



Perinatal Sepsis Prevention: A Health Equity Perspective

PA Perinatal Quality Collaborative
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Feb 27, 2025

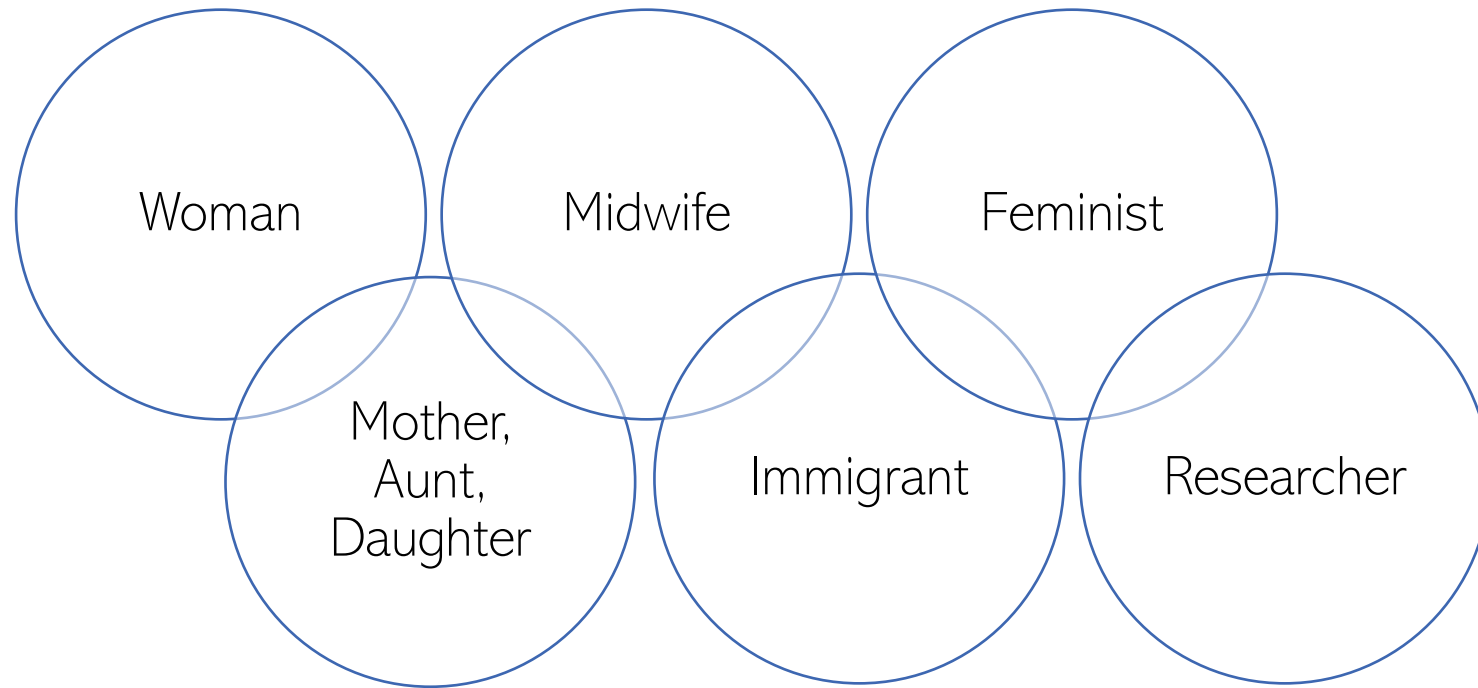


Land acknowledgment

I acknowledge the land politically designated as New York City to be the homeland of the Lenape (Lenapehoking) who were violently displaced as a result of European settler colonialism over the course of 400 years.

The Lenape are a diasporic people that remain closely connected with this land and are its rightful stewards. New York City has one of the largest urban Native American / Indigenous populations in the United States.

My positionality and identity







Received: 18 September 2020 | Accepted: 2 June 2021

DOI: 10.1111/birt.12565

ORIGINAL ARTICLE

BIRTH SAFE IN PERINATAL CARE WILEY

Kairos care in a *Chronos* world: Midwifery care as model of resistance and accountability in public health settings

Paulomi Mimi Niles PhD¹  | Saraswathi Vedam PhD²  |
Amy Witkoski Stimpfel PhD¹  | Allison Squires PhD¹ 

Niles et al. *Reproductive Health* (2023) 20:67
<https://doi.org/10.1186/s12978-023-01584-1>

Reproductive Health

RESEARCH

Open Access

Examining respect, autonomy, and mistreatment in childbirth in the US: do provider type and place of birth matter?

P. Mimi Niles^{1*}, Monique Baumont², Nisha Malhotra³, Kathrin Stoll⁴, Nan Strauss², Audrey Lyndon¹ and Saraswathi Vedam³



SSM - Qualitative Research in Health 2 (2022) 100077



Contents lists available at ScienceDirect

SSM - Qualitative Research in Health

journal homepage: www.journals.elsevier.com/ssm-qualitative-research-in-health



“Real decision-making is hard to find” - Swiss perinatal care providers’ perceptions of and attitudes towards decision-making in birth: A qualitative study



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PLOS ONE

RESEARCH ARTICLE

“I fought my entire way”: Experiences of declining maternity care services in British Columbia

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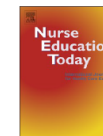
Nurse Education Today 123 (2023) 105742



Contents lists available at ScienceDirect

Nurse Education Today

journal homepage: www.elsevier.com/locate/next



Contemporary issues

The value of including reproductive justice into nursing curricula

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Review	how systemic inequities contribute to perinatal infections and sepsis
Explain	value of experiential factors in preventing sepsis infection
Describe	evidence-based interventions focused on perinatal sepsis prevention, care, & recovery

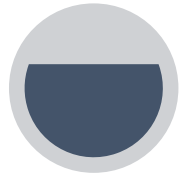


Women in the United States are more likely to die as a result of pregnancy and childbirth than women in any other highly industrialized country.

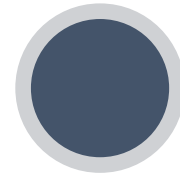
- The US spends more than other countries on maternal care
 - **13** billion dollars in spending
 - Most common billable for in-patient care
- **34th** highest maternal mortality rate of 35 OECD nations
- More than **80%** of pregnancy-related death are preventable (CDC)
- Morbidity & mortality rates are rising in the US.



Lack of universal
healthcare



Systematized
gendered racism



Lack of integrated
midwifery

- **Obstetric Sepsis:**

- 2nd Leading cause of maternal mortality
- Primary cause of severe maternal morbidity (SMM)
- Risk increases with:
 - Chronic disease, breast infection, twins/multiple birth, invasive procedure in the antepartum period
- Linked with c-birth, preterm birth, maternal & infant death
- **23%** of in-hospital deaths were related to sepsis

Maternal sickness/death has generational impacts on families & communities



Maternal Sepsis rates spiked after Texas abortion ban (SB8)

- Rates of sepsis increased from 9.4% to 29.2%
- This means the risk of sepsis increased over 4X

Ghafir, Fahl, Ukoh...et al. (2025) The Frequency and Severity of Complications after Previaible PROM in Texas following SB8. Oral plenary, Society for Maternal Fetal Medicine. Retrieved <https://smfm2025.eventscribe.net/fsPopup.asp?PresentationID=1552970&mode=presInfo>



Treatment of Maternal/Obstetric Sepsis: Clinical Emphasis... but what else is needed?





Treatment of
Maternal/Obstetric
Sepsis:
Clinical Emphasis...
**what else is
needed?**



Clinical domains

- Screening
- Management
- Algorithms
- Safety bundles
- Clinical teams effectiveness

Affective domains

Respectful care
autonomy
decision-making
Mistreatment
Compassion/empathy

A wholistic perspective on perinatal sepsis care

- Pregnancy is a state of *health**
- A social, cultural, mental, spiritual & physiological *process*.
- Focus on educated *decision-making*, *autonomy*, and *trust* building
- The *relationship* is the engine that drives this high-quality care model
 - Requires continuity
 - Trust
 - Culture/language match



Original Investigation | Obstetrics and Gynecology

Postpartum Emergency Department Use Following Midwifery-Model vs Obstetrics-Model Care

Carla Sorbara, RM, MPP, MSc; Joel G. Ray, MD, MSc; Elizabeth K. Darling, RM, PhD; Hannah Chung, MPH; Sho Podolsky, MSc; Therese A. Stukel, PhD

Theoretical foundations of care

- **Feminist care**
- **Intersectionality**
- **Ethics of care**



What **we** want

- Agency & control
- Supportive relationships
- Effective communication
- Demonstration of caring
- Respect & regard
- Competence
- Time



What **we** do not want

- Disrespect
- Discrimination
- Non-consented care
- Abandoned/dismissed
- Verbal & physical abuse
- Intimidation
- Mistreatment
- Lack of choice
- Rude & inappropriate communication

Do people's social & emotional experiences
increase the risks of a poor outcome?

A large orange circle is centered on the page. Inside the circle, the text is arranged in a vertical stack. The words "Prompt", "of", "improve", and "outcomes" are in a bold, black, sans-serif font. The word "recognition" is in a white, italicized, sans-serif font. The words "and" and "maternal sepsis" are in a bold, black, sans-serif font. The overall message is that prompt recognition and rapid treatment of maternal sepsis lead to improved outcomes.

Prompt
recognition **and**
rapid treatment
of
maternal sepsis
improve
outcomes

Quality of care matters

- Outcomes improve with 1) early recognition and 2) appropriate and timely care
- Missed or delayed care in 8-20% of cases
- Inadequate follow-up
- Communication failures: not listening
- Suboptimal assessment: includes dismissive or inadequate
- Wrongly attributing symptoms to illicit drug use
- Repeated visits



WARNING SIGNS FOLLOW-UP GUIDE

..... FOR HEALTH CARE PROFESSIONALS



BACKGROUND

These questions, tips, and red flags were created based on near-miss cases of patients who suffered severe maternal morbidity.

Many patients called in with symptoms but were met with reassurance that symptoms were typical of pregnancy or postpartum rather than follow up questions that would have identified severe illness to allow prompt treatment.



FOLLOW UP QUESTIONS

These follow up questions are suggested to evaluate when patients call with symptoms of concern.

- > Please tell me in your own words what is wrong.
- > Is this your first time calling about this?
- > How long has this been going on?
- > Is it getting better, staying the same, or getting worse?
- > On a scale of 1 to 10 (worst) how bad is _____? (pain/tiredness/symptoms of concern)
- > Are you able to perform your normal day-to-day activities and take care of yourself?
- > Are you able to eat, drink, urinate, pass gas, have bowel movements?
- > Can you explain how this is limiting you?
- > What prompted you to call?
- > Have you had this before?
- > Can you explain how you are feeling and how this is different from your baseline?
- > Are there any barriers to coming in today?



ACTION ITEMS

- > If the patient does not need assessment now, explain red flag warning signs when the patient should call back or come in for evaluation.
- > Express empathy and concern. Many patients reported feeling like a burden and not feeling heard and subsequently delayed calling and seeking care when symptoms worsened.
- > Keep track of a list of patients to reach back out to follow up on and encourage them to call back if not improving or getting worse.



RED FLAGS (should prompt in-person evaluation)

- > Patient reaching out multiple times with concerns.
- > A support person calling on behalf of the patient with concerns.
- > Patient requests to be seen.
- > Symptoms that are worsening over time.
- > Patient unable to perform activities of daily living (climbing stairs, showering, brushing teeth, holding baby, etc.)
- > Signs of severe dehydration: inability to urinate, inability to make tears, abrupt stopping of milk production.
- > Severe pain.

CMQCC
California Maternal
Quality Care Collaborative

MI AIM
MICHIGAN ALLIANCE FOR INNOVATION
ON MATERNAL HEALTH

Stanford MEDICINE
Dukeleone Maternal-Fetal Medicine
Center for Research, Innovation and Clinical Impact

*Disclaimer: The information provided on the MI AIM site is for educational purposes only, and does not substitute for professional medical advice.

Many patients report they felt like a burden and did not feel heard and as a result they delayed their care even as the symptoms worsened.

https://www.cmqcc.org/files/Warning%20Signs%20Follow%20Up%20Questions_v2%5B70%5D.pdf

Analysis

Impacts of Provider and Setting

1. Communication & decision-making autonomy (MADM)
2. Respect (MORi)
3. Mistreatment (MIST)
4. Time spent during visits



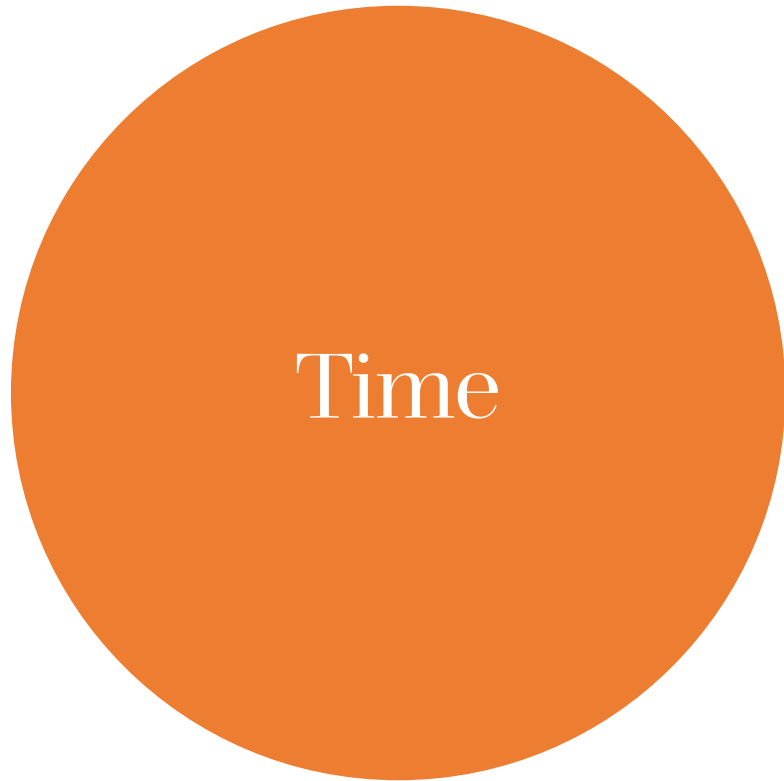
	UNADJUSTED ODDS RATIO (95% CI)	ADJUSTED ODDS RATIO ^A (95% CI)
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High **AUTONOMY** (MADM)

MW + Comm	5.62* (4.27-7.38)	5.22** (3.65-7.45)
MW + hospital	1.70* (1.17-2.46)	1.70* (1.11-2.61)
MD + hospital	REF	REF



	UNADJUSTED ODDS RATIO (95% CI)	ADJUSTED ODDS RATIO ^A (95% CI)
High RESPECT (MORI)		
MW + Comm	6.40** (4.84-8.48)	5.39** (3.72-7.82)
MW + hospital	1.20 (0.80-1.80)	1.32 (0.83-2.09)
MD + hospital	REF	REF



	UNADJUSTED ODDS RATIO (95% CI)	ADJUSTED ODDS RATIO ^A (95% CI)
ENOUGH TIME during prenatal visits		
MW + Comm	12.59 ** (8.60-18.44)	14.65 ** (8.41-25.51)
MW + hospital	2.16** (1.51-3.09)	1.95* (1.28-2.97)
MD + hospital	REF	REF



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Designing Wholistic Recovery from Sepsis



Enhancing recovery: Mental health resources

- PTSD/Birth Trauma
- 45% of pregnant patients report feeling traumatized after birth
- After a near fatal event, we suspect this number is significantly higher
- After a severe event, many report not fully understanding what happened to them
- Pre-discharge support/discussion/teaching is essential
- Involve mental health team/social work with therapeutic capacity

Maternal and Child Health Journal (2024) 28:1432–1441
<https://doi.org/10.1007/s10995-024-03927-1>

“We don’t really address the trauma”: Patients’ Perspectives on Postpartum Care Needs after Severe Maternal Morbidities

P. Mimi Niles¹  · Adina Nack² · Folake Eniola³ · Hannah Searing⁴ · Christine Morton⁵

Accepted: 13 May 2024 / Published online: 12 June 2024

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Enhancing Care with Sepsis: Supportive Communication:

Instead of...	Say...
“You almost died, but we were able to save you”	“You were quite sick, but your body is tough and resilient.”
“All that matters is a healthy mom and healthy baby.”	“I know this wasn’t the birth experience you expected. It’s okay to have feelings about that.”
“You are very lucky to be alive”	Provide a brief overview of what happened to the patient and the interventions used.
“Everything happens for a reason.”	This wasn’t your fault. Here’s what we know about why this may have happened to you.”
“You should be so grateful.”	“I know this might be scary and a lot to process. What questions can I help you answer?”

<https://www.cmqcc.org/files/Words%20after%20a%20SME%2006Aug2024%20with%20LOGOs.pdf>

Supportive Communication: Pre-Discharge

Step 1: Assess Patient Understanding

- Have them recap in your own words what they experienced.
- Do not stop the patient to correct information
- Ask what they need/want to understand more deeply

Step 2: Provide an overarching description of the condition

- Define (in lay terms) the condition that they experienced, including how common
- Briefly review risk factors and in general the diagnosis and treatment approaches

Step 3: What happened with this specific patient

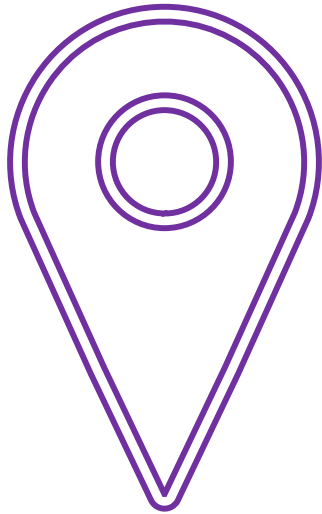
- Review in lay terms, how the patient presented and how the diagnosis was made
- If and why they were transferred to a higher level of care (such as an ICU) and what happened there
- Provide the summary document of the key elements of the diagnosis and care for her to share with her follow-up providers
- Stress that this was not her fault

Step 4: Pause for questions

- Make time for them to process
- Allow for silence
- Allow for a break
- Allow for notes and support people's questions

Step 5: Review what to expect next

- Review plans for discharge, including who and when to see for follow up
- Early follow-up is almost always required
- Discuss return precautions and “what to watch for”,
- Involve family/support
- Emphasize the need for support from providers, family
- Emphasize the importance of continuing discussions & Give opportunity for more questions



Care models oriented to create
an optimal care relationship
provide a **protective** effect

Implications

Move beyond the bedside to build quality & equity

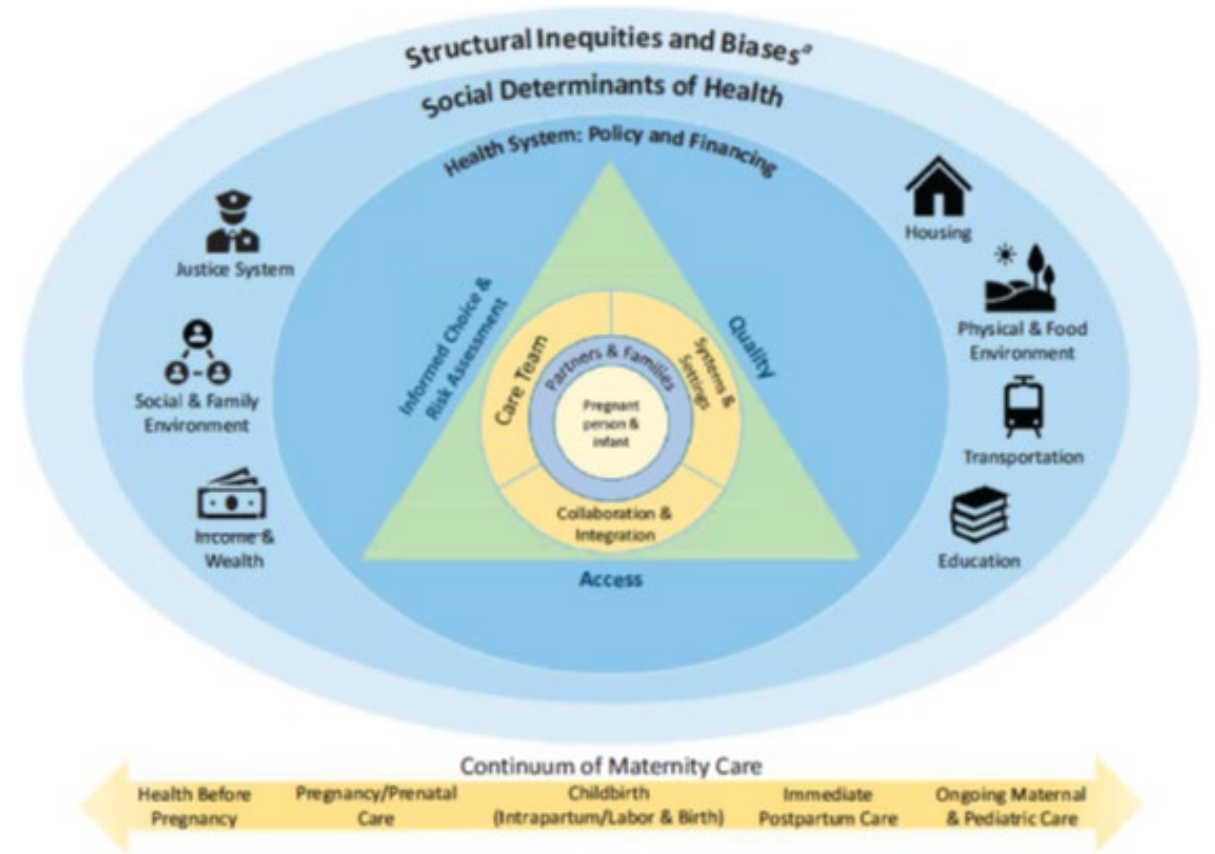


Figure 1: Continuum of Maternity Care Model