Section	Resource	Description	Link
Reporting & Systems Learning			
Reporting & Systems Learning	Women's Experiences with Severe Maternal Morbidity in New York City: A Qualitative Report *New York City Department of Health and Mental Hygiene, 2020*	This publication details the results of a qualitative research study aimed at learning about mothers' needs and experiences after an SMM event. Lessons learned can help with strategic planning for maternal health programs across New York City and other jurisdictions. Key findings and lessons from this study include the following: • The style of health care providers' interactions with women and their families influenced women's experience of, and recovery from, SMM. • Generally, women preferred clinicians who utilized patient-centered interaction styles to develop mutually respectful partnerships. • Some women reported perceptions of not being listened to or believed by health providers. • Experiences of poor care led women to mistrust health care providers and facilities and influenced their decisions about whether and when to seek future, needed care. • Women's experiences of SMM were made more challenging by complex social and medical needs and stressors, including housing conditions and stability, financial insecurity, and the need to navigate multiple, uncoordinated care systems.	
Reporting & Systems Learning	Obstetric Care Consensus #5: Severe Maternal Morbidity: Screening and Review *ACOG, 2021*	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.	

Section	Resource	Description	Link
Reporting & Systems Learning	Respectful Management of Serious Clinical Adverse Events *IHI, 2011*	Every day, clinical adverse events occur within our health care system, causing physical and psychological harm to one or more patients, their families, staff (including medical staff), the community, and the organization. In the crisis that often emerges, what differentiates organizations, positively or negatively, is their culture of safety, the role of the board of trustees and executive leadership, advanced planning for such an event, the balanced prioritization of the needs of the patient and family, staff, and organization, and how actions immediately and over time bring empathy, support, resolution, learning, and improvement. The risks of not responding to these adverse events in a timely and effective manner are significant, and include loss of trust, absence of healing, no learning and improvement, the sending of mixed messages about what is really important to the organization, increased likelihood of regulatory action or lawsuits, and challenges by the media.	
Respectful, Equitable & Supportive Care			
Respectful, Equitable & Supportive Care	Achieving Health Equity: A Guide for Health Care Organizations *IHI, 2016*	Significant disparities in life expectancy and other health outcomes persist across the United States. Health care has a significant role to play in achieving health equity. While health care organizations alone do not have the power to improve all of the multiple determinants of health for all of society, they do have the power to address disparities directly at the point of care, and to impact many of the determinants that create these disparities.	
Respectful, Equitable & Supportive Care	Black Women Disproportionately Suffer Complications of Pregnancy and Childbirth. Let's Talk About It. *ProPublica, 2017*	About 700 to 900 women die each year from causes related to pregnancy and childbirth. And for every death, dozens of women suffer life-threatening complications. But there is a stark racial disparity in these numbers. Black mothers are three to four times more likely to die than white mothers. Nevertheless, black women's voices are often missing from public discussions about what's behind the maternal health crisis and how to address the problems.