1

KHC Office Hours

May 28th, 2025

Kansas Maternal and Child Health

Severe Hypertension in Pregnancy: A Comprehensive Approach for Kansas

Jill Nelson- Kansas Department of Health and Environment
Terrah Stroda, CNM- Kansas Perinatal Quality Collaborative

KANSAS MEDICAL SOCIETY Established 1859

Kansas Healthcare COLLABORATIVE

KHA Kansas Hospital ASSOCIATION

2

DISCLAIMER

All Kansas Healthcare Collaborative, Inc. ("**KHC**") content and information in KHC's publications, presentations, and on KHC's website ("**KHC Content**") are for informational and educational purposes only. KHC Content does not create any type of relationship with, or duty to, the reader, attendee, or user. KHC Content does not constitute legal, tax, business, professional, or personal advice. KHC disclaims any and all liabilities and warranties, express or implied, arising from users' access and use of KHC Content.

Kansas Healthcare COLLABORATIVE

3

3

Today's Webinar Agenda

- Welcome – 5 mins
- Content Presentation 45 mins
- Q&A 5 Mins
- Closing Comments 2 mins

Kansas Healthcare COLLABORATIVE

4

4

Severe Hypertension in Pregnancy: A Comprehensive Approach for Kansas

Jill Nelson- Kansas Department of Health and Environment

Terrah Stroda, CNM- Kansas Perinatal Quality Collaborative

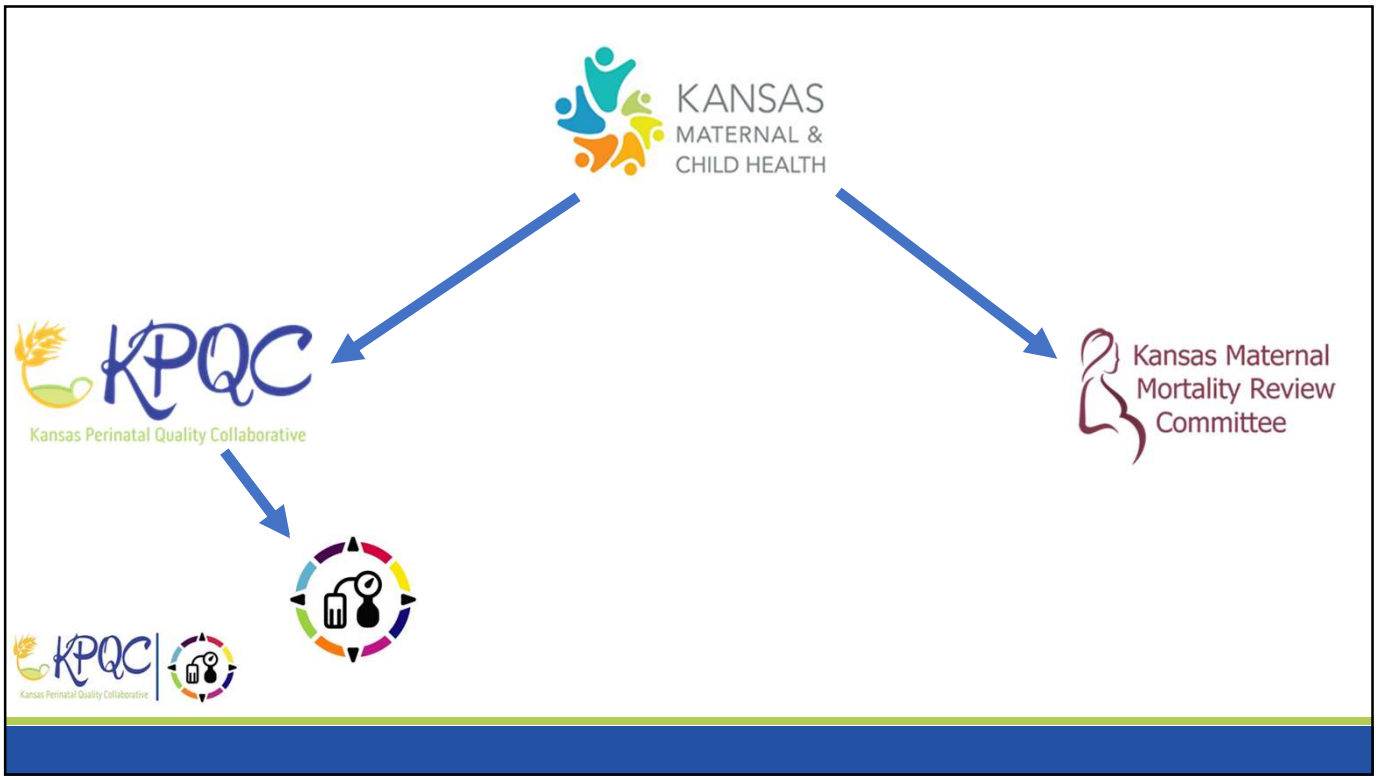
5

Session Presenters

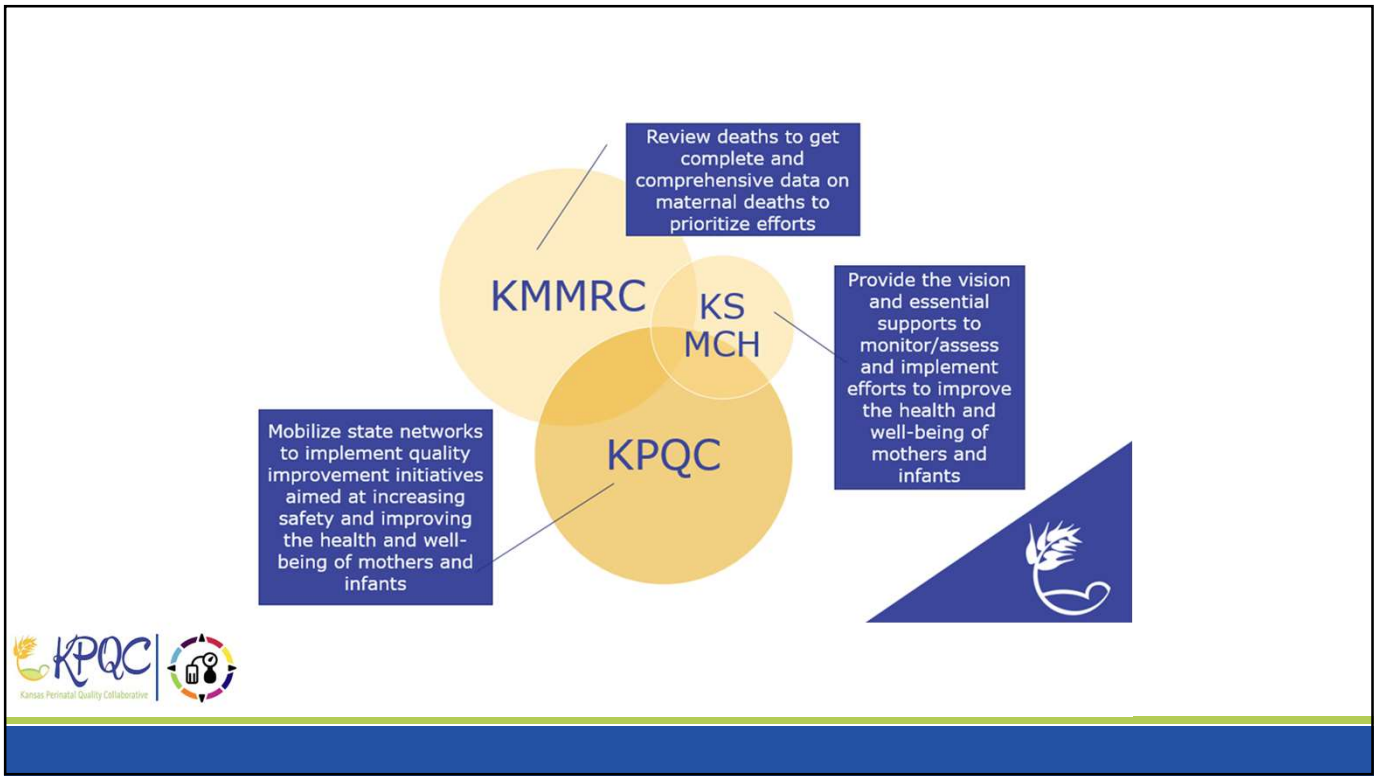
Jill Nelson

Terrah Stroda, CNM

6


KANSAS
MATERNAL &
CHILD HEALTH
KPQC
Kansas Perinatal Quality Collaborative
Kansas Maternal
Mortality Review
Committee

7


Review deaths to get complete and comprehensive data on maternal deaths to prioritize efforts
KMMRC
KS
MCH
KPQC
Provide the vision and essential supports to monitor/assess and implement efforts to improve the health and well-being of mothers and infants
Mobilize state networks to implement quality improvement initiatives aimed at increasing safety and improving the health and well-being of mothers and infants

8

Community Support for Positive Clinical Outcomes

9

Maternal Health in the Sunflower State

10

10

	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**

Source: St. Pierre A; Zaharatos J; Goodman D; Callaghan WM. Jan 2018. Challenges and opportunities in identifying, reviewing, and preventing maternal deaths. Obstetrics and Gynecology. 131; 138-142.

11

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.

12

Pregnancy-Associated Deaths 2016-2022 (Total=153)

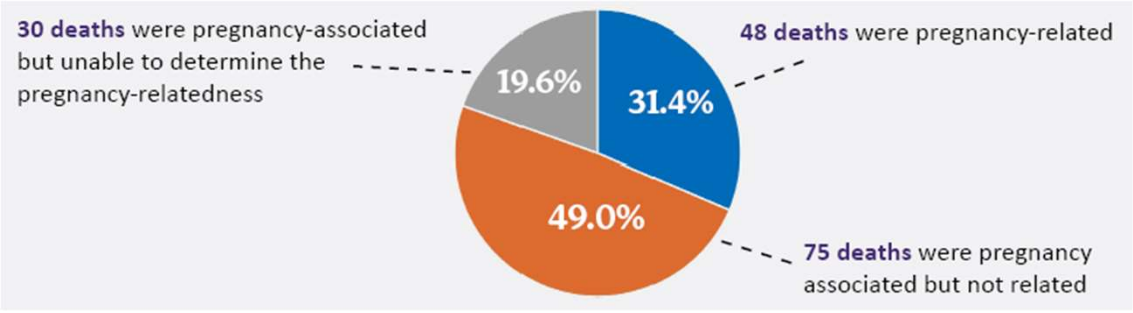
Preliminary Data – Subject to Change

- Total deaths occurred in Kansas: 195
- Pregnancy-associated deaths determined by KMMRC: **153**

Source: KMMRC Determinations, Kansas, 2016-2022 (Preliminary Data, Subject To Change)

13

Pregnancy-Associated Deaths 2016-2022 (Total=153)

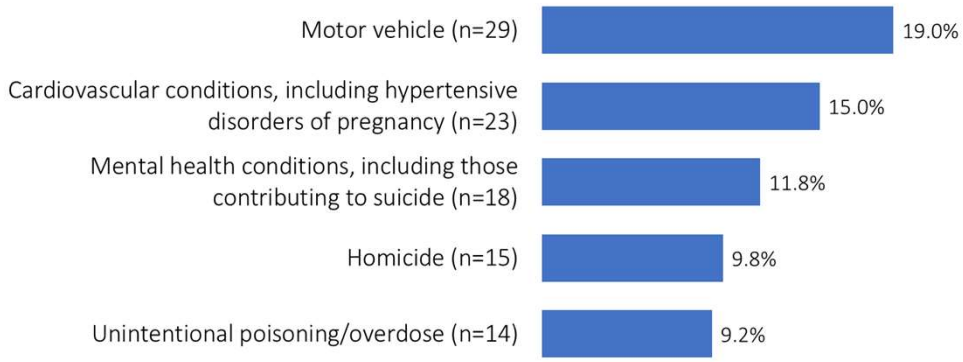


More than half (51.6%) of all pregnancy-associated deaths occurred after 42 days postpartum.

Source: KMMRC Determinations, Kansas, 2016-2022 (Preliminary Data, Subject To Change)

14

Leading Causes of Pregnancy-Associated Deaths 2016-2022 (Total=153)



Source: KMMRC Determinations, Kansas, 2016-2022 (Preliminary Data, Subject To Change)

15

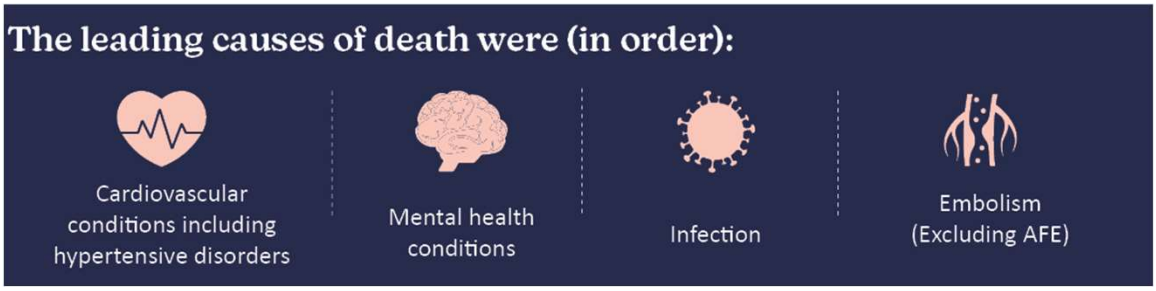
Pregnancy-Associated Deaths 2016-2022 (Total=153)

- **Nearly half (69 deaths, 45.1%) were related to medical causes of death, such as:**
  - **Cardiovascular conditions including hypertensive disorders of pregnancy**
  - **Infection**
  - **Malignancies**
  - **Embolism**
  - **Hemorrhage**
- Nearly one-third (47 deaths, 30.7%) were caused by:
  - Mental health conditions, including those contributing to suicide
  - Homicide
  - Unintentional poisoning/overdose
- The remainder (37 deaths, 24.2%) were caused by:
  - Motor vehicle crash
  - Fire or burn accidents
  - Unknown

Source: KMMRC Determinations, Kansas, 2016-2022, (Preliminary Data, Subject To Change)

16

Pregnancy-Related Deaths 2016-2022 (Total=48)

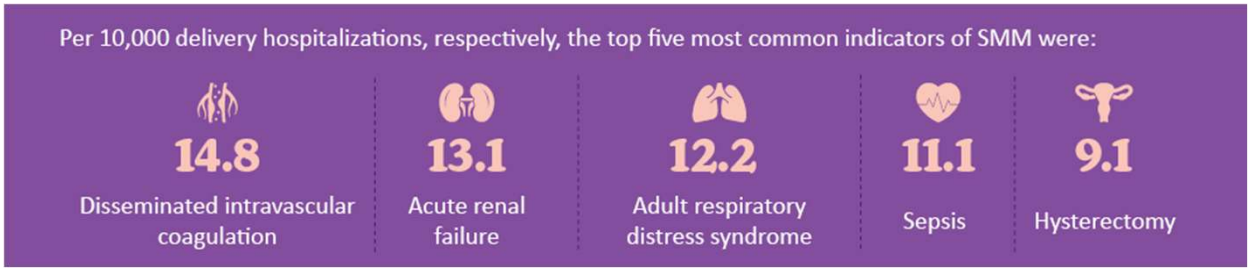


Note: Mental health conditions, including those contributing to suicide.

Source: KMMRC Determinations, Kansas, 2016-2022 (Preliminary Data, Subject To Change)

17

Severe Maternal Morbidity 2018-2022 (Total=1,067)



Source: Kansas Department of Health and Environment, Kansas Hospital Discharge Data, Kansas, 2018-2022, (Preliminary Data, Subject To Change).

18

Definition

Preeclampsia is a serious disorder that can affect all the organs in the body. It usually develops after 20 weeks of pregnancy, often in the third trimester. When it develops before 34 weeks of pregnancy, it is called early-onset preeclampsia. It can also develop in the weeks after childbirth.

Source: Preeclampsia and High Blood Pressure During Pregnancy. The American College of Obstetricians and Gynecologists. acog.org/womens-health/faqs/preeclampsia-and-high-blood-pressure-during-pregnancy

19

2022 Natality Report

Table 22. Number of Births Where Reported Medical Risk Factors by Population Group, Kansas, 2022*

Medical Risk Factors†	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	217	0.9	31	1.4	2	1.2	15	1.3	14	1.5	99	1.6	1	1.0	379	1.1
Gestational Diabetes	1,945	8.3	173	7.9	16	9.7	195	17.3	74	7.8	608	9.7	6	6.3	3,017	8.8
Pre-pregnancy Hypertension	636	2.7	113	5.2	6	3.6	23	2.0	26	2.7	107	1.7	3	3.1	914	2.7
Pre-eclampsia	2,467	10.5	204	9.3	20	12.1	83	7.4	80	8.4	462	7.3	3	3.1	3,319	9.7
Eclampsia	84	0.4	8	0.4	0	0.0	1	0.1	3	0.3	19	0.3	0	0.0	115	0.3
Previous Pre-term Birth	656	2.8	124	5.7	6	3.6	26	2.3	26	2.7	203	3.2	1	1.0	1,042	3.0
Previous Poor Pregnancy Outcome	776	3.3	144	6.6	12	7.3	56	5.0	23	2.4	303	4.8	1	1.0	1,315	3.8
Vaginal Bleeding	216	0.9	28	1.3	0	0.0	9	0.8	10	1.1	63	1.0	0	0.0	326	0.9
Previous C-Section	3,536	15.0	456	20.8	29	17.6	168	14.9	131	13.8	941	14.9	20	20.8	5,281	15.4
Infertility Treatment	618	2.6	13	0.6	2	1.2	47	4.2	11	1.2	45	0.7	3	3.1	739	2.1
Infections Contracted or Treated During Pregnancy§	874	3.7	178	8.1	13	7.9	40	3.6	76	8.0	285	4.5	4	4.2	1,470	4.3
Smoking During Pregnancy	1,442	6.1	166	7.6	23	13.9	10	0.9	89	9.4	143	2.3	0	0.0	1,873	5.4
Alcohol Use During Pregnancy	39	0.2	6	0.3	0	0.0	0	0.0	2	0.2	9	0.1	0	0.0	56	0.2
Total of Medical Risk Factors¶	13,506	n/a¶	1,644	n/a¶	129	n/a¶	673	n/a¶	565	n/a¶	3,287	n/a¶	42	n/a¶	19,846	n/a¶
Total Births	23,569		2,191		165		1,124		949		6,295		96		34,389	

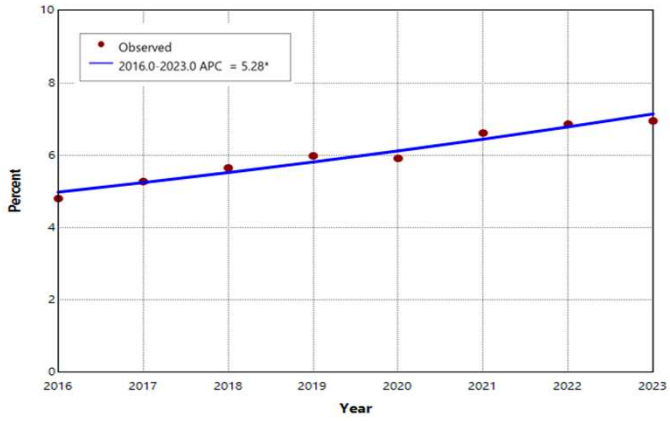
*Residence data
†More than one medical risk factor may have been reported for a birth. Therefore, actual number of births maybe lower than totals.
‡n.s. = not stated
§Infections include: Gonorrhea, Syphilis, Herpes Simplex Virus, Chlamydia, HIV, Hepatitis B & Hepatitis C
¶ n/a: Not Applicable
¶The data provided only includes births with reported medical risk factors, each risk factor is counted individually. The total of birth with risk factor does not equal the total of births.

Source: Kansas Department of Health and Environment, Natality Report by Racial and Ethnic Population Groups, Kansas, 2022
Available at: kdhe.ks.gov/DocumentCenter/View/40442/

20

Preeclampsia prevalence increased significantly from 4.8 to 6.9 per 100 delivery hospitalizations (2016-2023).

Kansas Prevalence of Preeclampsia among Delivery Hospitalization by Year, 2016-2023



Year	Preeclampsia*	Delivery Hospitalizations	Prevalence (%)
2016	1679	34952	**4.8**
2017	1766	33499	5.3
2018	1793	31739	5.6
2019	1941	32453	6.0
2020	1857	31406	5.9
2021	2079	31434	6.6
2022	2116	30849	6.9
2023	2145	30878	**6.9**

*ICD-10-CM diagnosis codes for preeclampsia (O15)

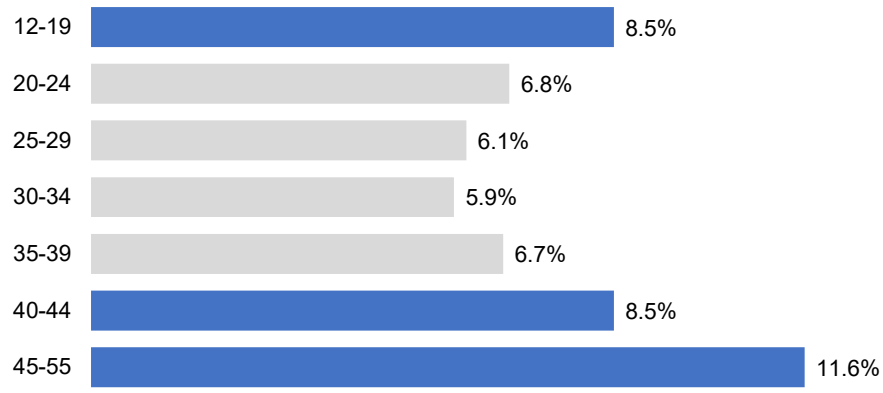
* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.
Final Selected Model: 0 Joinpoints.

Source: Kansas Department of Health and Environment, Kansas Hospital Discharge Data, Kansas, 2016-2023

21

The prevalence is highest at the youngest (12-19 years, 8.5%) and oldest (45-55 years, 11.6%) age groups

Kansas prevalence of Preeclampsia among Delivery Hospitalization by Maternal Age Group (Years) 2019-2023 (five years combined)



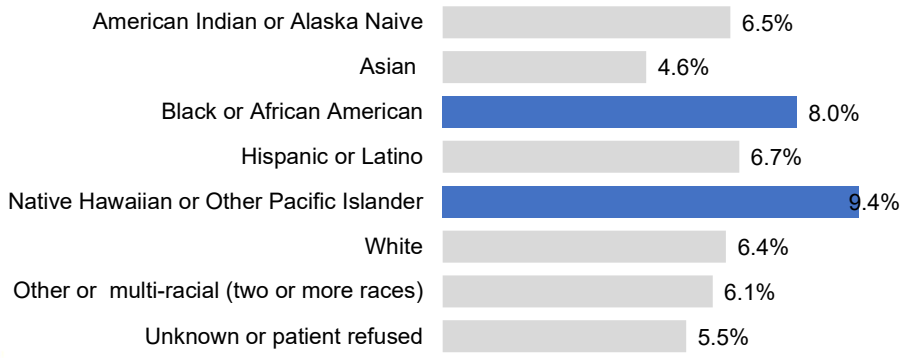
Source: Kansas Department of Health and Environment, Kansas Hospital Discharge Data, Kansas, 2019-2023

22

Non-Hispanic Native Hawaiian or Other Pacific Islander and Non-Hispanic Black or African American mothers face the highest prevalence.

Kansas Prevalence of Preeclampsia among Delivery Hospitalization by **Race and Ethnicity** 2019-2023 (five years combined)

Patients with Hispanic ethnicity are classified as Hispanic and all non-Hispanic patients are classified according to their reported race.



Source: Kansas Department of Health and Environment, Kansas Hospital Discharge Data, Kansas, 2019-2023

23

2023 Annual Summary of Vital Statistics

Live Births: **34,041**

Stillbirths: 186

Total Births: **34,227**

Preterm Birth (<37 wks): 10.5%

Source: Kansas Department of Health and Environment, Kansas Annual Summary of Vital Statistics, 2023. Available at kdhe.ks.gov/DocumentCenter/View/43918/

24

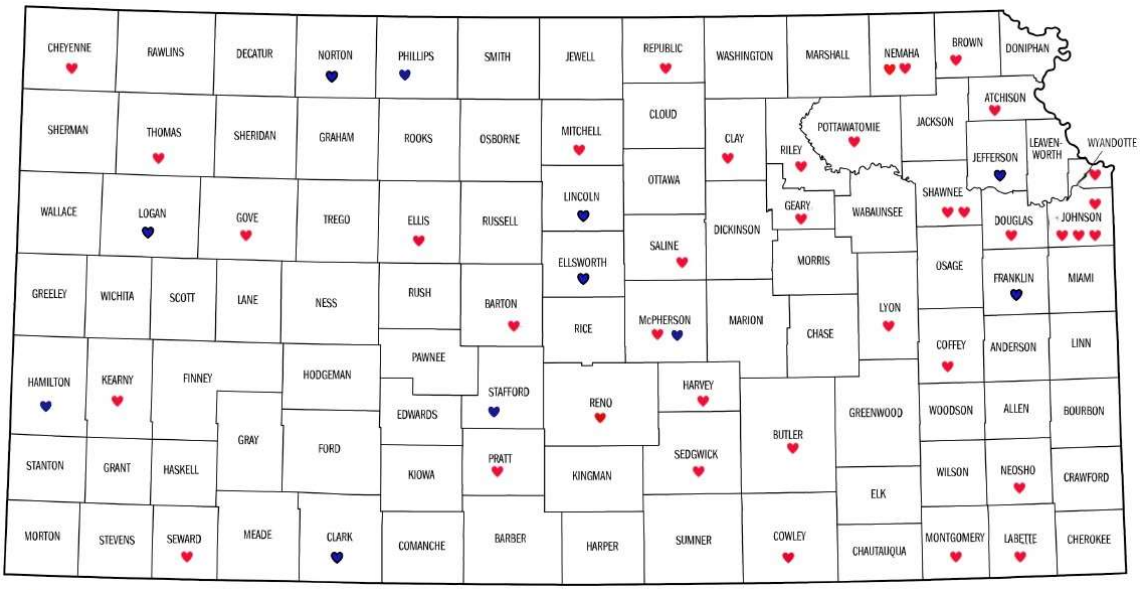
What do we need to do?!

An *intentional* Kansas intervention to address severe HTN in PG and the postpartum period by enrolling in the national Alliance for Innovation on Maternal Health (AIM) Safety Bundle.

KANSAS: Severe Hypertension in Pregnancy

Began in Jan 2025 as a statewide initiative to address this and other adverse maternal outcomes.

25



26

Red ❤ Birthing Facilities

Advent Health Shawnee Mission, Johnson Co
AdventHealth South Overland Park, Johnson Co
Amberwell Hiawatha, Brown Co
Ascension Via Christi Manhattan, Riley Co
Amberwell Atchison, Atchison Co
Cheyenne County Hospital, Cheyenne Co
Citizens Medical Center, Thomas Co
Clay County Medical Center, Clay Co
Coffey County Hospital, Coffey Co
Coffeyville Regional Medical Center, Montgomery Co
Community Healthcare System, Pottawatomie Co
Gove Regional Medical Center, Gove Co
Hays Medical Center, Ellis Co
Hospital District #1 of Rice County, Rice Co
Hutchinson Regional Medical Center, Reno Co
Kearny County Hospital, Kearny Co
Labette Health, Labette Co
Lawrence Memorial Hospital, Douglas Co
McPherson County, McPherson Co
Mitchell County Hospital Health System, Mitchell Co
Nemaha Valley Community Hospital, Nemaha Co
Neosho Memorial Regional Medical Center, Neosho Co
Newman Regional Health, Lyon Co
Newton Medical Center, Harvey Co
Overland Park Regional, Johnson Co
Pratt Regional Medical Center, Pratt Co
Republic County Hospital, Republic Co
Sabetha Community Hospital, Nemaha Co
Salina Regional Health Center, Saline Co
Southwest Medical Center, Seward Co
Stormont Vail Health, Shawnee Co
Stormont Vail Health Flinthills, Geary Co
Susan B Allen Memorial Hospital, Butler Co
University of Kansas Health System- Great Bend, Barton Co
University of Kansas Health System- Olathe, Johnson Co
University of Kansas Health System- St. Francis, Shawnee Co
University of Kansas Health System-KC, Wyandotte Co
Wesley Medical Center, Sedgwick, Co
William Newton Hospital, Cowley Co

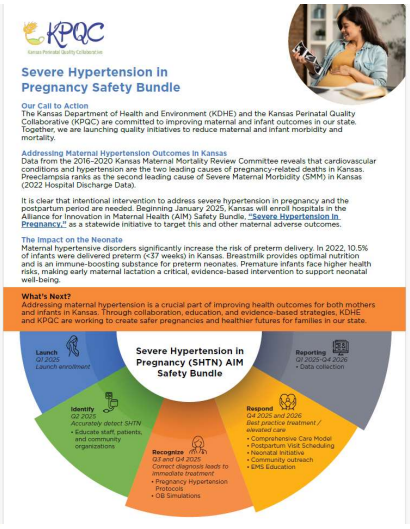
Blue 💙 Non-Birthing Facilities

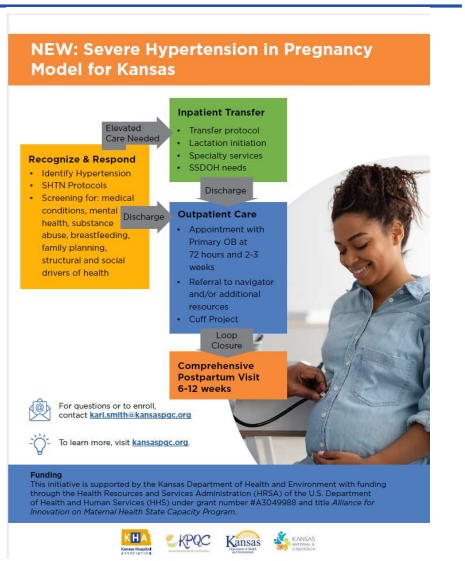
AdventHealth Ottawa, Franklin Co
Ellsworth County Medical Center, Ellsworth Co
FW Huston Medical Center, Jefferson Co
Hamilton County Hospital, Hamilton Co
Lincoln County Hospital, Lincoln Co
Logan County Health Services, Logan Co
Mercy Hospital, Inc., McPherson Co
Minneola Healthcare, Clark Co
Norton County Hospital, Norton Co
Phillips County Health Systems, Phillips Co
Stafford County Hospital, Stafford Co

KPQC Kansas Perinatal Quality Collaborative

27

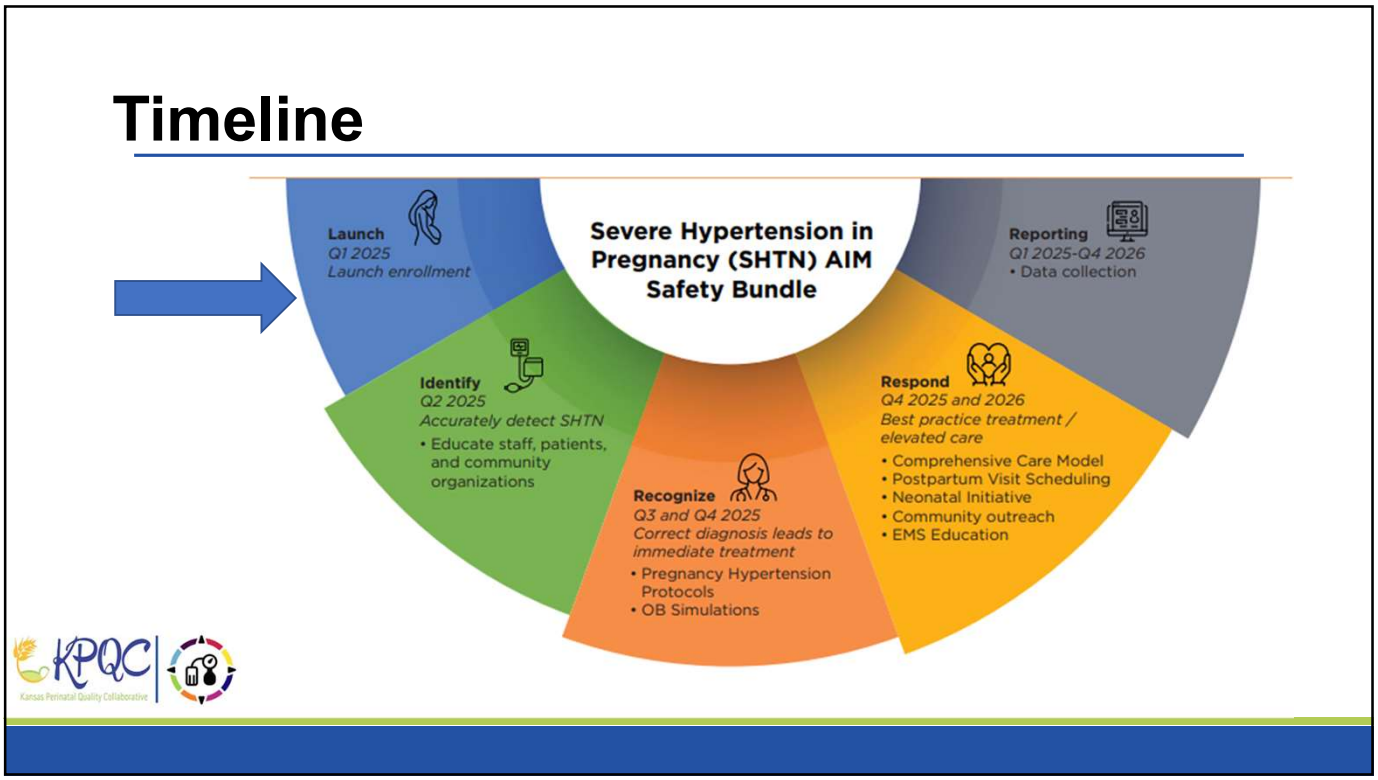
SHTN: Facts Sheet



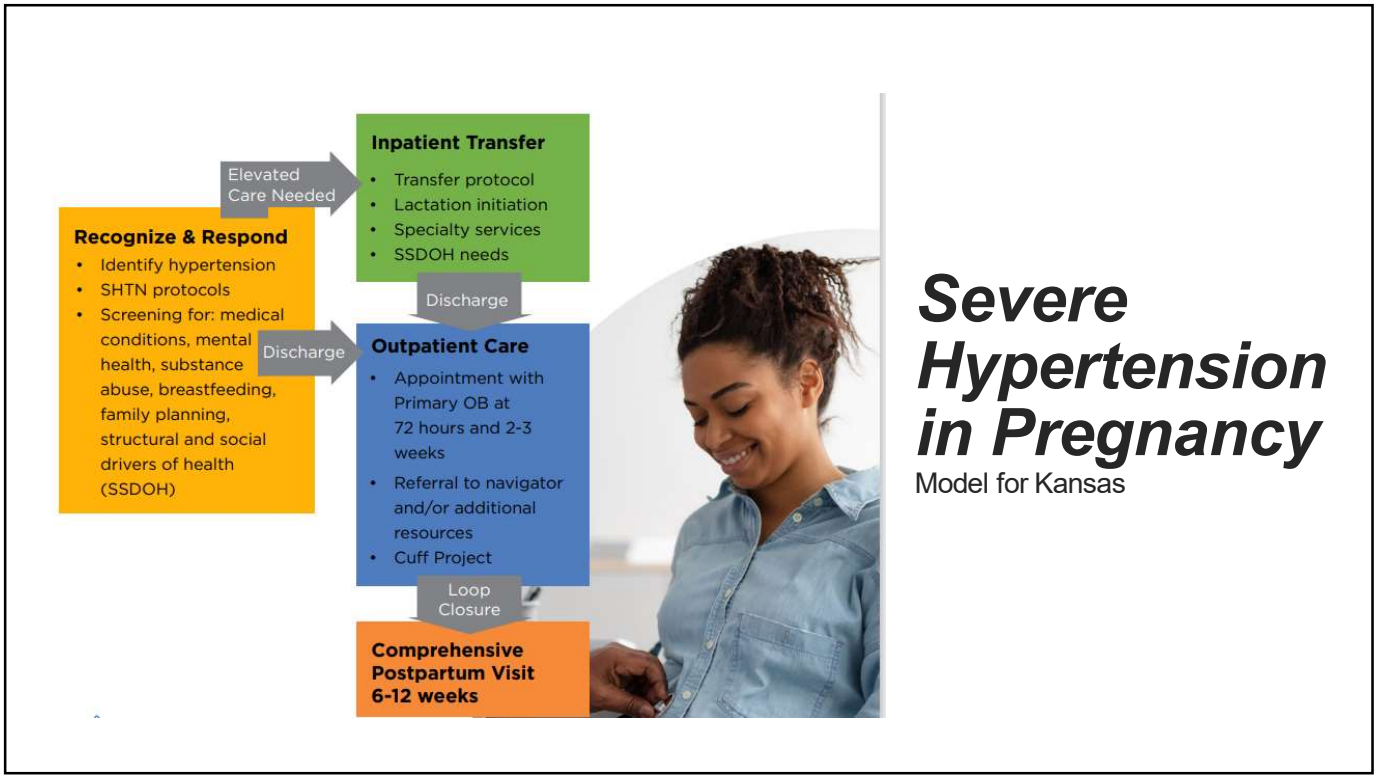


KPQC Kansas Perinatal Quality Collaborative

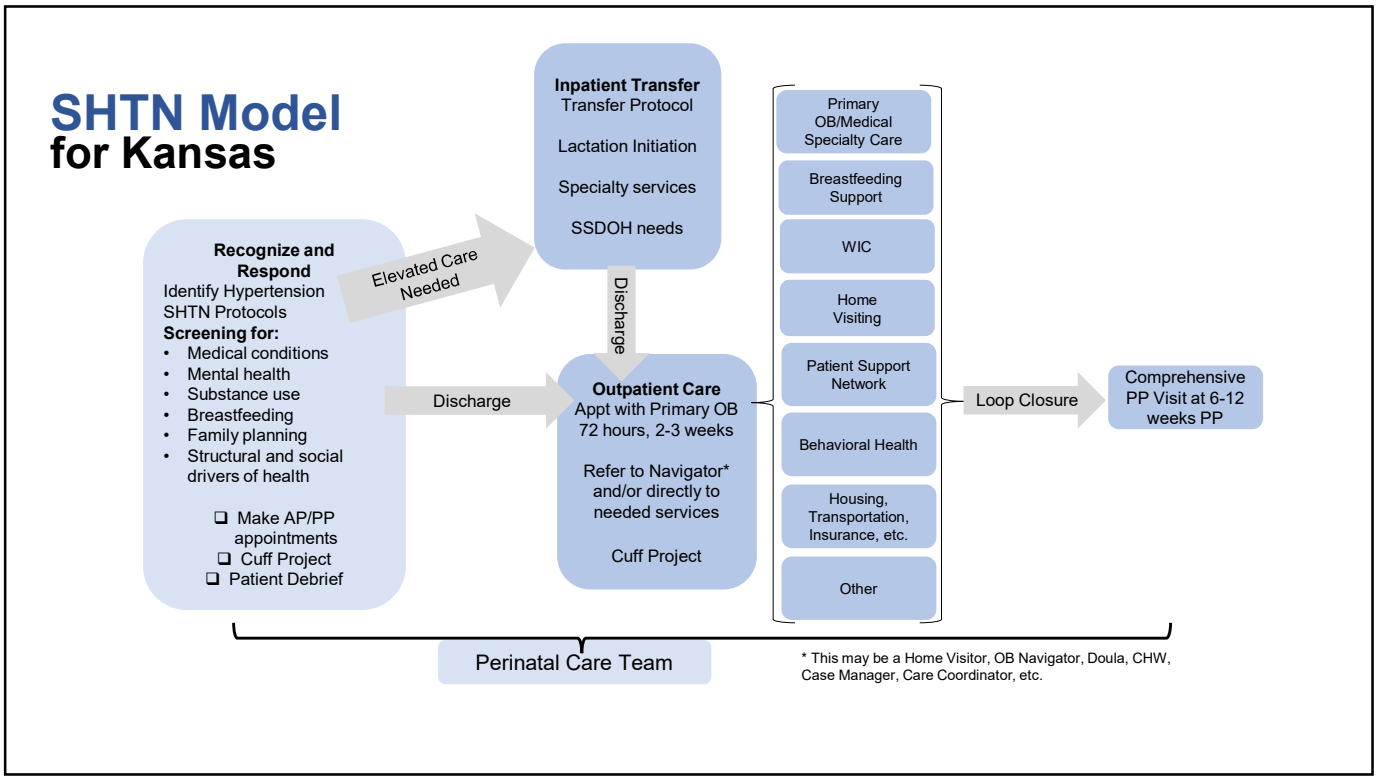
28


Timeline
Launch
Q1 2025
Launch enrollment
Severe Hypertension in Pregnancy (SHTN) AIM Safety Bundle
Reporting
Q1 2025-Q4 2026
• Data collection
Identify
Q2 2025
Accurately detect SHTN
• Educate staff, patients, and community organizations
Recognize
Q3 and Q4 2025
Correct diagnosis leads to immediate treatment
• Pregnancy Hypertension Protocols
• OB Simulations
Respond
Q4 2025 and 2026
Best practice treatment / elevated care
• Comprehensive Care Model
• Postpartum Visit Scheduling
• Neonatal Initiative
• Community outreach
• EMS Education
KPQC
Kansas Perinatal Quality Collaborative

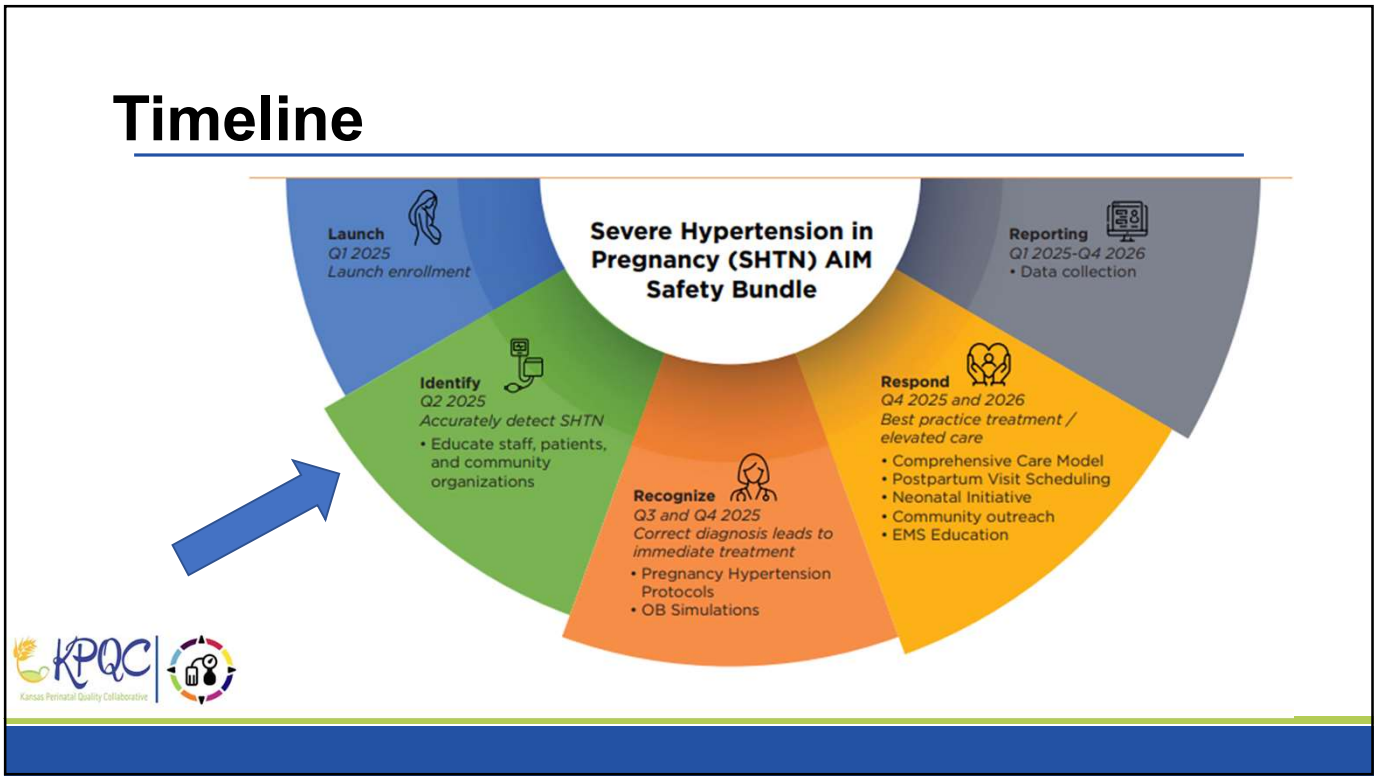
29


Recognize & Respond
• Identify hypertension
• SHTN protocols
• Screening for: medical conditions, mental health, substance abuse, breastfeeding, family planning, structural and social drivers of health (SSDOH)
Elevated Care Needed
Discharge
Inpatient Transfer
• Transfer protocol
• Lactation initiation
• Specialty services
• SSDOH needs
Discharge
Outpatient Care
• Appointment with Primary OB at 72 hours and 2-3 weeks
• Referral to navigator and/or additional resources
• Cuff Project
Loop Closure
Comprehensive Postpartum Visit 6-12 weeks
Severe Hypertension in Pregnancy
Model for Kansas

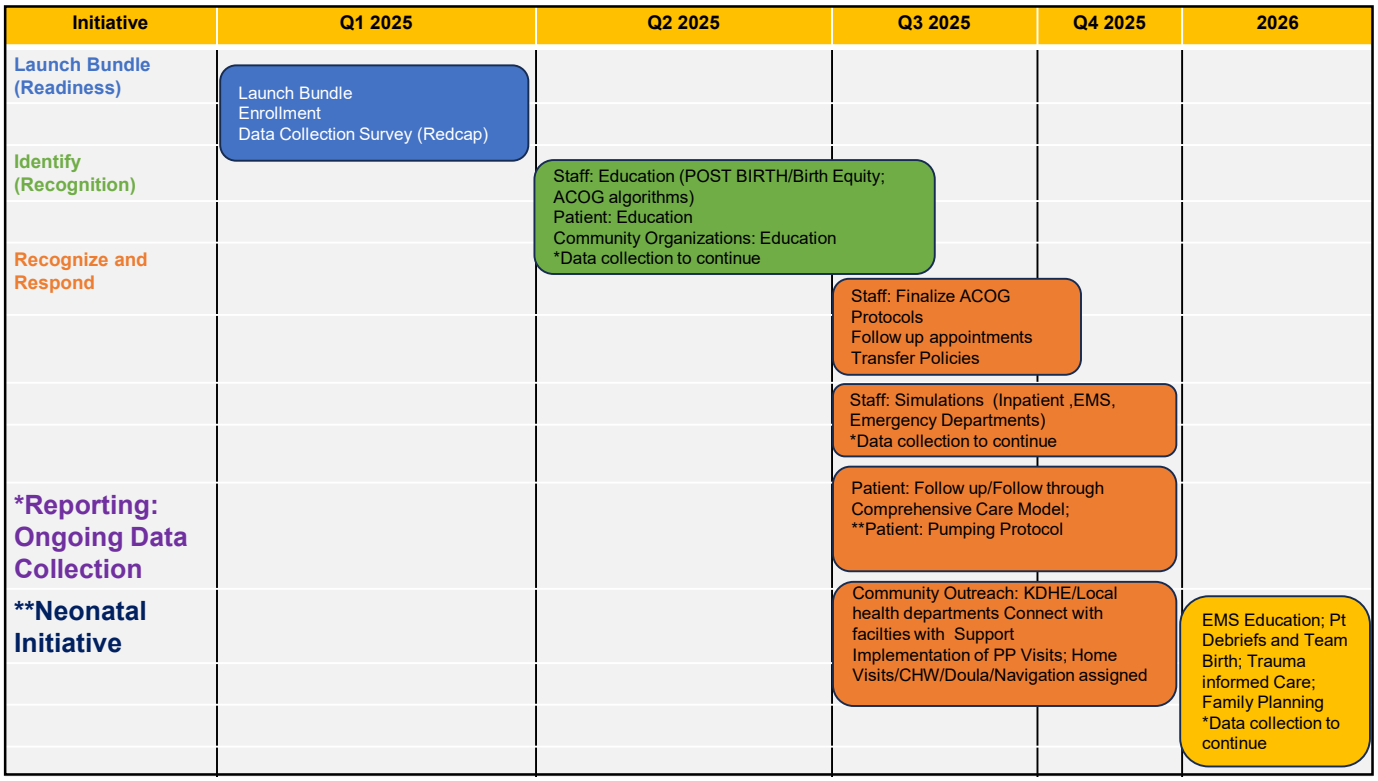
30


SHTN Model for Kansas
Recognize and Respond
Identify Hypertension
SHTN Protocols
Screening for:
• Medical conditions
• Mental health
• Substance use
• Breastfeeding
• Family planning
• Structural and social drivers of health
❑ Make AP/PP appointments
❑ Cuff Project
❑ Patient Debrief
Elevated Care Needed
Discharge
Inpatient Transfer
Transfer Protocol
Lactation Initiation
Specialty services
SSDOH needs
Discharge
Outpatient Care
Appt with Primary OB 72 hours, 2-3 weeks
Refer to Navigator* and/or directly to needed services
Cuff Project
Primary OB/Medical Specialty Care
Breastfeeding Support
WIC
Home Visiting
Patient Support Network
Behavioral Health
Housing, Transportation, Insurance, etc.
Other
Loop Closure
Comprehensive PP Visit at 6-12 weeks PP
Perinatal Care Team
* This may be a Home Visitor, OB Navigator, Doula, CHW, Case Manager, Care Coordinator, etc.

31


Timeline
Severe Hypertension in Pregnancy (SHTN) AIM Safety Bundle
Launch
Q1 2025
Launch enrollment
Identify
Q2 2025
Accurately detect SHTN
• Educate staff, patients, and community organizations
Recognize
Q3 and Q4 2025
Correct diagnosis leads to immediate treatment
• Pregnancy Hypertension Protocols
• OB Simulations
Respond
Q4 2025 and 2026
Best practice treatment / elevated care
• Comprehensive Care Model
• Postpartum Visit Scheduling
• Neonatal Initiative
• Community outreach
• EMS Education
Reporting
Q1 2025-Q4 2026
• Data collection
KPQC
Kansas Perinatal Quality Collaborative

32



33

Identify

Normal vs Abnormal Blood Pressure in female patients, including Pregnant and Postpartum (One year!)

34

Accurate Diagnosis

- **Chronic Hypertension**
- **Chronic Hypertension with Superimposed Preeclampsia**
- **Gestational Hypertension**
- **Preeclampsia**
  - With Severe Features
- **Eclampsia**

35

Definitions ACOG:

Types of Hypertension	
Chronic Hypertension	○ SBP ≥ 140 **or** DBP ≥ 90 ○ Pre-pregnancy or <20 weeks
Gestational Hypertension	○ SBP ≥ 140 **or** DBP ≥ 90 on at least two occasions at least 4 hrs apart after 20 weeks gestation in women with previously normal BP ○ Absence of proteinuria or systemic signs/symptoms
Preeclampsia – Eclampsia	○ SBP ≥ 140 **or** DBP ≥ 90 ○ Proteinuria with or without signs/symptoms ○ Presentation of signs/symptoms/lab abnormalities but no proteinuria **Proteinuria not required for diagnosis eclampsia seizure in setting of preeclampsia*
Chronic Hypertension with Superimposed Preeclampsia	○ Preeclampsia in a woman with a history of hypertension before pregnancy or before 20 weeks of gestation
Preeclampsia with severe features *(ACOG Practice Bulletin #202, Gestational Hypertension and Preeclampsia, & ACOG Practice Bulletin #203, Chronic Hypertension in Pregnancy)*	○ SBP ≥ 160 **or** DBP ≥ 110 (can be confirmed within a short interval to facilitate timely antihypertensive therapy) ○ Thrombocytopenia (platelet count less than 100,000/microliter) ○ Impaired liver function that is not accounted for by alternative diagnoses and as indicated by abnormally elevated blood concentrations of liver enzymes (to more than twice the upper limit normal concentrations), or by severe persistent right upper quadrant or epigastric pain unresponsive to medications. ○ Renal insufficiency (serum creatinine concentration more than 1.1 mg/dL or a doubling of the serum creatinine concentration in the absence of other renal disease) ○ Pulmonary edema ○ New-onset headache unresponsive to medication and not accounted for by alternative diagnoses ○ Visual disturbances

36

Taking a Blood Pressure

Correct Position!

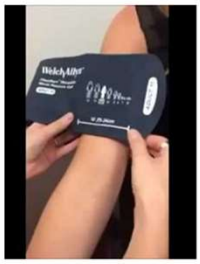
- Sitting or Semi Fowlers
- Feet flat, not dangling
- If BP ≥ 160 systolic **and/or** ≥ 110 diastolic, take steps to initiate treatment for severe hypertension—notifying provider, procuring medication

DO NOT REPOSITION PATIENT (yet)

- **Retake BP after 15 minutes.** If BP remains severe, obtain order for medication.
- Administer medication as ordered

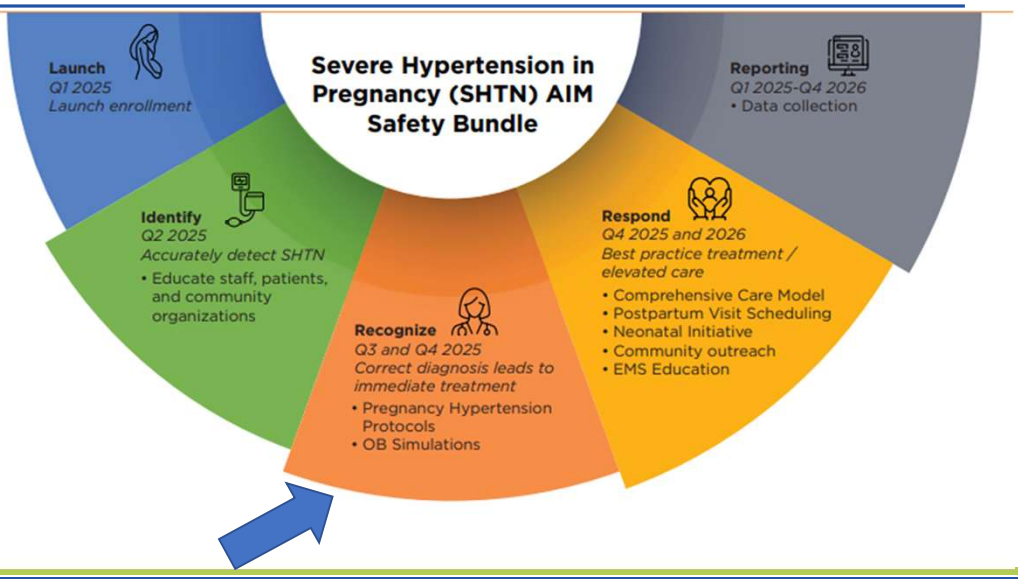
***Treat ASAP*—at least within 1 hour of 1st severe reading**

Correct Cuff Size!



37

Timeline



38

Recognize

Recognize the Problem and think “ALGORITHM”!

39

Avoiding Mistakes

Racism is a risk factor, NOT race

Do not assume:
Race, Obesity, SES status, Diet, Mental health, Pain, or Anxiety is the cause

CMQCC Preeclampsia Early Recognition Tool (PERT)

Everyone knows: POSTBIRTH!

NEURO symptoms= Immediate triage to facility or RESPONSE to change of status

40

KPQC
Kansas Perinatal Quality Collaborative

Statewide SHTN Initiative work

Prevention works!
and
Prevention starts in the preconception and antepartum settings!

41

Everyone Needs Aspirin….?

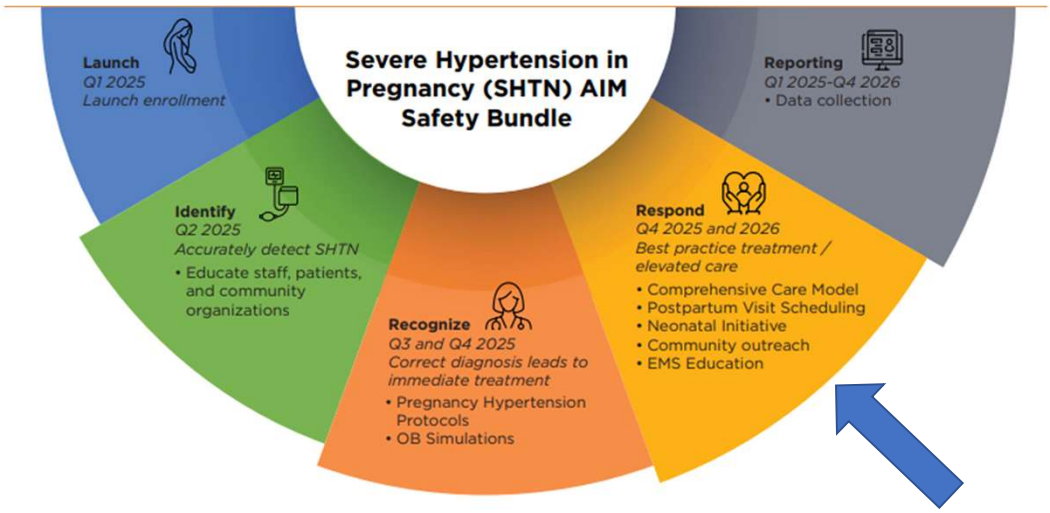
Table S1: Cross-sectional survey of recommendations on the use of aspirin in pregnancy for the prevention of pre-eclampsia

Guideline (year)	Aspirin dose	Treatment duration	Recommendations for pregnant women with NSAID hypersensitivity
World Health Organization (2021)	75 mg daily	Start before 20 weeks' gestation	Not addressed
Australian Pregnancy Care Guidelines (2024; pending NHMRC approval)	150 mg daily	Start before 16 weeks' gestation	Contraindicated in patients with hypersensitivity to aspirin
National Institute for Health and Care Excellence, United Kingdom (2023)	75–150 mg daily	Start from 12 weeks' gestation and continue till delivery	Not addressed
Society of Obstetric Medicine of Australia and New Zealand (2023)	150 mg daily	Start before 16 weeks' gestation and stop between 34 weeks to delivery	Not addressed
European Society of Hypertension (2023)	100–150 mg daily	Start before 16 weeks' gestation and continue till 35 weeks	Not addressed
Society of Obstetricians and Gynecologists of Canada (2022)	81–162 mg daily	Start before 16 weeks' gestation and continue till 36 weeks	Not addressed
Sri Lanka College of Obstetricians and Gynaecologists (2022)	75–100 mg daily	Start from the early second trimester and continue till delivery	Not addressed
South African Society of Obstetricians and Gynaecologists (2022)	150 mg daily	Start from 12 weeks' gestation and continue till 36 weeks	Not addressed
American College of Obstetrics and Gynecology/Society for Maternal-Fetal Medicine (2021)	81 mg daily	Start between 12–28 weeks' gestation (optimally before 16 weeks) and continue till delivery	Contraindicated in patients with aspirin allergy, e.g., urticaria or hypersensitivity to NSAIDs (ACOG Committee Opinion No. 743)
US Preventive Services Task Force (2021)	81 mg daily	Start from 12 weeks' gestation	Not addressed

KPQC Kansas Perinatal Quality Collaborative

42

Timeline



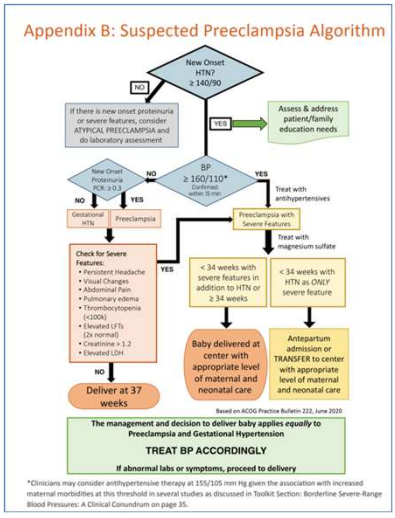
43

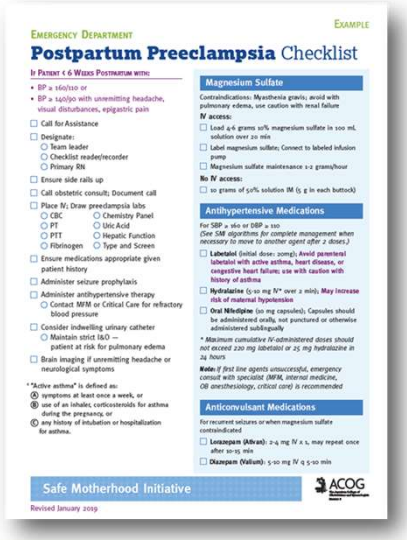
Respond

Treatment= Algorithms, Algorithms and MORE Algorithms!

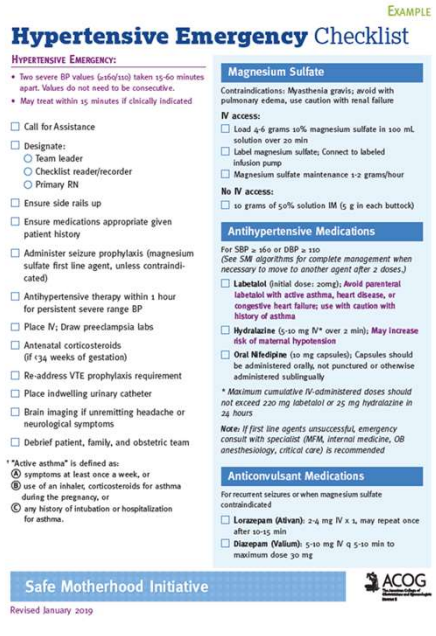
44

Recognition to Treatment

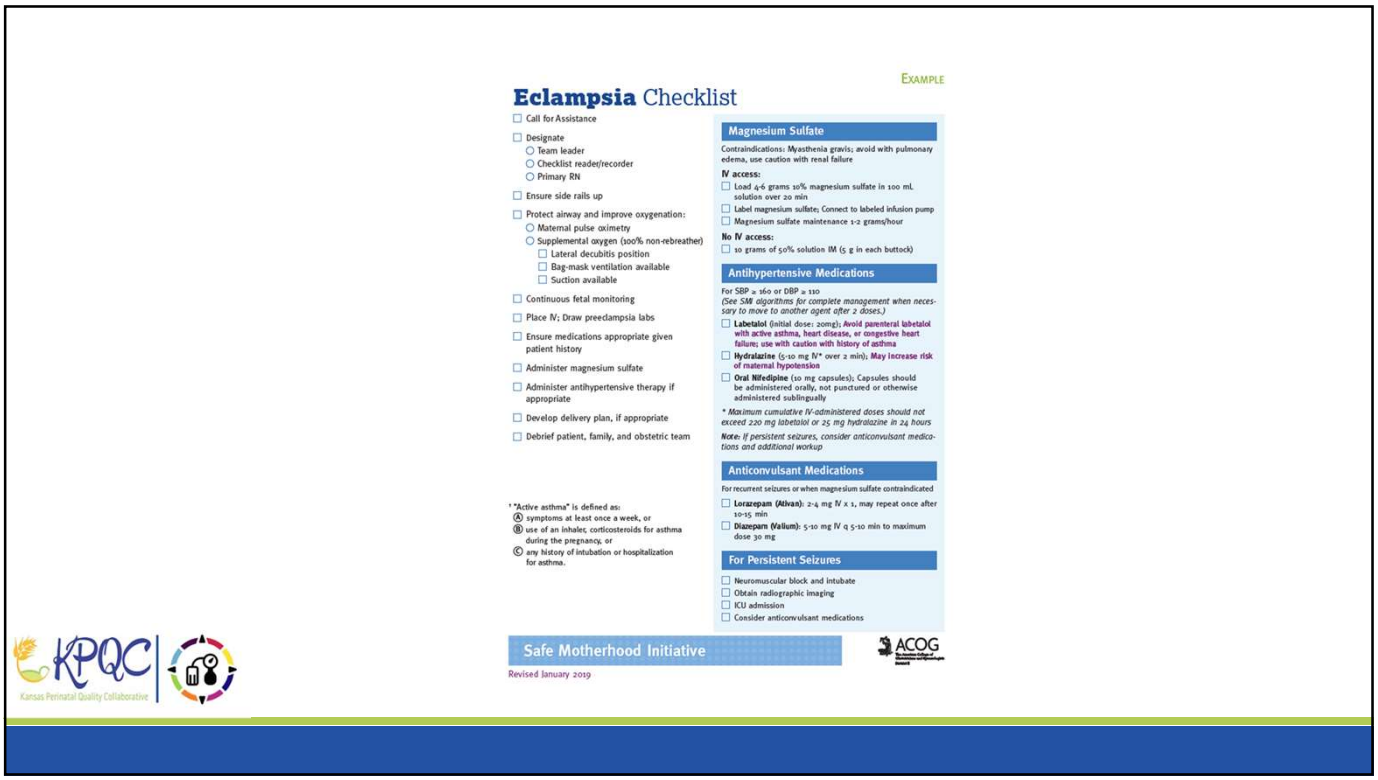




45

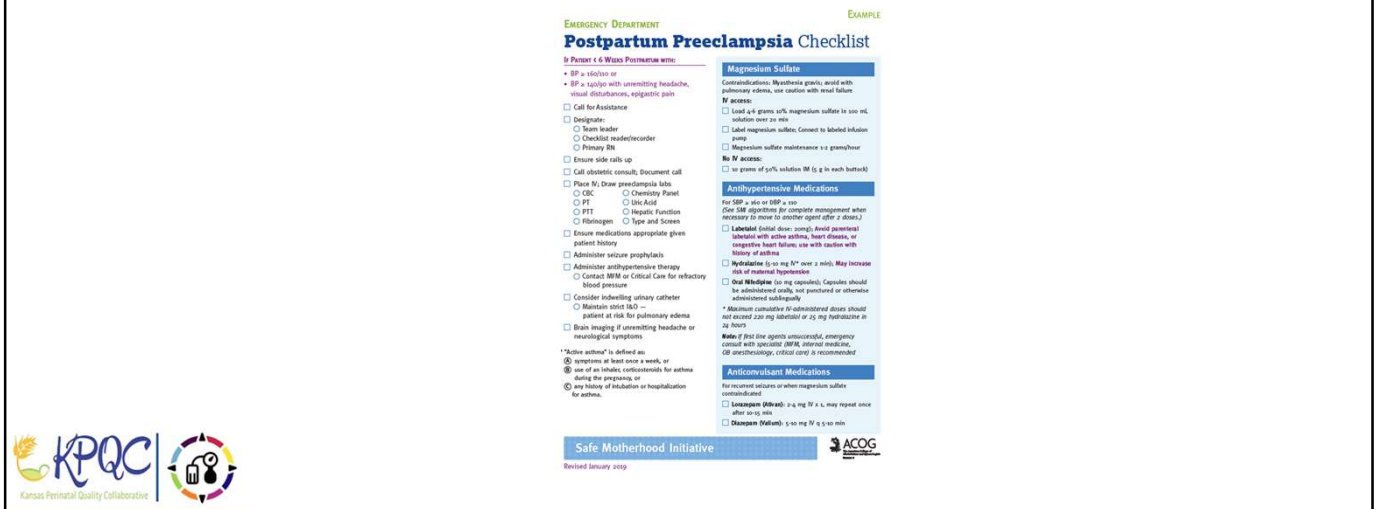


46



47

Postpartum (and Antepartum) Preeclampsia



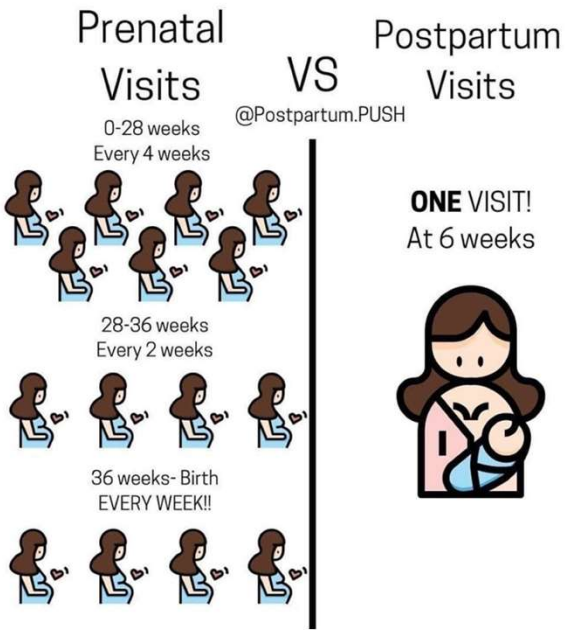
48

KPQC
Kansas Perinatal Quality Collaborative

YOU are vital to this work!

"Eyes on" at home, clinic, community

49



50

Postpartum Surveillance

Necessary to prevent additional morbidity as preeclampsia/eclampsia can develop postpartum

INPATIENT

- Measure BP every 4 hours after delivery until stable
- Do not use NSAIDs for women with elevated BP
- Do not discharge patient until BP is well controlled for at least 24 hours

OUTPATIENT

- For pts with preeclampsia, visiting nurse evaluation recommended:
- ✓ Within 3-5 days
- ✓ Again in 7-10 days after delivery (earlier if persistent symptoms)

ANTIHYPERTENSIVE THERAPY

- Recommended for persistent postpartum HTN: SBP ≥ 150 or DBP ≥ 100 on at least two occasions at least 4 hours apart
- Persistent SBP ≥ 160 or DBP ≥ 110 should be treated within 1 hour

51

Post-Discharge Evaluation

ELEVATED BP AT HOME, OFFICE, TRIAGE

Postpartum triggers:
- SBP ≥ 160 or DBP ≥ 110 or
- SBP ≥ 140-159 or DBP ≥ 90-109 with unremitting headaches, visual disturbances, or epigastric/RUQ pain

- Emergency Department treatment (OB /MICU consult as needed)
- AntiHTN therapy suggested if persistent **SBP ≥ 150 or DBP ≥ 100** on at least two occasions at least 4 hours apart
- Persistent **SBP ≥ 160 or DBP ≥ 110** should be treated within 1 hour

Good response to antiHTN treatment and asymptomatic

Admit for further observation and management (L&D, ICU, unit with telemetry)

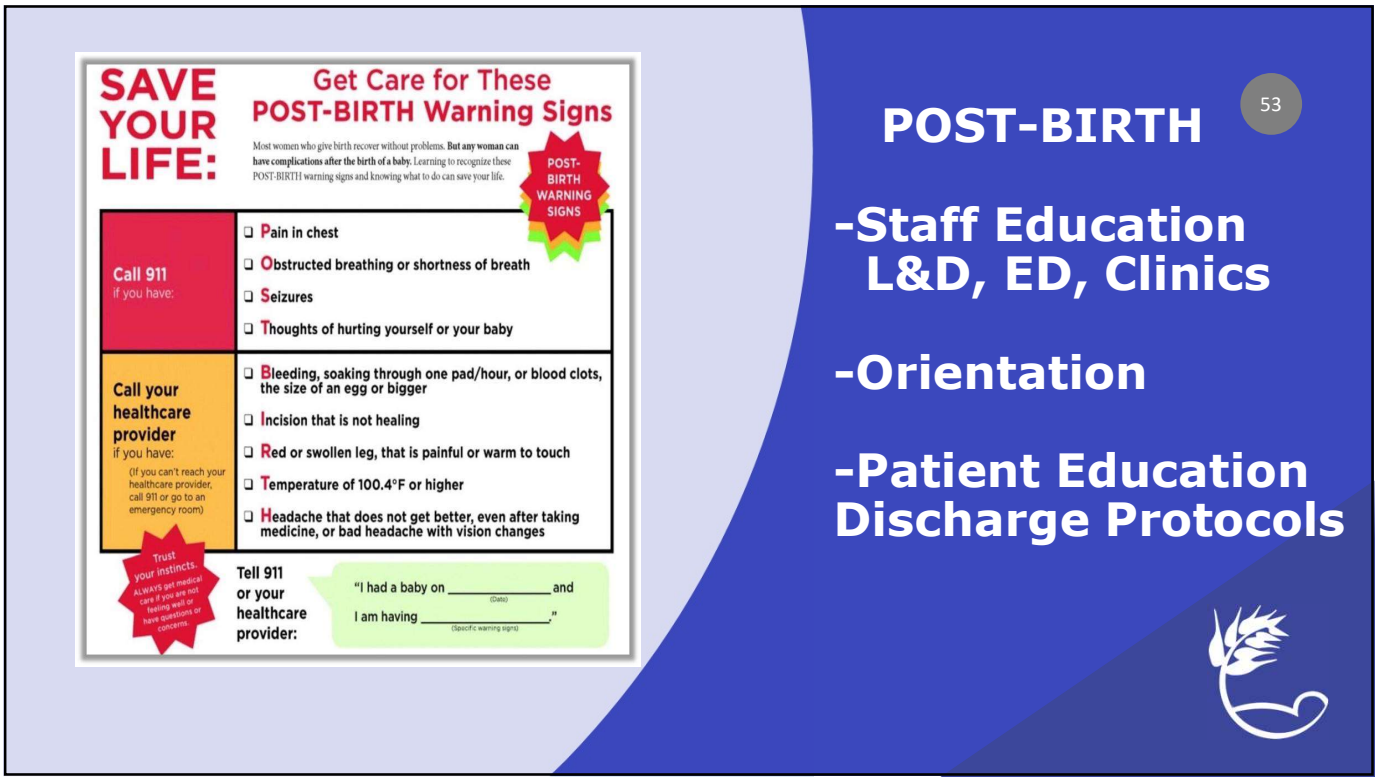
Signs and symptoms of eclampsia, abnormal neurological evaluation, congestive heart failure, renal failure, coagulopathy, poor response to antihypertensive treatment

Recommend emergency consultation for further evaluation (MFM, internal medicine, OB anesthesiology, critical care)

Safe Motherhood Initiative

29

52


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:
Pain in chest
Obstructed breathing or shortness of breath
Seizures
Thoughts 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)
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 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)."
POST-BIRTH
53
-Staff Education L&D, ED, Clinics
-Orientation
-Patient Education Discharge Protocols

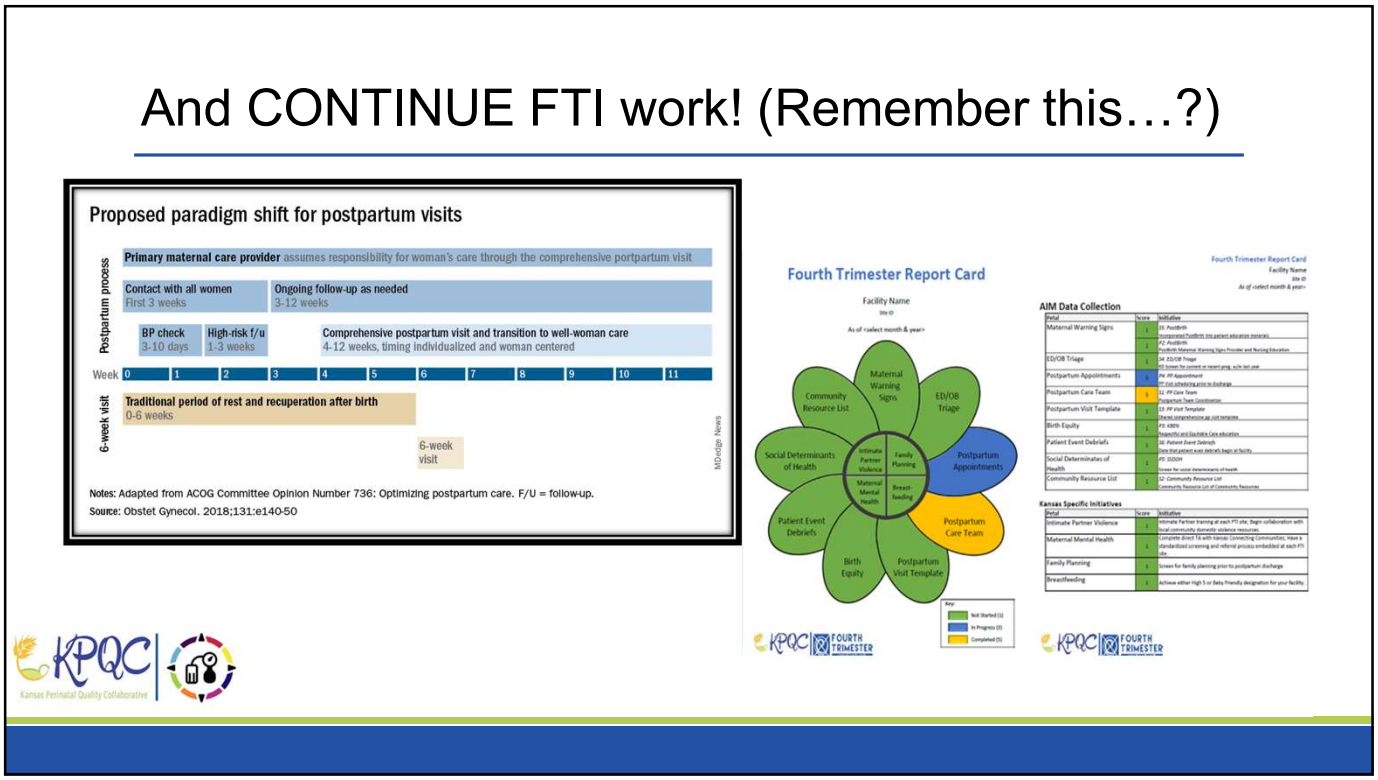
53


POST-BIRTH: No Wrong Door
EMERGENCY
URGENT CARE
KPQC
Kansas Perinatal Quality Collaborative

54


55
Innovative ideas!
ER/OB/EMS Collaborations

55


And CONTINUE FTI work! (Remember this…?)
Proposed paradigm shift for postpartum visits
Primary maternal care provider assumes responsibility for woman's care through the comprehensive portpartum visit
Postpartum process
Contact with all women
First 3 weeks
Ongoing follow-up as needed
3-12 weeks
BP check
3-10 days
High-risk f/u
1-3 weeks
Comprehensive postpartum visit and transition to well-woman care
4-12 weeks, timing individualized and woman centered
Week 0 1 2 3 4 5 6 7 8 9 10 11
6-week visit
Traditional period of rest and recuperation after birth
0-6 weeks
6-week visit
Notes: Adapted from ACOG Committee Opinion Number 736: Optimizing postpartum care. F/U = follow-up.
Source: Obstet Gynecol. 2018;131:e140-50
Fourth Trimester Report Card
Facility Name
Community Resource List
Maternal Warning Signs
ED/OB Triage
Postpartum Appointments
Postpartum Care Team
Postpartum Visit Template
Birth Equity
Patient Event Debriefs
Social Determinants of Health
Intimate Partner Violence
Family Planning
Maternal Mental Health
Breastfeeding
AIM Data Collection
Kansas Specific Initiatives
KPQC
Kansas Perinatal Quality Collaborative

56

Contact Information

Jill Nelson
Maternal & Perinatal Initiatives Consultant/
KMMRC & KPQC Coordinator
jillelizabeth.nelson@ks.gov

Terrah Stroda, CNM
Maternal QI Coordinator
KS Perinatal Quality Collaborative(KPQC)
tstroda@gmail.com

57

Questions?

58

Upcoming Education and Important Dates

- 5/28 KHC Office Hours - KHDE Maternal Health Programs
- 6/25 KHC Office Hours
- 7/15 KHC CAP Lunch and Learn - RHC Billing Basics
- 7/1-7/2 CMS Quality Conference
- 9/4-9/5 KHA Convention and Trade Show
- 10/23 Kansas Health Impact Conference - Topeka

Kansas Healthcare COLLABORATIVE

59

59

Kansas Healthcare COLLABORATIVE

Connect with us on:

KHCqi

@KHCqi

Kansas Healthcare Collaborative

→ *Find contact info and more at:*
www.KHConline.org/staff

Malea Hartvickson
Executive Director

Mandy Johnson
Senior Director, Programs

Treva Borcher
Director of Operations

Eric Cook-Wiens
Data & Measurement Director

Liz Warman
Quality Improvement Advisor

Jill Daughhetee
Director of Education and Communications

Azucena Gonzalez
Health Care Quality Data Analyst

Jenni Peters
Quality Improvement Advisor

Patty Thomsen
Quality Improvement Advisor

Rebecca Wagner
Grants Coordinator

Kansas Healthcare COLLABORATIVE

60

60


Kansas Healthcare
COLLABORATIVE
Incremental change, exponential impact.

61