



WHAT CAN YOU DO *to Reduce Maternal Severe Morbidity & Mortality*

by SARAH J. KILPATRICK, MD, PHD

Review all maternal deaths at your institution.¹

Participate in Levels of Maternal Care designation.⁹

Implement bundles: hemorrhage, hypertension, etc.³

Have all perinatal staff take implicit bias training.⁶

Have clear severe hypertension treatment guidelines posted and treat acute severe hypertension within 30 minutes.⁶

Debrief after each adverse event.⁸

Have a massive transfusion protocol and hemorrhage kit on L+D.¹²

Participate in multidisciplinary simulations in the L+D unit and in testing areas.¹⁰

Expand community outreach for better access for Medicaid and others.¹¹

Screen for VTE risk and treat appropriately.⁷

Utilize toolkits.⁴

Review all cases of severe maternal morbidity (ICU admissions and/or transfusions of 4 or more units of red blood cells).²

Contemporary OB/GYN[®]



What Can You Do to Reduce Maternal Severe Morbidity & Mortality



IMAGE: ADOBESTOCK/INAGAEIS

SCAN TO DOWNLOAD PRINTABLE PDF.



WE WANT TO HEAR FROM YOU



Leave comments on our Facebook page:
[facebook.com/ContempOBGYN](https://www.facebook.com/ContempOBGYN)



Follow us and tweet to
[@ContempOBGYN](https://twitter.com/ContempOBGYN)

REFERENCES

1. Berg C, Danel I, Atrash H, Zane S, Bartlett L. Strategies to reduce pregnancy-related deaths: from identification and review to action. Centers for Disease Control and Prevention. 2001. <https://stacks.cdc.gov/view/cdc/6537>
2. ACOG, SMFM; Kilpatrick SJ, Ecker JL. Severe maternal morbidity: screening and review. *Am J Obstet Gynecol.* 2016;215:B17-22.
3. a. Burgansky A, Montalto D, Siddiqui NA. The safe motherhood initiative: the development and implementation of standardized obstetric care bundles in New York. *Semin Perinatol.* 2016;40(2):124-131. b. <http://safehealthcareforeverywoman.org/>
4. a. Main EK, Cape V, Abreo A, et al. Reduction of severe maternal morbidity from hemorrhage using a state perinatal quality collaborative. *Am J Obstet Gynecol.* 2017;216(3):298.e1-298.e11. b. CMQCC.org
5. a. ACOG. Postpartum hemorrhage. *Practice Bulletin.* 2017;183. <https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2017/10/postpartum-hemorrhage> b. <http://safehealthcareforeverywoman.org/> c. Blood product replacement: obstetric hemorrhage. CMQCC.org.
6. Rogers, VL, Nesbitt, SD. Overcoming racism and unconscious bias in ob/gyn. *Contemporary OB/GYN.* 2020;64(8)15-17.
7. D'Alton ME, Friedman AM, Smiley RM, et al. National partnership for maternal safety: consensus bundle on venous thromboembolism. *Obstet Gynecol.* 2016;128(4):688-698.
8. a. Kilpatrick SJ, Berg C, Bernstein P, et al. Standardized severe maternal morbidity review: rationale and process. *Obstet Gynecol.* 2014;124(2 pt 1):361-366. b. Gardner R. Introduction to debriefing. *Semin Perinatol.* 2013;37(3):166-174.
9. a. Kilpatrick SJ, Menard K, Zahn CM, et al. Maternal Levels of Care. ACOG/SMFM Obstetric Care Consensus. *Am J Obstet Gynecol.* 2019;134:e41-55. b. Building US capacity to review and prevent maternal deaths. CDC Foundation. <https://www.cdc-foundation.org/building-us-capacity-review-and-prevent-maternal-deaths>
10. a. Emergencies in clinical obstetric (ECO). ACOG. <https://www.acog.org/education-and-events/simulations/eco> b. Deering S, Rowland J. Obstetric emergency simulation. *Semin Perinatol.* 2013;37(3):179-188.
11. Petersen EE, Davis NL, Goodman D, et al. Vital signs: pregnancy-related deaths, United States 2011-2015, and strategies for prevention, 13 states, 2013-2017. *MMWR Morb Mortal Wkly Rep.* 2019;68(18):423-429.
12. Gestational Hypertension and Pre-eclampsia: ACOG Practice Bulletin, Number 222. *Obstet Gynecol.* 2020 Jun;135(6):e237-e260. doi: 10.1097/AOG.0000000000003891

