This document is intended to provide overarching considerations for establishing effective processes for and implementing severe maternal morbidity (SMM) chart reviews at a birthing facility. These reviews are intended to assess instances of SMM for quality of care and whether SMM could have been prevented or minimized, and to identify actionable, birthing facility-specific quality improvement opportunities. SMM reviews do not replace root cause analysis but are intended to augment it. SMM reviews may overlap with or be done in conjunction with peer review processes. It is important to note state and facility peer review protection and specific legal and reporting policy guidelines when implementing SMM reviews.

Readiness – Every Unit/Team

- Develop a process for review of severe maternal morbidity (SMM) outcomes including:
  - Establish a designated multidisciplinary standing committee at each birthing facility that reflects the professional makeup of clinicians and staff within the birthing facility.[1]
    - Example members may include but are not limited to:
      - Obstetric providers (i.e., obstetricians, certified nurse midwives, family physicians, or advanced practice nurses)
      - Anesthesia providers
      - Obstetric care nurses from clinical area (i.e., outpatient, intrapartum, and postpartum units)
      - Quality improvement (QI) team
      - Birthing facility leaders (i.e., department chair, medical director, nurse manager, or service line director)
      - Other members as determined by the facility, including community birth providers if home birth or community birth transfer
  - Ascertain peer review protections and considerations for the facility based on policy and facility legal counsel recommendations.
  - Train all committee members in a standardized process to understand the purpose for the review, protections and confidentiality considerations, and review processes.
  - Follow a standard format to support the collection of data and the intended purpose of the SMM review, including a narrative which ideally includes a patient discharge interview. Reviews should conclude with identified recommendations for improvements in future care or processes.[2]
  - Review all pertinent patient medical records and facility records regarding care the patient received that contributed to this SMM outcome, including from other facilities if the patient was transferred to or from the facility reviewing care.
- Establish a mechanism, such as a QI team or department charged with implementation of recommendations and evaluation of effectiveness of changes made because of the SMM review.

[1] If a small birthing facility, consider partnering with a regional perinatal center or outsourcing the review.

[2] Collaborate with a designated reviewer/abstractor to complete the Abstraction Section of the SMM Review Form.

Recognition and Prevention – Every Patient

- Review all pregnant, peripartum and postpartum patients receiving 4 or more units of packed red blood cells, admitted to an ICU as defined by the birthing facility, or other unexpected and severe medical event at the discretion of the birthing facility.[3]
  - Other conditions or events may include but are not limited to:
    - Return to operating room following cesarean birth
    - Unplanned hysterectomy
    - Postpartum stay greater than 7 days
    - Uterine rupture
    - Maternal cardiorespiratory arrest
- Identify the primary contributing clinical diagnosis associated with the SMM outcome.
- Utilize the appropriate condition specific questions to create a pertinent timeline and guide the review and abstraction of medical record information.
- Assess potential system, health care team, and patient factors contributing to the SMM outcome.

Response – Every Event

- Utilize a standardized process for completing SMM reviews with the review form and policies to support systems changes.
- Focus reviews on improving systems and care provisions and not just solely on peer review or performance issues.
- Ensure the culture and tone of reviews are nonjudgmental and use a Just Culture approach.
- Determine the best method to disseminate important recommendations for improvement in the birthing facility and as feedback for transfer facilities if relevant.

Reporting Systems Learning – Every Unit

- Establish a culture of multidisciplinary planning, huddles, and post-event debriefs which identify successes, opportunities for improvement, and action planning to support the facilitation of future SMM reviews.
- Perform multidisciplinary reviews as close as possible to the time of the event. The severity of the event should prompt timelier review.
- Monitor outcomes, process measures, and trends related to the birthing facility's SMM data, with disaggregation by race and ethnicity due to known racial and ethnic disparities.
  - De-identified aggregate data reviewed at regional and national levels via engagement in perinatal quality collaboratives (PQCs) and other state quality improvement teams could aid in the identification of trends and opportunities for improvement.
- Establish processes for data reporting and sharing of data with providers and care teams as appropriate to inform and support sustainable systems change as necessary.

[3] Refer to *Guidelines for Perinatal Care* for additional conditions or events to consider reviewing.

Respectful, Equitable, and Supportive Care – Every Unit/Provider/Team Member

- Engage in open, transparent, and empathetic communications during reviews.
- Assess all factors associated with SMM, including:
  - Contributing factors associated with social and structural determinants of health.
  - Appropriate referral and follow-up for identified unmet social needs.
  - An assessment of racism, discrimination, and implicit or explicit bias and how these may have impacted quality of care provided.

This document was developed with support by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award, UC4MC49476, totaling $3,000,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.