Rapid Response: Welcome, Kari Smith!
RAPID RESPONSE: Feedback?

February FTI Learning Forum-
Mandated Reporting and Perinatal Substance Use
RAPID RESPONSE: Learning Opportunity

2023 Obstetric Emergency Readiness Community of Learning

Registration Closing March 17th!

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

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

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

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

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

Register Here!
Important Dates:

Next Learning Forum: April 25, 2023

Speaker: Dr. Kourtney Bettinger
Topic: Hot Topics in Kansas: Neonatal Care
Kansas Perinatal Quality Collaborative

Spring Conference

Save the Date

May 23, 2023

General KPQC Membership (virtual)
9:00-12:00

FTI Champions (in-person)
9:00-4:00
Sunflower Foundation, Topeka, KS

KPQC

Fourth Trimester Initiative
The women speak: Birth & Death data and what it means to FTI
Live Births: 34,368

Stillbirths: 169

Total Births: 34,537

3,645 abortions

5 maternal deaths (7 in 2019)

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

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

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

- **Pregnancy-associated, but not-related death.** The death of a woman during pregnancy or within one year of the end of pregnancy from a cause that is not related to pregnancy.

- **Pregnancy-associated but unable to determine pregnancy relatedness.** The death of a woman while pregnant or within one year of pregnancy, due to a cause that could not be determined to be pregnancy-related or not pregnancy-related.

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# The Role of the MMRC

<table>
<thead>
<tr>
<th>Data Source</th>
<th>CDC – National Center for Health Statistics (NCHS)</th>
<th>CDC – Pregnancy Mortality Surveillance System (PMSS)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Death certificates</td>
<td>Death certificates linked to fetal death and birth certificates</td>
</tr>
<tr>
<td>Time Frame</td>
<td>During pregnancy – 42 days</td>
<td>During pregnancy – 365 days</td>
</tr>
<tr>
<td>Source of Classification</td>
<td>ICD-10 codes</td>
<td>Medical epidemiologists (PMSS-MM)</td>
</tr>
<tr>
<td>Purpose</td>
<td>Show national trends and provide a basis for international comparison</td>
<td>Analyze clinical factors associated with deaths, publish information that may lead to prevention strategies</td>
</tr>
</tbody>
</table>

**Maternal Mortality Review Committees**

- Death certificates linked to **fetal death and birth certificates**, medical records, social service records, autopsy, informant interviews...
  - During pregnancy – 365 days

**Multidisciplinary committees**

- Understand medical and non-medical contributors to deaths, prioritize interventions that effectively reduce maternal deaths

Pregnancy-Associated deaths
KMMRC Determinations
Kansas, 2016-2020
(Preliminary Data, Subject To Change)

More than half (52.4%) of all pregnancy-associated deaths occurred after 42 days postpartum
Pregnancy Associated Deaths
Kansas, 2016-2020
(Preliminary Data, Subject to Change)

Source: Kansas Maternal Mortality Review Committee

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 live in the highest median household income (quartile 4, wealthiest).

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

Figure 1
Chart Title: Percent of Pregnancy-associated deaths and live births by race and ethnicity, Kansas, 2016-2020
Source: Kansas Maternal Mortality Review Committee; Kansas Department of Health and Environment, birth data (occurrence)
Pregnancy Associated deaths
Causes of death; Kansas, 2016-2020
(Preliminary Data, Subject To Change)

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

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

• The remainder were caused by motor vehicle crash, fire or burn accidents, and unknown (27 deaths, 25.7%).
KMMRC determinations on circumstances surrounding death were:

- **Obesity** contributed to **23.8%**
- **Discrimination** contributed to **7.4%**
- **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%).
The leading causes of death were (in order):

- Cardiovascular conditions
- Hypertensive disorders
- Embolism
- Infection
Covid related fallouts set us back BIG!
What GAO Found

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

Maternal Deaths, 2018 through 2021

Number of deaths

<table>
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<tr>
<th>Year</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
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<td>Deaths not related to COVID-19</td>
<td>650</td>
<td>754</td>
<td>691</td>
<td>573</td>
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<tr>
<td>Deaths related to COVID-19</td>
<td>902</td>
<td>709</td>
<td>721</td>
<td>777</td>
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Source: GAO analysis of Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS) data. GAO-23-1038T

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

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

Disparities in other adverse outcomes, such as preterm and low birthweight births, persisted for Black or African-American (not Hispanic or Latina) women, according to GAO analysis of CDC data.
Maternal Mortality Rates in U.S., 2021

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

- Total: 20.8 deaths per 100,000 live births in 2021
- Non-Hispanic Black: 18.9 deaths per 100,000 live births in 2021
- Non-Hispanic White: 18.2 deaths per 100,000 live births in 2021
- Hispanic: 18.2 deaths per 100,000 live births in 2021

Statistically significant increase from previous year (p < 0.05).

NOTE: Race groups are single race.


KPCQ

Fourth Trimester Initiative
“...stillbirths and maternal mortality are shockingly high in the United States compared with other similarly developed nations, and that Black women are paying the highest price.”
Additional COVID-19 set-backs

Prenatal Care visits decreased as did postpartum visits
Healthcare infrastructure was strained
Increase in maternal anxiety and depression
Domestic violence spiked

Struggle with increased childcare demands
Women more vulnerable to loss of income during pandemic
Total % of preterm births increased
Drug Related Deaths in Kansas

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

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

* per 100,000 U.S. 2000 Standard Population
Let’s Talk about Nursing!

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

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

• March 2022, COVID-19 Impact Assessment Survey found 52% of nurses are considering leaving their current position
  • primarily to insufficient staffing, work negatively affecting health and well-being, and inability to deliver quality care.
  • 60% of acute care nurses report feeling burnt out, and 75% report feeling stressed, frustrated, and exhausted.
• How Do We Improve Patient Outcomes Without Nursing?
DO
MORE
WITH
LESS
## KPQC Fourth Trimester Initiative
### Champion Timeline

<table>
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<tr>
<th>FTI Project</th>
<th>Start</th>
<th>Finish</th>
<th>Sept '22</th>
<th>Oct '22</th>
<th>Nov '22</th>
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In every patient, in every birth setting, in every protocol:

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

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

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

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

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

Conduct a comprehensive postpartum visit.*
Hospitals will need to submit the following items MONTHLY:

1- Number of maternal discharges after live birth
   a. **NOTE:** goal is to provide data disaggregated by race
2- Number of patients discharged that have been:
   a. Given education and discharge materials on POSTBIRTH (Magnet, Mom Card, etc)
   b. Screened for Social Determinants of Health
   c. Provided a Postpartum Appointment prior to discharge
3- Number of educational offerings done each month that are related to FTI work
   For example: POSTBIRTH or KBEN trainings, Learning Forums, General Meetings/Conferences, Hospital Trainings/Simulations, Perinatal community meetings and trainings
4- Number of agencies or hospital units involved in those trainings referenced in #3
5- When the Emergency Dept in your facility begins to incorporate a screening question for current or future PG in each triage of female patients of childbearing age
6- TBD: Birth Equity Training, PP Visit Template sharing with outpatient clinics, Patient Debriefs after adverse outcome
QHi
Quality Health Indicators

Email: your@email.com
Password: ********
Login

An enterprise-wide benchmarking program committed to improving the quality of care and financial viability of rural healthcare providers since 2003.
From the Welcome Page
Select Submit Data from the Data Submission menu

All measures selected to collect appear on the Data Submissions page

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

Select the FTI: Fourth Trimester Initiative
Now, only FTI measures appear

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