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.	

Section	Resource	Description	Link
Respectful, Equitable & Supportive Care	Postpartum Hemorrhage Outcomes and Race *AJOG, 2018*	A total of 360,370 women with postpartum hemorrhage from 2012 to 2014 were included in this analysis. Risk for severe morbidity was significantly higher among non-Hispanic black women (26.6%) than non-Hispanic white, Hispanic, or Asian or Pacific Islander women (20.7%, 22.5%, and 21.4%, respectively, P < .01). For non-Hispanic black compared with non-Hispanic white, Hispanic, and Asian or Pacific Islander women risk was higher for disseminated intravascular coagulation (8.4% vs 7.1%, 6.8%, and 6.8%, respectively, P < .01) and transfusion (19.4% vs 13.9%, 16.1%, and 15.8%, respectively, P < .01). Black women were also more likely than non-Hispanic white women to undergo hysterectomy (2.4% vs 1.9%, P < .01), although Asian or Pacific Islander women were at highest risk (2.9%). Adjusting for comorbidity, black women remained at higher risk for severe morbidity (P < .01). Risk for death for non-Hispanic black women was significantly higher than for nonblack women (121.8 per 100,000 deliveries, 95% confidence interval, 94.7-156.8 vs 24.1 per 100,000 deliveries, 95% confidence interval, 19.2-30.2, respectively, P < .01).	
Respectful, Equitable & Supportive Care	Reduction of Peripartum Racial and Ethnic Disparities: A Conceptual Framework and Maternal Safety Consensus Bundle *JOGNN, 2018*	Racial and ethnic disparities exist in both perinatal outcomes and health care quality. For example, Black women are three to four times more likely to die from pregnancy-related causes and have more than a twofold greater risk of severe maternal morbidity than White women. In an effort to achieve health equity in maternal morbidity and mortality, a multidisciplinary workgroup of the National Partnership for Maternal Safety, within the Council on Patient Safety in Women's Health Care, developed a concept article for the bundle on reduction of peripartum disparities. We aimed to provide health care providers and health systems with insight into racial and ethnic disparities in maternal outcomes, the etiologies that are modifiable within a health care system, and resources that can be used to address these etiologies and achieve the desired end of safe and equitable health care for all childbearing women.	
Respectful, Equitable & Supportive Care	Reduction In Racial Disparities In Severe Maternal Morbidity From Hemorrhage In A Large-Scale Quality Improvement Collaborative *AJOG, 2020*	A large-scale quality improvement collaborative reduced rates of severe maternal morbidity due to hemorrhage in all races and reduced the performance gap between black and white women. Improving access to highly effective treatments has the potential to decrease disparities for care-sensitive acute hospital-focused morbidities.	