CONNECTICUT MATERNAL MORTALITY REVIEW COMMITTEE SCOPE, MISSION, GOALS, AND VISION

Scope:

The scope of cases for committee review is all pregnancy-associated deaths or any deaths of women with indication of pregnancy up to 365 days, regardless of cause (i.e. motor vehicle accidents during pregnancy, motor vehicle accidents postpartum, suicide, homicide). Deaths are identified from review of death certificates with a pregnancy checkbox selection and linkage of vital records by searching death certificates of women of reproductive age and matching them to birth or fetal death certificates in the year prior.

Mission:

The mission is to increase awareness of the issues surrounding pregnancy-related death and to promote change among individuals, healthcare systems, and communities in order to reduce the number of deaths.

The mission of the Connecticut Maternal Mortality Review Committee is to identify pregnancy-associated deaths, review those caused by pregnancy complications and other associated causes, and identify the factors contributing to these deaths and recommend public health and clinical interventions that may reduce these deaths and improve systems of care.

Goals:

The goals of the Maternal Mortality Review Committee are to:

- **Perform a multidisciplinary review of cases** to gain a holistic understanding of the issues.
- **Determine the annual number of maternal deaths related to pregnancy** (pregnancy-related mortality).
- **Identify trends and risk factors** among pregnancy-related deaths in CT.
- **Recommend improvements to care** at the provider and system levels with the potential for reducing or preventing future events.
- **Prioritize findings and recommendations** to guide the development of effective preventive measures.
- **Recommend actionable strategies for prevention** and intervention.
- **Promote the translation of findings and recommendations** into quality improvement actions at all levels.

Vision:

The Maternal Mortality Review Committee's vision is to eliminate preventable maternal deaths, reduce maternal morbidities, and improve population health for women of reproductive age in Connecticut.

Membership:

The Connecticut Maternal Mortality Review Committee is a multidisciplinary committee whose geographically diverse members represent various specialties, facilities, and systems that interact with and impact maternal health. At any one time, the committee consists of approximately 15-20 members who commit to serve a renewable 1-year term.

Meeting structure:

Maternal Mortality Review Committees review and make decisions about each case based on the case narrative and abstracted data. The committee examines the cause of death and contributing factors, and determines:

- Was the death pregnancy-related?
- If pregnancy-related, what was the underlying cause of death? (PMSS-MM)
- Was the death preventable?
- If there were chances to alter the outcome, what were they?
- What were the contributing factors to the death?
- What specific and feasible recommendations for actions should be taken to prevent future deaths?

Process:

Information is gathered from death certificates, birth certificates, medical records, autopsy reports, and other pertinent resources. Records are abstracted by a trained abstractor, who prepares de-identified case narratives for review by a committee of experts from diverse disciplines.