

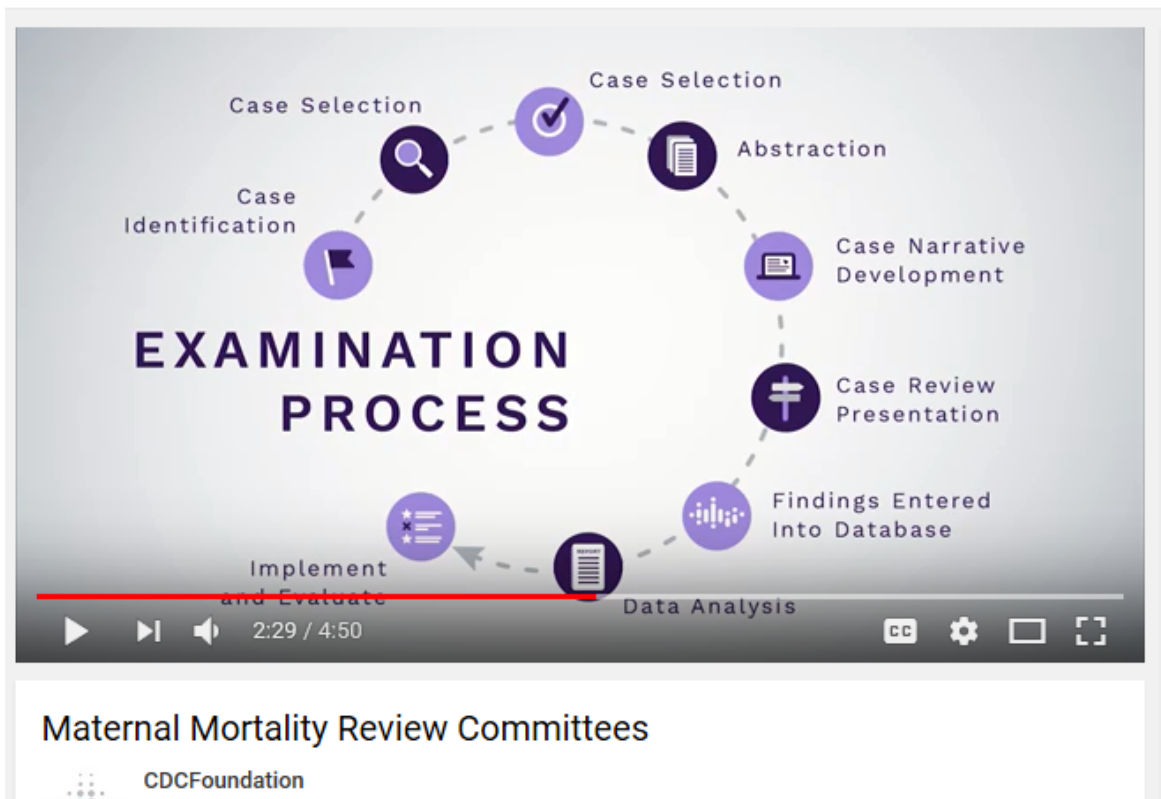
“Building US Capacity to Review and Prevent Maternal Deaths”

CDC

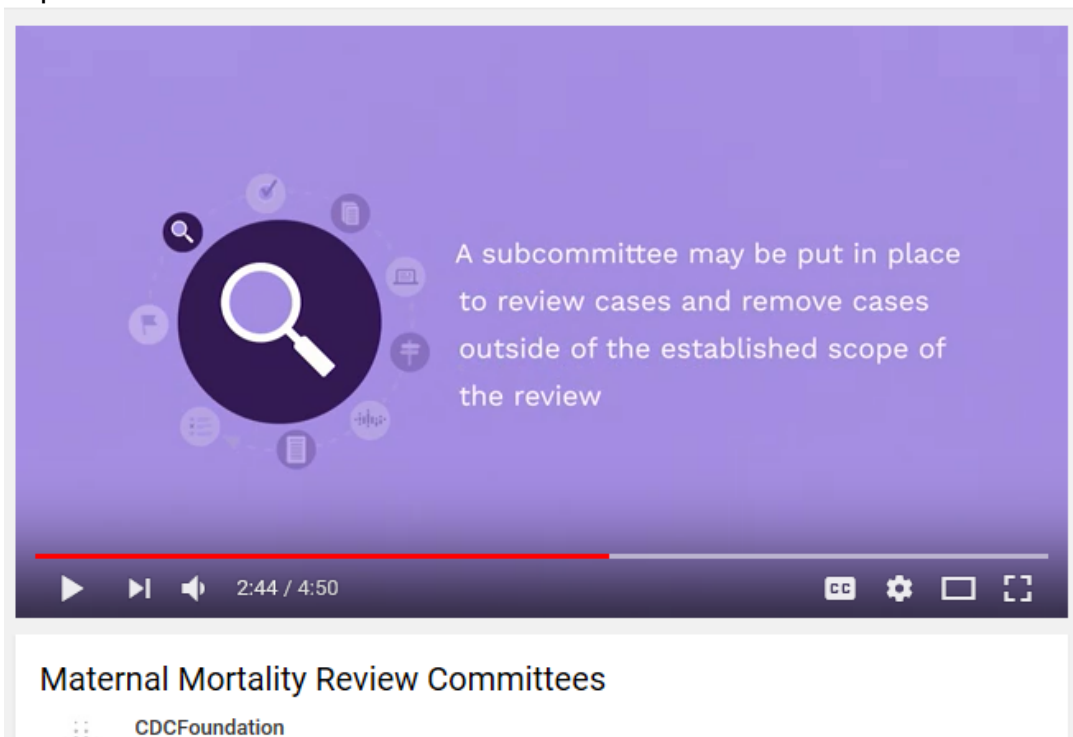


1. Ensure Protections are in Place
 - a. Committee members should have protection from subpoenas from their participation in case reviews
2. Identify Stakeholders and Select Membership
 - a. Include a multidisciplinary team. Broad representation.
 - b. Medical Specialties: OB/GYN, Family Practice, Internal Medicine, Anesthesiology, Cardiology, Mental Health, Rheumatology, Nursing and Nurse Midwifery. Medical Examiners and Coroners. Public Health and Title V MCH Program Staff. Social Services, Social Work, and Care Coordinators. Insurance, Medicaid and Managed Care. Patient Advocates and Clergy. Abstractors and Epidemiologists.
 - c. There should be a Chairperson to provide overall leadership and vision.
3. Define Scope and Reach
4. Determine Where the Committee will Live
 - a. Where data and administrative responsibilities lie.
 - b. Who has responsibility for collecting/reporting data, scheduling meetings, and contacting members.

5. Define Process Flow



6. Implement and Evaluate






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

3:03 / 4:50

Maternal Mortality Review Committees

CDCFoundation

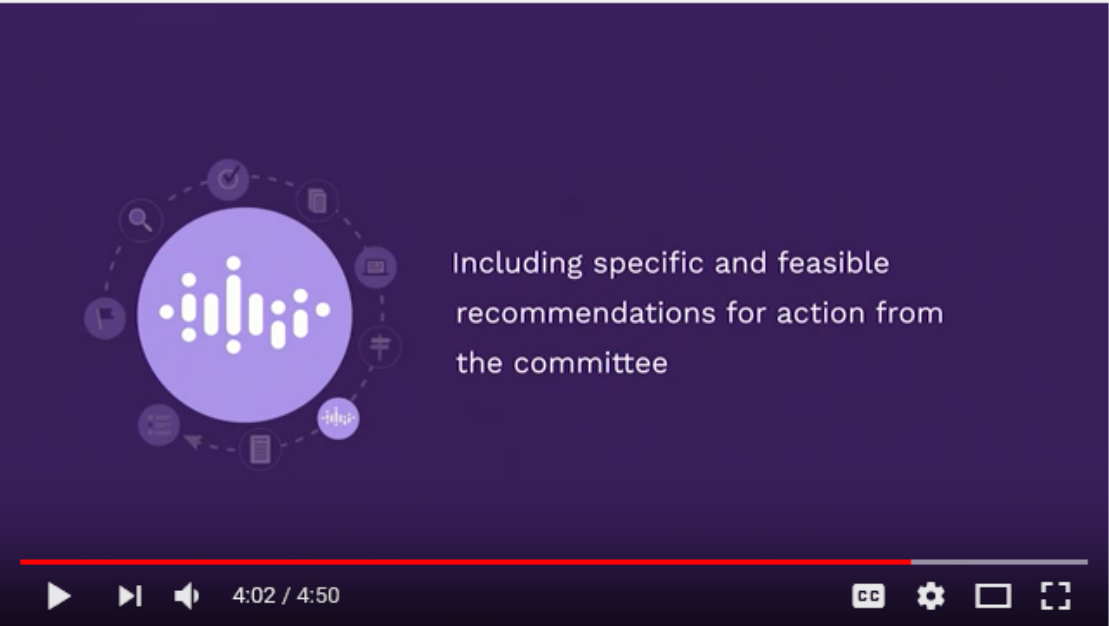


The Review Committee determines whether a death was pregnancy-related, or pregnancy-associated but not related; the cause of death; preventability; missed opportunities for prevention or intervention; and, makes recommendations to prevent future deaths

3:45 / 4:50

Maternal Mortality Review Committees


CDCFoundation



Including specific and feasible recommendations for action from the committee

4:02 / 4:50

Maternal Mortality Review Committees

 CDCFoundation