Resource	Description	Link
Guidelines for Perinatal Care. American College of Obstetricians and Gynecologists and American Academy of Pediatrics; 2017.	*Guidelines for Perinatal Care* was developed through the cooperative efforts of the American Academy of Pediatrics (AAP) Committee on Fetus and Newborn and the American College of Obstetricians and Gynecologists (ACOG) Committee on Obstetric Practice. This information is designed as an educational resource to aid clinicians in providing obstetric and gynecologic care, and use of this information is voluntary. This information should not be considered as inclusive of all proper treatments or methods of care or as a statement of the standard of care. It is not intended to substitute the independent professional judgment of the treating clinician. Variations in practice may be warranted when, in the reasonable judgment of the treating clinician, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology.	
Kilpatrick SJ. Understanding severe maternal morbidity: hospital-based review. Clin Obstet Gynecol 2018;61(2):340–6. doi: 10.1097/GRF.0000000000000351	Cases of severe maternal morbidity (SMM) share similarities to maternal deaths, including increasing in frequency and having similar rates of preventability. This article reviews steps for organizing and implementing standard reviews of all cases of SMM. These steps include create multidisciplinary SMM review committee; identify potential SMM cases and confirm true SMM; identify the morbidity; abstract and summarize data; present case to review committee for discussion; determine events leading to morbidity; determine opportunities to improve outcome; assess provider, system and patient factors in cases with opportunities to improve outcome; make recommendations; and effect change and evaluate improvement.	
Kilpatrick SJ, Berg C, Bernstein P, Bingham D, Delgado A, Callaghan WM, et al. Standardized severe maternal morbidity review: rationale and process. Obstet Gynecol 2014;124(2 Pt 1):361–6. doi: 10.1097/AOG.0000000000000397	Severe maternal morbidity and mortality have been rising in the United States. To begin a national effort to reduce morbidity, a specific call to identify all pregnant and postpartum women experiencing admission to an intensive care unit or receipt of 4 or more units of blood for routine review has been made. While advocating for review of these cases, no specific guidance for the review process was provided. Therefore, the aim of this expert opinion is to present guidelines for a standardized severe maternal morbidity interdisciplinary review process to identify systems, professional, and facility factors that can be ameliorated, with the overall goal of improving institutional obstetric safety and reducing severe morbidity and mortality among pregnant and recently pregnant women. This opinion was developed by a multidisciplinary working group that included general obstetrician-gynecologists, maternal-fetal medicine subspecialists, certified nurse-midwives, and registered nurses all with experience in maternal mortality reviews. A process for standardized review of severe maternal morbidity addressing committee organization, review process, medical record abstraction and assessment, review culture, data management, review timing, and review confidentiality is presented. Reference is made to a sample severe maternal morbidity abstraction and assessment form.	

Resource	Description	Link
Koch AR, Roesch PT, Garland CE, Geller SE. Implementing statewide severe maternal morbidity review: the Illinois experience. J Public Health Manag Pract 2018;24(5):458–64. doi: 10.1097/PHH.0000000000000752	**Context:** Severe maternal morbidity (SMM) rates in the United States more than doubled between 1998 and 2010. Advanced maternal age and chronic comorbidities do not completely explain the increase in SMM or how to effectively address it. The Centers for Disease Control and Prevention and American College of Obstetricians and Gynecologists have called for facility-level multidisciplinary review of SMM for potential preventability and have issued implementation guidelines. **Implementation:** Within Illinois, SMM was identified as any intensive or critical care unit admission and/or 4 or more units of packed red blood cells transfused at any time from conception through 42 days postpartum. All cases meeting this definition were counted during statewide surveillance. Cases were selected for review on the basis of their potential to yield insights into factors contributing to preventable SMM or best practices preventing further morbidity or death. If the SMM review committee deemed a case potentially preventable, it identified specific factors associated with missed opportunities and made actionable recommendations for quality improvement. **Evaluation:** Approximately 1100 cases of SMM were identified from July 1, 2016, to June 30, 2017, yielding a rate of 76 SMM cases per 10 000 pregnancies. Reviews were conducted on 142 SMM cases. Most SMM cases occurred during delivery hospitalization and more than half were delivered by cesarean section. Hemorrhage was the primary cause of SMM (>50% of the cases). **Discussion:** Facility-level SMM review was feasible and acceptable in statewide implementation. States that are planning SMM reviews across obstetric facilities should permit ample time for translation of recommendations to practice. Although continued maternal mortality reviews are valuable, they are not sufficient to address the increasing rates of SMM and maternal death. In-depth multidisciplinary review offers the potential to identify factors associated with SMM and interventions to prevent women from moving along the continuum of severity.	
Marx D. Patient Safety and the Just Culture. Obstet Gynecol Clin North Am. 2019 Jun;46(2):239-245. doi: 10.1016/j.ogc.2019.01.003	Within health care, the Just Culture is a model of workplace justice intended to create fairness for providers and create better outcome for patients. It is about creating a common language to evaluate provider conduct. A Just Culture helps create an open reporting culture. To create better patient safety outcomes, a Just Culture shifts the focus from errors and outcomes to system design and the facilitation of good behavioral choices.	

Resource	Description	Link
New York City Department of Health and Mental Hygiene. A guide to integrating severe maternal morbidity case review into hospital quality improvement committees. New York, 2020. Accessed August 1, 2023. https://www.nyc.gov/assets/doh/downloads/pdf/csi/guide-to-integrating-severe-maternal-morbidity-case-review.pdf	In collaboration with the Fund for Public Health in New York City and with funding from Merck for Mothers, NYC Health Department implemented a project to: 1) improve the quality of maternity care at NYC hospitals; 2) learn about mothers' needs and their experiences with SMM; and the ramifications of SMM on their lives, to inform action and further research; and 3) mobilize and inform communities about maternal health. This guide outlines the work implemented in the first component of the SMM Project: improving the quality of maternity care at hospitals through implementation of facility-level SMM review in hospital quality improvement (QI) committees. This guide describes each step in the process and what NYC Health Department did to address challenges that arose along the way. It also provides examples of contracts and agreements and templates for data collection and reporting as Supplemental Online Content (SOC).	
Ozimek JA, Greene N, Geller A, Zakowski M, Wong MS, Franco R, et al. Routine multidisciplinary review of severe maternal morbidity is associated with a reduction in preventable cases of severe maternal morbidity. Am J Perinatol 2022;39(3):307–11. doi: 10.1055/s-0040-1715846	**Objective:** Severe maternal morbidity (SMM) has increased by 45% in the United States and is estimated to affect up to 1.5% of all deliveries. Research has not yet been conducted that demonstrates a benefit to multidisciplinary review of SMM. The aim of our study was to determine if standardized, routine review of the cases of SMM by a multidisciplinary committee results in a reduction of potentially preventable cases of SMM. **Study Design:** A retrospective cohort study of all women admitted for delivery at Cedars-Sinai Medical Center from March 1, 2012 to September 30, 2016. Our cohort was separated into two groups: a preintervention group composed of women admitted for delivery prior to the implementation of the Obstetric Quality and Peer Review Committee (OBQPRC), and a postintervention group where the committee had been well established. Cases of confirmed SMM were presented to a multidisciplinary research committee, and the committee determined whether opportunities for improvement in care existed. The groups were compared to determine if there was a decreased incidence of preventable SMM following the implementation of the OBQPRC standardized review process. **Results:** There were 30,319 deliveries during the study period; 13,120 deliveries in the preintervention group; and 13,350 deliveries in the postintervention group (2,649 deliveries during the transition period). There was no difference in the rate of SMM between the preintervention (125; 0.95%) and postintervention (129; 0.97%) groups, ($p = 0.91$). There was a significantly lower rate of opportunity for the improvement in care in the postintervention group (29.5%) compared with the preintervention group (46%; $p = 0.005$). **Conclusion:** The authors demonstrated a significant reduction in the rate of potentially preventable SMM following the implementation of routine review of all SMM suggesting that this process plays an important role in improving maternal care and outcomes.	

Resource	Description	Link
Patient Safety Network. A just culture guide. Accessed March 28, 2024.	Although focusing on system failure has been highlighted as key to improving patient safety, individual behaviors must also be recognized as contributors to risks. This guide provides tactics for managers to address concerns associated with practitioner performance that arise during incident investigations. The guide helps managers initiate constructive conversations with clinical staff when their performance creates conditions for unsafe care delivery.	
Severe maternal morbidity: screening and review. Obstetric Care Consensus No. 5. American College of Obstetricians and Gynecologists & Society for Maternal¬–Fetal Medicine. Obstet Gynecol 2016;128(3):e54-e60. doi: 10.1097/AOG.0000000000001642	This document builds upon recommendations from peer organizations and outlines a process for identifying maternal cases that should be reviewed. Severe maternal morbidity is associated with a high rate of preventability, similar to that of maternal mortality. It also can be considered a near miss for maternal mortality because without identification and treatment, in some cases, these conditions would lead to maternal death. Identifying severe morbidity is, therefore, important for preventing such injuries that lead to mortality and for highlighting opportunities to avoid repeat injuries. The two-step screen and review process described in this document is intended to efficiently detect severe maternal morbidity in women and to ensure that each case undergoes a review to determine whether there were opportunities for improvement in care. Like cases of maternal mortality, cases of severe maternal morbidity merit quality review. In the absence of consensus on a comprehensive list of conditions that represent severe maternal morbidity, institutions and systems should either adopt an existing screening criteria or create their own list of outcomes that merit review.	
Sun, M., Oliwa, T., Peek, M., & Tung, E. (2022). Negative Patient Descriptors: Documenting Racial Bias in the Electronic Health Record. Health Affairs, 41(2), doi: 10.1377/hlthaff.2021.01423	Little is known about how racism and bias may be communicated in the medical record. This study used machine learning to analyze electronic health records (EHRs) from an urban academic medical center and to investigate whether providers' use of negative patient descriptors varied by patient race or ethnicity. The authors analyzed a sample of 40,113 history and physical notes (January 2019–October 2020) from 18,459 patients for sentences containing a negative descriptor (for example, resistant or noncompliant) of the patient or the patient's behavior. The authors used mixed effects logistic regression to determine the odds of finding at least one negative descriptor as a function of the patient's race or ethnicity, controlling for sociodemographic and health characteristics. Compared with White patients, Black patients had 2.54 times the odds of having at least one negative descriptor in the history and physical notes. Our findings raise concerns about stigmatizing language in the EHR and its potential to exacerbate racial and ethnic health care disparities.	

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