Maternal Mortality Review Committees

As maternal mortality rates continue to rise in the United States, maternal mortality review committees play a vital role in examining ways to prevent future cases from occurring, by identifying and recommending strategies for eliminating preventable maternal deaths.

To establish a maternal mortality review committee, you need to:

- **Have Protections in Place.** Ensure committee members have complete access to data sources and that information collected is protected from disclosure. Additionally, review committee members should have legal protection from subpoena related to their participation in case reviews.

- **Select a Committee.** Identify stakeholders and select a review committee that represents multidisciplinary backgrounds. Review committees should be composed of state and local organizations, such as health departments and state OB/GYN societies; medical and social service providers; and other community stakeholders.

- **Define scope and reach of case review.**

- **Determine where data and administrative responsibilities lie** (collecting and reporting data, scheduling meetings, communicating with members, etc.)

- **Define a Process.** Lay out the steps to ensure committees examine maternal death cases effectively.

- **Implement and evaluate your efforts.** During the review process, issues may arise that require technical assistance. Evaluate implementation as it occurs and make adjustments or course corrections as needed.

Maternal Mortality Review usually includes the following steps:

1. **Case Identification:** Cases are identified through vital records, hospital reporting, media and/or word of mouth.

2. **Case Selection:** Cases within the scope of review are sent for abstraction. A subcommittee may be put in place to review cases and remove cases outside of the established scope of the review.

3. **Abstraction:** Abstractors compile data on cases using every piece of information available to them, such as death and birth certificates, autopsy reports, prenatal care records, hospital records, social service records, and informant interviews.

4. **Case Narrative Development:** Then the abstractor develops a case narrative, including critical factors that answer key questions surrounding a woman’s death such as who, what, when, where, and how.

5. **Case Review Presentation:** Maternal mortality review committees make decisions based on discussions of the available information. The review committee determines whether a death was pregnancy-related; the cause of death; preventability; missed opportunities for prevention or intervention; and makes recommendations to prevent similar future deaths.

6. **Tracking, Analysis, and Implementation:** Enter findings into a database including specific and feasible recommendations for action. Data are analyzed for regular reporting and translated for public health action. These regular reports demonstrate value and are key to keeping review committee members and stakeholders informed and engaged.