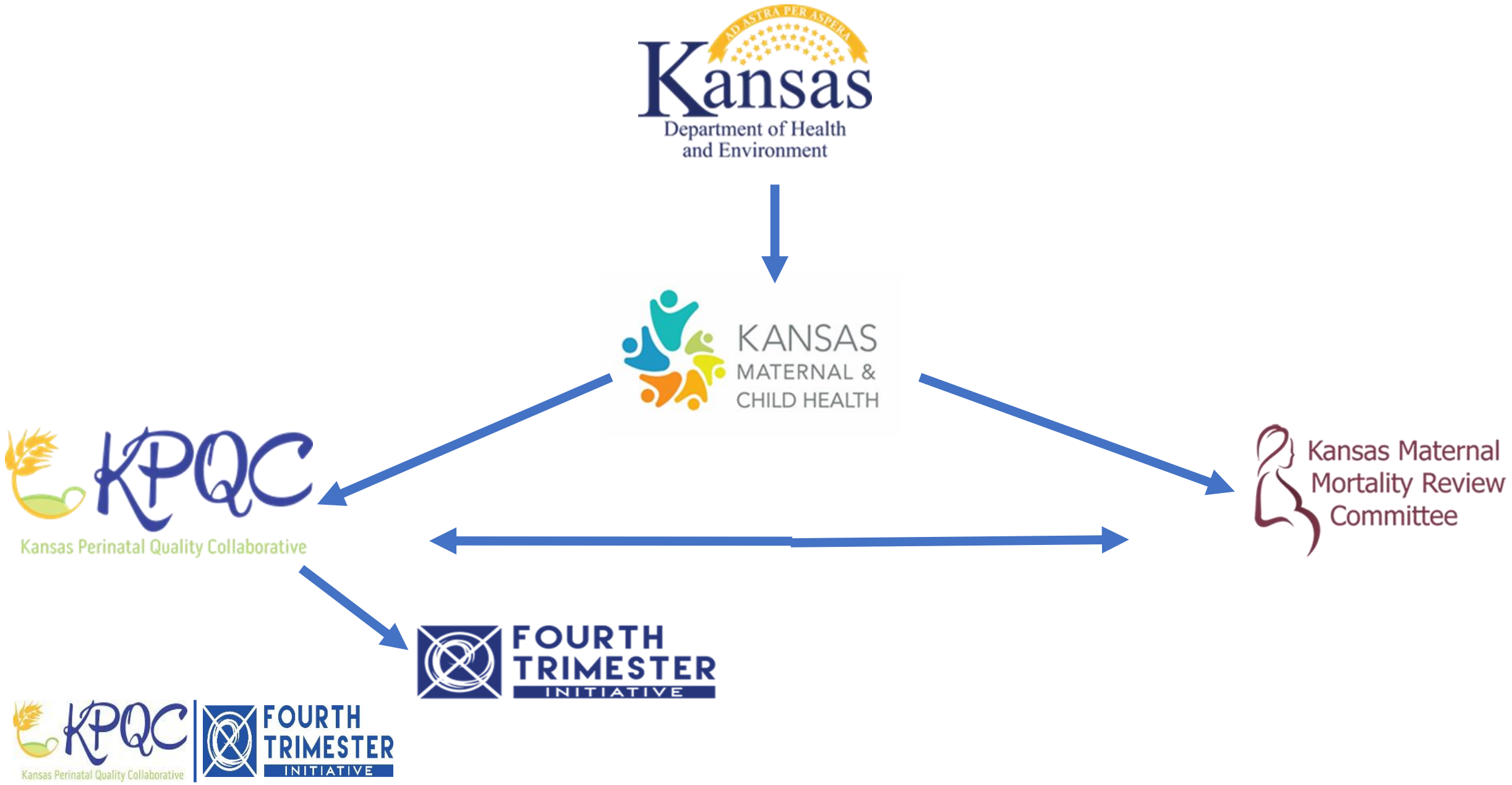
Terrah's passion for quality improvement in maternal health didn't stop there, as she became the Maternal QI Coordinator for the KS Perinatal Quality Collaborative and KS Dept of Health & Environment in 2020, targeting maternal adverse outcomes throughout the state.

When she's not delivering babies or connecting hospitals with best practice models across the state, Terrah enjoys running and embarrassing her two teenage boys, Braedon and Braxton.

Kari Smith, RN, RNC-OB, C-EFM

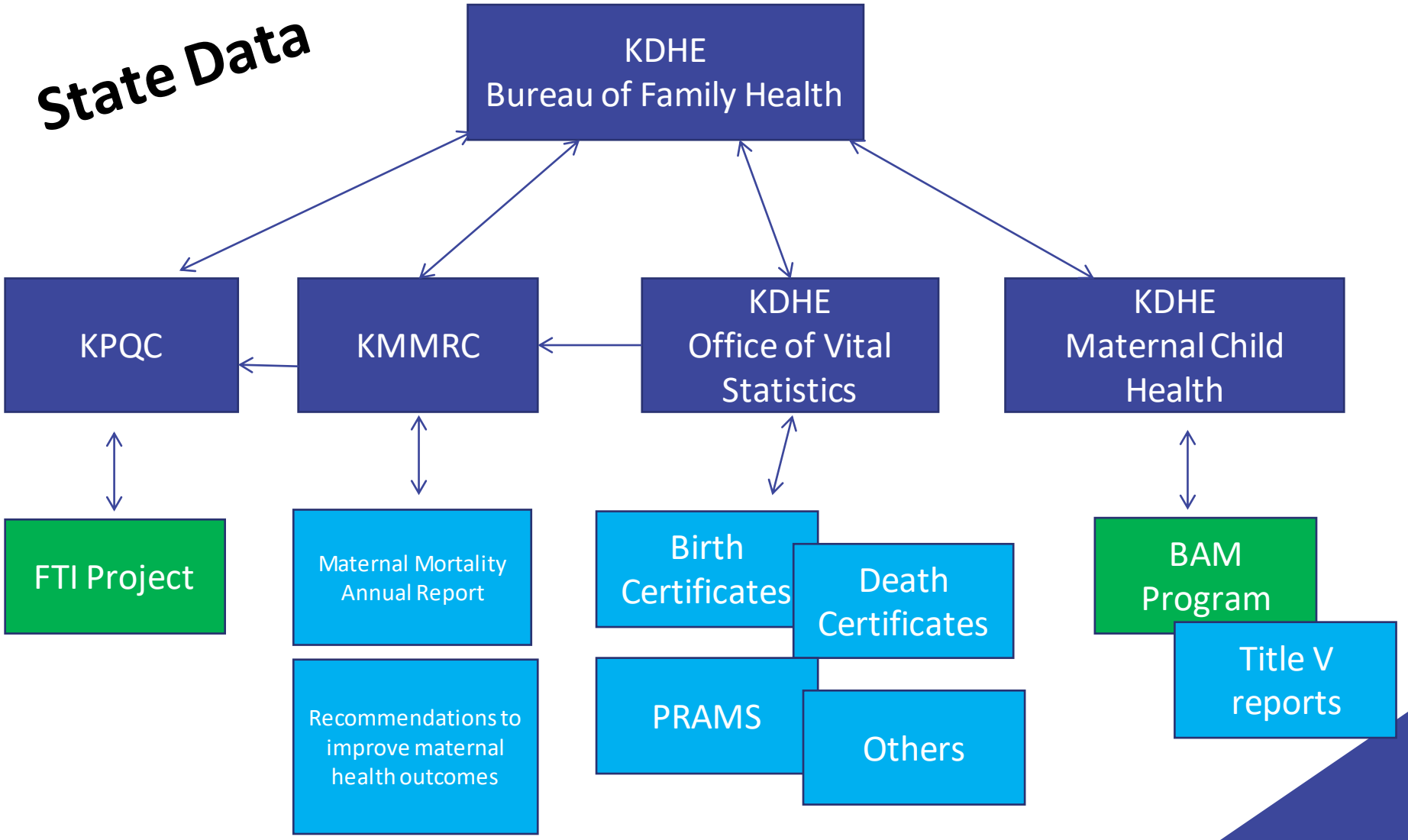
Kari has spent the past seven years as a Clinical Nurse Educator at Advent Health Shawnee Mission. Her passion for health education started during her undergraduate time at Clemson University where she received her Bachelor of Science in Health Science and Public Health Education. She went on to obtain additional degrees from Johnson County Community College (ADN), University of St. Mary (BSN), and her Master of Science in Nursing Education from Oklahoma Wesleyan.

Over the years Kari has lead nursing students in and out of the clinical settings as an Adjunct Professor for Rockhurst University, Research College of Nursing, as well as Johnson County Community College. She supervised students during OB Clinicals and has taken multiple groups to Gulu, Uganda. While in Uganda, Kari educated these students along with their Ugandan colleagues on critical initiatives including Postpartum Hemorrhage and Helping Babies Breathe, as well as facilitated simulations. Kari is nationally certified in both Inpatient Obstetric Nursing and Electronic Fetal Monitoring. She is an AWHONN Intermediate and Advanced Fetal Heart Monitoring Instructor and has been published in the *Journal for Nurses in Professional Development* for her advanced work in development of nursing simulations in obstetric sepsis. Kari also currently co-chairs the AWHONN Kansas City chapter.


Kansas
Department of Health and Environment
KANSAS MATERNAL & CHILD HEALTH
KPQC
Kansas Perinatal Quality Collaborative
Kansas Maternal Mortality Review Committee
FOURTH TRIMESTER INITIATIVE

What triggered our work?

State Data


KDHE
Bureau of Family Health
KPQC
KMMRC
KDHE
Office of Vital
Statistics
KDHE
Maternal Child
Health
FTI Project
Maternal Mortality
Annual Report
Recommendations to
improve maternal
health outcomes
Birth
Certificates
Death
Certificates
PRAMS
Others
BAM
Program
Title V
reports

2021 Data

(Annual Summary of Vital Statistics)

Live Births: **34,697**

Stillbirths: 194

Total Births: **34,891**

3,933 abortions

Maternal Deaths: 37 (2017-2021)
MCHB Federally Available Data

Rapid Response: Kansas Data Update

Table 22. Number of Births Where Reported Medical Risk Factors by Population Group, Kansas, 2021*

Medical Risk Factors†	Population Group: White NH		Black NH		American Indian-Alaska Native NH		Asian-PI NH		Multi Race-Other NH		Hispanic-Any Race		n.s.‡		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Pre-pregnancy Diabetes	214	0.9	44	1.9	1	0.6	17	1.6	10	1.0	79	1.3	0	0.0	365	1.1
Gestational Diabetes	1,967	8.2	171	7.5	22	12.2	191	17.7	82	8.3	654	10.7	4	4.5	3,091	8.9
Pre-pregnancy Hypertension	574	2.4	99	4.3	4	2.2	14	1.3	16	1.6	129	2.1	1	1.1	837	2.4
Pre-eclampsia	2,345	9.8	240	10.5	8	4.4	60	5.6	88	8.9	443	7.2	2	2.3	3,186	9.2
Eclampsia	67	0.3	3	0.1	0	0.0	1	0.1	0	0.0	17	0.3	1	1.1	89	0.3
Previous Pre-term Birth	622	2.6	123	5.4	6	3.3	31	2.9	32	3.2	190	3.1	1	1.1	1,005	2.9
Previous Poor Pregnancy Outcome	915	3.8	135	5.9	7	3.9	43	4.0	43	4.3	260	4.3	1	1.1	1,404	4.0
Vaginal Bleeding	207	0.9	26	1.1	1	0.6	7	0.6	9	0.9	53	0.9	0	0	303	0.9
Previous C-Section	3,678	15.3	416	18.2	31	17.2	165	15.3	147	14.8	964	15.8	14	15.9	5,415	15.6
Infertility Treatment	568	2.4	18	0.8	2	1.1	36	3.3	14	1.4	40	0.7	2	2.3	680	2.0
Infections Contracted or Treated During Pregnancy§	855	3.6	203	8.9	14	7.8	41	3.8	66	6.7	270	4.4	2	2.3	1,451	4.2
Smoking During Pregnancy	1,893	7.9	223	9.8	30	16.7	13	1.2	68	6.9	162	2.6	4	4.5	2,393	6.9
Alcohol Use During Pregnancy	20	0.1	2	0.1	0	0.0	2	0.2	3	0.3	6	0.1	0	0.0	33	0.1
Total of Medical Risk Factors	13,925	n/a¶	1,703	n/a¶	126	n/a¶	621	n/a¶	578	n/a¶	3,267	n/a¶	32	n/a¶	20,252	n/a¶
Total Births	23,965		2,280		180		1,080		990		6,114		88		34,697	

*Residence data

†More than one medical risk factor may have been reported for a birth. Therefore, actual number of births maybe lower than totals.

‡n.s. = not stated

§Infections include: Gonorrhea, Syphilis, Herpes Simplex Virus, Chlamydia, HIV, Hepatitis B & Hepatitis C

58%

KPQC Kansas Perinatal Quality Collaborative

FOURTH TRIMESTER INITIATIVE

The Role of the MMRC

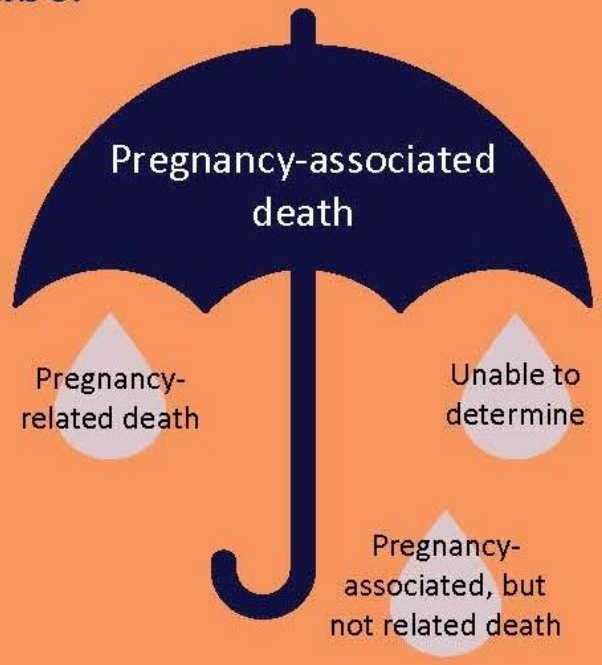
	CDC – National Center for Health Statistics (NCHS)	CDC – Pregnancy Mortality Surveillance System (PMSS)	Maternal Mortality Review Committees
Data Source	Death certificates	Death certificates linked to fetal death and birth certificates	Death certificates linked to **fetal death and birth certificates, 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 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]

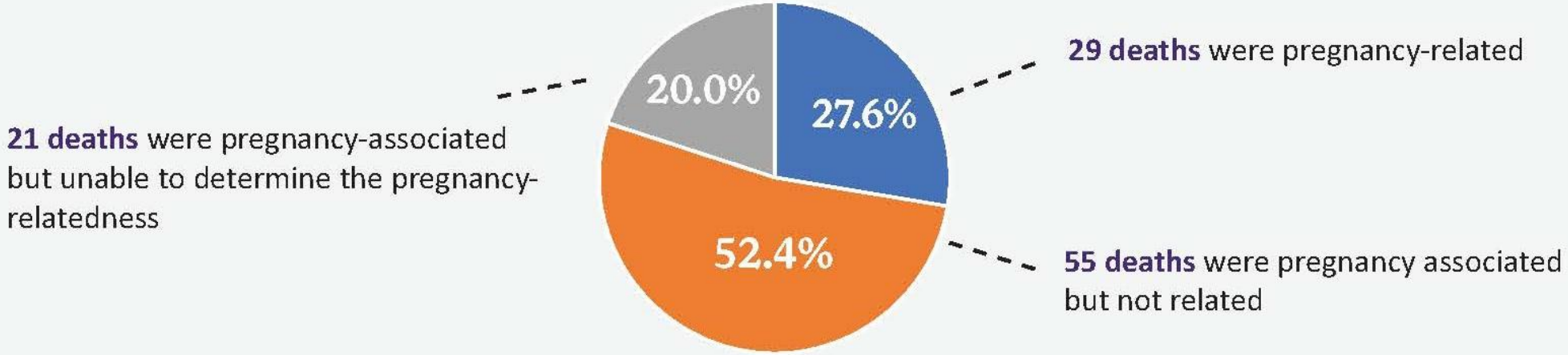
- **Pregnancy-related death.** The death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.
- **Pregnancy-associated, but 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.

KPQC Kansas Perinatal Quality Collaborative | FOURTH TRIMESTER INITIATIVE

Pregnancy Associated Deaths



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

KPQC Kansas Perinatal Quality Collaborative | FOURTH TRIMESTER INITIATIVE

Source: KMMRC Determinations, Kansas, 2016-2020 (Preliminary Data, Subject To Change)

Pregnancy Associated Deaths
Kansas, 2016-2020
(Preliminary Data, Subject to Change)

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).

Source: Kansas Maternal Mortality Review Committee

KPQC Kansas Perinatal Quality Collaborative | FOURTH TRIMESTER INITIATIVE

Pregnancy Associated Deaths

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.

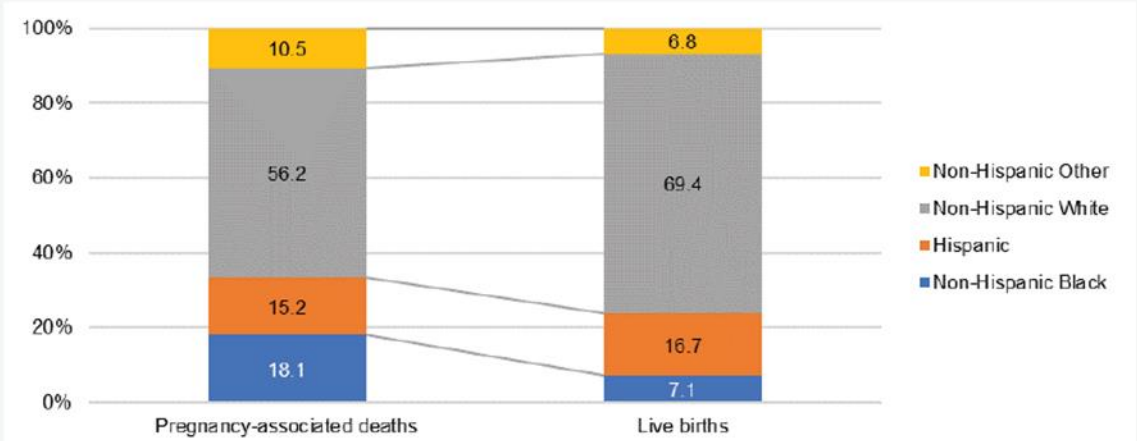


Figure 1

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)*

KPQC Kansas Perinatal Quality Collaborative | FOURTH TRIMESTER INITIATIVE

Source: KMMRC Determinations, Kansas, 2016-2020, (Preliminary Data, Subject To Change)

Pregnancy Associated Deaths

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

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

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

KPQC Kansas Perinatal Quality Collaborative | FOURTH TRIMESTER INITIATIVE

Source: KMMRC Determinations, Kansas, 2016-2020, (Preliminary Data, Subject To Change) **N=105**

Pregnancy Associated Deaths

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%

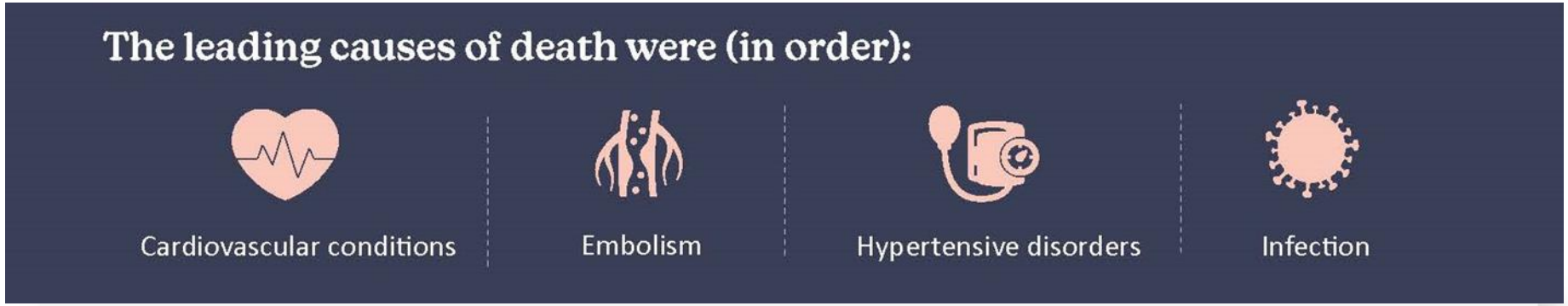
Substance Use Disorder
contributed to 26.7%

- 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%).

KPQC Kansas Perinatal Quality Collaborative | FOURTH TRIMESTER INITIATIVE

Source: Contributing Factors, Kansas, 2016-2020, (Preliminary Data, Subject To Change)

Pregnancy Related Deaths



KMMRC determinations on circumstances surrounding death were:

- **Obesity contributed to two in three deaths** (18 deaths, including 1 probably contributed, 62.1%).
- **Discrimination* contributed to about one in four deaths** (4 deaths, including all 4 probably contributed, 23.5%). *All deaths reviewed afer May 29, 2020.
- **Mental health conditions contributed to about one in six deaths** (5 deaths, 17.2%).
- **Substance use disorder contributed to one in four deaths** (8 deaths, 27.6%).

KPQC Kansas Perinatal Quality Collaborative | FOURTH TRIMESTER INITIATIVE

Source: KMMRC Determinations, Kansas, 2016-2020 (Preliminary Data, Subject To Change)

Pregnancy Related Deaths

Racial and ethnic minorities were disproportionately affected. Approximately two-thirds (18 deaths, 62.1%) of the women were racial and ethnic minorities and 11 (37.9%) were non-Hispanic White women.

- Most deaths (24 deaths, 82.8%) occurred between the ages of 25 and 39 years.
- More than half (16 deaths, 55.2 %) of the women had either completed high school or general educational development (GED), or had less education than high school.
- Just over a third (11 deaths, 37.9 %) of the women had private insurance, while the other 62.1% had

Medicaid, no insurance or unknown insurance status

KPQC Kansas Perinatal Quality Collaborative | FOURTH TRIMESTER INITIATIVE

Source: KMMRC Determinations, Kansas, 2016-2020 (Preliminary Data, Subject To Change)

Key KMMRC Recommendations

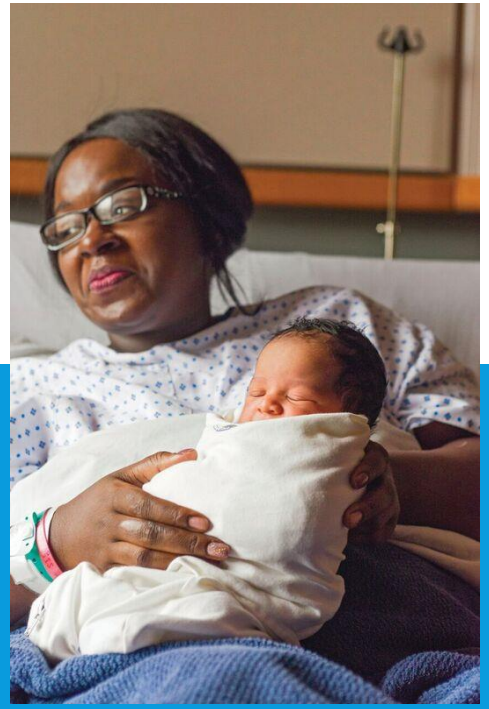
Based on 23 preventable pregnancy-related deaths, recommendations are as follows*:*

- **Patient education and empowerment**
- **Screen, brief intervention and referrals to treatment** (SBIRT) for:
  - **Comorbidities and chronic illness**
  - Intimate partner violence
  - Pregnancy intention
  - Mental health conditions (including postpartum anxiety and depression)
  - Substance use disorder - alcohol, illicit or prescription drugs
  - Social Determinants of Health
- Better **communication and multi-disciplinary collaboration** between providers, including referrals

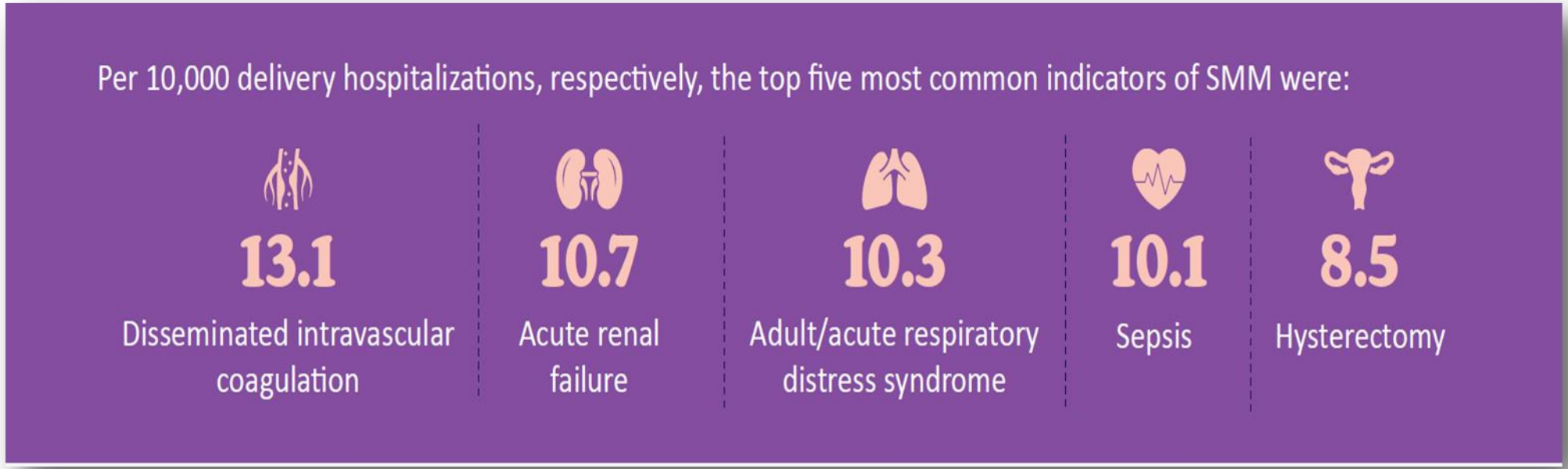
Source: Kansas Maternal Mortality Review Committee Report, 2016-2020, (Preliminary Data, Subject To Change)

KPQC Kansas Perinatal Quality Collaborative | FOURTH TRIMESTER INITIATIVE

“NEAR MISSES”



Severe Maternal **Morbidity**



Source: Kansas Department of Health and Environment, Kansas Hospital Discharge Data, Kansas, 2016-2020, (Preliminary Data, Subject To Change).

KPQC Kansas Perinatal Quality Collaborative | FOURTH TRIMESTER INITIATIVE

Severe Maternal **Morbidity**

- Severe maternal morbidity rate was highest among women aged *40+ years* and lowest for those aged 25-29 years.
- The rate of severe maternal morbidity was **83.5%** higher for non-Hispanic Blacks than for non-Hispanic Whites.
- Compared with other deliveries, *those involving severe maternal morbidity were more likely paid by Medicaid* and from *lower-income communities.*

Source: Kansas Department of Health and Environment, Kansas Hospital Discharge Data, Kansas, 2016-2020, (Preliminary Data, Subject To Change).

KPQC Kansas Perinatal Quality Collaborative | FOURTH TRIMESTER INITIATIVE

JAMA: Maternal Mortality & SMM in the United States, 2008-2021 (*In-hospital)

Maternal *Comorbid* Conditions

- Obesity (91.0 per 1000 discharges), gestational diabetes (74.3 per 1000 discharges), and tobacco use (58.2 per 1000 discharges) were the most common comorbidities, followed by gestational hypertension, asthma, preeclampsia, preexisting hypertension, and substance use disorder

Prevalence and Trend of SMMs

Adjusted prevalence of any SMM increased from Q1 2008 (146.8 per 10 000 discharges) to Q4 2021 (179.8 per 10 000 discharges). The increasing trend was observed in all age groups with the greatest change observed in patients aged 45 years or older and those aged 10 to 19 years (Figure 1B). Consistent increasing trend was also observed in all racial and ethnic groups, with the biggest increase observed among Pacific Islander patients

KPQC Kansas Perinatal Quality Collaborative | FOURTH TRIMESTER INITIATIVE

JAMA: Maternal Mortality & SMM in the United States, 2008-2021 (*In-hospital)

This cross-sectional study examined rates of delivery-related in-hospital maternal mortality and SMM in a large national inpatient database. In this sample encompassing more than 11 million inpatient discharges delivery-related in-hospital mortality was found to decrease significantly over a period of 14 years. The adjusted mortality per 100 000 discharges decreased by more than 50% from Q1 of 2008 to Q4 of 2021, likely demonstrating the impact of national strategies focused on improving the maternal quality of care provided by the hospitals during delivery-related hospitalizations. In contrast, the rates of overall SMM increased over time for the overall population, which may be attributable to preexisting conditions and the increasing trend in the age of delivering patients in the past decade. The increasing trend of adjusted SMM rates was seen in all racial and ethnic minority groups and was most prominent in Asian, American Indian, and Pacific Islander patients.

KMMRC (2019):

"A review of Kansas maternal deaths has determined that the majority of deaths occur between the time immediately after birth and the end of the 1st year"

"Seatbelts" was never really the story

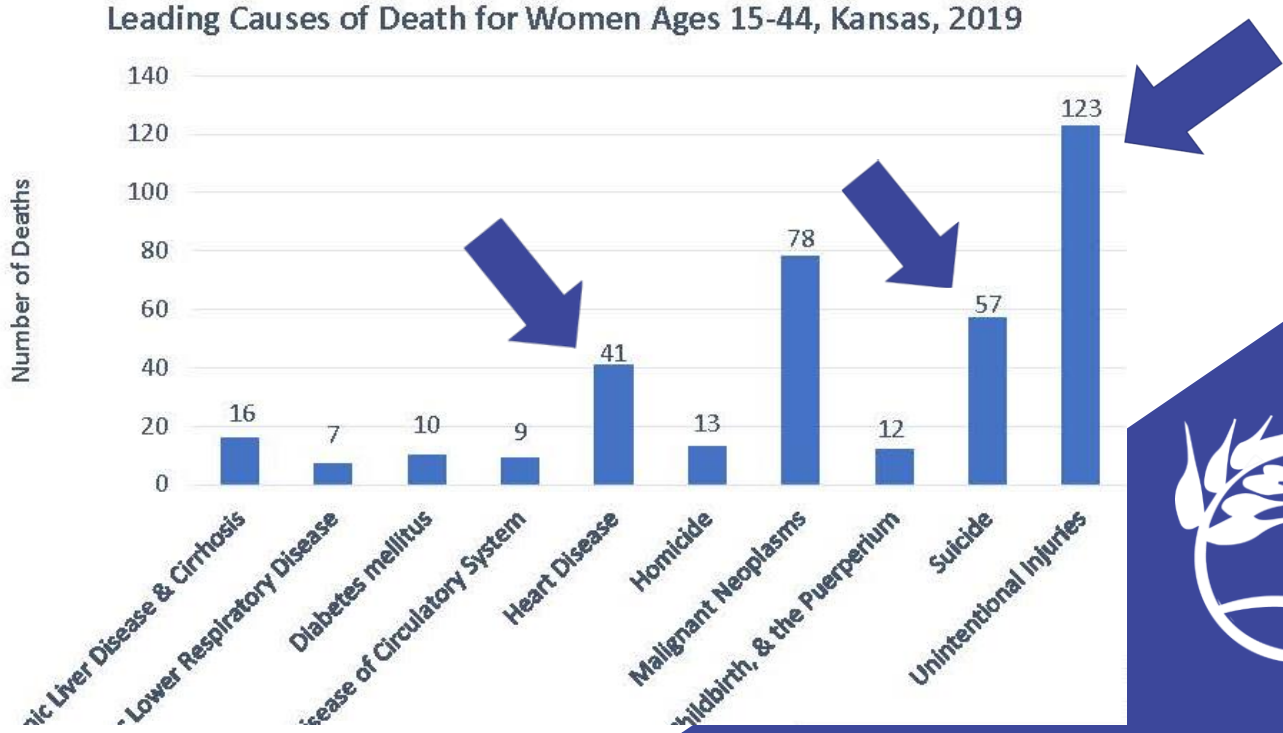
KMMRC determinations on circumstances surrounding death were:

Obesity	*Discrimination	Mental Health Conditions	Substance Use Disorder
contributed to 23.8%	contributed to 7.4%	contributed to 22.9%	contributed to 26.7%

*All deaths reviewed after May 29, 2020

- 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%).

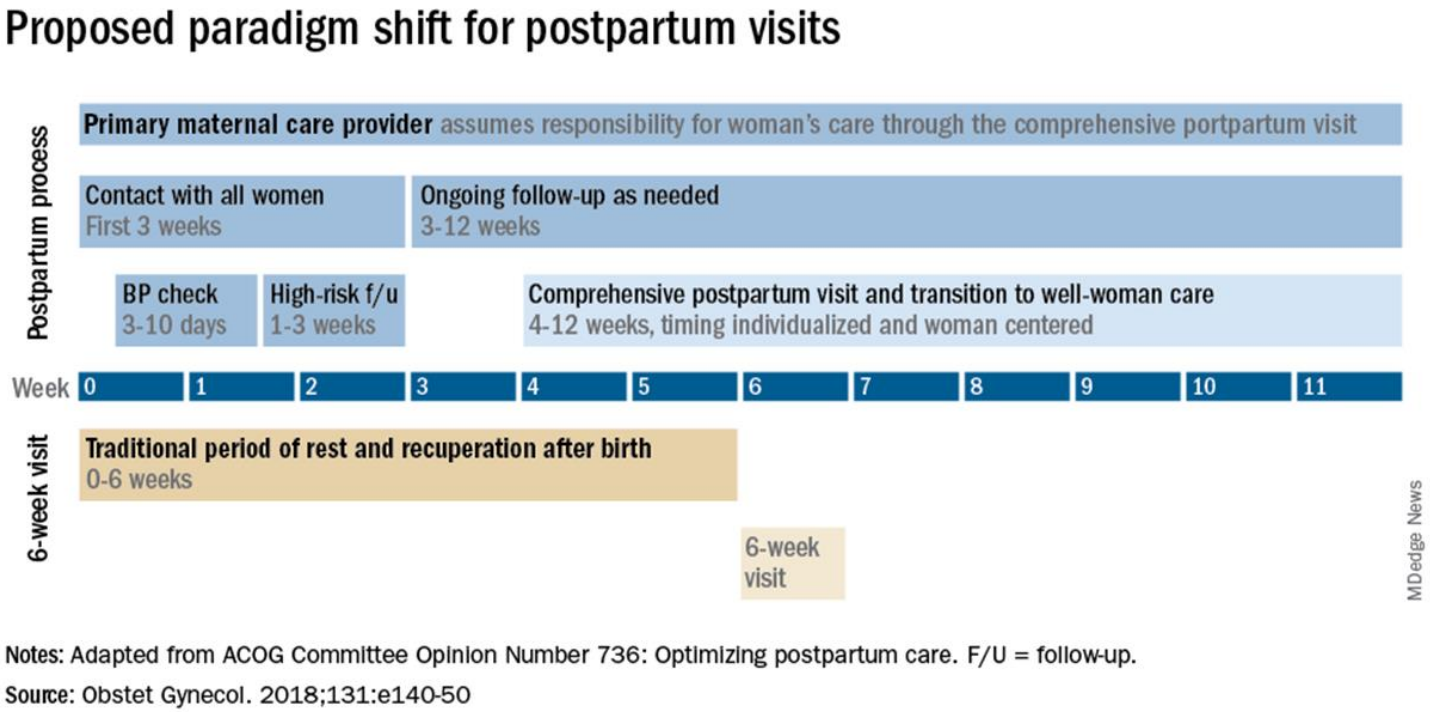
KMMRC Data (2019)



ACOG Committee Opinion "Optimizing Postpartum Care" (2018)

The Fourth Trimester

- Ongoing Process, not single encounter
  - 3 weeks, 6 weeks minimum, no later than 12 wks
  - 12 weeks: comprehensive well woman exam
- Counseling regarding chronic disease
- Stillbirth, neonatal deaths included
- Reimbursement policy change required
- Prenatal care is where PP care starts



Notes: Adapted from ACOG Committee Opinion Number 736: Optimizing postpartum care. F/U = follow-up.

Source: Obstet Gynecol. 2018;131:e140-50

FOURTH TRIMESTER INITIATIVE

a *cutting edge approach* to study and improve the experience of our mothers and families in Kansas.

GOAL: Forever change the care provided to women immediately after delivery and extending through the vital first year after birth in Kansas. (2020)

"Mom Plan"

+

The Postpartum Care Team

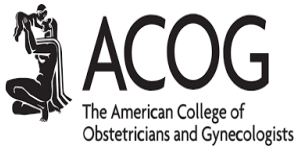
=

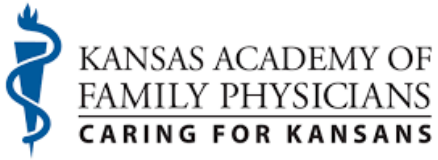
Healthy Moms

Kansas Perinatal Quality Collaborative

FOURTH TRIMESTER INITIATIVE

Stakeholders at the table





FTI Overview

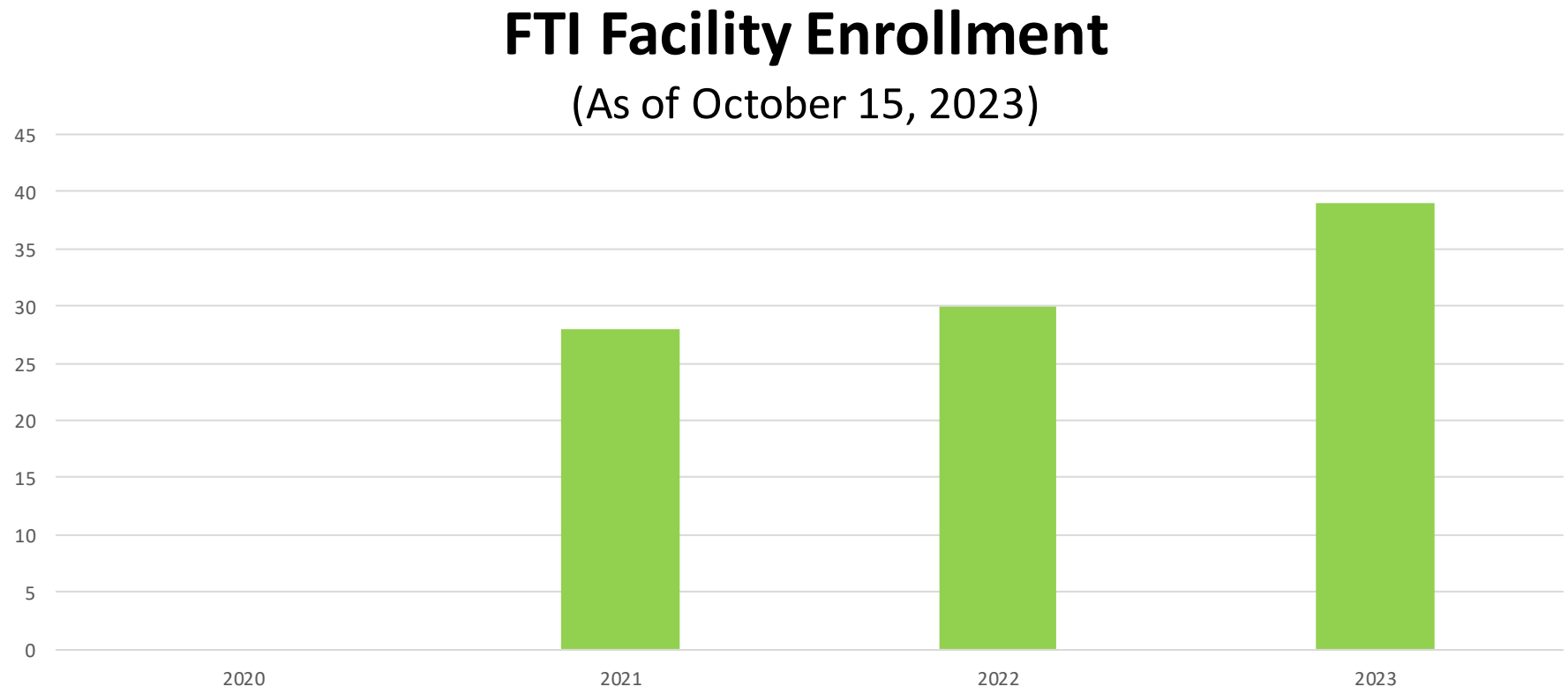
2021

- Hospitals & Birth Centers start **FTI Enrollment**
- October: Enrollment in **AIM Bundle**- Postpartum Transitions
  https://safehealthcareforeverywoman.org/aim/patient-safety-bundles/maternal-safety-bundles/postpartum-discharge-transition

Postpartum Discharge Transition
Bundle-In Development

Kansas Perinatal Quality Collaborative

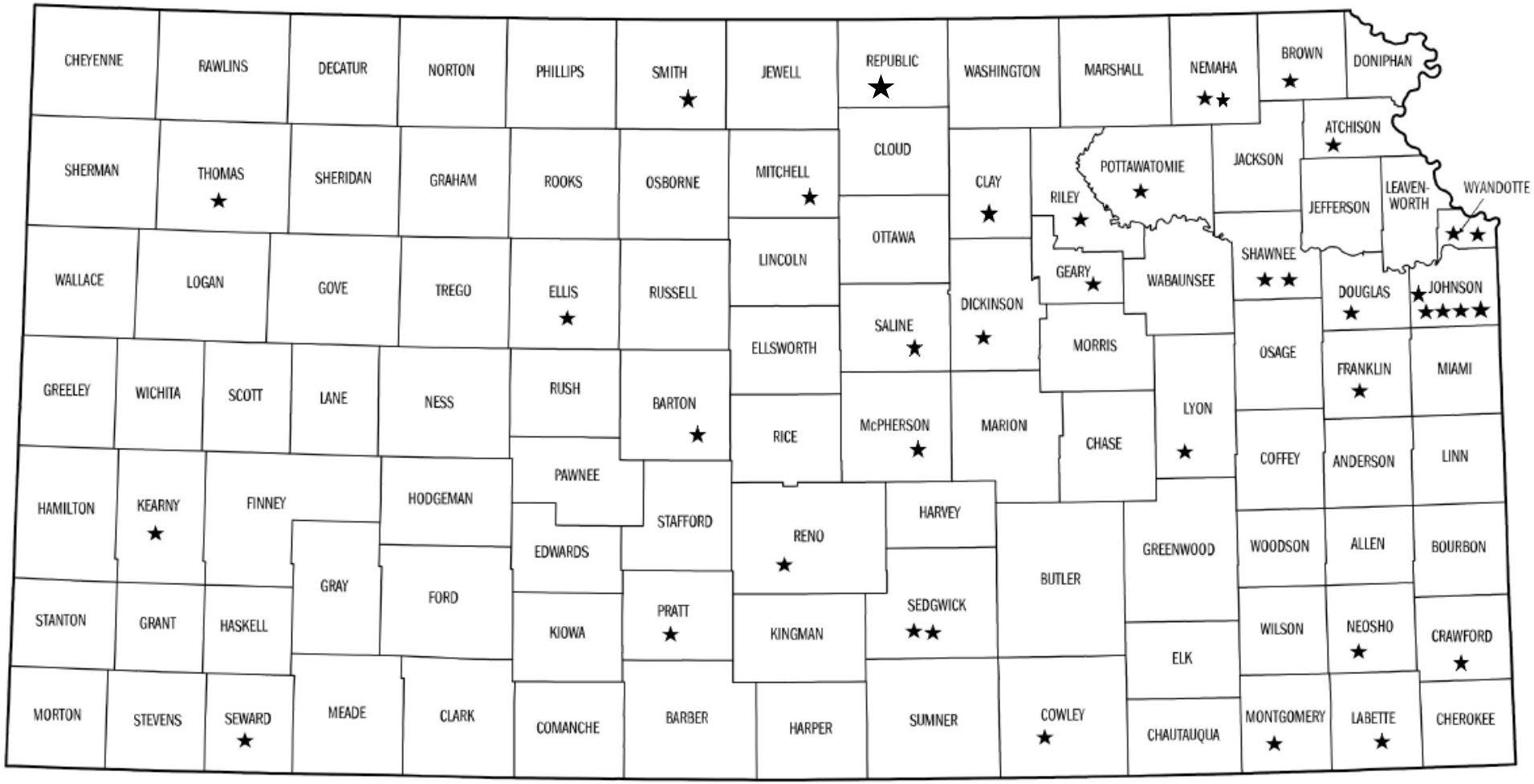
Fourth Trimester Initiative



Kansas Perinatal Quality Collaborative

FOURTH TRIMESTER INITIATIVE

Enrolled FTI Sites = Impact 90% of Kansas Births!



KPQC Kansas Perinatal Quality Collaborative

FOURTH TRIMESTER INITIATIVE

Facilities:

AdventHealth Ottawa, Franklin Co.
AdventHealth Shawnee Mission, Johnson Co.
AdventHealth South Overland Park, Johnson Co.
Amberwell Atchison, Atchison Co.
Amberwell Hiawatha Community Hospital, Brown Co.
Ascension Via Christi Manhattan, Riley Co.
Ascension Via Christi St. Joseph, Sedgwick Co.
Ascension Via Christi Pittsburg, Crawford Co.
Citizens Medical Center, Thomas Co.
Clay County Medical Center, Clay Co.
Coffeyville Regional Medical Center, Montgomery Co.
Community Healthcare System, Pottawatomie Co.
Hays Medical Center, Ellis Co.
Hutchinson Regional Medical Center, Reno Co.
Kearny County Hospital, Kearny Co.
Labette Health, Labette Co.
Lawrence Memorial Hospital, Douglas Co.
McPherson Center for Health, McPherson Co.
Memorial Health System, Dickinson Co.
Mitchell County Hospital Health System, Mitchell Co.
Nemaha Valley Community Hospital, Nemaha Co.
Neosho Memorial Regional Medical, Neosho Co.
Newman Regional Health, Lyon Co.
Olathe Medical Center, Johnson Co.
Overland Park Regional Medical Center, Johnson Co.

Facilities:

Pratt Regional Medical Center, Pratt Co.
Providence Medical Center, Wyandotte Co.
Republic County Hospital, Republic Co.
Sabetha Community Hospital, Nemaha Co.
Salina Regional Health Center, Saline Co.
Smith County Memorial Hospital, Smith Co.
Southwest Medical Center, Seward Co.
Stormont Vail Health Flint Hills, Geary Co.
Stormont Vail Health, Shawnee Co.
University of KS Health System Great Bend, Barton Co.
University of KS Health System KC, Wyandotte Co.
University of KS Health System St. Francis, Shawnee Co.
Wesley Medical Center, Sedgwick Co.

Birth Centers:

New Birth Company Overland Park, Johnson Co.
Sunflower Birth & Family Wellness, Cowley Co.

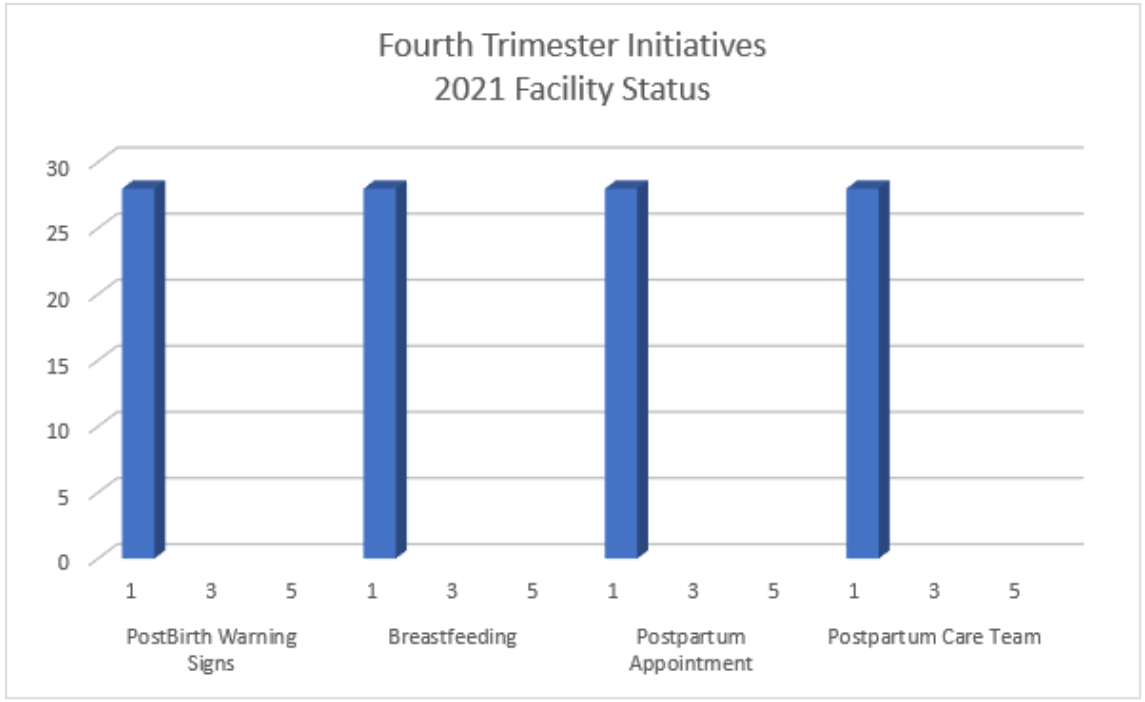
FOURTH TRIMESTER INITIATIVE

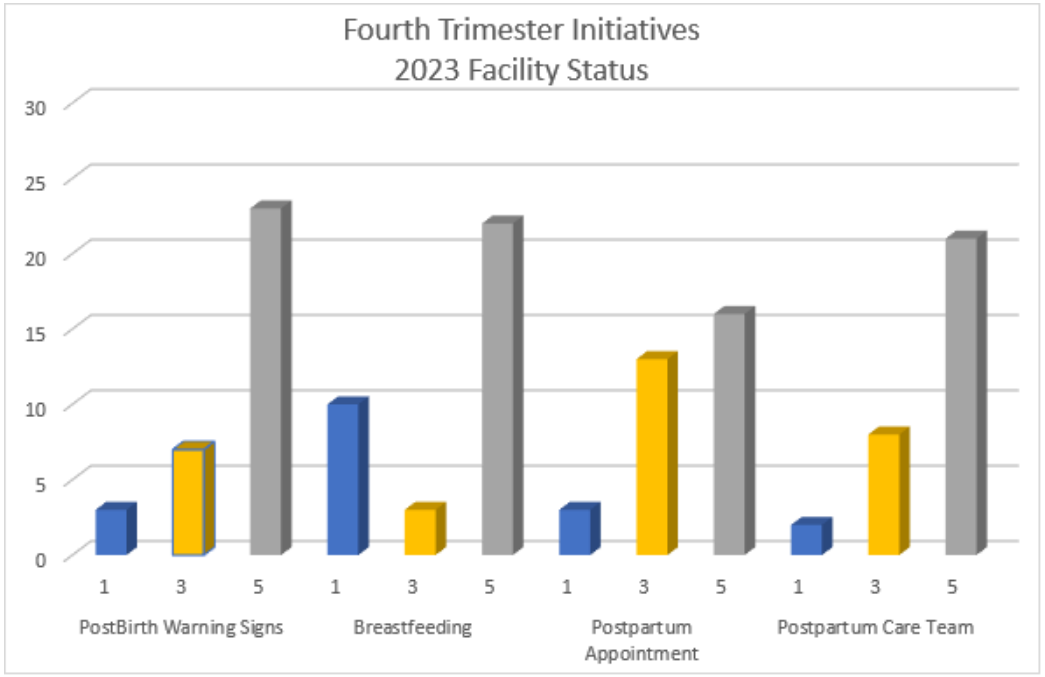
Postpartum Discharge Transition Bundle-In Development

Fourth Trimester Projects

KPQC Kansas Perinatal Quality Collaborative | FOURTH TRIMESTER INITIATIVE

AIM Enrollment: Project Start vs Now

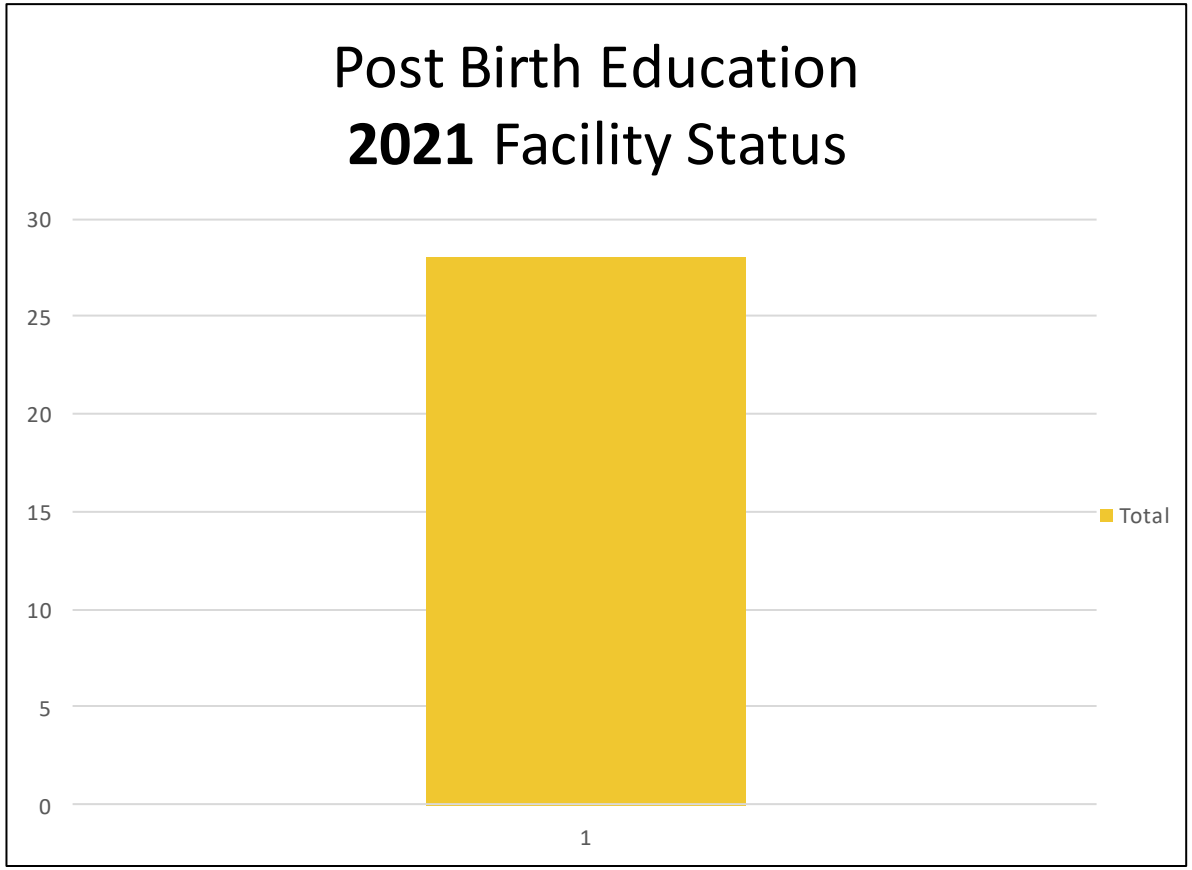


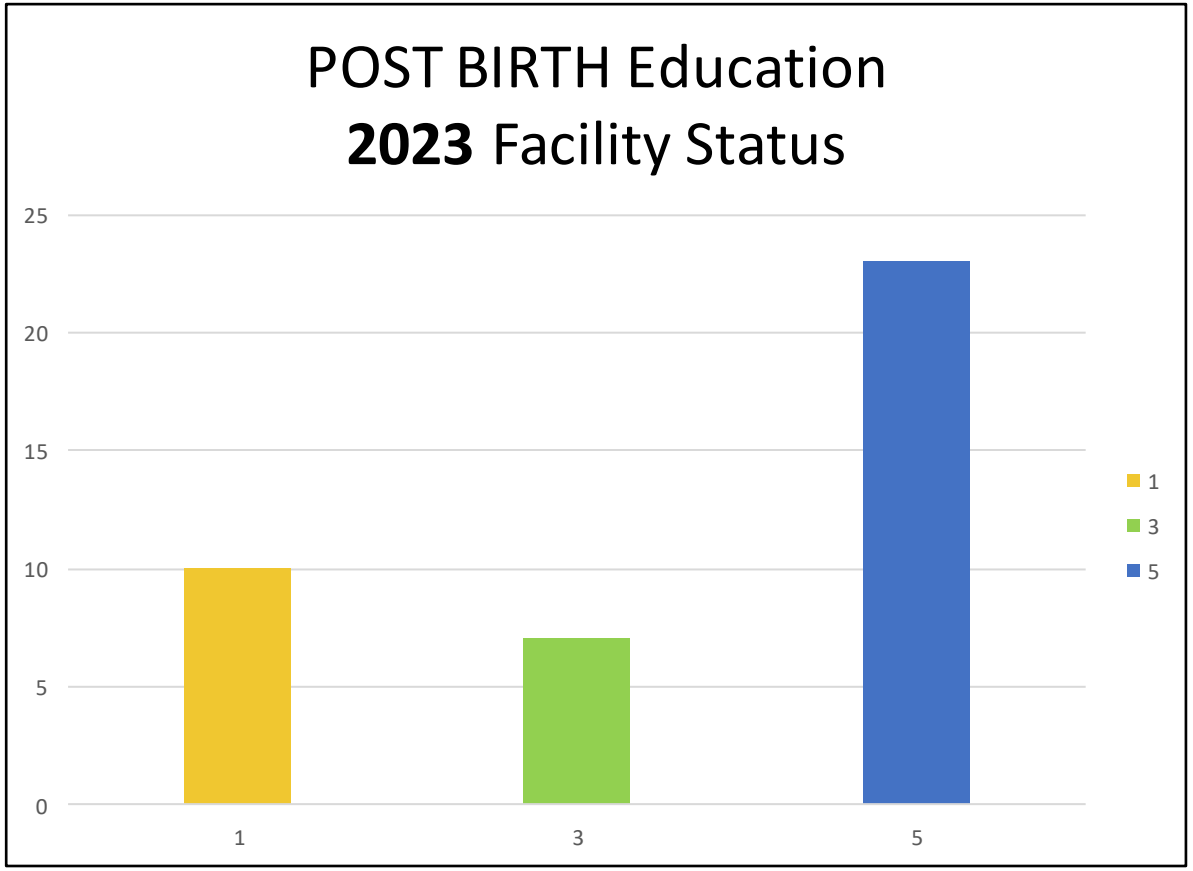


Kansas Perinatal Quality Collaborative

FOURTH TRIMESTER INITIATIVE

FTI: Project #1 POSTBIRTH





KPQC Kansas Perinatal Quality Collaborative

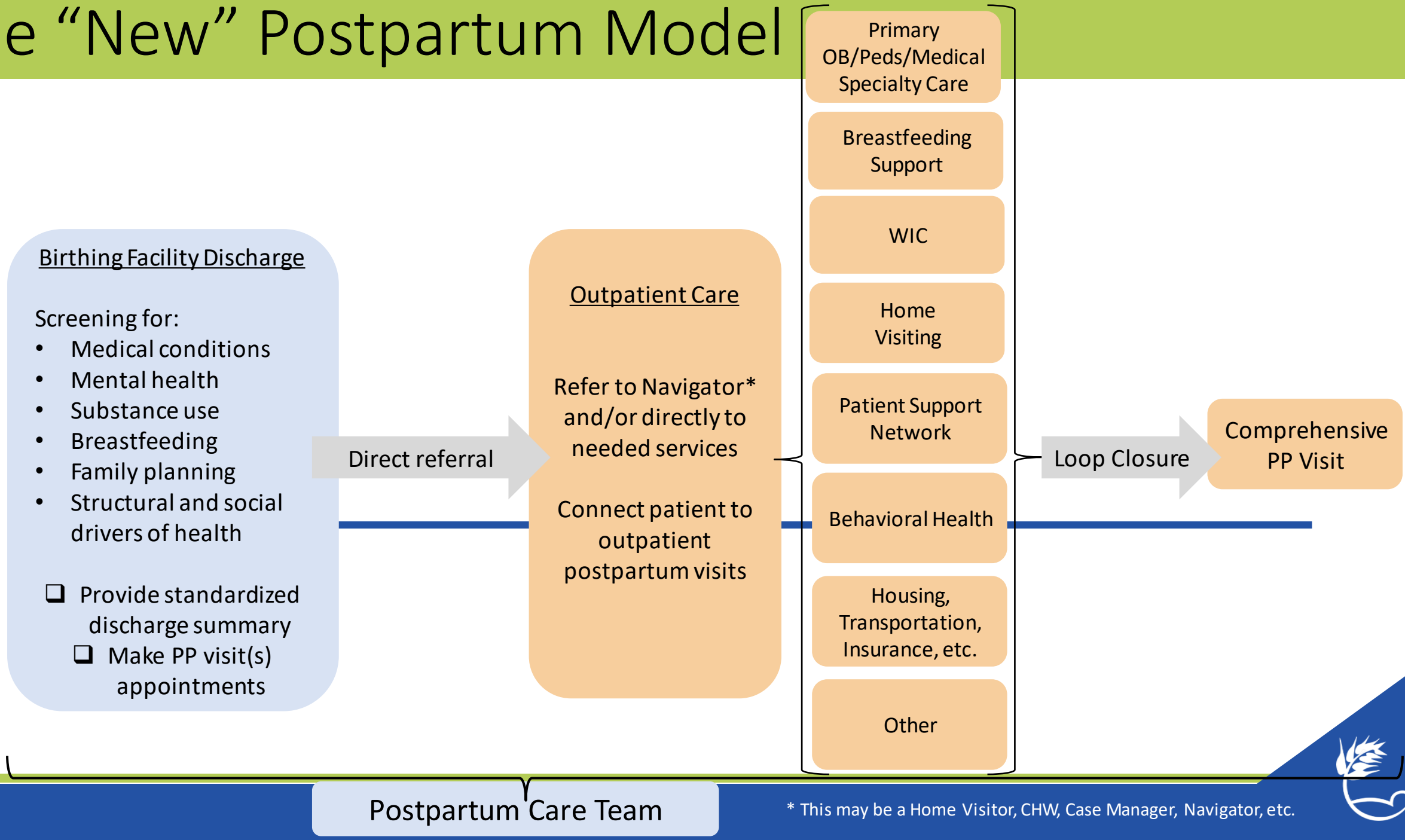
FOURTH TRIMESTER INITIATIVE

KPQC

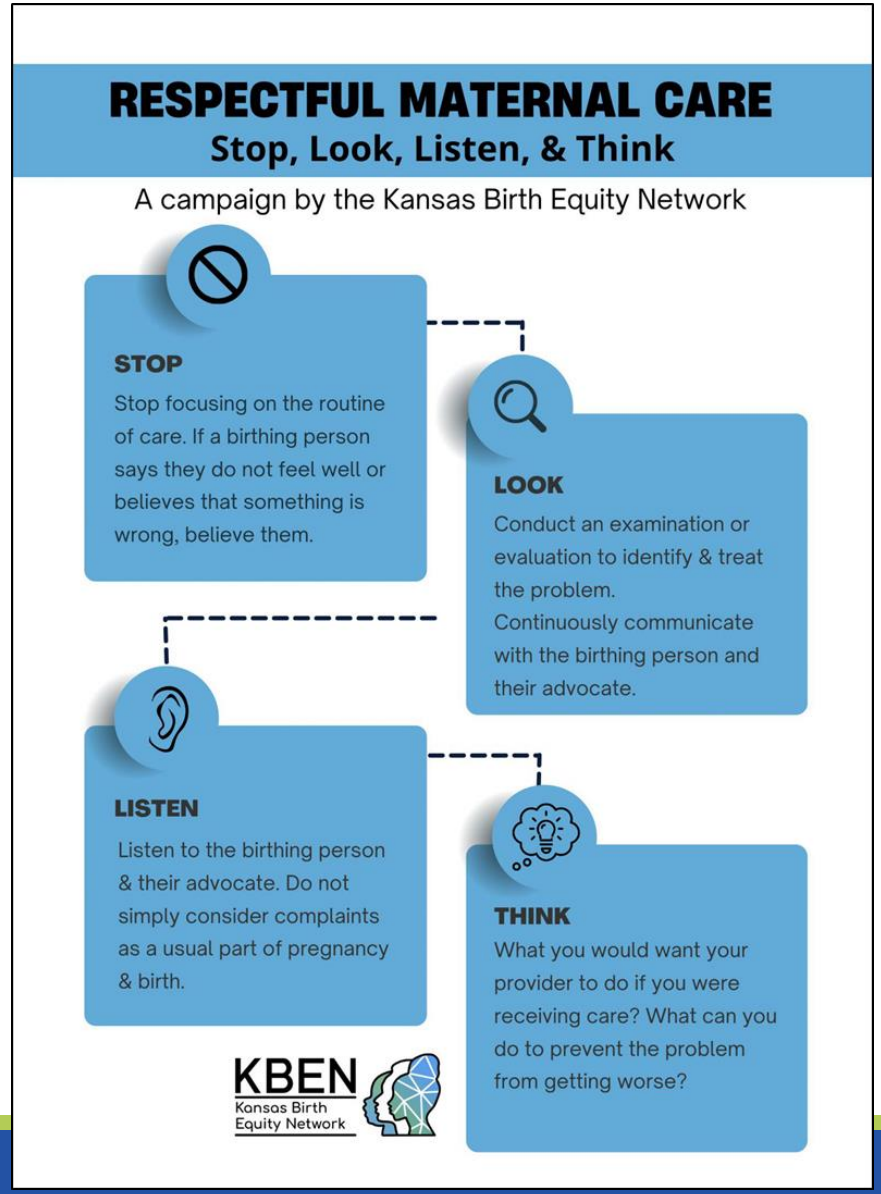
Kansas Perinatal Quality Collaborative

What we've changed... forever

The "New" Postpartum Model



Birth Equity = Baseline for change



KPQC
Kansas Perinatal Quality Collaborative

FOURTH TRIMESTER INITIATIVE

MARCH OF DIMES

FOURTH TRIMESTER INITIATIVE

Mom's Name:_____

Date of Delivery:_____ Vaginal Birth C-Section Birth

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

Other:_____

Medications at discharge:_____

Upcoming Appointments:

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

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

Baby's Name:_____

Term Preterm _____weeks

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

Infant Feeding: Breast Milk Formula Both

Upcoming Appointments:

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

Created by: Delivering Change, Inc.

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.

POST-BIRTH WARNING SIGNS

Call 911 if you have:

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

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

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

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

Tell 911 or your healthcare provider: "I had a baby on _____ (Date) and I am having _____ (Specific warning signs)."

Innovative ideas!

The "Mom Card"

POST-BIRTH 1) Education
2) No Wrong Door

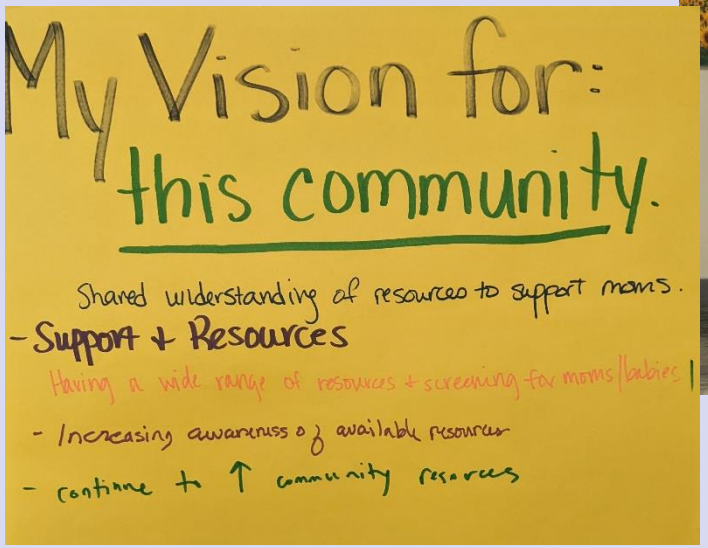
KPQC
Kansas Perinatal Quality Collaborative

Innovative ideas!

FINALLY use Navigation

Referrals for:
+ Mental health screen
+ Medical risk screen
+ Breastfeeding
+ Fam Planning
+ SSDOH

FOURTH TRIMESTER INITIATIVE



Contact Us!

- Terrah Stroda, CNM
Maternal QI Coordinator, KPQC
terrah.stroda@stormontvail.org

- Kari Smith, MSN, RN, RNC-OB, C-EFM
Maternal QI Coordinator, KPQC
kari.smith@kansaspqc.org

- Jill Nelson, B of Mus.
Maternal & Perinatal Initiatives Consultant
jillelizabeth.nelson@ks.gov

www.kansaspqc.org

Ginger Breedlove, PhD, CNM, FACNM, FAAN

Dr. Breedlove is a past president of the American College of Nurse-Midwives. In the fall of 2017 she formed Grow Midwives, a consulting firm dedicated to build optimal maternity care practices. She served as a professor 16 years including founding the Midwifery Specialty Track at University of Kansas. She co-founded the first birth center in Kansas in 1979 and first Midwife practice in Kansas City in 1994. In 2016 she cofounded and serves as President of the March for Moms. In fall of 2018 she edited a best-selling book for first-time parents titled, Nobody Told Me About That!

Dr. Breedlove, is already making a wonderful addition to the DONA International advisory committee as her warm, but solid guidance is invaluable. Recently, Dr. Breedlove joined DONA International in Houston, TX as both a keynote speaker and a special guest for the DONA International trainers. She is immensely supportive of the work of doulas.

Beyond the Bundles:

Additional Factors That Influence Maternal Events

Ginger Breedlove, PhD, CNM, FACNM, FAAN

October 20, 2023

Disclosures

No relevant financial or non-financial relationships to disclose relating to the content of this activity.

Learning Objectives

Explore	…consequences of maternal events from patient and institutional lens.
Examine	…biases in healthcare that influence care delivery.
Increase	…initiatives to champion change at every opportunity and every level.

My 4 Decade Lens on KS Maternal Health

Maternal Mortality – KS, 1978

9.8/100,000

- Few designated MCH provider shortage areas
- Wide coverage of state-funded M&I clinics leaving few maternity care access deserts
- Comprehensive services at point of care: Family planning, WIC, Social Workers
- High engagement in Childbirth Education & Preparation

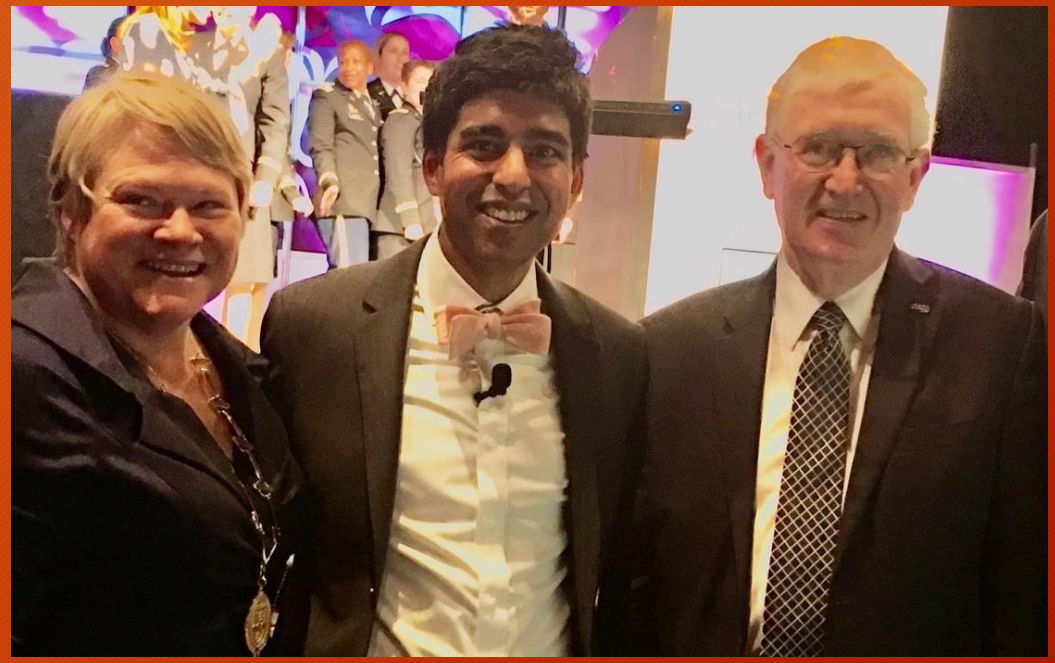
Maternal Mortality – KS, 2016-2020

56/100,000

- Care delivery; "Too much too soon or too little too late"
- Provider shortage worsening
- Loss of community programs and services
- Less access to culturally congruent risk-reduction education and services
- Fragmented and widening disparate services
- Increase in SUD and Mental Health disorders

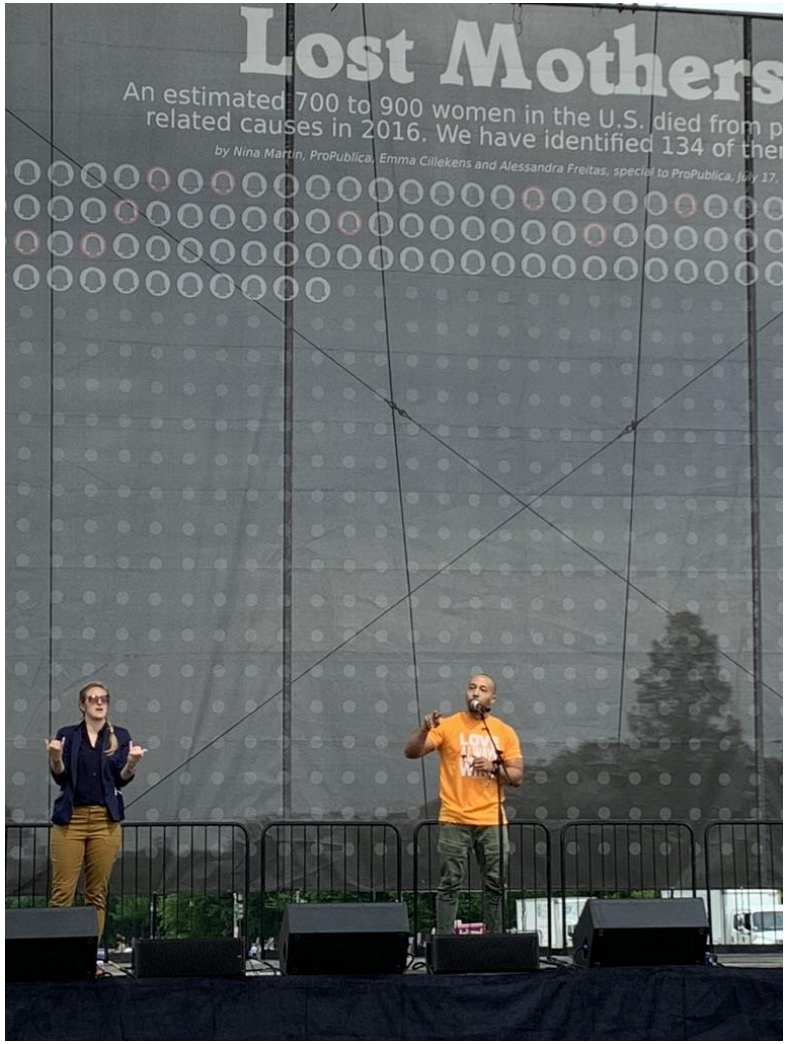
March for Moms, Fall 2017: Collective Call to Action

Started as gathering of Inter Professional Societies to increase awareness and advocacy around Maternal Mortality



Current Board Leadership

- Ebony Marcelle, CNM, DNP, FACNM, DC Birth Center
- Chanel Porchia-Albert, Ancient Song Doulas, NY
- Angelina Spicer, Comedienne/Activist, Los Angeles
- Eugene DeClercq, PhD, Boston College
- Mary D'Alton, MD, MFM, Columbia Univ, NYC
- Jamila Taylor, PhD, Century Foundation
- Charles Johnson, 4Kira4Moms Foundation
- Lastascia Coleman, CNM, Univ Iowa
- Elon Kotlar, MD Jefferson Health System, PA
- Irogue Igbinosa, MD, MFM, Stanford
- Tia Tilson, Fundraiser, Treasurer
- Neel Shah, MD, CMO Maven, Vice-President
- Ginger Breedlove, PhD, CNM, President
- Laneceya Russ, Executive Director



Why Rise in US Maternal Morbidity and Mortality

- Absence of universal health care coverage
- Worsening overall health of population
- System and Provider errors
- Maternal Deserts
- Rise of C-section and subsequent complications
- Co-morbid conditions
- Workforce Shortage, Burnout, Fatigue
- Poorly functioning models of team-based care
- Data collection systems e.g. PQC's, PAMR, MMRCs

What we know about KANSAS (2016-2020)

- KDHE established the Maternal Mortality Review Committee (MMRC) in 2018
- The committee consists of 25-35 geographically diverse members
- Executive Summary KEY findings:
  - 1/161 women experienced Severe Maternal Morbidity (SMM), significantly increasing over 4 years
  - SMM for non-Hispanic Blacks significantly higher than any other group
  - Women on KS Medicaid or low-income ZIP code more likely to experience SMM
  - Of 132 deaths, 105 designated pregnancy-associated
  - 79% of deaths designated preventable

https://kmmrc.org/wp-content/uploads/2023/08/Kansas-Severe-Maternal-Morbidity-Maternal-Mortality-2016-2020-Executive-Summary.pdf

Who Knows What in Kansas?

- Professional Societies
- The Public
- Policy Makers
- Childbearing Families
- Employers
- Payers
- Today's audience

https://www.theguardian.com/global-development/2018/sep/24/why-do-women-still-die-giving-birth

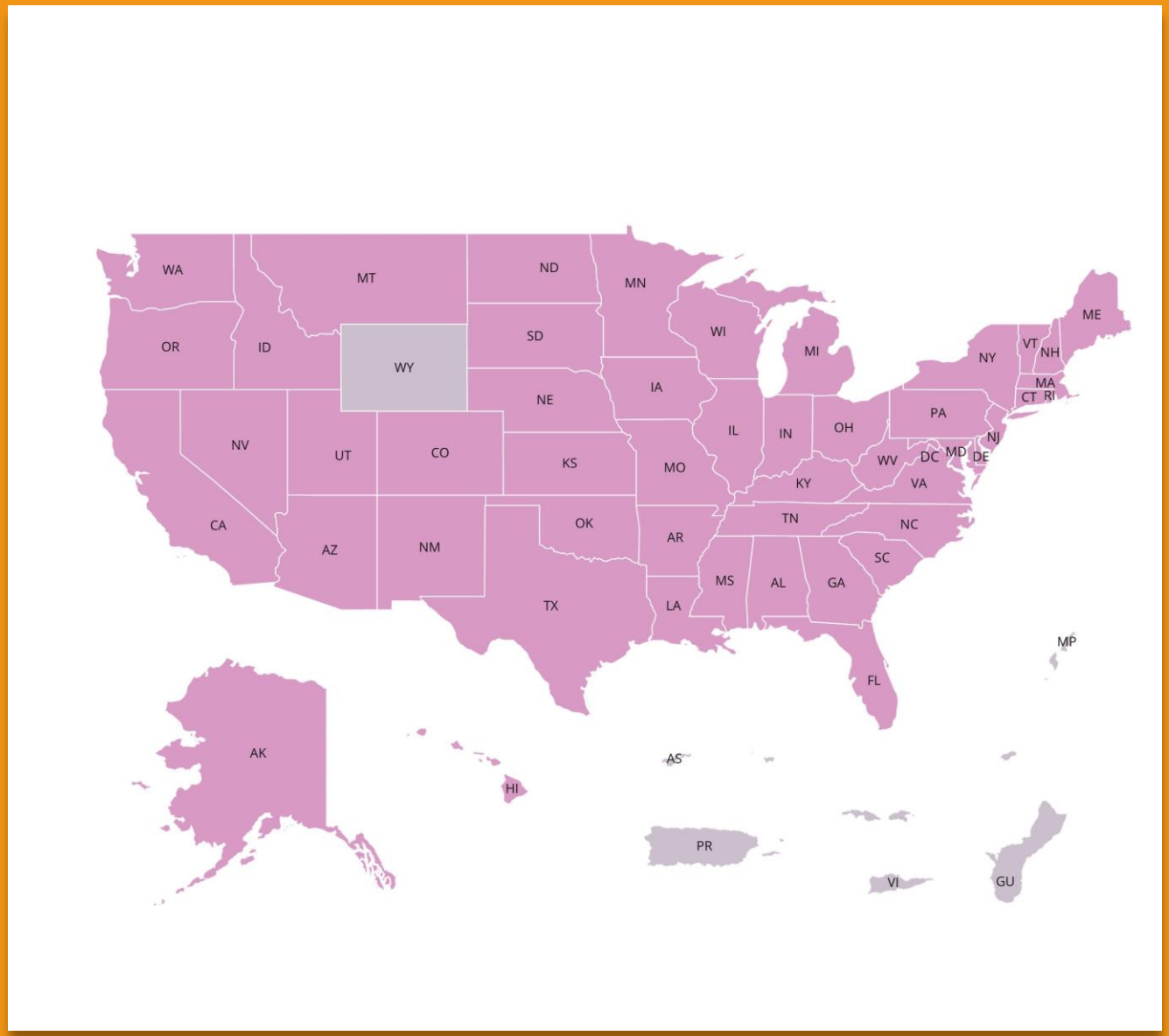
AIM Initiatives

To equip every state, perinatal quality collaborative, hospital, birth facility and maternity care providers with information to significantly reduce severe maternal morbidity and maternal mortality through proven implementation of consistent maternity care practices.

https://safehealthcareforeverywoman.org/patient-safety-bundles/

AIM States

- What guides selection of AIM Bundle/state?
- Why do some hospitals not participate?
- CA 2016 (4 Bundles)
- KS 2021 (PPDT/Post partum Discharge Transition)

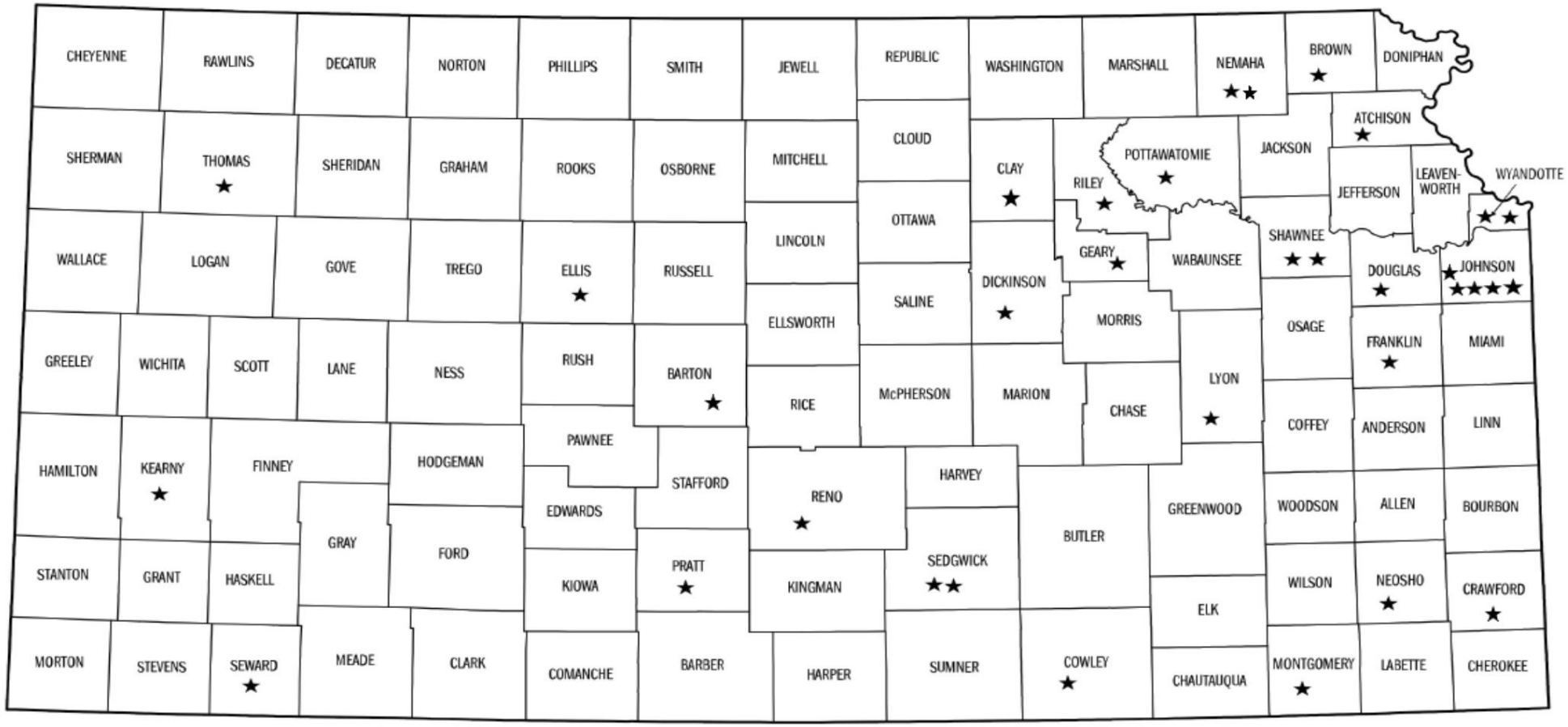


https://saferbirth.org/about-us/enrolled-states-and-jurisdictions/

8 AIM BUNDLES

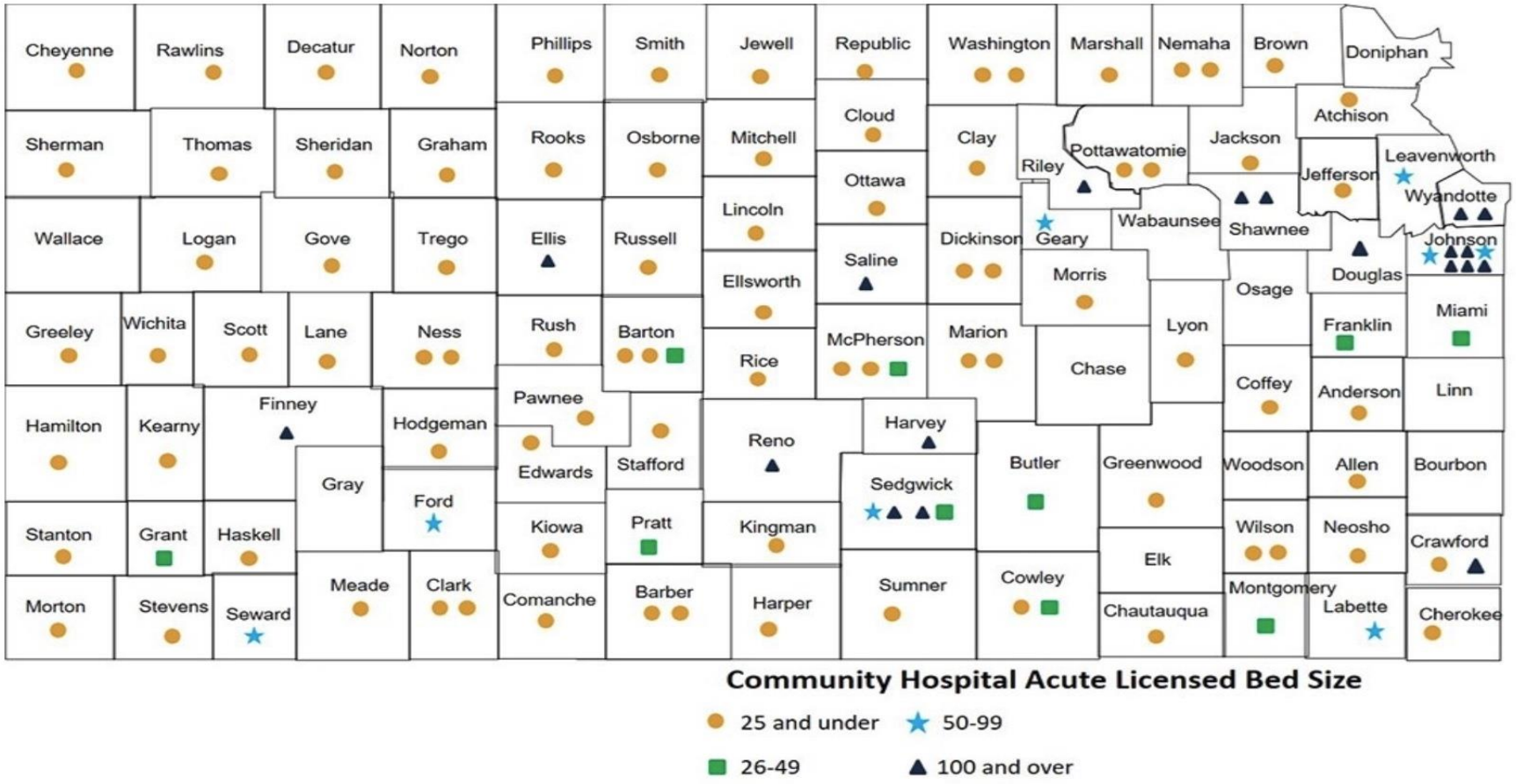
- How many KS hospitals with maternity care services have NOT implemented PPDT Bundle?
- What can you do to encourage increased participation?

Fourth Trimester Initiative Enrolled Facilities by County



Distribution of Kansas Community Hospitals

Of the 105 counties in Kansas, 18 counties contain more than one community hospital, 77 counties contain only one community hospital, and ten counties are without any community hospitals. The following counties do not have a hospital: Bourbon, Chase, Doniphan, Elk, Gray, Linn, Osage, Wabaunsee, Wallace and Woodson. Kansas has 123 community hospitals.



://www.kha-net.org/DataProductsandServices/STAT/HospitalCharacteristics/

Kansas Community Hospitals

TOP 25 PRINCIPAL INPATIENT PROCEDURES -- 2018 (Kansas Community Hospitals)

Rank	ICD10-CM Code	Procedure Description	Percent of Total Discharges	Average Length of Stay	Percent Female Cases	Average Age
1	10E0XZZ	Manually Assisted Vaginal Delivery	6.72	2.2	100	28.4
2	0VTTXZZ	Circumcision	3.43	2.7	0	0.0
3	10D00Z1	Low Cervical Cesarean Section	3.17	3.4	100	29.9

https://www.kha-net.org/DataProductsandServices/STAT/HospitalUtilization/PrincipalInpatientProcedures/

Questions to Ponder

- Why are some hospitals not participating?
- What benchmarks guide evaluation of AIM bundle to measure value and determine end point?
- Are hospital Emergency Depts that do not provide obstetric services participating in PPDT?
- Is funding for FTE to support the project within their setting an issue?
- What about the other Bundles that address KS MMRC key findings e.g. Equity, Cardiovascular Disease and Maternal SUD?

Lens of Patient/Family

(With permission/March for Moms)

NearMiss

DenyandDelay Stroke
MaternalDeath
MentalHealth
Suicide Homicide HealthInequity
RuralAmerica Hemorrhage
AmnioticFluidEmbolism
Eclampsia Accreta Deaths
Racism PulmonaryEmbolism
GeographicLocation
Infection Cardiomyopathy
BlackWomen Preventable
SubstanceAbuse
LostMothers
Hypertension

NJ Near Miss Survivor (Bio-tech Scientist)

STOP If a patient does not feel well, or believes something is wrong, stop and not assume that they are typical complaints that all new mothers experience.

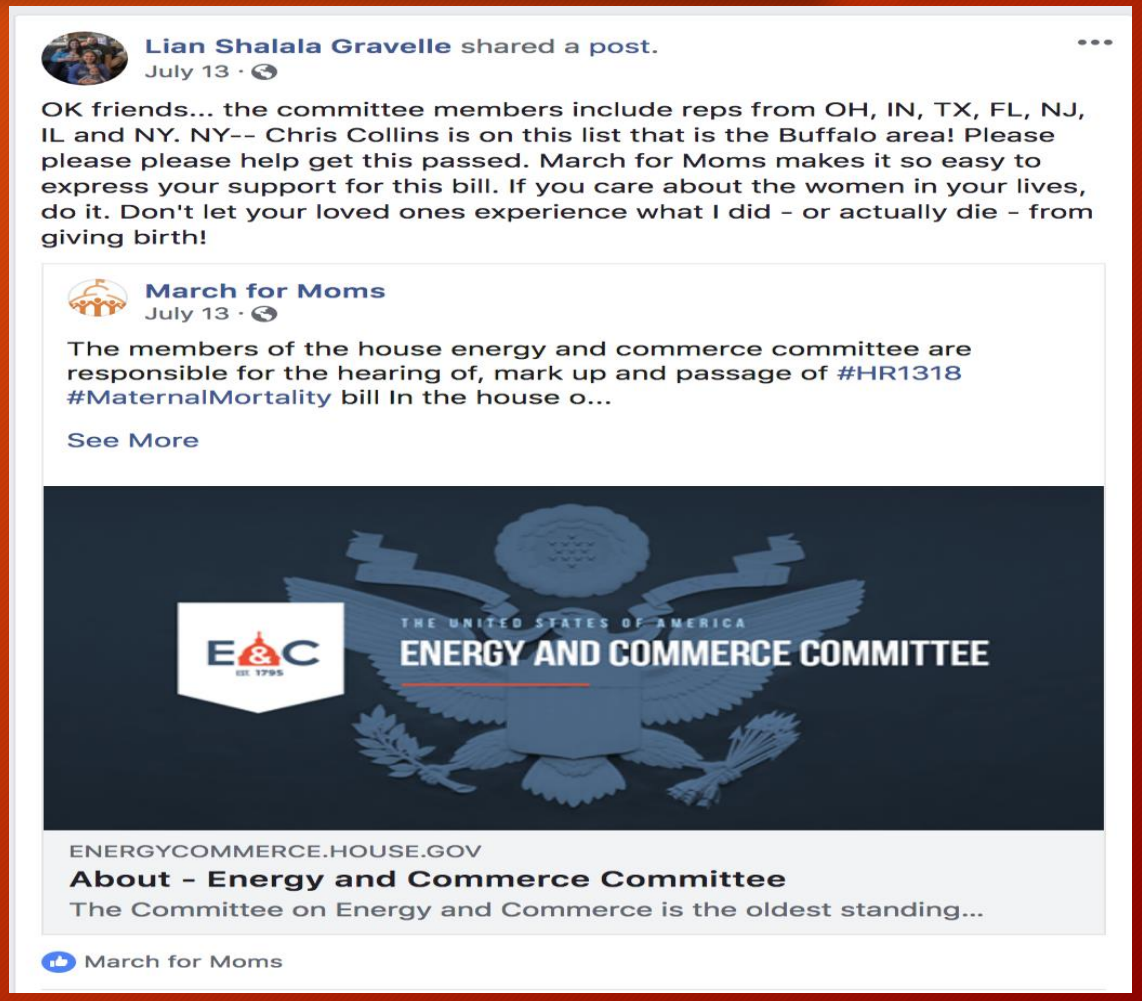
LOOK Examine the patient to be sure there are no evolving problems.

LISTEN to the patient's complaints in their own words and never consider them a usual part of having a baby.

NY Dad left behind: BrianGravelle

- Lian posted on Face Book on **July 13th** after surviving a near-miss postpartum event (With Permission/March for Moms)

- On her passing **September 24th**, 2018, she was 6 months postpartum and Mom to her first children, twin boys



Lian Shalala Gravelle shared a post.
July 13 ·

OK friends... the committee members include reps from OH, IN, TX, FL, NJ, IL and NY. NY-- Chris Collins is on this list that is the Buffalo area! Please please please help get this passed. March for Moms makes it so easy to express your support for this bill. If you care about the women in your lives, do it. Don't let your loved ones experience what I did - or actually die - from giving birth!

March for Moms
July 13 ·

The members of the house energy and commerce committee are responsible for the hearing of, mark up and passage of #HR1318 #MaternalMortality bill In the house o...

See More

ENERGYCOMMERCE.HOUSE.GOV
About - Energy and Commerce Committee
The Committee on Energy and Commerce is the oldest standing...

March for Moms

Brian has influenced NY Policy: “Lian’s Law”

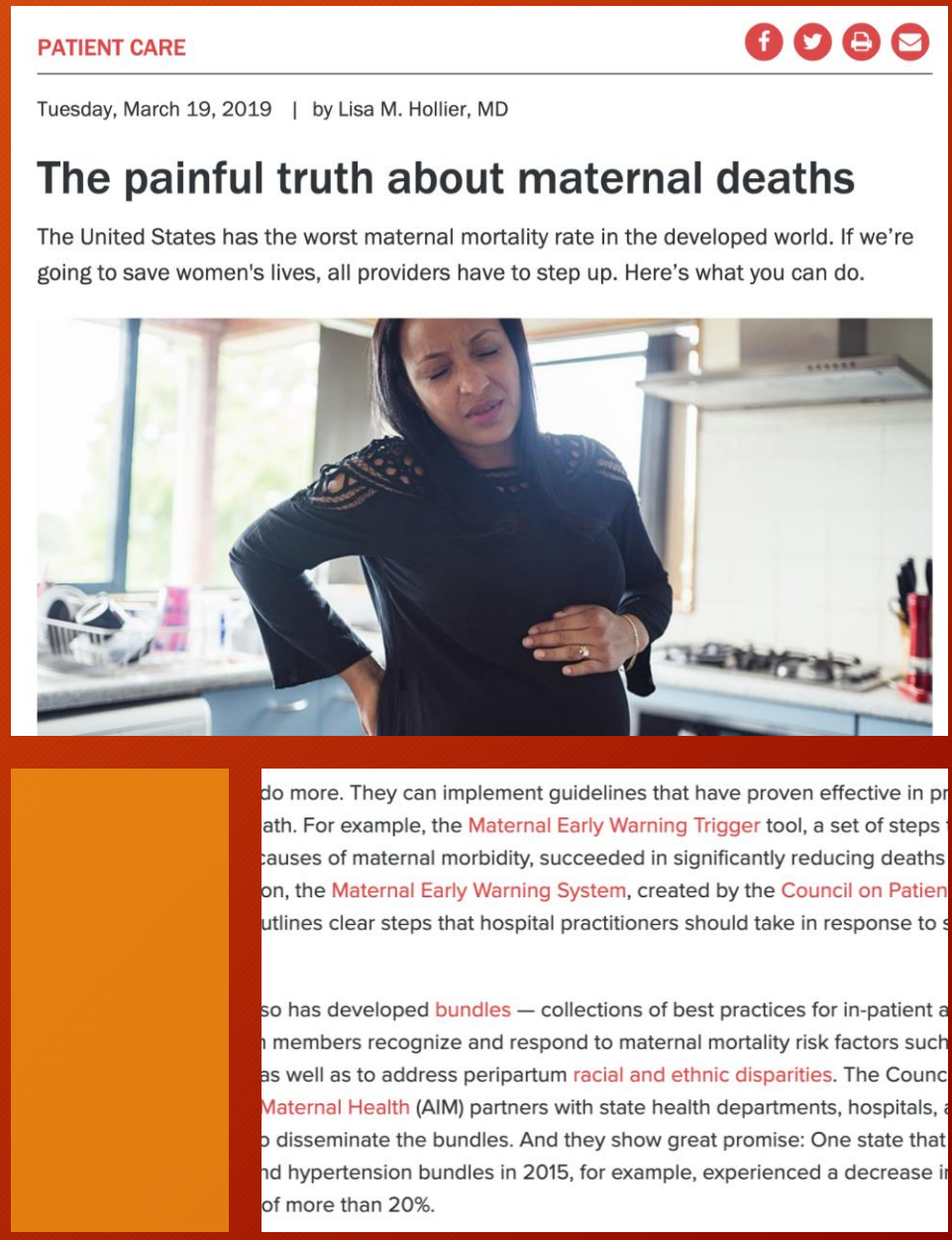
NYC mother, Amber Rose Isaac

- Bruce McIntyre spoke at March for Moms 2022 Rally in DC

Lens of Institution/Setting

- Can **more be done** to implement changes to reduce preventable events?
- Are written policies race based?
- Are programs designed for the most marginalized?
- What are hot button QI issues and stratify data with race conscious lens

https://news.aamc.org/patient-care/article/painful-truth-about-maternal-deaths/



PATIENT CARE

Tuesday, March 19, 2019 | by Lisa M. Hollier, MD

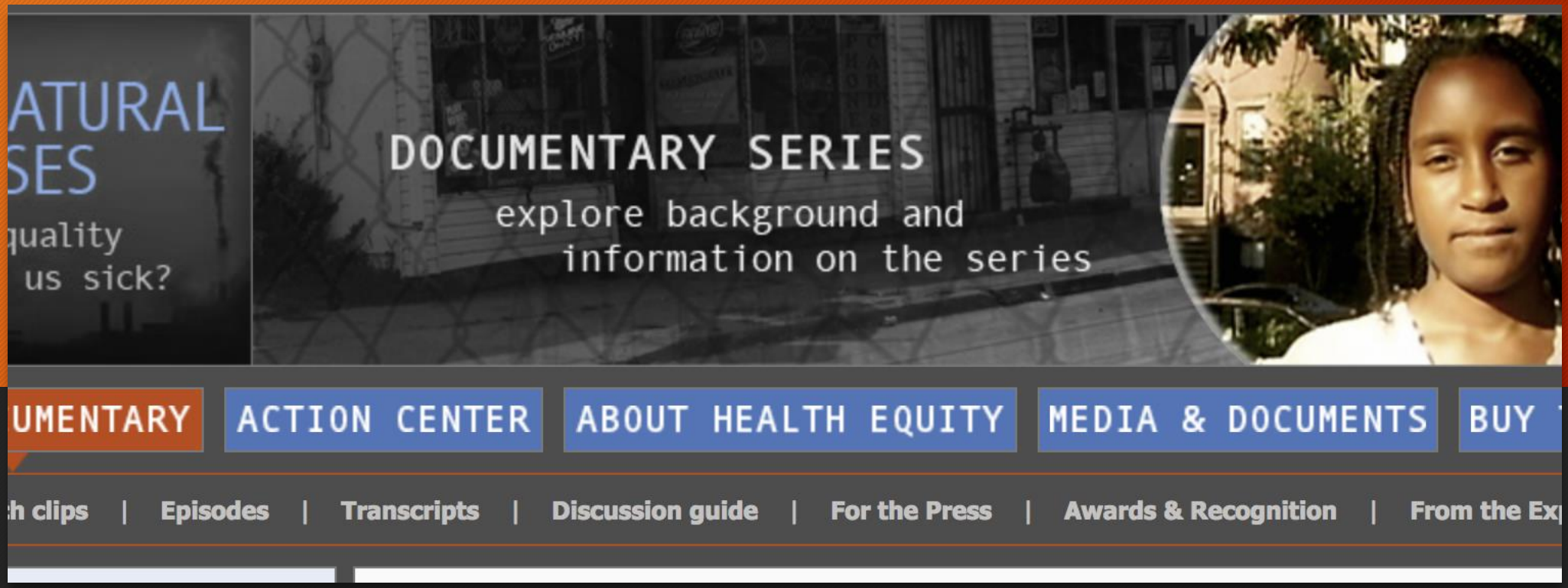
The painful truth about maternal deaths

The United States has the worst maternal mortality rate in the developed world. If we're going to save women's lives, all providers have to step up. Here's what you can do.

do more. They can implement guidelines that have proven effective in pr
ath. For example, the Maternal Early Warning Trigger tool, a set of steps
causes of maternal morbidity, succeeded in significantly reducing deaths
on, the Maternal Early Warning System, created by the Council on Patien
utlines clear steps that hospital practitioners should take in response to s

so has developed bundles — collections of best practices for in-patient a
members recognize and respond to maternal mortality risk factors such
as well as to address peripartum racial and ethnic disparities. The Counc
Maternal Health (AIM) partners with state health departments, hospitals, a
o disseminate the bundles. And they show great promise: One state that
nd hypertension bundles in 2015, for example, experienced a decrease i
of more than 20%.

WHY have we ignored INEQUITY for so long?



https://www.unnaturalcauses.org/video_clips_detail.php?res_id=70

Implicit Bias, Institutional, and Structural Racism permeates healthcare

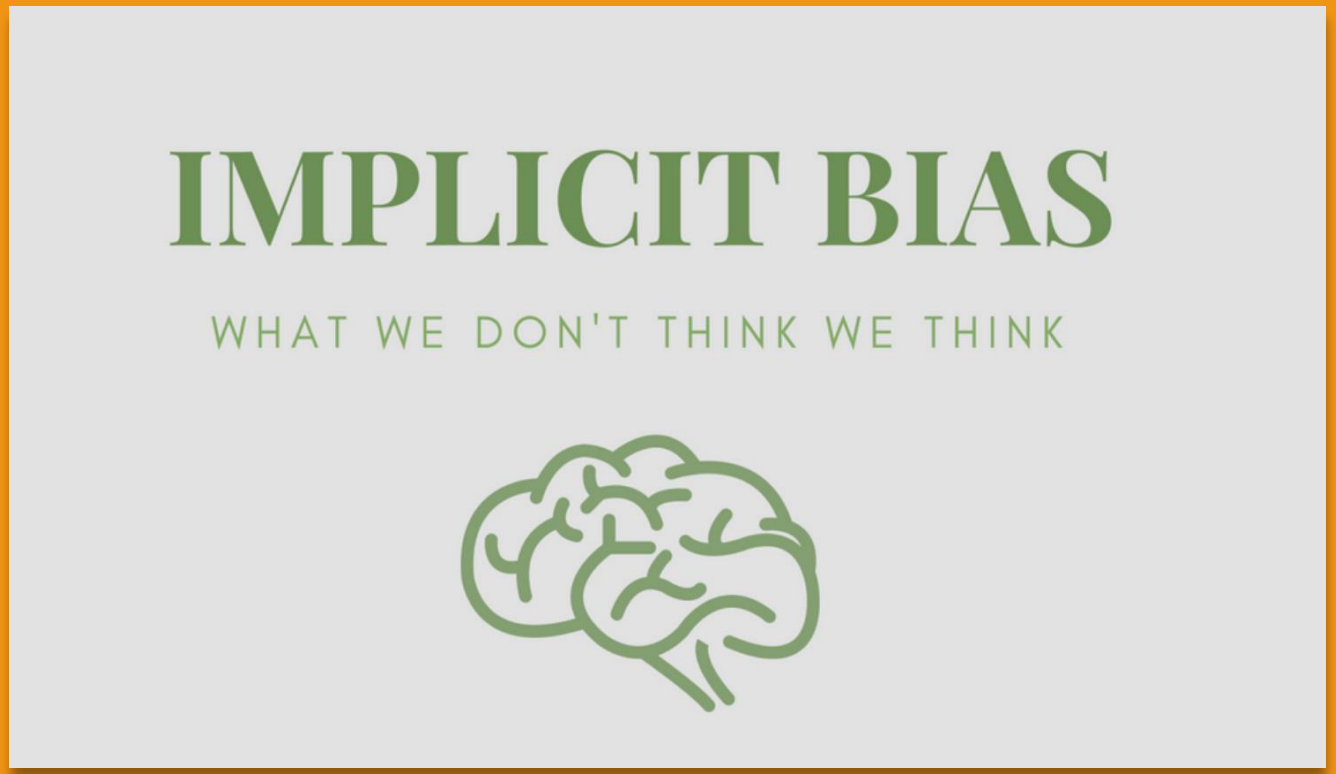
Implicit Bias aka Unconscious Bias is recommended required training. Includes:

1. Unconscious Bias Test (IAT/Harvard most commonly used)
2. Debrief of results
3. Education on unconscious bias theory
4. Impact of unconscious bias on health delivery outcomes
5. Suggested techniques to reduce or mitigate

https://implicit.harvard.edu/implicit/takeatest.html

Beyond IBT

- ***Can be effective for reducing implicit bias but unlikely to eliminate it.***
- *AWARENESS raising is most likely aim.*
- *Don’t get stuck there!*



Center Concept of “Birth Equity” in ALL Work

CMQCC
California Maternal Quality Care Collaborative

FOR FAMILIES | CMQCC Accounts Login | Contact Us

ABOUT CMQCC | MATERNAL DATA CENTER | QI INITIATIVES | RESEARCH | RESOURCES & TOOLKITS

- QI INITIATIVES
- BIRTH EQUITY
- CARDIOVASCULAR DISEASE
- EARLY ELECTIVE DELIVERIES
- HYPERTENSIVE DISORDERS OF PREGNANCY
- LOW DOSE ASPIRIN TO PREVENT PREECLAMPSIA
- MOTHER & BABY SUBSTANCE EXPOSURE
- OBSTETRIC HEMORRHAGE
- QI ACADEMY
- SEPSIS
- SUPPORTING VAGINAL BIRTH
- VENOUS THROMBOEMBOLISM

Birth Equity

Racism and social injustice perpetuate a violent cycle that includes inequities in maternal and infant health. As our nation grapples with issues of social injustice, we at CMQCC acknowledge our past misalignment of strategies to address birth equity and are committed to furthering our understanding of structural racism and health inequities. Our mission at CMQCC is to end preventable morbidity, mortality and racial disparities in maternity care, and our work will continue until the gap in maternal health outcomes is closed.

CMQCC has adopted the definition of birth equity put forward by Joia Adele Crear-Perry, MD, Founder and President of the National Birth Equity Collaborative: “*The assurance of the conditions of optimal births for all people with a willingness to address racial and social inequities in a sustained effort.*”

Implicit Bias and Birth Equity Trainings

The following key trainings are available to help hospital’s meet *California Dignity in Pregnancy and Childbirth Act*’s Implicit Bias and Birth Equity Training Requirement:

Diversity Sciences

- “Dignity in Childbirth and Pregnancy” course available for free online or for purchase for 1 Continuing Education Unit

March of Dimes

- "Breaking Through Bias in Maternity Care" course available to purchase online for 1 Continuing Nurse Education or Continuing Medical Education Unit

Office of Minority Health (US Department of Health and Human Services)

- “Culturally and Linguistically Appropriate Services (CLAS) in Maternal Health Care” available for free online for 2 Continuing

Workforce Assessment/ Workforce Shortage

- Staffing ratio's
- Call coverage & overtime expectations
- Engagement in change projects
- Patient vs Person Centered culture
- Frequency of temp staff
- Adequate resources and supplies
- Episodic Care vs. Team Huddles
- Workplace Bullying, vertical and lateral
- Job Satisfaction and burn out

Utilizing:
Midwives and Doulas

Role Confusion

Misunderstood

Disrespected

Fragmented Care

https://www.wnpr.org/post/women-america-are-dying-childbirth-are-midwives-and-doulas-answer

Women In America Are Dying From Childbirth. Are Midwives And Doulas The Answer?

By BETSY KAPLAN • JUL 31, 2019

PROGRAM
The Colin McEnroe Show

Share Tweet Email

Leadership Behavior that brings CHANGE

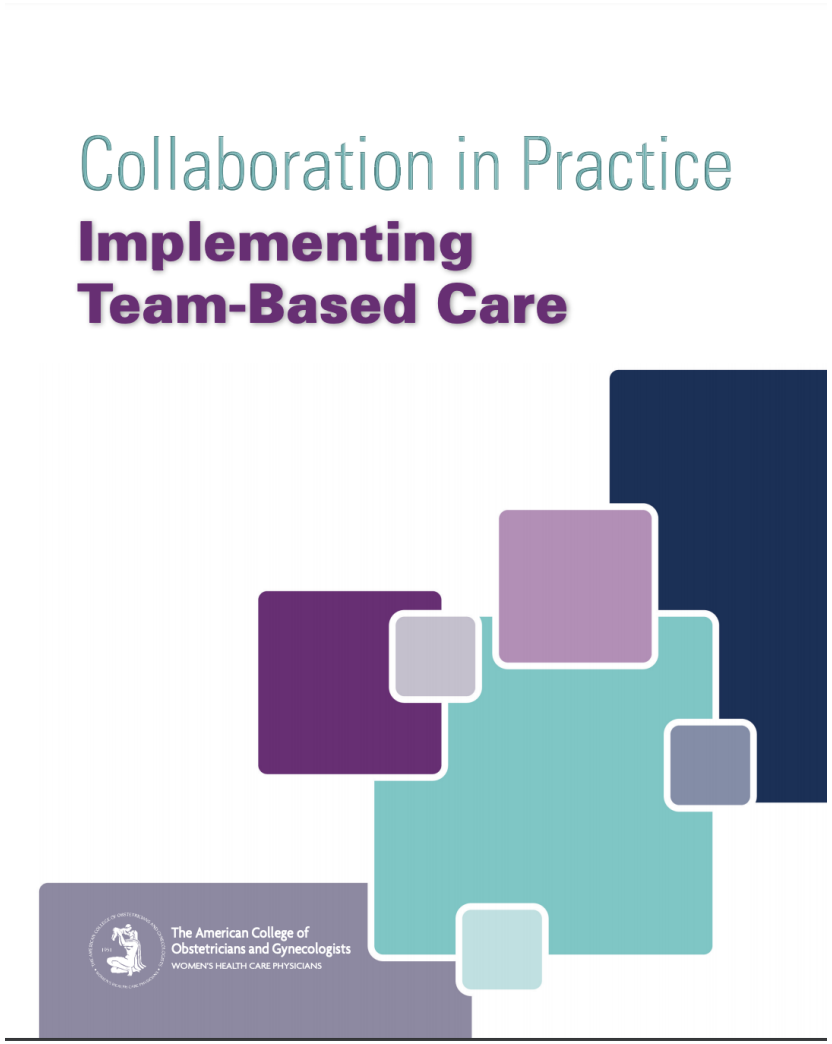
- Collaboration is the Cornerstone
- Embracing Change is Non-Negotiable
- Must Let Go of Status Quo
- Take Personal Steps to Change

ACOG Team-Based Care (2016)

Learn What That Looks Like

Break Down the Silos

https://www.acog.org/Clinical-Guidance-and-Publications/Task-Force-and-Work-Group-Reports/Collaboration-in-Practice-Implementing-Team-Based-Care



World Health Organization, 2015

What is RESPECTFUL CHILDBIRTH

https://www.mhtf.org/topics/respectful-maternity-care/

World Health Organization

hrp

The prevention and elimination of disrespect and abuse during facility-based childbirth

WHO statement

Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care.

photo: UNICEF

Many women experience disrespectful and abusive treatment during childbirth in facilities worldwide. Such treatment not only violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity, and freedom from discrimination. This statement calls for greater action, dialogue, research and advocacy on this important public health and human rights issue.

Background

Ensuring universal access to safe, acceptable, good quality sexual and reproductive health care, particularly contraceptive access and maternal health care, can dramatically reduce global rates of maternal morbidity and mortality. Over recent decades, facility delivery rates have improved as women are increasingly incentivized to utilize facilities for childbirth, through demand generation, community mobilization, education, financial incentives or policy measures.

However, a growing body of research on women's experiences during pregnancy, and particularly childbirth, paints a disturbing picture. Many women across the globe experience disrespectful, abusive or neglectful treatment during childbirth in facilities. (*1-3*) This constitutes a violation of trust between women and their health-care providers and can also be a powerful disincentive for women to seek and use maternal health care services. (*4*) While disrespectful and abusive treatment of women may occur throughout pregnancy, childbirth and the postpartum period, women are particularly vulnerable during childbirth. Such practices may have direct adverse consequences for both the mother and infant.

Reports of disrespectful and abusive treatment during childbirth in facilities have included outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay.(*5*) Among others, adolescents, unmarried women, women of low socio-economic status, women from ethnic minorities, migrant women and women living with HIV are particularly likely to experience disrespectful and abusive treatment.(*5*)

Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care throughout pregnancy and childbirth, as well as the right to be free from violence and discrimination. Abuse, neglect or disrespect during childbirth can amount to a violation of a woman's fundamental human rights, as described in internationally adopted human rights standards and principles.(*6-9*) In particular, pregnant women have a

One in 5 Women Reported Mistreatment While Receiving Maternity Care

Survey finds clear disparities by race/ethnicity and insurance types

Español Print

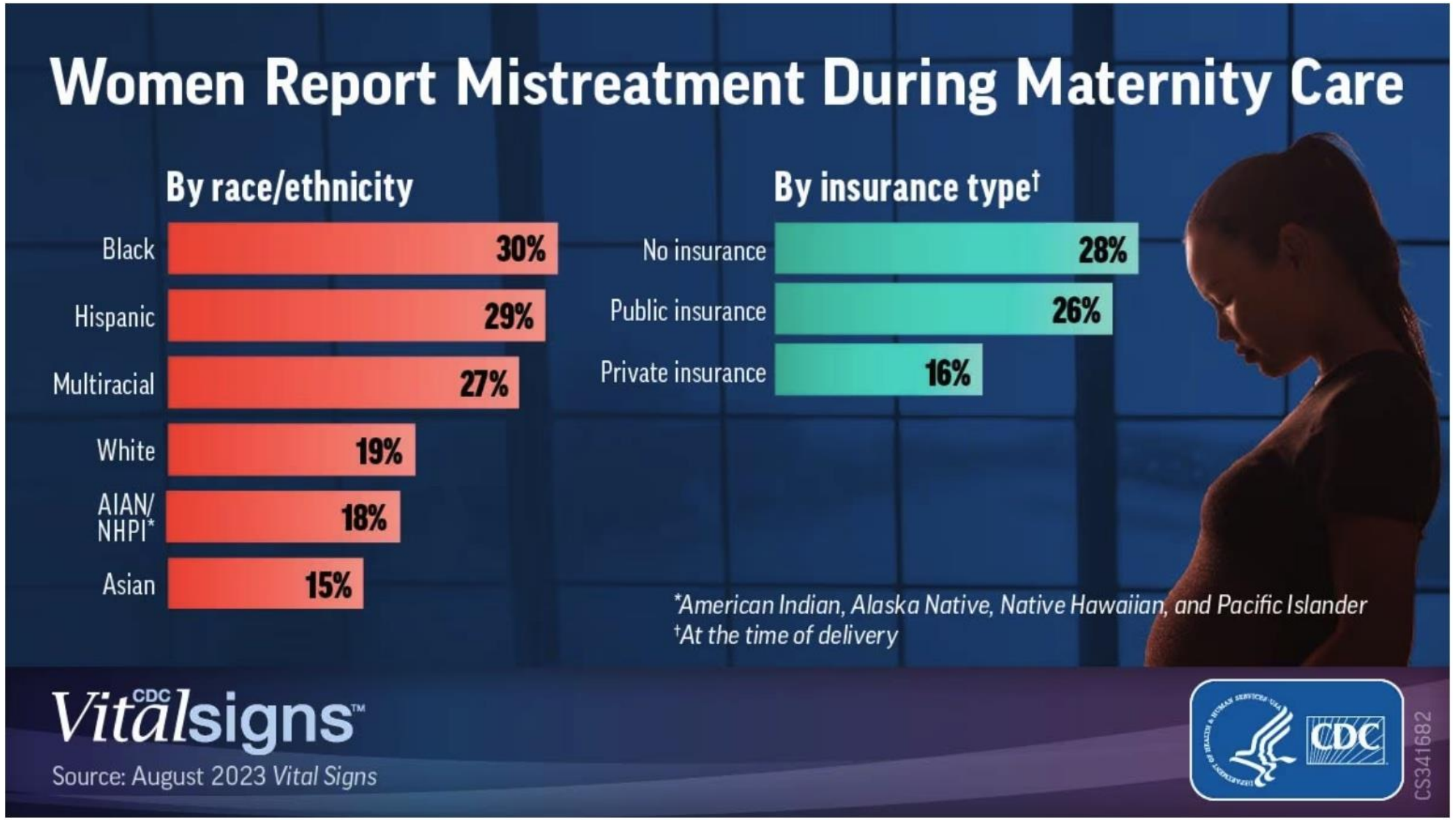
Media Statement

Embargoed Until: Tuesday, August 22, 2023, 1:00 p.m. ET
Contact: Media Relations
(404) 639-3286

Twenty percent of women surveyed reported experiences of mistreatment during pregnancy and delivery care, according to a new CDC *Vital Signs* report. Mistreatment during maternity care was higher among Black (30%), Hispanic (29%), and multiracial (27%) women.

https://www.cdc.gov/media/releases/2023/s0822-vs-maternity-mistreatment.html

Women Report Mistreatment During Maternity Care



Partner with Patients (RWJ Project)

Engaging with Maternal Near Miss Advocates

https://www.facebook.com/POP.PowerofPartnership/videos/324358014960730/

Assess Facility Design for the Marginalized

DOI: 10.1097/JPN.0000000000000376

J Perinat Neonat Nurs • Volume 33 Number 1, 26–34 • Copyright © 2018 Wolters Kluwer Health, Inc. All rights reserved.

Facility Design

Reimagining Approaches to Childbirth in Hospital and Birth Center Settings

Ginger Breedlove, PhD, CNM, FACNM, FAAN; Lesley Rathbun, MSN, FNP, CNM, FACNM

ABSTRACT

Few maternity care clinicians are aware of the current regulations that guide design standards for childbirth facilities in the United States or the regulatory history. There is considerable variance among state regulations as well as oversight of facility standards for healthcare settings. Understanding evidence-based recommendations on how facility design affects health outcomes is critical to reversing the rise in maternal mortality and morbidity. A variety of measures can be implemented that promise to improve user satisfaction, quality of care, and efficiency for all who engage in the childbirth environment. Recommendations for change include broader assessment to better understand how clinicians and consumers simultaneously maneuver within a complex system. Key metrics include evaluation of workflow within available space, patient acuity and census patterns, integration of evidence-based recommendations, and options that promote physiologic birth. For the changes to succeed, human centered design must be implemented and diverse clinicians and consumers engaged in all phases of planning and implementation. Exploring characteristics and outcomes of low-risk women who receive care in a freestanding birth center or the European alongside maternity unit provides opportunity to reimagine and address improvements for inpatient, hospital birth.

Author Affiliation: Grow Midwives, LLC, Shawnee, Kansas.

Disclosure: The authors have disclosed that they have no significant relationships with, or financial interest in, any commercial companies pertaining to this article.

Each author has indicated that he or she has met the journal's requirements for Authorship.

Corresponding Author: Ginger Breedlove, PhD, CNM, FACNM, FAAN, Grow Midwives, LLC, 13608 W 54th St, Shawnee, KS 66216 (ginger@growmidwives.com).

Submitted for publication: July 28, 2018; accepted for publication: September 30, 2018.

Key Words: alongside birth unit, birth center, childbirth setting, design influence on childbirth, evidence-based design of childbirth setting, facility design

In the United States (US), the healthcare setting (HCS) is constructed by balancing architectural recommendations with federal standards, state regulations, city codes, and operating budget. Design considerations include structural and environmental safety, infection control, staff function and efficiency, organizational philosophy, operational workflow of the unit, and federal requirements for individuals with physical accessibility needs.[1–3] Equally important is an environment that provides spiritual comfort, hospitality-based service, and homelike privacy for patients. For childbirth settings, physical surroundings can affect the performance of staff as well as the mother's perception of how easy or difficult it is to give birth.[4–6]

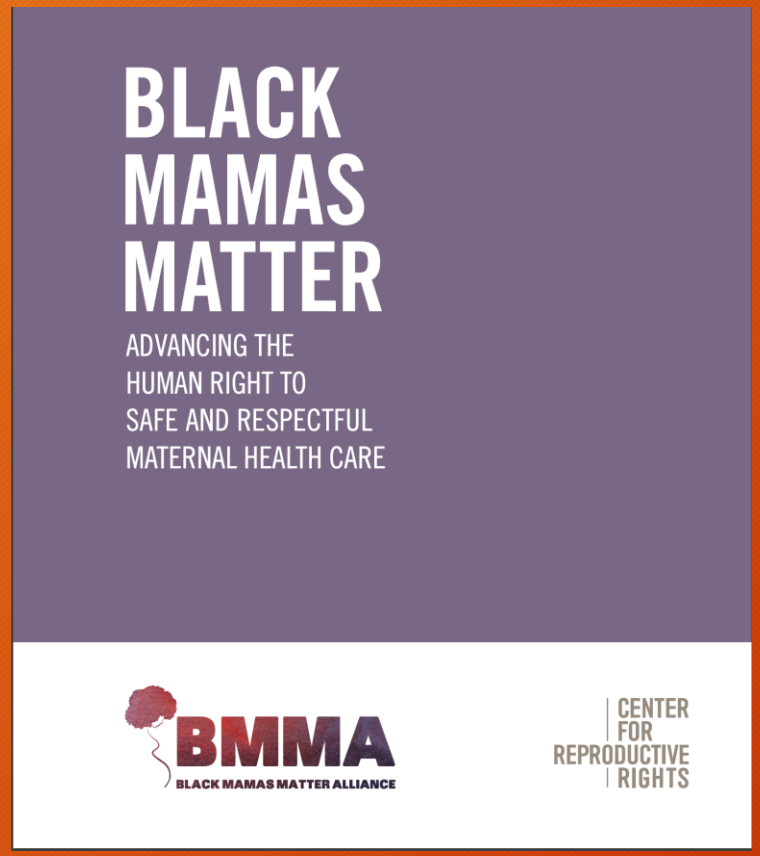
The Centers for Disease Control and Prevention final data for 2016 indicate that 98% of all births occurred in-hospital with a physician in attendance.[7] Safe care requires that trained staff are ready to manage inductions, spontaneous labor admissions, peak admission times, variance in patient acuity level, emergency cases, and obstetric triage. Safe and satisfying care includes staff who promote physiologic birth for women who desire low intervention offering an array of options, care not universally provided in all obstetric units. To reimagine childbirth settings for the majority, those who are at low risk, clinicians must increase knowledge about how facility design influences maternity outcomes and embrace approaches that promote a human-centered experience. For this to happen, clinicians and consumers must be engaged in all phases of design planning and implementation. The primary aim of this review is to increase awareness of US guidelines and standards that

Does Your Setting IMPEDE Optimal Service and Outcomes?

Could you design a more person-centered approach to care?

Journal of Perinatal and Neonatal Nursing, Vol 33, Number 1, 26-34

Discuss Black Mommas Matter Toolkit



https://blackmamasmatter.org/

Essential Elements of the Right to Health

Availability: Health care facilities, goods, services, and programs must be available in sufficient quantity in all areas, urban and rural. This includes, for example, a sufficient number of health clinics, trained medical personnel receiving domestically competitive salaries, and adequate stocking of medicines in health facilities.

Accessibility: Health facilities, goods, and services have to be accessible to everyone without discrimination. Accessibility has four overlapping dimensions:

1. **Non-discrimination** – health facilities, goods, and services must be accessible—both in law and in fact—to everyone regardless of race, sex, gender, sexual orientation, nationality, disability or other status.

2. **Physical accessibility** – health facilities, goods, and services must be within safe physical reach for all sections of the population, and especially for vulnerable or marginalized groups such as women and ethnic minorities, residents of rural areas, and people with disabilities.

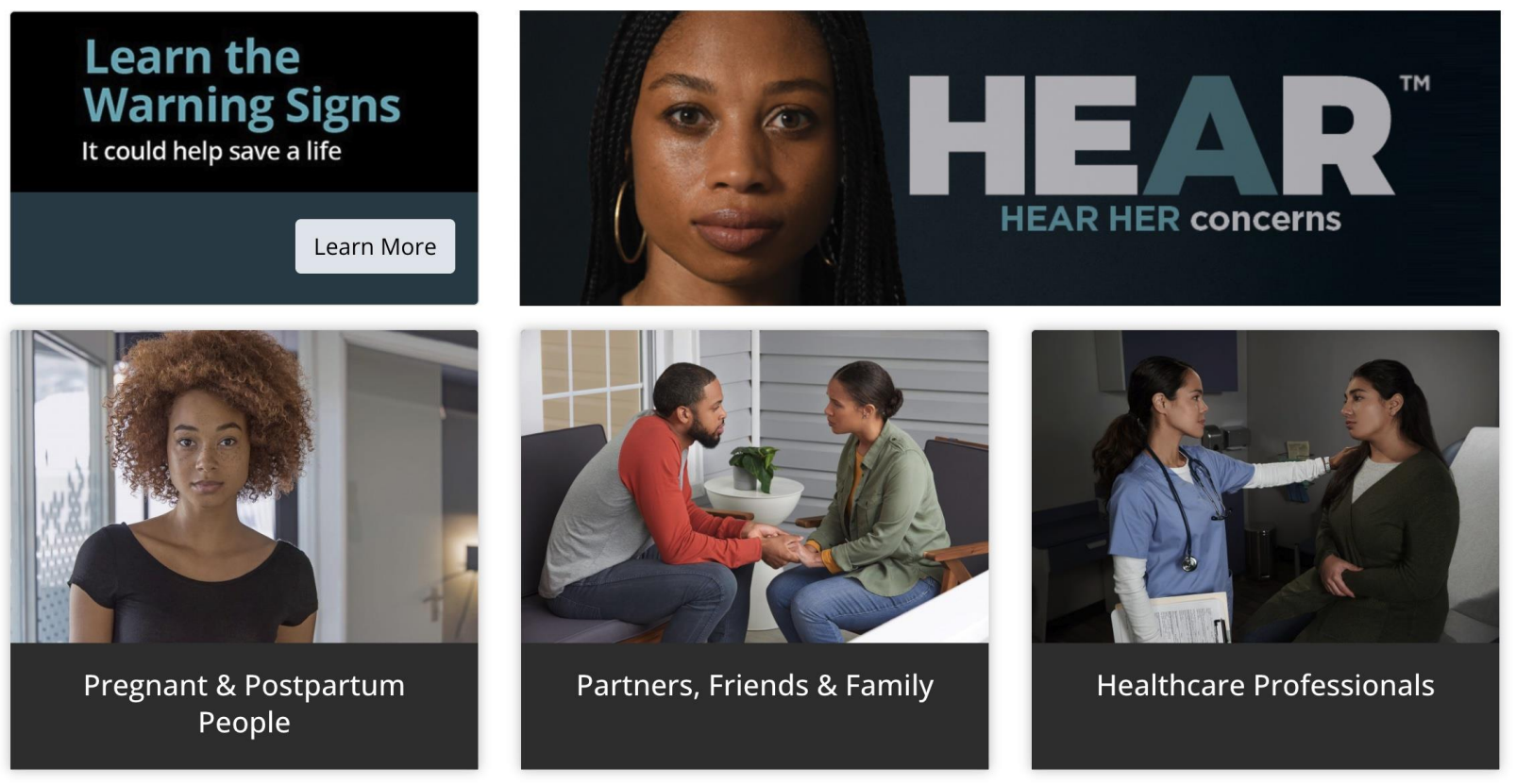
3. **Economic accessibility** – whether publicly or privately provided, health facilities, goods, and services must be affordable for all, and payment for health care services should be based on the principle of equity.

4. **Information accessibility** – information and ideas concerning health issues should be made accessible to everyone, without discrimination, and provided in an accessible format.

Acceptability: Health facilities, goods, and services must respect medical ethics, respect the culture of individuals and their communities, and be sensitive to gender and life-cycle requirements.

Quality: Health facilities, goods, and services must be scientifically and medically appropriate and of good quality.[22]

Implement CDC Hear Her Campaign



https://www.cdc.gov/hearher/index.html

“One voice can change a room.” Barack Obama

Frustrated by a lack of collaboration?
Start by asking yourself a simple question:

What have I done to encourage it today?

Only by regularly owning our mistakes, listening actively and supportively to people’s ideas, and being respectful but direct when challenging others’ views and behavior that we encourage lasting collaboration.

ACTIONS THAT LEAD TO CHANGE

What will YOU do?

Need Ideas? Watch March for Moms September 2023 CBO Event

www.marchformoms.org

American College of Obstetricians and Gynecologists, ACOG Collaboration in Practice: Implementing Team-Based Care. Retrieved January 23, 2020 https://www.acog.org/Clinical-Guidance-and-Publications/Task-Force-and-Work-Group-Reports/Collaboration-in-Practice-Implementing-Team-Based-Care

American Women's Health, Obstetric and Neonatal Nurses, AWHONN, Maternal Mortality Resources. Retrieved January 23, 2020 https://www.awhonn.org/page/MaternalMortality

Breedlove, G., and Rathbun, L. (2018). Facility Design: Reimagining approaches to childbirth in hospital and birth center setting. Journal Perinatal and Neonatal Nursing, 33, (1), 26-34.

California Maternal Quality Collaborative, CMQCC Resources and Toolkits. Retrieved January 23, 2020 https://www.cmqcc.org/resources-tool-kits/toolkits

Centers for Disease Control and Prevention, Maternal Mortality. Retrieved January 23, 2020 https://www.cdc.gov/reproductivehealth/maternal-mortality/index.html

Council on Patient Safety in Women's Health Care, Alliance for Innovation in Maternal Health (AIM) Patient Safety Bundles. Retrieved January 23, 2020 https://safehealthcareforeverywoman.org/patient-safety-bundles/

Pritlove, C., Juando-Prats, C., Ala-leppilampi, K., and Parsons, J. (2019) The good, the bad and the ugly of implicit bias. The Lancet, 393, (10171), 502-504.

World Health Organization, WHO Prevention and elimination of disrespect and abuse during childbirth. Retrieved January 23, 2020 https://www.who.int/reproductivehealth/topics/maternal_perinatal/statement-childbirth/en/?utm_content=buffer34ea9&utm_medium=social&utm_source=twitter.com&utm_campaign=buffer

Questions

ginger@growmidwives.com

Juliet Swedlund

Juliet is a Perinatal/Infant Health Consultant in the Bureau of Family Health at the Kansas Department of Health & Environment. She worked for a year in the Community Health Worker (CHW) Section for the advancement and promotion of CHWs across Kansas. She is a Birth Doula, Lamaze Childbirth Educator, and Birth Trauma Specialist, and in 2017 she founded the Topeka Doula Project, a 501c3 organization providing Doula support and Childbirth Education to low-income families and adolescents, and incarcerated pregnant people.

She loves efforts toward environmental sustainability, social and economic justice, bicycles, ice cream, vermicomposting, plants, and spending time with her husband, two kids, dogs, and cat!

Stephanie Wolf, RN, BSN, CLC

Stephanie Wolf is a Registered Nurse, serving as the Clinical Perinatal and Infant Health Consultant for the Kansas Department of Health and Environment (KDHE) Bureau of Family Health (BFH) since 2015. Prior to her time at KDHE, Stephanie spent 15 years as the Maternal Child Health (MCH) Coordinator at the Saline County Health Department. Stephanie is passionate about public health, and is committed to helping support local providers to better serve the MCH population. In 2019, Stephanie was honored by receiving the Association of Maternal and Child Health Programs (AMCHP) Emerging MCH Professional Award for Region VII.

KPCC
Kansas Perinatal Community Collaboratives

KANSAS MATERNAL & CHILD HEALTH

Kansas
Department of Health and Environment

Kansas Perinatal Community Collaboratives

CONNECTING INPATIENT AND OUTPATIENT SUPPORTS

OCTOBER 2023

Introduction

Family
Matt, Tennessee (11), Stella (8)
Four dogs and one cat

Small town, big family

Health Behavior Change & Chronic Disease Management

Trained Birth Doula

Childbirth Educator

Birth Trauma Specialist

KPCC
Kansas Perinatal Community Collaboratives

KANSAS MATERNAL & CHILD HEALTH

Kansas Department of Health and Environment

What are KPCCs?

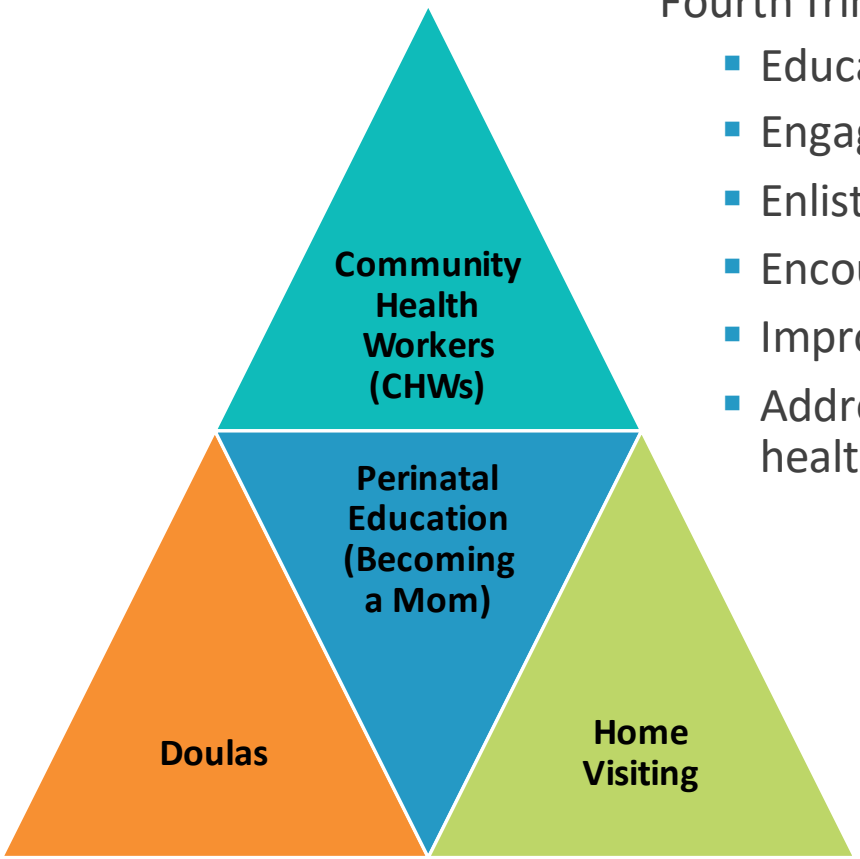
Improved Maternal & Child Health Outcomes

KPCC
Kansas Perinatal Community Collaboratives

KANSAS MATERNAL & CHILD HEALTH

Kansas Department of Health and Environment

Perinatal Support



Fourth Trimester Initiative Goals and Actions

- Educate
- Engage patients and support systems
- Enlist referral networks
- Encourage Postpartum Visit Attendance
- Improve PP care
- Address social determinants of health and health equity

KPCC Kansas Perinatal Community Collaboratives

KANSAS MATERNAL & CHILD HEALTH

Kansas Department of Health and Environment

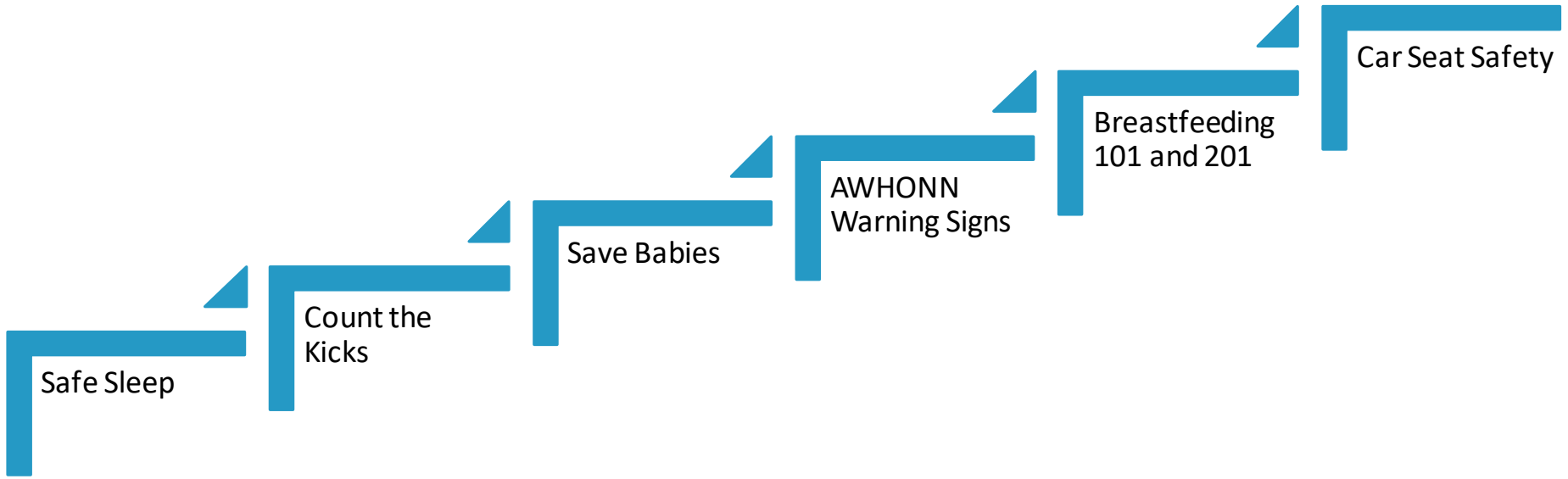
Community Health Workers

KPCC
Kansas Perinatal Community Collaboratives

KANSAS MATERNAL & CHILD HEALTH

Kansas Department of Health and Environment

Perinatal CHW Training Pathway



Additional Trainings (always growing)

- Perinatal Mental Health resources
- Fetal/Infant/Loss
- Family Planning
- Birth Doula
- Trauma and Birth

KPCC Kansas Perinatal Community Collaboratives

KANSAS MATERNAL & CHILD HEALTH

Kansas Department of Health and Environment

Doulas

"My doula gave me and my partner the tools to prepare for labor and then was a great coach during labor for both of us! She has a way of saying the right thing at just the perfect time to help you **keep moving through your labor with a healthy mindset** and makes you think you can do it. Her **calming presence** in the delivery room was just what I needed. She was also available day or night to answer any questions we had leading up to labor."

"My doula helped me **cope with some of my anxieties**, showed my husband massage techniques to help with labor pains and even **introduced us to a backup doula** in the off chance that she was unavailable for our birth. When labor started, she was in contact during early labor. When we felt, labor had progressed to the point that we might need to go to the hospital, our Doula arrived at our house within 5 minutes! She assessed the situation, we decided to go on a walk to see if labor would progress or slow down. It ended up progressing. **With her there, I was able to labor at home for the vast majority of my labor**. Throughout the whole process, she helped with massage, words of encouragement and guiding my husband."

Doulas

"I had a traumatic birth with my first born, not to mention the PPD, PPA, and labor ptsd. I realized for my second baby that extra support may be the way to go. I wanted better coping mechanisms under my belt to manage pain, I wanted help with the my past labor trauma, and my husband wanted better guidance on how to be helpful in the delivery room. She checked in almost daily and always stayed in the loop on how my pregnancy was going. She even gave me stretches to do when I was experiencing PSD, which were life changing!! I couldn't get out of bed one morning and her stretches totally turned that around. She was always fast to text back to me, even at 3am when I was in labor. She had so much knowledge about labor and delivery and exactly what to do in the moment to help with pain and coping. She had this warm calming nature that just instantly made me feel safe. But she also has a strong streak to her that gave me comfort. I had the best birthing experience, one I had always dreamed of. And my husband was able to be included soo much more this time. My breastfeeding experience is better this time around, no signs of PPD or PPA, and my over all bonding with my baby has improved. I just have an overall positive change in perspective when it comes to labor and delivery than I did before."

Doulas

"Our doula met with us several times for pre-partum visits, both virtually and in person. **Based on our input and some great conversations, she crafted a Birth Values Summary that clearly and thoughtfully conveyed the birth experience we hoped to have. She helped us stay open-minded and willing to accept changes to our situation.** When my OB offered a scheduled induction, she was available right away to help me sort out the pros and cons. Early on the day of the scheduled induction, **we found out that a C-section would be the best option for both me and the baby.** That meant that I never actually went into labor. Nonetheless, **she was there the whole time, and she stayed for a couple of hours after the delivery. It was a new and scary experience for me and it meant so much to have her by my side.** During her post-partum visits, **she changed the baby's diaper, showed me how to wear a baby wrap and harness, and offered advice on parenting and breastfeeding.** There are so many things she offered as a doula, like **late-night text conversations about early contractions or helpful input to help us navigate serious decisions.** She is truly dedicated to the well-being of the families she serves."

"She was a **saving grace during my labor and delivery** and stayed the whole 18 hours and **made me feel so supported when I was not ready to speed up the process with induction medications.**"

"**It will be better with her there. I won't be alone.**"

KPCC Kansas Perinatal Community Collaboratives

KANSAS MATERNAL & CHILD HEALTH

Kansas Department of Health and Environment

Doulas

What is a Doula?

A trained professional who provides continuous physical, emotional, and informational support to a pregnant person before, during, and shortly after childbirth to help them achieve the healthiest, most satisfying experience possible.

What Doulas Do Not Do

- Doulas are not medical professionals
- Doulas do not perform clinical tasks
- Doulas do not give medical advice or diagnose conditions
- Doulas do not replace the birth partner or other support

Evidence on Doulas

2017 Cochrane review, 26 trials, 15,000+ people

15%	↑	in the likelihood of a spontaneous vaginal birth
31%	↓	in the use of Pitocin
39%	↓	in the risk of Cesarean
10%	↓	in the use of any medications for pain relief
31%	↓	in the risk of being dissatisfied with the birth experience

Source: Evidence Based Birth

KPCC Kansas Perinatal Community Collaboratives

KANSAS MATERNAL & CHILD HEALTH

Kansas Department of Health and Environment

In Support of Community Doula Programs

Up to 45% of birthing women experience childbirth as traumatic. They feel intense fear, helplessness, loss of control, and isolated. Those at the greatest risk are:

- People of color
- Low income
- Prior trauma (sexual abuse)
- History of mental health concerns

Source: Beck et al. (2013) Traumatic Childbirth. Routledge Taylor & Francis Group: London

KPCC Kansas Perinatal Community Collaboratives

KANSAS MATERNAL & CHILD HEALTH

Kansas Department of Health and Environment

Home Visiting

Kansas Home Visiting is a voluntary program that brings a trained family-support professional to your home at no-cost to you. Home visits are proven to:

Kansas Home Visiting Video

KPCC Kansas Perinatal Community Collaboratives
KANSAS MATERNAL & CHILD HEALTH
Kansas Department of Health and Environment

Toolkits and Resources

MCH Integration Toolkits

Action Alerts and Infographics

KPCC Kansas Perinatal Community Collaboratives

KANSAS MATERNAL & CHILD HEALTH

Kansas Department of Health and Environment

Kansas Perinatal Community Collaborative (KPCC)

Using the Becoming a Mom® (BaM) Curriculum

Becoming a Mom® (BaM)/Comenzando bien® (Cb) is a prenatal education curriculum (English and Spanish languages) for pregnant women created by the March of Dimes. The prenatal curriculum and supplement materials are designed to improve participants' chances of having a healthy pregnancy. The program has been implemented in settings including community-based organizations, hospitals, health departments, clinical care settings, faith-based communities and worksites.

Three-Fold Approach

Perinatal **Care** + Perinatal **Education** + Perinatal **Support**

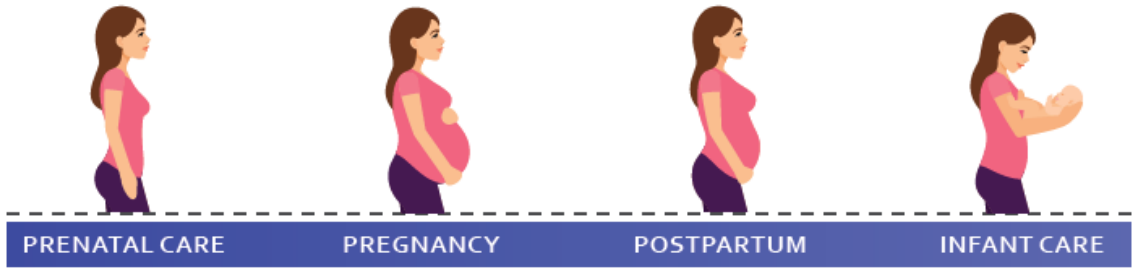
KPCC
Kansas Perinatal Community Collaboratives

KANSAS MATERNAL & CHILD HEALTH

DESIGNED TO PROMOTE HEALTHY PREGNANCIES THROUGH TWO CORE COMPONENTS:

COGNITIVE

Provides accurate and timely information about:



BEHAVIORAL

Promotes changes in prenatal health behaviors, such as:

- Seeking Prenatal Care
- Taking Prenatal Vitamins
- Eating Healthy Foods
- Avoiding Harmful Substances
- Infant Care Support

KPCC
Kansas Perinatal Community Collaboratives

KANSAS MATERNAL & CHILD HEALTH

MOTHERS RECEIVING PRENATAL EDUCATION IN THE KANSAS BaM/Cb PROGRAM WERE:

More likely to be of **racial/ethnic minorities** than mothers giving birth in the state.

More likely to have a **lower education level** than Kansas mothers giving birth in general

More likely to be **younger** than Kansas mothers giving birth

More likely to have **non-private insurance** than Kansas mothers giving birth in general

More likely to be **enrolled in WIC**

These are all indicators of the program reaching targeted high risk populations.

KPCC
Kansas Perinatal Community Collaboratives

KANSAS MATERNAL & CHILD HEALTH

After Completing the BaM/Cb Program Mothers Shared They Were:

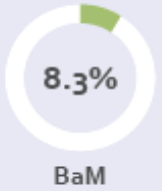
- Very likely to talk with their health care provider if they experience depression or anxiety
- Very knowledgeable about available resources in their community if they experience depression or anxiety
- Very likely to breastfeed their baby
- Very confident or confident in their ability to breastfeed their baby
- More knowledgeable about signs and symptoms of preterm labor and what to do in the case of preterm labor
- More likely to put their infant to sleep in a safe position and location

KPCC
Kansas Perinatal Community Collaboratives

KANSAS MATERNAL & CHILD HEALTH

For BaM/Cb Mothers, They:

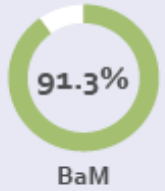
Had a lower pre-term birth rate



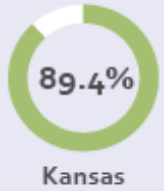
BaM

Kansas

Had a higher rate of breastfeeding initiation

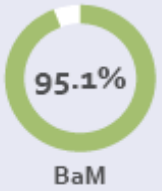


BaM



Kansas

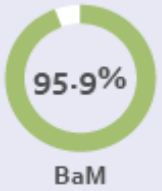
Reported placing baby down to sleep only on its back



BaM

Kansas

Reported putting baby down to sleep in a crib, bassinet or portable crib only

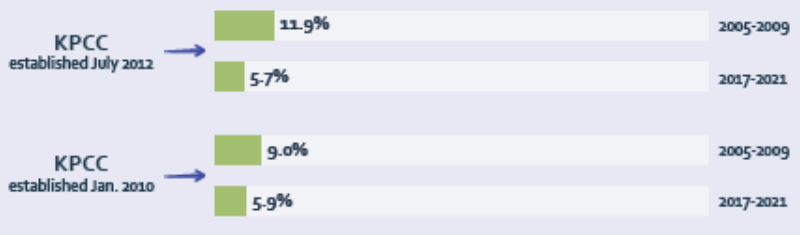


BaM

These outcomes equate to healthier moms and babies and lower healthcare and other associated costs.

Source: Bureau of Epidemiology and Public Health Informatics analysis of Becoming a Mom program data, 2018 and Kansas Department of Health and Environment, Birth data, 2018

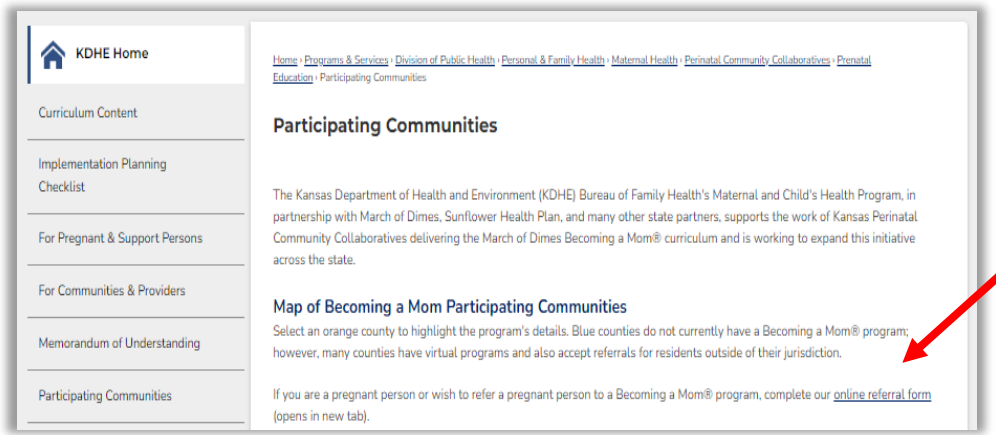
Drop in infant mortality rates in the two longest running KPCC sites



KPCC
Kansas Perinatal Community Collaboratives

KANSAS MATERNAL & CHILD HEALTH

Want to Learn More?



kdhe.ks.gov/588/

KPCC Kansas Perinatal Community Collaboratives

KANSAS MATERNAL & CHILD HEALTH

Kansas Department of Health and Environment

Opportunities for Your Partnership

KPCC/BaM not In Your Area?

Navigate the website to learn more about implementing the model or program

Look for other champions to join you in starting a KPCC

Refer to a virtual program

KPCC/BaM In Your Area?

Refer a patient

Facilitate a session

Be a guest presenter

Join the Collaborative

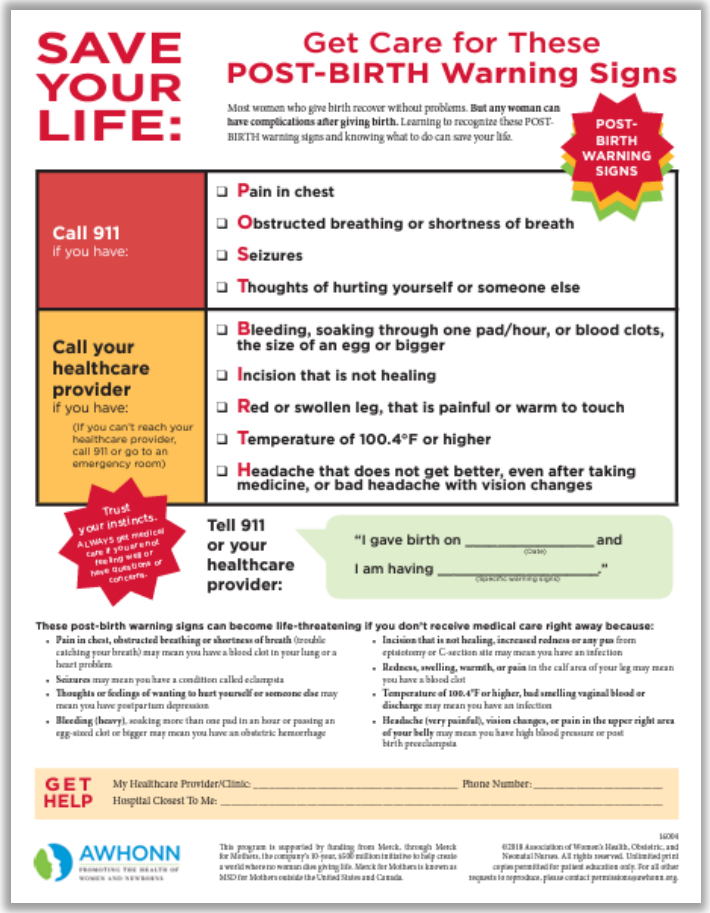
Look for KPCC/BaM Near You!

KANSAS MATERNAL & CHILD HEALTH

AWHONN POST-BIRTH Training

Time Limited Opportunity

- AWHONN POST-BIRTH Warning Signs Online Education Course training seats available at no cost to you
  - Expire December 31, 2023
  - 1 CNE credit
  - Includes access to AWHONN's POST-BIRTH Warning Signs Implementation Toolkit
  - Email if interested:
    - JillElizabeth.Nelson@ks.gov
    - kdhe.KPCC@ks.gov



SAVE YOUR LIFE:

Get Care for These POST-BIRTH Warning Signs

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

POST-BIRTH WARNING SIGNS

Call 911 if you have:

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

Call your healthcare provider if you have:

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

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

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

Tell 911 or your healthcare provider:

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

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

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

GET HELP

My Healthcare Provider/Clinic: _____ Phone Number: _____

Hospital Closest To Me: _____

AWHONN

PROMOTING THE HEALTH OF WOMEN AND NEWBORNS

This program is supported by funding from Merck, through Merck for Mothers, the company's $1-year, $500 million initiative to help create a world where no woman dies giving life. Merck for Mothers is known as MSD for Mothers outside the United States and Canada.

16084

KPCC Kansas Perinatal Community Collaboratives

KANSAS MATERNAL & CHILD HEALTH

Kansas Department of Health and Environment

Questions and Discussion

BREAK

Chandra Burnside, RN, MSN, CNL, IBCLC

Chandra is a graduate of the University of Virginia and The George Washington University. Chandra currently teaches health policy in the graduate nursing programs at Georgetown University and serves as the Clinical Mentor for Women's Health at INOVA Alexandria Hospital in Alexandria, Virginia. She is a graduate of the AWHONN Emerging Leaders Program and a former member of the AHWONN Policy Committee. Chandra's clinical expertise is in labor and delivery, postpartum, and perinatal mental health. Prior to her nursing career, Chandra spent a decade working as a registered lobbyist, representing a number of special interest groups, including registered nurses. Chandra continues to have a passion for public policy, especially where policy and the nursing profession intersect. In addition to her academic and hospital administration roles, she currently moderates a peer support group for women and families struggling with postpartum anxiety and depression. Chandra lives in the Washington, DC area with her husband and three children.

AVOIDING THE MENU

THE WHO, WHAT, WHEN, WHERE, AND WHY OF CLAIMING OUR PLACE AT THE POLICY TABLE

CHANDRA BURNSIDE, MSN, RN, CNL, IBCLC

Conflict of Interest Disclosure

- I have no actual or potential conflicts of interest.
- I do not have any relationships with companies that manufacture medical devices, pharmaceuticals, biologics, or other companies producing FDA-regulated products.
- Opinions presented are my own, and do not necessarily reflect those of my employers.

LEARNING OBJECTIVES

- Understand the “who” of current state of nurse participation in advocacy and national political leadership
- Understand “why” it is critical for women’s health nurses to not only be aware of what is happening politically, but to make sure they are taking a seat at the policy table.
- Understand “what” kind of activities are included in political participation
- Understand “when” in the policy making process input from women’s health nurses is necessary
- Understand “where/how” participation can occur for women’s health nurses

Before we get started– use your phone to scan the QR code and give me the first
word that comes to mind when you hear the phrase ”government policy”…

REFLECTION

WHAT DOES IT MEAN TO BE "POLITICALLY ACTIVE" ANYWAY?

- Burns[1] defines political participation as: "activity that has the intent or effect of influencing government action."
- Directly: Implementation of policy
  - I run for office/take a government position and serve in a role that puts policy into action
- Indirectly: Influencing the individuals who make the policy
  - I call or meet with my elected members of government and share my unique perspective
- Political Activity: **Doing something with politics rather than just being aware.**

[1]Burns, N., Schlozman, K.L., & Verba, S. (2001). The private roots of public action: Gender, equality, and political participation. Cambridge, Massachusetts. Harvard University Press.

HOW DO NURSES STACK UP WITH PHYSICIANS IN POLITICAL ACTIVITY: POLITICAL ACTION COMMITTEE CONTRIBUTIONS IN THE 2020 ELECTION CYCLE[1]

	Total Raised	Total Spent	Begin Cash on Hand
American Society of Anesthesiologists	**$7,423,340**	$6,916,171	$597,670
American Assn of Nurse Anesthetists	**$1,925,840**	$1,543,515	$960,374
American Medical Assn	**$1,617,198**	$1,722,900	$1,142,153
American Nurses Assn	**$513,077**	$397,735	$155,147
American Academy of Family Physicians	**$801,565**	$602,351	$463,866
American Assn of Nurse Practitioners	**$515,905**	$224,954	$295,623
American Congress of Obstetricians & Gynecologists	**$1,024,784**	$996,359	$377,617
American College of Nurse Midwives	**$115,644**	$74,451	$257,884

[1]Source: http://www.opensecrets.org/pacs/sector.php?cycle=2016&txt=H01

NAME A PHYSICIAN WHO IS A "HOUSEHOLD NAME"

NOW, NAME A NURSE WHO IS A "HOUSEHOLD NAME"

TAKEAWAYS?

WHY DO I NEED TO KNOW ABOUT POLICY?

- Fewer than 30% of Congressional seats are held by women[1]
- Fewer than 0.4% of Members of Congress are nurses[2]
- And yet, nearly 1,400 pieces of legislation touching women's health have been introduced since January in the current Congress[3]
- In the history of the US Congress, only ten members (out of roughly 11,000 people) have given birth while serving a term in Congress[4]

Zero babies* have been elected to the United States Congress

[1]https://cawp.rutgers.edu/facts/levels-office/congress/women-serving-118th-congress-2023-2025
[2]https://www.nursingworld.org/practice-policy/advocacy/federal/nurses-serving-in-congress/
[3]https://www.congress.gov/search?q=%7B%22congress%22%3A%5B%22118%22%5D%2C%22source%22%3A%22all%22%2C%22search%22%3A%22women%27s%20health%22%7D
[4]https://www.congress.gov/search?q=%7B%22congress%22%3A%5B%22118%22%5D%2C%22source%22%3A%22all%22%2C%22search%22%3A%22women%27s%20health%22%7D

SO WHO IS TELLING THE POLICY MAKERS ABOUT OUR WORK AS NURSES AND THE LIVES OF OUR PATIENTS?

I wouldn‘t likely call this person to fix a broken tooth, or do my taxes (even though presumably he has both teeth and taxes)…

YOU MAY HAVE HEARD THIS BEFORE, BUT…

"IF YOU'RE NOT AT THE TABLE, YOU'RE ON THE MENU."

JUST LIKE THE MOVIES…

Okay, not really…

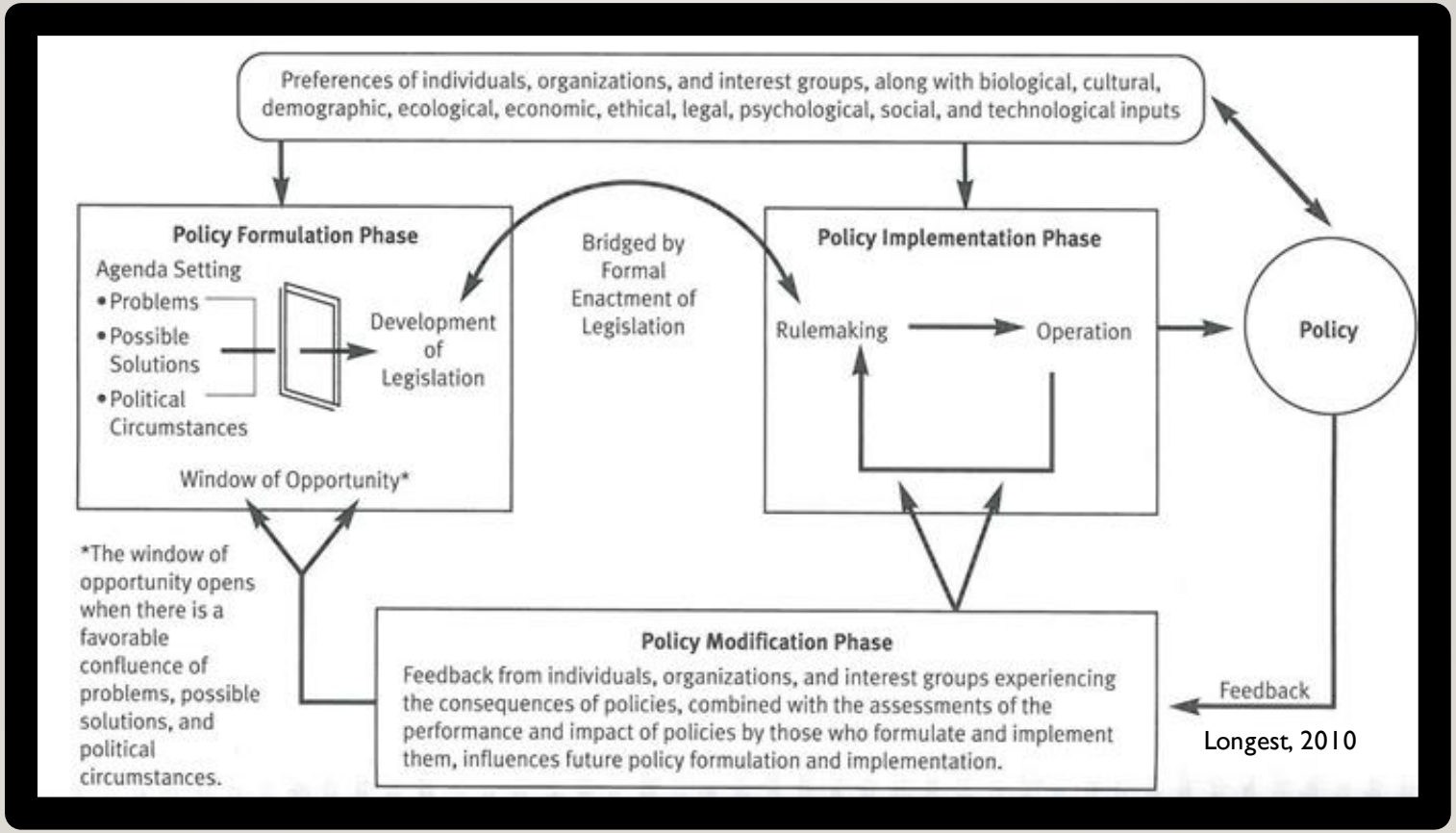
Not for nurses, and not for the practice of politics either

But what happens if policy makers only see nurses as Jackie, Morgan, or Hot Lips?

WHAT KINDS OF THINGS CAN A NURSE DO TO IMPACT POLICY?

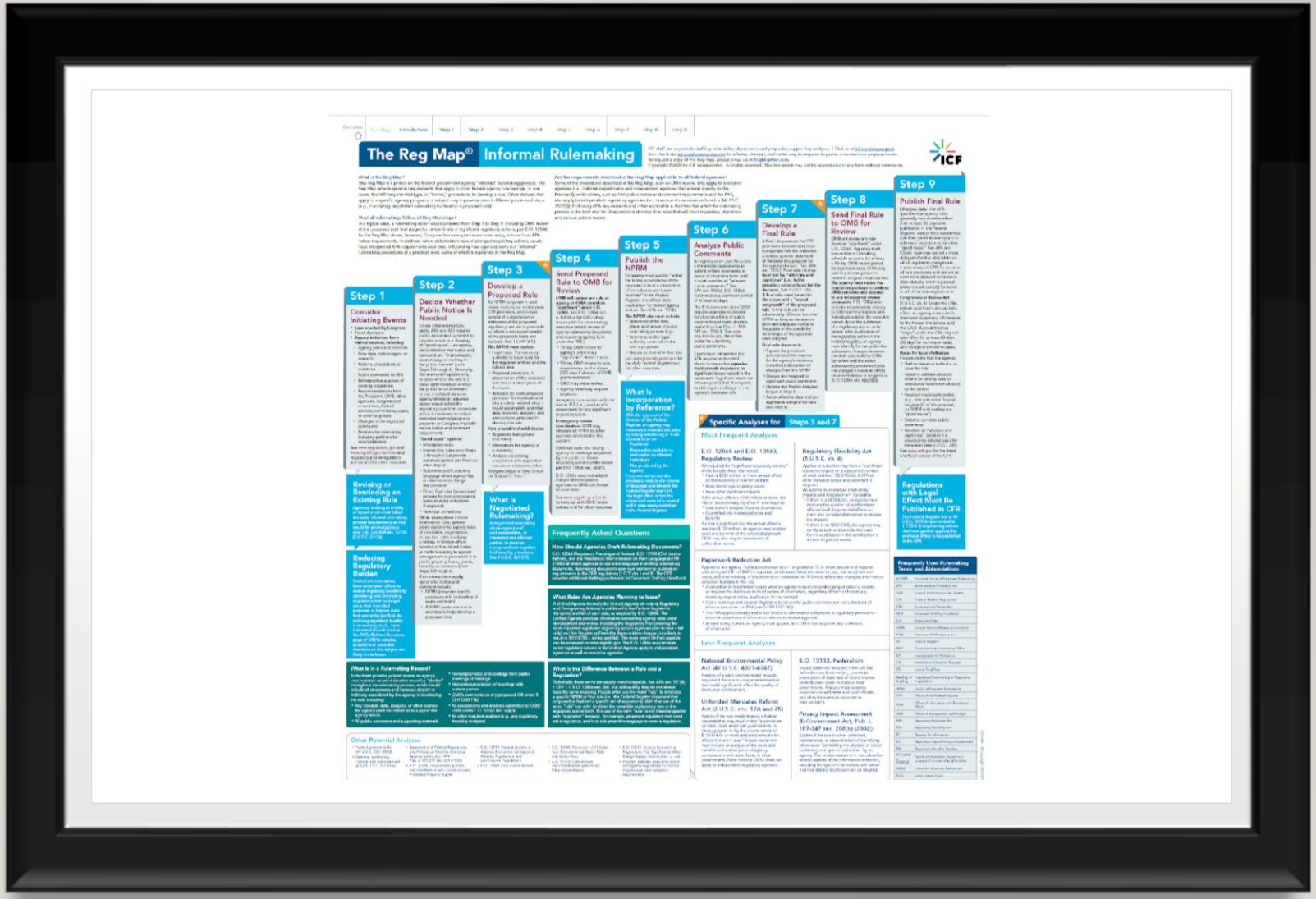
- Register to vote
- Familiarize yourself with your elected officials
  - Local (City/County)
  - State (Governor/State Executives, State Legislature)
  - Federal (Senators and Representatives, President)
- Join your nursing organization ( you're already engaged in AWHONN!)
- Donate to a campaign or Political Action Committee (time, talent, or treasure)
- But wait, there's more…

WHEN ARE THE OPPORTUNITIES FOR INFLUENCE?



Longest, 2010

THE REGULATORY PROCESS



SO WHEN?

- Budget process (typically ahead of the President's budget introduction in February)
- Appropriations process (typically in the spring when all is functional. Shut downs happen when this process falters)
- When programs are up for reauthorization (ex. Title VIII of the Public Health Service Act– the Nursing Workforce Development Programs. Timing varies.)
- Whenever called upon by your nursing organizations

AND HOW?

BEING AWARE IS THE FIRST STEP, BUT DOING IS THE KEY

- Attend town hall meetings
- Visit with elected officials when they are home in the district
- Communicate regularly
- Consider volunteering for a campaign of a candidate you believe in
- Join voter registration drives
- Present yourself as available for expert testimony on topics related to your practice
- Be an election monitor
- Consider writing opeds for local papers about topics impacting your practice as a nurse:
  - Staffing
  - Student loan burden for nurses
  - Maternal mortality crisis
  - Social determinants of health
  - Opioid crisis
- Run for elected office yourself!

FINAL THOUGHTS

- Nurses understand complex systems and operate within them everyday
- We work in systems of politics and intuitively and inherently understand priorities and trade offs (horse trading)
- There are 5.2 million nurses in the United States (nearly four times the number of physicians).[1] If we don't amplify our voices and take our seat at the table, we leave ourselves on the menu

(S1-S90). Smiley, R.A., Allgeyer, R.L., Shobo, Y., Lyons, K.C., Letourneau, R., Zhong, E., Kaminski-Ozturk, N., & Alexander, M. (April 2023). The 2022 National Nursing Workforce Survey. *Journal of Nursing Regulation,* 14(1), Supplement

LUNCH & VENDOR NETWORKING

Organon/JADA
Molnlycke Health Care
Johnson & Johnson
OBIX by Clinical Computer Systems, Inc.
Alexion Pharmaceuticals
Hologic, Inc.
Amico Corporation
Abbott Nutrition
Salina Regional Health Center Foundation
Kansas Breastfeeding Coalition

Welcome Back & Introduction of Panels:

Who are the Experts at the Table?

State-Level Perinatal Resources and Organizations

Jennifer Miller, DrPH

Title V MCH Director, Kansas Department of Health & Environment (KDHE)

Christy Schunn, LSCSW

Kansas Infant Death and SIDS (KIDS) Network

Oluoma Obi, BA, MPH student

Kansas Birth Equity Network

Brenda Bandy, IBCLC

Kansas Breastfeeding Coalition, Inc.

Erin Bider, MD

Kansas Connecting Communities

BREAK

State and National Perinatal Clinical Experts

Heather Scruton, RN

Obstetric Emergency Services RN

Devika Maulik, MD

Maternal Fetal Medicine

Allison Haynes, MD

Family Practice

Ginger Breedlove, PhD, CNM, FACNM, FAAN

Certified Nurse Midwife

Kourtney Bettinger, MD, MPH

Pediatrician

Tara Chettiar, MD

American College of Obstetricians and Gynecologists (ACOG)

Traci Johnson, MD

Dr. Traci Johnson was born and raised in rural Texas, and her skill as a left-fielder earned her a softball scholarship to Prairie View A&M University outside of Houston. She attended MCP Hahnemann College of Medicine in Philadelphia, now Drexel University College of Medicine, due to its rich history of paving the way for women in medicine and women of color. She entered residency at the vigorous Washington University in St. Louis, where she was honored to serve as Administrative Chief Resident.

After repaying her service as a National Health Service Corps Scholar at a rural Federally-Qualified Health Center, she slowly migrated to the private practice sector of Kansas City but felt the pull of academics where she feels most impactful. At University Health, she oversaw a busy Labor and Delivery Unit as the Director for L&D while serving as Associate Program Director for the OBGYN residency program. Her passion, however, is her work in population health equity and special communities. She serves as a leader in Missouri's Hospital Association's Perinatal Quality Review Board, overseeing efforts to decrease maternal and infant mortality in the state. She also was appointed as a member of the Pregnancy-Associated Mortality Review Board in Jeff City, reviewing all pregnancy-related deaths in Missouri. She was recently elected Chair-Elect of this prestigious board and will focus the next two years on health equity.

She recently completed a life-long dream of subspecialty training in Maternal-Fetal Medicine at the University of Missouri-Kansas City and will return to academics this summer.

When she is not doing all this, you will see her and her husband cheering their two sons and daughter emphatically at soccer or gymnastics.

Upcoming events:

In case you missed it:

https://www.hhdesignsks.com/products/kpqc-wordle

Sweatshirts, long sleeves, etc. also available!

Closing