



Obstetric Hemorrhage Change Package

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Introduction

The Alliance for Innovation on Maternal Health (AIM) is a national data-driven patient safety and quality improvement (QI) initiative. AIM works through state and jurisdiction-based teams to align national, state, jurisdiction, and hospital level QI efforts to reduce preventable maternal mortality and severe maternal morbidity across the United States.

The AIM Patient Safety Bundles are a core part of this work. To promote the successful implementation of these bundles, AIM partnered with the Institute for Healthcare Improvement (IHI) to create a series of associated change packages. This specific change package is designed to support Perinatal Quality Collaboratives (PQCs) and other state- and jurisdiction-based initiatives to leverage the AIM Obstetric Hemorrhage Patient Safety Bundle more effectively.

Why is this important?

The US remains in a maternal mortality crisis. According to a 2022 report by the National Center for Health Statistics, the maternal mortality rate in 2020 was 23.8 deaths per 100,000 live births. When disaggregated by race, the rate of maternal death for non-Hispanic Black people (55.3 deaths for 100,000 live births) was 2.9 times the rate for non-Hispanic White people (19.1 deaths per 100,000) and 3 times that of Hispanic people (18.2 people per 100,000 live births).¹ Maternal death represents a tragic sentinel event with near miss morbidity events growing in number as well. Severe maternal morbidity (SMM) poses great risk to maternal health and provides a greater opportunity to intervene.

Postpartum hemorrhage is a leading cause of preventable, pregnancy-related illness and death with an estimated 54-90% of all OB Hemorrhage related deaths being preventable.^{2,3} The aim of this change package is to aid teams implementing the AIM Obstetric Hemorrhage Patient Safety Bundle by preparing them to recognize and respond to hemorrhage at all stages of care, and laying the foundation for respectful, equitable, and supportive care for all.

What is a change package?

A change package is a document listing evidence-based or best practice changes specific to a topic and is usually organized around a framework or model. In this case, the Obstetric Hemorrhage Change Package is structured around the [AIM Obstetric Hemorrhage Patient Safety Bundle](#).⁴

Changes packages, including this one, are structured around the following components:

- **Primary Drivers:** Major processes, operating rules, or structures that will contribute to moving toward the aim. In this change package, the primary drivers are based on AIM's Five Rs Framework (Readiness, Recognition & Prevention, Response, Reporting/Systems Learning, and Respectful Care).
- **Change Concepts:** Broad concepts (e.g., move steps in the process closer together) that are not yet specific enough to be actionable but that will be used to generate specific ideas for change.
- **Change Ideas:** Actionable, specific idea for changing a process. Change ideas can come from research, best practices, or from other organizations that have recognized a problem and have demonstrated improvement on a specific issue related to that problem.

Taken as a whole, a change package has the potential to seem overwhelming. Based on the priorities of your state and community, we encourage you to start small by testing a couple of ideas connected to the aim you set. Through iterative tests of change (also known as Plan-Do-Study-Act (PDSA) cycles), you will have an opportunity to learn what works and what does not in your efforts to improve your processes. Initially, these cycles are carried out on a small scale (e.g., one patient on one day) to see if they result in improvement. Teams can then expand the tests and gradually incorporate larger and larger samples until they are confident that the changes will result in sustained improvement.

How to prioritize changes?

No team is expected to test all the listed change ideas. Consider this a menu of options from which you may choose what to tackle first. Each team will review their baseline data, progress to date, organizational priorities, and select an area(s) to prioritize. For example, some may start with one driver. Others may start by tackling one idea across all drivers. Start by choosing an area that you think could lead to an easy win.

You can also leverage the following tools to help you decide where to start:

1. [Pareto chart](#): A type of bar chart in which the various factors that contribute to an overall effect are arranged in order according to the magnitude of their effect. This ordering helps identify the "vital few" – the factors that warrant the most attention.⁵
2. [Priority matrix](#): A tool that can better help you to understand important relationships between two groupings (i.e., steps in a process and departments that conduct that step) and make decisions on where to focus.⁶
3. [Impact-effort matrix](#): A tool that helps identify which ideas seem easiest to achieve (least effort) with the most effects (highest impact). The ideas identified via this tool, would be a great place to start.⁷

The [IHI QI Workbook: Better Maternal Outcomes: Reducing Harm from Obstetric Hemorrhage](#), is another great tool to use as you begin this work, containing relevant descriptions, examples, and templates for quality improvement (QI) tools.⁸


Change Package

A Note on Symbols

Respectful, Equitable, and Supportive Care

In the latest revision of the AIM Obstetric Hemorrhage Patient Safety Bundle, a fifth R was added; Respectful, Equitable, and Supportive Care. This R is integrated throughout the change package, and all change ideas that fall under this R are marked with a  symbol.

Additional Considerations

It is understood that every team utilizing this change package will be at a different point in this work. If your organization is further along in your obstetric hemorrhage improvement work and has found reliability in some of the change ideas below, we suggest testing the additional considerations in *italics* and marked by the  symbol.

Readiness

Every Unit/Team

Change Concept	Change Idea	Key Resources and Tools
<p>1. Develop processes for the management of patients with obstetric (OB) hemorrhage, including:</p> <p>A designated rapid response team co-led by nursing, obstetrics, and anesthesia with membership appropriate to the facility's Level of Maternal Care</p>	<p>Create OB response team with specified roles and responsibilities</p>	<p>Preparing for Clinical Emergencies in Obstetrics and Gynecology, ACOG CO #590⁹</p> <p>AHRQ TeamSTEPPS Rapid Response Systems Module¹⁰</p>
	<p>Establish a known phrase (appearing on overhead page or in digital alerts) for hemorrhage emergencies so all disciplines develop situational awareness</p>	
<p>A standardized, facility-wide, stage-based, obstetric hemorrhage emergency management plan with checklists and escalation policy</p>	<p>Develop clear emergency hemorrhage protocol that includes stage-based algorithm and systems of escalation</p>	<p>CMQCC Obstetric Hemorrhage Toolkit V3.0 Appendix C and D (p194-195)¹¹</p>
<p>Emergency release and massive transfusion protocols to ensure immediate access to blood products</p>	<p>Create emergency release and massive transfusion protocols</p> <p><i>Include communication between OB and blood bank and recommendations for type & screen and type & cross*</i></p>	<p>CMQCC Obstetric Hemorrhage Toolkit V3.0 Appendix S and T (p235-243)¹¹</p>
	<p>Develop blood availability dashboard and protocols specific to shortages with clarity about decision-maker</p> <p><i>Identify lead staffer in blood bank to update dashboard (if not automated)*</i></p>	<p>Blood Bank: Massive Transfusion Protocol (ACOG)¹²</p>
	<p>Document communication from outpatient OB visits about red cell alloantibodies/any abnormalities and expected delivery dates</p>	

	<p>Order blood products to be prepared for high-risk patients as described in stage-based algorithm</p> <p><i>Type & screen all patients if feasible in setting*</i></p>	<p>How we treat: transfusion medicine support of obstetric services¹³</p> <p>Obstetric Hemorrhage Checklist (ACOG)¹⁴</p>
<p>A protocol, including education and consent practices, to collaborate with patients who decline blood products, but may accept alternative approaches</p>	<p>Develop or adapt protocol for declination of blood products and have clear documentation in patient record</p> <p><i>For those who decline blood products and have an elevated risk for hemorrhage, arrange for intraoperative cell salvage set-up*</i></p>	<p>Guidance Document: Patients Who Decline Blood Products¹⁵</p> <p>CMQCC Obstetric Hemorrhage Toolkit V3.0 (p 64-68)¹¹</p> <p>Refusal of Medically Recommended Treatment During Pregnancy, ACOG CO #664¹⁶</p>
<p>Review policies to identify and address organizational root causes of racial and ethnic disparities in outcomes related to the diagnosis, management, and surveillance of OB hemorrhage ♦</p>	<p>Identify lead staffer for this process and utilize race, ethnicity, and language (REAL) data in prioritization of improvement efforts</p> <p><i>Incorporate question about bias into case review*</i></p> <p><i>Incorporate respectful care questions into Team Debrief Tool*</i></p> <p><i>Use patient-reported experience measures (PREMs)*</i></p> <p><i>Create bias reporting system*</i></p>	<p>New York City Standards for Respectful Care at Birth¹⁷</p>
<p>2. Maintain a hemorrhage cart or equivalent with supplies, checklists, and instruction cards</p>	<p>Create supply list for cart with multidisciplinary input</p> <p><i>Update supply list annually*</i></p>	<p>CMQCC Obstetric Hemorrhage Toolkit V3.0, Hemorrhage Cart Checklist (p 252 - 253)¹¹</p>

<p>for devices or procedures where antepartum, laboring, and postpartum patients are located</p>		<p>Development of an Obstetric Hemorrhage Response Intervention: The Postpartum Hemorrhage Cart and Medication Kit¹⁸</p>
	<p>Place carts in all relevant care areas where unplanned birth could occur (e.g., antepartum, labor & delivery, emergency department operating room, postpartum unit)</p> <p><i>Adapt to setting with plan to rotate/update materials (could be a single cart in small rural setting)*</i></p>	
	<p>Have reliable and regular restocking system for both after use and to keep materials up to date</p> <p><i>Can mirror restocking process to code cart processes*</i></p> <p><i>Consider restocking as a step after debriefing*</i></p>	
	<p>Include materials like uterine devices (e.g., Bakri balloon tamponade, Jada uterine vacuum), uterine compression sutures, and quick reference diagrams of the B-lynch procedure technique</p>	<p>Uterine balloon tamponade for the treatment of postpartum hemorrhage: a systematic review and meta-analysis¹⁹</p> <p>B-Lynch Compression Suture as an Alternative to Peripartum Hysterectomy²⁰</p> <p>Florida Obstetric Hemorrhage Initiative Tool Kit (p 22)²¹</p>
<p>3. Ensure immediate access to first- and second-line hemorrhage medications in a kit or equivalent per the unit’s obstetric</p>	<p>Localize all key uterotonics and other medications (oxytocin, methylergonovine, hemabate, misoprostol, tranexamic acid, fibrinogen concentrate) together in proximity to labor & delivery, operating room, and emergency departments and ensure appropriate storage</p> <p><i>The meds often together are:*</i></p>	<p>Florida Obstetric Hemorrhage Initiative Tool Kit, Table 4 (p 18)²¹</p>

<p>hemorrhage emergency management plan</p>	<ul style="list-style-type: none"> • <i>Misoprostol, five 200 mcg tablets</i> • <i>Oxytocin, 10 to 40 units per 500 to 1000 mL NS 1 bag</i> • <i>Methylergonovine, 0.2 mg/mL 1 ampule (requires refrigeration)</i> • <i>Carboprost, 250 mcg/mL 1 ampule (requires refrigeration)</i> <p><i>Include med administration tip sheets (like for fibrinogen)*</i></p>	
	<p>Have order sets for hemorrhage medications in electronic health record (EHR)</p>	
<p>4. Conduct interprofessional and interdepartmental team-based drills with timely debriefs that include the use of simulated patients</p>	<p>Have drills for use of cart and obtaining medications with use of stage-based algorithm and activation of rapid-response team</p>	<p>Readiness: Utilizing bundles and simulation²²</p> <p>Obstetric Emergency Drills Trainer’s Manual²³</p>
	<p>Have drills for measurement of QBL and use of blood bank dashboard</p>	
	<p>Ensure that simulations include varied forms of patient expression and include processing with patient ♦</p> <p><i>Vary patient race/language/ethnicity in simulations*</i></p>	
	<p>Ensure that regular drills and simulations are held on all shifts for all OB staff and providers (including anesthesia, blood bank, and support departments) and test all parts of system</p> <p><i>Hold drills and simulations at least quarterly, can strive for monthly*</i></p>	<p>Simulation: Emergencies in Clinical Obstetrics ACOG²⁴</p> <p>Video: Quantification of Blood Loss AWHONN²⁵</p>

Recognition and Prevention

Every Patient

Change Concept	Change Idea	Key Resources and Tools
<p>1. Assess and communicate hemorrhage risk to all team members as clinical conditions change or high-risk conditions are identified; at a minimum, on admission to labor & delivery, during the peripartum period, and on transition to postpartum care</p>	<p>Conduct formal assessment for hemorrhage risk at multiple points in prenatal, delivery, and postpartum care and document in EHR with associated alerts</p>	<p>National Partnership for Maternal Safety: consensus bundle on obstetric hemorrhage²⁶</p> <p>Obstetric Hemorrhage Outcomes by Intrapartum Risk Stratification at a Single Tertiary Care Center²⁷</p>
	<p>Conduct formal assessment for anemia and use anemia protocol <i>Include iron diffusion logistics for iron deficiency anemia*</i></p>	<p>CMQCC Obstetric Hemorrhage Toolkit V3.0 (p 41-50)¹¹</p>
	<p>Match risk level to intended delivery hospital level <i>Transfer to a tertiary care center for suspicion of abnormal placentation*</i></p>	<p>Levels of Maternal Care AGOC²⁸</p>
	<p>Review and document risk during huddles, shift changes, and at times of transfer then note level of risk on census board <i>Consider color-coding on census board (red, yellow, green) for easy identification*</i></p>	
	<p>Discuss risk assessment and its implications with patient and family ♦ Include birth trauma history in risk assessment <i>Consider patient symptoms and concerns voiced as potential serious precursors to hemorrhage event*</i></p>	<p>City Birth Trauma Scale City, University of London¹⁸</p>
	<p>Include “equity pause” to look at bias risk within multidisciplinary care planning and to ask, “What are considerations to ensure respectful care without discrimination?” ♦</p>	

	<p>Please note, an equity pause is an emerging idea being tested in different fields. If you are interested in trying it, start small and consider testing on admission, during shift change, or at transfer to postpartum. It mirrors an operating room time out to prevent harm.</p>	
	<p>Have anesthesia consult (depending on setting) for high-risk patients (antepartum if high risk determination is antepartum) ♦</p> <p><i>May need to first establish an anesthesia consult protocol*</i></p>	
	<p>Screen and treat for anemia antenatally and implement a protocol for IV iron therapy in those with moderate to severe iron deficiency anemia</p>	<p>Recommendations to prevent and control iron deficiency in the United States CDC²⁹</p> <p>Anemia in Pregnancy: ACOG Practice Bulletin, Number 233³⁰</p> <p>Global nutrition targets 2025: policy brief series WHO³¹</p> <p>Anemia WHO³²</p>
	<p>Discuss option of epidural analgesia with high-risk patients ♦</p>	
<p>2. Measure and communicate cumulative blood loss to all team members, using quantitative approaches</p>	<p>Perform quantifiable blood loss (QBL) as part of patient assessment in and across care settings (adapted to capability of hospital): emergency department, operating room, labor & delivery, postpartum, intensive care unit</p> <p><i>Assign QBL lead*</i></p>	<p>Quantification of Blood Loss: AWHONN Practice Brief Number 13³³</p>
	<p>Pair specific QBL total with stage-based algorithms (including on postpartum unit with triggering of rapid-response team when threshold is met)</p>	
	<p>Calculate and provide real-time QBL updates to team</p>	

	<p>Have specific method for calculating volume of amniotic and irrigation fluids</p>	<p>CMOCC Obstetric Hemorrhage Toolkit V3.0 Appendix M (p226-232)¹¹</p>
	<p>Make sure scales are available in appropriate rooms with tared weights of pads and drapes</p>	
	<p>Use calculation tools and have laminated listed dry weights on cart or use apps with similar information</p>	
	<p>Use QBL alerts in EHR <i>Include estimated blood loss data if delivery occurred in transit*</i></p>	
	<p>Continue QBL in recovery phase to assess for active on-going blood loss</p>	
<p>3. Actively manage the third stage of labor per department-wide protocols</p>	<p>Establish, disseminate, and verify use of a protocol to actively manage third stage of labor</p>	<p>Active versus expectant management for women in the third stage of labor³⁴</p> <p>WHO recommendations for the prevention and treatment of postpartum hemorrhage³⁵</p> <p>Guidelines for Active Management of the Third Stage of Labor using Oxytocin: AWHONN Practice Brief Number 12³⁶</p>
<p>4. Provide ongoing education to all patients on obstetric hemorrhage risk and causes, early warning signs, and risk for postpartum complications</p>		

Response

Every Event

Change Concept	Change Idea	Key Resources and Tools
<p>1. Utilize a standardized, facility-wide, stage-based, obstetric hemorrhage emergency management plan, with checklists and escalation policies for stage-based management of patients with obstetric hemorrhage, including:</p> <p>Advance preparations made based on hemorrhage risk (e.g., cell saver, blood bank notification, etc.)</p>	<p>Designate a patient and identified support network liaison to provide updates in real-time and include these communications on emergency checklist ♦</p>	<p>Florida Obstetric Hemorrhage Initiative Tool Kit (p 33)²¹</p> <p>Preparing for Clinical Emergencies in Obstetrics and Gynecology, ACOG CO #590⁹</p>
	<p>Perform multi-disciplinary debriefing at the following timepoints:</p> <ul style="list-style-type: none"> • After resolution of an acute hemorrhage • At the time of transfer to reassess hemorrhage risk and to convey risk to the postpartum team 	<p>Obstetric Team Debriefing Form ACOG³⁷</p>
Evaluate patients for etiology of hemorrhage		
Use of obstetric rapid response team		
<p>Evidence-based medication administration or use of nonpharmacological interventions</p>	<p>Communicate directly with patient about clinical concerns and planned management, prior to performing any physical interventions such as bimanual pelvic exam, tamponade placement, or speculum exam ♦</p>	<p>The SHARE Approach AHRQ³⁸</p> <p>Partnering in healthcare: A framework for better care and outcomes³⁹</p>
	<p>Include patient-reported pain in assessment and have clear plans for pain management</p>	

	<p><i>Increase staff awareness of atypical pain that may represent concealed bleeding*</i></p>	
	<p>Using respectful care training, respond in real time to staff and providers' cultural assumptions about pain, which can show up as positive bias and negative bias ◇</p> <p><i>Increase reliable use of standardized pain assessment tool to mitigate bias*</i></p>	
	<p>Ensure that qualified interpreters are being used with patients and identified support network who need them ◇</p> <p><i>Do not rely on family to do interpretation*</i></p> <p><i>Recognize that a patient's language needs may change in midst of crisis*</i></p>	
	<p>Following transfer, continue to monitor patient with emergency management checklist</p>	
<p>2. Provide trauma-informed support for patients, identified support network, and staff for all obstetric hemorrhages, including discussions regarding birth events, follow up care, resources, and appointments</p>	<p>Have clear mechanism with a designated provider to ensure all family support processes are completed following hemorrhage</p>	<p>National Partnership for Maternal Safety: Consensus Bundle on Support After a Severe Maternal Event²⁶</p> <p>CMOCC Obstetric Hemorrhage Toolkit V3.0 Appendix W¹¹</p>
	<p>Provide written summary of events following hemorrhage to patient and family ◇</p> <p><i>If patient is in intensive care unit (ICU), provide ICU diaries to family to be able to share with patient later*</i></p>	
	<p>Ensure processes to support infant feeding preferences following hemorrhage</p>	

	<i>Ensure breast pump is accessible and lactation support available*</i>	
	Begin trauma care in postpartum setting with conversation and referral to trauma specialist ◇	
	Screen for maternal depression and PTSD and depression following trauma <i>Use PREMs survey*</i>	Birth Place Lab website ⁴⁰ Edinburgh Postnatal Depression Scale ⁴¹
	Ensure that patient can talk with a provider who was at the event ◇ <i>Increase understanding that the above change idea is in support of patient and provider*</i>	
	Ensure private space for family meetings ◇	
	Have protocol for patients experiencing infant loss <i>Hand sign on door indicating infant loss*</i> <i>Move patient out of L&D and avoid postpartum unit*</i>	
	Understand if family has any equity concerns about care given and screen for equitable care with scales (Mother’s Autonomy in Decision Making (MADM), Mothers on Respect Index (MORI)) after each delivery ◇	The Mother’s Autonomy in Decision Making (MADM) scale ⁴² The Mothers on Respect (MOR) index ⁴³

Reporting and Systems Learning

Every Unit

Change Concept	Change Idea	Key Resources and Tools
<p>1. Establish a culture of multidisciplinary planning, huddles, and post-event debriefs for every obstetric hemorrhage, which identify successes, opportunities for improvement, and action planning for future events.</p>	<p>Conduct huddles in conjunction with stage-based algorithm to be responsive to evolving clinical scenarios</p> <p><i>Include patients and families in bedside huddles if they want to participate*◇</i></p>	
	<p>Have immediate post-event debrief (with equity lens) for support and learning</p> <p><i>Establish standardized briefing documentation to capture successes and actionable follow-up*</i></p>	<p>Severe Maternal Morbidity Review Form AIM⁴⁴</p>
	<p>Have more formal after-action review with designated leader and standardized content</p> <p><i>Reflect on the equity in case as part of review*</i></p>	
	<p>Archive debriefing documentation for OB hemorrhage events and review systematically with unit-specific and QI leadership teams</p> <p><i>Establish unit-specific and QI leadership teams to review and address quality and safety issues*</i></p>	
	<p>Have health equity rounds (like department grand rounds) led by someone with appropriate experience</p> <p><i>Start with at least quarterly equity rounds*</i></p>	
<p>2. Perform multidisciplinary reviews of serious complications per established facility criteria to identify systems issues.</p>	<p>Have formal review following serious hemorrhage to assess alignment with standard policies and procedures (with appropriate updates) and to identify opportunities for improvement (including identification of discriminatory practices)</p>	<p>AIM Data Resources⁴⁵</p>

	<p><i>Include REAL data to identify potential bias and need for systemic changes*</i></p> <p><i>Use reporting pathways to communicate and document consistent issues*</i></p>	
	<p>Establish, review, and update as needed facility criteria and processes for review of serious hemorrhages</p>	
	<p>Include execution of QBL in review</p>	
<p>3. Monitor outcomes and process measures related to obstetric hemorrhage, with disaggregation by race and ethnicity due to known racial and ethnic disparities in obstetric hemorrhage outcomes</p>	<p>Identify key processes and outcomes for quality improvement data collection</p> <p><i>Include staff training metrics among run charts*</i></p> <p><i>Align quality improvement data collection with a perinatal quality collaborative*</i></p>	
	<p>Collaborate with health information technology (HIT) or appropriate staff to modify EHR and automate data collection and reporting</p>	
	<p>Set specific goals for closing identified disparities using the SMARTIE format (strategic, measurable, ambitious, realistic, time-bound, inclusive, and equitable)</p>	
	<p>Collect and analyze REAL data</p> <p><i>Have staff training on importance of REAL data and respectful collection*</i></p> <p><i>Assess quality of REAL data and develop processes for improved data collection*</i></p>	
	<p>Review all process and outcome data disaggregated by REAL to assess for disparities with unit-specific and QI leadership teams</p>	

	<p><i>Identify alternative strategies to integrate equity considerations into reporting and systems learning in settings where use of disaggregated data may cause potential patient identifiability or unstable data*</i></p>	
<p>4. Establish processes for data reporting and the sharing of data with the obstetric rapid response team, care providers, and facility stakeholders to inform care and change care systems, as necessary</p>	<p>Include race/ethnicity data in the analysis of OB hemorrhage morbidity review and debriefing documentation to identify potential bias and need for systemic changes or staff education</p> <p><i>Educate staff on metrics used in run charts for quality improvement*</i></p>	
	<p>Establish and maintain health equity rounds (like department grand rounds) led by someone with appropriate experience</p> <p><i>Start with quarterly equity rounds*</i></p>	
	<p>Develop run charts and reports for staff with both outcome and process measures</p> <p><i>Include REAL data in reports and run charts*</i></p>	
	<p>Disaggregate data to inform content of health equity and clinical rounds and other staff education opportunities</p> <p><i>Start with quarterly rounds*</i></p> <p><i>Share data during rounds and staff education opportunities*</i></p>	

Respectful, Equitable, and Supportive Care*

Every Unit, Provider, and Team Member

Change Concept	Change Idea	Key Resources and Tools
<p>1. Include each patient that experienced an obstetric hemorrhage and their identified support network as respected members of and contributors to the multidisciplinary care team and as participants in patient-centered huddles and debriefs</p>	<p>Schedule time for a formal debrief including the patient and family prior to discharge ♦</p> <p><i>Incorporate perspectives of patients and people with lived experience into reviews in a trauma-informed and equitable manner*</i> ♦</p>	<p>Achieving Health Equity: A Guide for Health Care Organizations⁴⁶</p>
<p>2. Engage in open, transparent, and empathetic communication with pregnant and postpartum people and their identified support network to understand diagnoses, options, and treatment plans, including consent regarding blood products and blood product alternatives.</p>	<p>Provide communication in the patient’s preferred language and support access to interpretation services; provide educational materials for patients in common languages spoken in your community ♦</p> <p>Educate clinicians on providing respectful care by engaging in the life-long learning of cultural humility, understanding that individuals cannot learn all aspects of any culture, including their own ♦</p>	<p>National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care⁴⁷</p> <p>AWHONN Respectful Maternity Care Implementation Toolkit⁴⁸</p> <p>ACOG Respectful Care eModules⁴⁹</p> <p>The Cycle to Respectful Care: A Qualitative Approach to the Creation of an Actionable Framework to Address Maternal Outcome Disparities⁵⁰</p>

*Further respectful care change ideas are integrated throughout the previous primary drivers as well. They are indicated by the ♦ symbol.

Appendix

1. Maternal Mortality Rates in the United States, 2020. Published February 22, 2022. Accessed May 2, 2022. <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm>
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