

**BETTER DATA AND BETTER OUTCOMES:
REDUCING MATERNAL MORTALITY IN THE U.S.**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
ONE HUNDRED FIFTEENTH CONGRESS
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¹ The information can be found at: <https://docs.house.gov/meetings/IF/IF14/20180927/108724/HHRG-115-IF14-20180927-SD022.pdf>.

² The information can be found at: <https://docs.house.gov/meetings/IF/IF14/20180927/108724/HHRG-115-IF14-20180927-SD023.pdf>.

³ The information can be found at: <https://docs.house.gov/meetings/IF/IF14/20180927/108724/HHRG-115-IF14-20180927-SD004.pdf>.

BETTER DATA AND BETTER OUTCOMES: REDUCING MATERNAL MORTALITY IN THE U.S.

THURSDAY, SEPTEMBER 27, 2018

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:00 a.m., in room 2123 Rayburn House Office Building, Hon. Michael Burgess (chairman of the subcommittee) presiding.

Members present: Representatives Burgess, Guthrie, Barton, Shimkus, Latta, Lance, Griffith, Bilirakis, Long, Bucshon, Brooks, Mullin, Hudson, Carter, Walden(ex officio), Green, Engel, Schakowsky, Castor, Schrader, Kennedy, Cárdenas, DeGette, and Pallone (ex officio).

Staff present: Mike Bloomquist, Staff Director; Samantha Bopp, Staff Assistant; Daniel Butler, Staff Assistant; Adam Fromm, Director of Outreach and Coalitions; Zach Hunter, Director of Communications; Ed Kim, Policy Coordinator, Health; Ryan Long, Deputy Staff Director; Drew McDowell, Executive Assistant; Brannon Rains, Staff Assistant; Austin Stonebraker, Press Assistant; Josh Trent, Deputy Chief Health Counsel, Health; Hamlin Wade, Special Advisor, External Affairs; Jacquelyn Bolen, Minority Professional Staff; Jeff Carroll, Minority Staff Director; Evan Gilbert, Minority Press Assistant; Waverly Gordon, Minority Health Counsel; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Tim Robinson, Minority Chief Counsel; and Samantha Satchell, Minority Policy Analyst.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. And the Subcommittee on Health will now come to order. I recognize myself 5 minutes for purpose of an opening statement. And I want to thank everyone for joining us this morning to discuss a topic that is important to each and every one of us. This is a subject matter that has been brought to the forefront by members of this subcommittee, members of Congress generally, actions of state legislators, and the media.

Having spent 3 decades myself practicing OB/GYN, I believe it should be a national goal to eliminate all preventable maternal mortality. Even a single maternal death is too many. All too often we have read about the stories of seemingly healthy pregnant

women who are thrilled to be having a child and then to everyone's surprise suffers severe complications, death, or near death during a pregnancy, birth, or postpartum. The death of a new or expecting mother is a tragic event that devastates everyone involved, and if there are preventable scenarios we need to do what we can to stop that.

The alarming trend in our country's rate of maternal mortality first came to my attention in September 2016 reading a copy of the American College of Obstetricians and Gynecologists, The Green Journal. The original research found that the maternal mortality rate had increased in 48 states and Washington, D.C. from 2000 to 2014, while the international trend was moving in the opposite direction. Since reading that article, I have spoken to providers, hospital administrators, state task forces, and public health experts. The more I looked into this troubling issue, the more I realized that we have got much more we need to understand.

This subcommittee had an informational briefing last year on this topic to inform members and to start the road toward this hearing. This is an issue that we cannot solve without accurate data. There were efforts in our nation to address maternal and infant mortality in the first half of the 20th century and the data showed that these efforts were indeed successful.

But according to the Centers for Disease Control and Prevention the United States' maternal mortality rate, 7.2 deaths per 100,000 in 1999 and increased to 18 deaths per 100,000 live births in 2014. The Centers for Disease Control began conducting national surveillance of pregnancy related deaths in 1986 due to a lack of data on causes of maternal death.

In 2003, the Centers for Disease Control National Center for Health Statistics revised standards for certain death certificates and added a pregnancy checkbox. While this checkbox has led to increased data collection on maternal deaths, it does not provide enough insight as to why or how these deaths occurred. Representative Jaime Herrera Beutler joining us this morning, the discussion draft that she has put forward will address the complex issue of maternal mortality by enabling states to form maternal mortality review committees to evaluate, improve, and standardize their maternal death rate.

This is a critical step in the right direction as physicians, public health officials, and Congress are unable to reach conclusions based upon current data as to what the causes for maternal mortality increases are. Once we establish what these are, there will be an opportunity to use the data to implement the best practices toward a solution.

Texas is a good example of a state that has enacted legislation to create and sustain a Maternal Mortality and Morbidity Task Force. Texas has put time and effort in funding and to reviewing maternal deaths in order to find the trends in the increases and the causes of death. The Task Force's September 2018 report, which I have here and later on we will ask unanimous consent to be made part of the record, stated that the leading causes of pregnancy-related death in 2012 included cardiovascular, obstetric hemorrhage, infection sepsis, and cardiomyopathy.

This report is just a snapshot of the national picture as causes do vary from state to state. Additionally, this May, various researchers involved in the review of Texas' maternal deaths published a paper, again in *The Green Journal*, detailing that unintentional user error and other issues led to inaccurate reporting of maternal mortality. The researchers concluded that relying solely on obstetric codes for identifying maternal deaths appears to be insufficient and can lead to inaccurate ratios.

The moral of this story is we must ensure accurate data to accurately pinpoint the clinical issues contributing to these tragic deaths. I would like to submit a statement for the record from Dr. Gary Hankins and, without objection, so ordered, the chairman of the Department of OB/GYN at the University of Texas Medical Branch in Galveston.

[The information appears at the conclusion of the hearing.]

Mr. BURGESS. And Dr. Hankins was one of those doctors who briefed us during the briefing last year. Dr. Hankins has subspecialty training in maternal fetal medicine and served as vice chair for the Texas Morbidity and Mortality Review Committee.

At one time we were scheduled to be joined by Dr. Lisa Hollier, also of Texas, who is also part of that committee. I think we had to postpone last week because of a hurricane and she could not accommodate the reschedule. But Dr. Hollier has also been integral in working on this at the state level.

So I certainly look forward to hearing from our panel of witnesses today as how we can address this vital and devastating issue.

[The prepared statement of Mr. Burgess follows:]

PREPARED STATEMENT OF HON. MICHAEL C. BURGESS

Good morning. Thank you to everyone for joining us this morning to discuss a topic that is important to each and every one of us, maternal mortality. This is a subject matter that has been brought to the forefront by Members of this Subcommittee, actions of State Legislatures, and the media. Having spent nearly three decades as an OB/GYN, I believe it should be a national goal to eliminate all preventable maternal mortality—even a single maternal death is too many.

All too often do we read about stories of seemingly healthy pregnant women who are thrilled to be having a child, and to everyone's surprise, suffers severe complications, or death during pregnancy, birth, or post-partum. The death of a new or expecting mother is a tragic event that devastates everyone involved, but in many cases these are preventable scenarios.

The alarming trend in our country's rate of maternal mortality first came to my attention in September 2016, when I was reading my copy of *The Green Journal*. The original research found that the maternal mortality rate increased in 48 states and Washington DC from 2000 to 2014, while the international trend was moving in the opposite direction. Since reading that article, I have spoken with providers, hospital administrators, state task forces, and public health experts. The more I dove into this troubling issue, the more I realized how little we understand. This Subcommittee held an informational briefing last year on this topic to inform members and pave the road to this hearing.

This is an issue that we cannot solve without accurate data. There were great efforts in our nation to address maternal and infant mortality in the first half of the 20th Century, and the data showed that those efforts were successful. Yet, according to the Centers for Disease Control and Prevention (CDC), the U.S. maternal mortality rate was 7.2 deaths per 100,000 live births in 1999, and increased to 18 deaths per 100,000 live births in 2014.

CDC began conducting national surveillance of pregnancy-related deaths in 1986 due to a lack of data on causes of maternal death. In 2003, the CDC National Center for Health Statistics revised standards for certain death certificates, and added

a pregnancy checkbox. While this checkbox has led to increased data collection on maternal deaths, it does not provide enough insight into why or how these mothers are dying.

Representative Jamie Herrera-Beutler's discussion draft will address the complex issue of maternal mortality by enabling States to form maternal mortality review committees to evaluate, improve, and standardize their maternal death data. This is a critical step in the right direction, as physicians, public health officials, and Congress are unable to reach conclusions based upon current data as to what the causes for maternal mortality are. Once we establish what these are, there will be an opportunity to use the data to implement best practices.

Texas is a great example of a state that has enacted legislation to create and sustain a maternal mortality and morbidity task force. Texas has put much time, effort, and funding into reviewing maternal deaths in order to find trends in the causes of death. The Task Force's September 2018 report stated that leading causes of pregnancy-related death in 2012 included cardiovascular and coronary conditions, obstetric hemorrhage, infection/sepsis, and cardiomyopathy. This report is just a snapshot of the national picture, as causes vary from state to state.

Additionally, this May, various researchers involved in the review of Texas maternal deaths published a paper in the Green Journal detailing that unintentional user error and other issues led to inaccurate reporting of maternal mortality. The researchers also concluded that "relying solely on obstetric codes for identifying maternal deaths appears to be insufficient and can lead to inaccurate maternal mortality ratios." The moral of this story is that we must ensure accurate data to accurately pinpoint the clinical issues contributing to these tragic deaths.

I would like to submit a statement for the record from Dr. Gary Hankins, Chairman of the Department of OB/GYN at The University of Texas Medical Branch. He has subspecialty training in Maternal Fetal Medicine and served as Vice Chair for the Texas Maternal Morbidity and Mortality Review Committee.

I look forward to hearing from our expert panel of witnesses as to how we can address this vital yet devastating issue.

Mr. BURGESS. The chair recognizes the ranking member of the subcommittee, Mr. Green, 5 minutes for your opening statement, please.

**OPENING STATEMENT OF HON. GENE GREEN, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. GREEN. Thank you, Mr. Chairman, for calling today's hearing on maternal mortality in the United States, and I would also like to thank our colleague who is in our distinguished panelists for joining us this morning.

I would like to take just a moment, Mr. Chairman. My deputy chief of staff, LD/LA, Sergio Espinosa, this will be his last committee hearing and he has been working with me on health care in our office for many years—8 years, it has been 8 or 9. This is his last hearing. And those of you who someday decide you are not going to run for reelection, you will know that you will be losing staff members in the last 2 or 3 months. But I just want to thank Sergio for his work in the office on many issues, but particularly in the last number of months on health care.

So—and I will continue with my statement.

[Applause.]

Mr. GREEN. The Centers for Disease Control and Prevention reports that more than 700 women in the United States die each year due to complications related to pregnancy and childbirth, and more than 50,000 women experience a life-threatening complication. Maternal mortality in our country has more than doubled between 1987 and 2014, from 7.2 to 18 maternal deaths per 100,000 live births. In comparison, a recent World Health Organization

study found that maternal mortality is on the decline in 157 of the 183 countries.

These numbers are troubling as we are because even more acute when you look at the existing racial, socioeconomic, and geographic disparities, for example, African American women are nearly three times as likely to die of complications relating to pregnancy and childbirth compared to white women. In America in the 21st century, no woman should ever die of complications related to pregnancy and childbirth.

Congress has a duty to act and reverse this terrible trend. I would like to thank my colleagues both Congresswoman Diane DeGette and Congresswoman Jaime Herrera Beutler for offering their discussion draft, The Preventing Maternal Deaths Act that will help protect pregnant and postpartum mothers. This legislation will provide grants to states and tribes to help establish and support already existing maternal mortality review committees, MMRCs, to identify and review pregnancy-related and pregnancy-associated deaths.

MMRCs which are currently operating in over 30 states have been helping strengthen public health surveillance by linking vital data to the multidisciplinary healthcare professionals practicing in women's health. I support the bipartisan legislation and hope our committee will recommend it in consideration before the full House before the end of the year.

My Preventing Maternal Deaths Act is an important first step. Our committee can and must do more to protect our nation's mothers. Despite the gains made under the Affordable Care Act, nearly one in seven women of childbearing age remain uninsured. The biggest barrier to women of childbearing age receiving healthcare coverage is continuing refusal of 19 states, including my home State of Texas, to expand Medicaid. Continuing of a comprehensive health insurance is critical for expecting and postpartum mothers to receive the post and postnatal care they need for themselves and their babies.

Medical research shows chronic conditions such as hypertension, diabetes, heart disease, and obesity which are becoming more common for expecting mothers can increase their risk for complications during pregnancy. Ensuring continuing of coverage preceding pregnancy will help women of childbearing age best manage these chronic conditions before they become a problem.

Last year I introduced Incentivizing Medicaid Expansion Act, H.R. 2688, in order to incentivize states to provide critical Medicaid coverage for uninsured Americans and avoid the kinds of tragedy that has led to the rising rate of mortality in my home State. My legislation would guarantee that the Federal Government covers a hundred percent of expansion costs for the first 3 years for states that have not yet expanded, and no less than 90 percent afterwards. I ask the committee to give this legislation the serious consideration that it deserves and help reverse the public health crisis that maternal mortality and severe maternal morbidity have become too many for our communities and our country.

And in my last 39 seconds, UTMB in Galveston has been the catchment for most of the births in East Texas and South Texas and for decades, and I appreciate that university and that medical

school for doing that for our families. In the Houston area we have a hospital district, but Medicaid would at least help get them reimbursed. But UTMB is the catchment for problem pregnancies in South Texas and East Texas.

Thank you, Mr. Chairman. I yield back.

Mr. BURGESS. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from Oregon, the chairman of the full committee, Mr. Walden, 5 minutes for your opening statement, please.

OPENING STATEMENT OF HON. GREG WALDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. WALDEN. Well, thank you, Chairman Burgess.

Doctor, we are glad that you are chairing this subcommittee and this subcommittee hearing especially given your many decades of real-world experiences in OB/GYN. So we are glad to have you at the helm for this hearing especially. It is a difficult topic and it is one that is close to many of us.

Far too many mothers die because of complications during pregnancy, and the effects of such a tragedy on any family is impossible to fully understand. What is both surprising and devastating is that despite massive innovation and advances in health care and technology we have experienced recent reports that have indicated that the number of women dying due to pregnancy complications is actually increasing. It is actually going up.

According to the Centers for Disease Control and Prevention, maternal mortality rates in America have more than doubled since 1987, and I think we are all asking how can that be? Well, this is not a statistic any of us wants to hear. There are questions as to whether the increases due to data collection are broader questions about healthcare delivery. The bill before us today will help us answer these really important questions and hopefully ensure that expectant newborn mothers receive even better care.

I want to thank Congresswoman Herrera Beutler, my neighbor to the north in Washington State, for bringing this issue to our attention. She has been a real leader on this effort for many, many months, if not years. And especially given what you have been through in your own situation, we are proud of you and of your children and so we are glad to have you before the committee.

I also want to thank my colleague and friend from Colorado, Diana DeGette, for her partnership on the draft legislation that is before us today. She has been a real leader on 21st Century Cures and other public health issues that are so important. And I want to extend a sincere thank you to the members of our second panel. Mr. Johnson, it is good to see you again. We appreciate you coming back here. I am sorry for what you have been through, but I appreciate your willingness to come share with us. Your testimony makes a difference in public policy.

The draft bill we are examining today is the Preventing Maternal Deaths Act of 2018. The bill would enhance our Federal efforts to support maternal mortality review committees in each of our states. And earlier this year, the Oregon legislature passed a bill to establish such a committee in my home State which brings a wide range of medical providers together with community organiza-

tions and with public health experts to study maternal mortality and figure out its underlying causes. That information and lessons learned will then be shared with law enforcement and healthcare providers across Oregon. Congress should support and it should build off of these efforts and others across the country so many of these deaths could be prevented if best practices for maternal health care were followed and more widely understood.

So that is what this hearing is all about. We appreciate you being here and we look forward to the testimony from our other panelists and of course from our colleague. I will tell you in advance we actually have two subcommittees going on simultaneously, and as chairman of the overall committee I have to bounce back and forth between them. But thank you for being here and we look forward to moving forward to find solutions.

And with that, Mr. Chairman, I yield back.

Mr. BURGESS. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from New Jersey, Mr. Pallone, the ranking member of the full committee, 5 minutes for an opening statement, please.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman. Hundreds of women die each year from pregnancy-related or pregnancy-associated complications in the United States, and more than 60 percent of these deaths are preventable. Shamefully, the maternal mortality rate in the U.S. has increased while most of the rest of the developed world has actually fallen. And this is not just alarming, it is unconscionable. We have a responsibility to understand why this is happening and what we should be doing to combat this crisis.

Mr. Green and I wrote a letter to Chairman Burgess and Chairman Walden on this issue in May and I am pleased we are finally holding a hearing today. Today we will discuss a draft of the Preventing Maternal Deaths Act, which mirrors a version that passed out of the Senate Health Committee. This is a good bill. It is critical that we have the necessary data to understand the underlying causes of maternal deaths and identify strategies that can help us combat it.

This bill encourages states to implement maternal mortality review committees to study this data and make recommendations on ways to combat maternal death. Review committees that are diverse and interdisciplinary can identify trends, patterns, and disparities that contribute to preventable maternal deaths. And with this information, healthcare providers can monitor the effectiveness of their policy and practice changes.

Now my home State of New Jersey was the second state in the nation to institute a maternal mortality review committee which has worked extensively to review New Jersey's maternal death cases to better understand their root causes and prevent deaths in the future. However, New Jersey's maternal mortality rate remains much too high and much more work still needs to be done.

Extensive public reporting has vividly described the risks American woman face in childbirth and the postpartum period and has

also highlighted the vast disparities in outcome. While women of all backgrounds are at risk for pregnancy-related complications, it is critical we also examine why maternal death rates are disproportionately higher for women of color, low-income women, and women living in rural areas. And we must understand why, and work together to address these disparities.

However, we must also consider other ways we can combat maternal mortality, including by expanding health insurance coverage and ensuring all women have access to the reproductive health services they need. Unfortunately, efforts by the Trump administration to sabotage the Affordable Care Act, curtail the Medicaid program, and limit family planning services have only served to harm women and their families. Reducing maternal deaths in the United States must be a public health priority. I look forward to working with my colleagues to advance this bill and to begin addressing this crisis in a meaningful way.

And I would like to now yield 2 minutes to my colleague, the Democratic sponsor of H.R. 1318, Ms. DeGette.

Ms. DEGETTE. Thank you very much for yielding.

Mr. Chairman, thank you so much for having this hearing. And I know my co-sponsor, Congresswoman Herrera Beutler, and I very much hope that we can mark this bill up and pass it during the lame duck session. In my opinion, it has been far too delayed given what we are seeing in this country.

Maternal mortality rose in the United States between 2000 and 2014 by 26 percent. This is really shocking to people who I talk to about this because other developed nations in the world have slashed their maternal mortality rates in half. And here is what is even worse, maternal mortality disproportionately affects women of color. Pregnancy-related death is nearly four times higher among African American women. And there are multiple factors that contribute to these maternal mortality rates—the high incidence of preeclampsia, obstetric hemorrhaging, and mental health conditions.

Now to combat this trend, 33 states have established maternal mortality review committees. These panels bring together local healthcare professionals who collectively review individual maternal deaths and then target individual policy solutions towards them. The panels have been very effective. In California, for example, which established one in 2006, they have reduced their maternal mortality by more than 55 percent. And that is why what this bill does is it provides federal support for state-based maternal mortality review committees including for states, critically, that have not yet established these panels. It also promotes efforts to standardize data collection practices for maternal mortality which will help public health experts, researchers, and policymakers develop evidence-based solutions to address this crisis.

The bill has 171 co-sponsors and a number of organizations, some which are here in the audience today. The March of Dimes, the American College of Obstetrics and Gynecologists, and others all support it and so I really hope we can quickly advance the bill. I hope we can pass it by the end of the year and send it to the President's desk. Thank you and I yield back.

Mr. BURGESS. The chair thanks the gentlelady. The gentlelady yields back and this concludes with member opening statements. The chair would remind all members that pursuant to committee rules, members' opening statements will be made part of the record.

We do want to thank our witness on the first panel for being here today and taking time to testify before the subcommittee.

I do want, as a housekeeping note, after Representative Herrera Beutler testifies we will move immediately to the second panel. We will not break in between the panels of witnesses. And again as is the custom, when we have a Member at the witness table there will not be questions from the dais to the Member, so we will go right into the second panel after Representative Herrera Beutler testifies.

So our first witness is Representative Herrera Beutler from the State of Washington who is principal author of this legislation. We appreciate you being here today and you are recognized 5 minutes for your opening statement, please.

STATEMENT OF HON. JAIME HERRERA BEUTLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Ms. HERRERA BEUTLER. Thank you, Mr. Chairman, for having this hearing and for your work in this field. This isn't an issue of the moment for you, but this is what you have dedicated your life to and we are very grateful.

Thank you, Ranking Member Green, for your support of this critical issue, and members of the subcommittee today for participating in this effort to reduce maternal mortality in the United States and for giving me this opportunity to speak in strong support of this discussion draft of the Preventing Maternal Mortality Deaths Act that is before us.

So you either are a mom or you have a mom, so this issue impacts you. The very title of this bill speaks to why I have introduced this bipartisan legislation with my co-sponsor Ms. DeGette from Colorado. We have to take vital steps towards moving this bill in Congress and I believe we are going to save lives and prevent more families from suffering the profound loss of a cherished family member.

The testimonies today will shed light on a truly disturbing trend in our nation. More mothers die from pregnancy-related or pregnancy-associated deaths here in the U.S. than in any developed country in the world. Although the assumption is often that a nation with some of the most advanced obstetric and emergency care would also demonstrate low maternal mortality rates, tragically, an estimated 700–900 maternal deaths occur in the U.S. every year.

And not only does the U.S. rank 47th for maternal mortality globally, we have actually seen an increase in maternal deaths in recent years. This makes us one of only eight nations in the world with rising maternal mortality rates. It is unacceptable. In fact, Iran has a better maternal mortality rate than we do here in the United States.

In New Jersey where Mr. Pallone is from, and he knows this, if you are a woman of color, a black woman, out of 100,000 deaths,

79 are likely to pass away from a pregnancy-associated or pregnancy-related death. You are three or four times more likely as a woman of color to experience this tragedy in our country. It is unacceptable. For families, single fathers, grandparents, and children who have all lost a mother, perhaps the most heart-wrenching of all of this is that according to the CDC 60 percent of these maternal deaths could have been prevented.

As a mother, as a citizen, and a lawmaker, I believe we can and we must do better. It is time for this to become a national priority, which is why I am proud to speak in support of the Preventing Maternal Deaths Act. This legislation would enable states to establish and strengthen maternal mortality review committees. MMRCs bring together local experts in maternal, infant, and public health to review each and every instance of a pregnancy-related or pregnancy-associated death. We are going to investigate every single one because these moms are worth it. This is going to give us the information to understand why it is happening and what we need to do to fix it. This is how we are going to save future mothers' lives.

As members of the committee are aware, we know many of the conditions that contribute to high maternal mortality rate such as preeclampsia, gestational diabetes, obstetric hemorrhage, as well as emerging challenges such as suicide and substance use disorder. However, the truth is that the available data is woefully inadequate, which greatly hinders our ability to understand why mothers are dying. The Preventing Maternal Deaths Act seeks to address this data deficiency by empowering states to participate in national information sharing through the CDC, allowing for increased collaboration and the development of best practices.

Now before closing, I want to note that the legislation before us was crafted from key policy recommendations made by multiple organizations supporting this bill including the Association of Maternal & Child Health Programs, the American College of Obstetricians and Gynecologists, the March of Dimes, Preeclampsia Foundation, the Society for Maternal-Fetal Medicine—thank you to all of you tireless warriors in this fight.

Finally, and most importantly, I would like to extend my deepest gratitude to the families, fathers—one of whom you are going to hear from today, sitting behind me. Charles Johnson is going to tell you the story of the preventable death of his hero and hopefully this will be a tribute to ending those tragedies. He wants no one else to go through what he has gone through.

And to every advocate who has spoken out, shared their stories, and called for change, these courageous individuals are the champions of this movement and this bill. With wide bipartisan support and well over a 160 co-sponsors in the House, I remain committed to passing the Preventing Maternal Deaths Act into law and I look forward to working with this committee, you, Mr. Chairman, and my colleagues in Congress to accomplish this imperative goal.

With that I thank you and I yield back.

[The prepared statement of Ms. Herrera Beutler follows:]

U.S. House of Representatives Energy and Commerce Committee

Subcommittee on Health Hearing:

“Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S.”

Testimony of: Congresswoman Jaime Herrera Beutler

September 27, 2018

Thank you Chairman Burgess, Ranking Member Green, and Members of the Subcommittee for holding this hearing on reducing maternal mortality in the United States and for this opportunity to speak in strong support of the discussion draft of the *Preventing Maternal Deaths Act* that is before us.

The very title of this bill speaks to why I have introduced this bipartisan legislation and to why we are here today. We are here to take vital steps toward moving a bill in Congress that I believe will save lives and prevent more families from suffering the profound loss of a mother.

The testimonies today will shed light on a truly disturbing trend in our nation – more mothers die from pregnancy-related or pregnancy-associated causes here in the U.S. than *any* other developed country in the world.

Although the assumption is often that a nation with some of the most advanced obstetric and emergency care would also demonstrate low maternal mortality rates, tragically, an estimated 700 - 900 maternal deaths occur in the U.S. every year. Not only does the U.S. rank 47th for maternal mortality globally, we have actually seen an *increase* in maternal deaths in recent years. This makes us one of only eight nations in the world with *rising* maternal mortality rates.

For the families, single fathers, grandparents, and children who have lost a mother, perhaps the most heart-wrenching of all is that the Centers for Disease Control and Prevention estimates that *60 percent* of these maternal deaths could have been prevented.

As a mother, a citizen, and a lawmaker, I believe that we can and must do better. It is time for this to become a national priority, which is why I am proud to speak in support of the Preventing Maternal Deaths Act.

This legislation would enable states to establish or strengthen maternal mortality review committees. MMRCs bring together local experts in maternal, infant, and public health to review each and every instance of a pregnancy-related or pregnancy-associated death in order to understand what went wrong and how to save future mothers' lives.

As Members of the Committee are aware, we know of many conditions that contribute to high maternal mortality rates, such as preeclampsia, gestational diabetes, obstetric hemorrhage, as well as emerging challenges such as suicide and substance use disorder. However, the truth is that the available data is woefully inadequate, which greatly hinders our ability to understand why mothers are dying.

The Preventing Maternal Deaths Act seeks to address this data deficiency by empowering states to participate in national information sharing through the CDC, allowing for increased collaboration and the development of best practices.

Before closing, I would like to note that the legislation before us was crafted from key policy recommendations made by multiple organizations that are supporting this bill - including the Association of Maternal & Child Health Programs, the American College of Obstetricians and Gynecologists, March of Dimes, Preeclampsia Foundation, and the Society for Maternal-Fetal Medicine.

Finally, and most importantly, I would like to extend my deepest gratitude to the families, fathers, and advocates who have spoken out, shared their stories, and called for change. These courageous individuals are the champions of this movement and this bill.

With wide bipartisan support and over 160 cosponsors in the House, I remain committed to passing Preventing Maternal Deaths Act into law and I look forward to working with the Committee and my colleagues in Congress to accomplish this imperative goal.

Thank you.

Mr. BURGESS. We thank you, Representative Herrera Beutler, for, number one, putting forward the discussion draft and working on it so hard over this past year in bringing all of the different people together that had to finally come together to get this hearing a reality today. And I know it took a lot of work on your part and we really appreciate your dedication. So thank for being with us this morning and we will move immediately to our second panel.

And while the transition is occurring, I will just use this time to thank all of our witnesses for being here today and taking time to testify before the subcommittee. Each witness will be given the opportunity to deliver an opening statement followed by questions from members.

Mr. GREEN. Mr. Chairman?

Mr. BURGESS. For what purpose does the gentleman from Texas seek recognition?

Mr. GREEN. I would like to submit the following letters, ask unanimous consent to submit the following letters for the record. From the Moms Rising, Alexis Joy Foundation, and the Society for Maternal Fetal Medicine into the record.

Mr. BURGESS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. BURGESS. Do we have copies of those?

Mr. GREEN. Yes.

Mr. BURGESS. So today we are going to hear from Mr. Charles Johnson, founder of 4Kira4Moms; Ms. Stacey Stewart, president of the March of Dimes; Dr. Lynne Coslett-Charlton, Pennsylvania District Legislative Chair, The American College of Obstetricians and Gynecologists; and Dr. Joia Crear Perry, president of the National Birth Equity Collaborative. We appreciate each of you being here today.

And Mr. Johnson, you are now recognized 5 minutes for an opening statement. Please turn your microphone on. Pull it close. This is the premier technology committee in the United States House of Representatives and we have fairly rudimentary amplification devices.

So Mr. Johnson, you are recognized.

STATEMENTS OF CHARLES S. JOHNSON, IV, FOUNDER, 4KIRA4MOMS; STACEY D. STEWART, PRESIDENT, MARCH OF DIMES; LYNNE COSLETT-CHARLTON, M.D., PENNSYLVANIA DISTRICT LEGISLATIVE CHAIR, THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS; AND, JOIA CREAR PERRY, M.D., FOUNDER AND PRESIDENT, NATIONAL BIRTH EQUITY COLLABORATIVE

STATEMENT OF CHARLES JOHNSON

Mr. JOHNSON. I think I will manage. Thank you so much. So, first and foremost, to members of this committee, thank you. It is an honor to be here speaking on behalf of the tens of thousands of families that have been affected by this maternal mortality crisis and hundreds of thousands of women who have been affected by near misses.

So let me just begin by telling you about the woman that absolutely changed my life. My wife, Kira Dixon Johnson, was the clos-

est thing that I had ever met to a superhero. She made me far better than I ever thought I could be and she was far better than I ever deserved. We are talking about a woman that ran marathons; that raced cars; that spoke five languages fluently.

So we were blessed to welcome our first son, Charles, on September 18th of 2014. We always wanted back-to-back boys, Chairman Burgess, and we were blessed to find out we were going to welcome our second son, Langston, in April of 2016. We walked into Cedars-Sinai Medical Center on April 12th of 2016 with a woman that just wasn't in good health, she was in exceptional health. This picture that you see on the screen is literally taken 10 days before Kira went in for the procedure.

We went in for what was supposed to be a routine scheduled C-section on what was supposed to be the happiest day of our lives and we walked right into what was a nightmare. Shortly after the procedure took place around 2 o'clock, shortly afterwards we went back to recovery. As I am sitting there reflecting in all this glow and pride of being a new father for the second time, Kira is resting, my new baby is resting, and as I look at her bedside I begin to see the catheter begin to turn red with blood.

I brought it to the attention of the staff, the nurses at Cedars-Sinai. They came in. They said we are going to do a couple of things. We are going to order a set of tests and we are going to order a CT scan to be performed stat. I was concerned, but I said you know what, my wife is healthy and we are at what is supposed to be one of the best hospitals in the world. I am concerned but we have got a plan, OK.

Blood work comes back, it is showing that it is abnormal and she is hemorrhaging and they ordered a CT scan that was supposed to be performed stat. Keep in mind this is around 4 o'clock. 5 o'clock comes, no CT scan. Her blood level was continuing to drop. By this time she is beginning to shiver uncontrollably. 6 o'clock and no CT scan. She is beginning to become pale, she is in extreme pain. 7 o'clock, 8 o'clock comes, no CT scan. I am begging, I am pleading the staff to do something.

And around 9 o'clock as I continue to plea for my wife's life, the staff at Cedars-Sinai Medical Center tells me, sir, your wife just isn't a priority right now. 8 o'clock comes, 9 o'clock, 10 o'clock. They said, well, we need to do a blood transfusion. I am saying, well, where is the CT scan? It wasn't until after midnight that they finally took my wife back to surgery, after I begged and pleaded for them to take action for more than 10 hours. When they took Kira back to surgery they opened her up and there were three and a half liters of blood in her abdomen and she coded immediately.

Now I am here to tell you this. I am not here to tell you what I think. I am here to tell you what I know. There are people on this panel that are far more intelligent than I will ever be that are going to talk to you about the statistics and how horrifying they are. What I am here to tell you is this. That there is no statistic that can quantify what it is like to tell an 18-month-old that his mother is never coming home. There is no matrices that can quantify what it is like to explain to a son that will never know his mother just how amazing she was.

My wife deserved better. Women all over this country deserve better. I am so grateful to my shero, Congresswoman Jaime Herrera Beutler. Thank you so much, Congresswoman DeGette. And for those of you all who have supported this bill, I honest to goodness would love to come up there and just give you a big hug, but I have been explained that that is not protocol.

And let me say this for those that choose to stand in opposition of this bill, you don't owe me an explanation. You owe an explanation to my boys. You owe Tara Hansen's son an explanation. You owe Mustafa Shabazz and his son an explanation. We have an opportunity to do something, here and now, to send a loud, definitive message to this country that women and babies matter.

Lastly, Kira and I always talked about raising men that would change the world. It is time for us to stop telling our children that they can change the world and show them how it is done. Thank you for your time.

[The prepared statement of Mr. Johnson follows:]

September 24, 2018

TESTIMONY
OF
CHARLES JOHNSON IV

HUSBAND OF THE LATE KIRA JOHNSON
FOUNDER OF 4KIRA4MOMS
ADVOCATE FOR IMPROVED MATERNAL HEALTH POLICIES

BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON ENERGY AND COMMERCE
U.S. HOUSE OF REPRESENTATIVES

“BETTER DATA AND BETTER OUTCOMES: REDUCING MATERNAL MORTALITY IN
THE U.S.”

9:15 a.m., THURSDAY, SEPTEMBER 27th, 2018

Testimony of Charles Johnson IV, Founder of 4Kira4Moms
in Support of H.R. 1318: Preventing Maternal Mortality Act of 2017

“BETTER DATA AND BETTER OUTCOMES: REDUCING MATERNAL MORTALITY IN
THE U.S.”

U.S. House Energy and Commerce Subcommittee on Health

September 27th, 2018

Good Morning Mr. Chairman, Ranking Member Green, members of the committee: my name is Charles Johnson the IV. I'd like to thank the committee for inviting me to testify today on H.R. 1318: Preventing Maternal Deaths Act of 2017. I have envisioned the opportunity to speak before this committee for sometime now and could not be more grateful than to share my family's story with you today.

I have just introduced myself to you in my opening statement as Charles Johnson the IV, however, these days I am known as “Charles and Langston's Dad.” Following the esteemed title of Dad, is that of “Kira's husband.”

I met Kira several times before we connected. Trying to catch Kira's attention was like trying to catch a butterfly. Kira was the most amazing person I have ever met. She spoke four different languages, lived in China and had run several companies. Her idea of a relaxing date

was skydiving...her idea of a romantic date was drag racing. I was smitten with her zest for life- her enthusiasm- I couldn't wait to see what was going to happen next. We got married in a surprise destination wedding, one which I took pains to make sure I made an impressive impact on my bride, like she made on me everyday. It was a dream come true: our wedding, our honeymoon, our new life as a married couple, the start of our new family. We had the rest of our lives in front of us! Nothing could stop us.

On April 12, 2016 my life partner, my best friend and amazing Mom, Kira lost her life after a routine scheduled c-section at Cedars Sinai delivering our 2nd son, Langston Johnson. Kira had delivered our first son, Charles V, via cesarean section, so we were both prepared for the process, procedure and recovery. After delivering another perfect baby, I was sitting next to Kira by her bedside in the recovery room. That is when I first noticed blood in her catheter. I notified staff immediately. A series of tests were ordered. Along with a CT scan to be performed "STAT". I understood "STAT" to mean the CT scan would be performed immediately. Hours passed and Kira's symptoms escalated throughout the rest of the afternoon and into the evening. We were told by the medical staff at Cedars Sinai Kira was not a priority and we waited for her CT scan to be done...we waited for the hospital to act so she could begin her recovery. Kira kept telling me, "Charles, I'm so cold; Charles, I don't feel right." She repeated these same words to me for several hours. After more than 10 hours of waiting. After 10 hours of watching my wife's condition deteriorate. After 10 hours of watching Kira suffer in excruciating pain needlessly. After 10 hours of begging and pleading them to help her. The medical staff at Cedars Sinai finally took action. As they prepared Kira for surgery, I was holding her hand as we walked down the hall to the operating room. Kira looked at me and

said, "Baby, I'm scared." I told her, without doubt, everything was going to be fine. The doctor told me I would see her in 15 minutes. Kira was wheeled into surgery and it was discovered that she had massive internal bleeding caused by horrible medical negligence that occurred during her routine C-section. She had approximately 3 liters of blood in her abdomen. Kira died at 2:22 a.m. April 17, 2016. Langston was 11 hours old.

As someone who experienced first hand what it is like to have your spouse die in front of you, I do not have the words to describe the loss my family has suffered. My boys no longer have their Mother. Kira was the most amazing role model and Mother any boy could ever wish to have. I no longer have the love of my life; my best friend.

I vowed that I would take this tragedy and turn it into a mission fueled by the memory of Kira and the passion she brought to life every day. I have taken my grief and found peace by tirelessly working on maternal health and maternal outcomes. I am the founder of 4Kira4Moms. 4Kira4Moms mission to advocate for improved maternal health policies and regulations, to educate the public about the impact of maternal mortality in communities, provide peer support to the victim's family, friends, and promote the idea that maternal mortality should be viewed, and discussed, as a human rights issue. My Kira lost her life, and I simply could not believe that her death, my family's experience, was not an anomaly. My situation and my family are not unique. The maternal mortality rate is rising in the United States. According to the Lancet, 26.7 women out of 100,000 die directly as a direct result of maternal mortality. Maternal mortality figures have been rising exponentially in the United States over the past 2 decades.. In 1990, the US had 674 recorded maternal mortality deaths

per 100K; by 2015, the number had risen to 1063 women per 100K. Women color, regardless of income or education, are dying at a rate of 3 to 4 times higher. My wife is now a 2017 maternal mortality rate statistic.

Each maternal death is equal to approximately 70 mothers experience a “near miss”, meaning they almost die. Based on CDC figures, approximately 50K mothers almost died from childbirth as recent as 2014. This has to stop!

I’m here today because the committee wanted to hear my story, Kira’s story, Charles and Langston’s story. The importance of passing H.R. 1318: Preventing Maternal Mortality Act of 2017 is part of that story. This country deserves to know why our Mothers are dying. Women and families who want to bear children should know what leads to maternal mortality, and “near misses.” I want to help everyone out there who wishes to someday become a parent, the most blessed gift in the world, and every provider who helps those amazing women bring life into the world, to understand what to look for; how to help, when to listen.

Thank you for the opportunity to hear my testimony today. The time is now for political will to address a situation that chose me without any knowledge. HR 1318: Preventing Maternal Mortality Act of 2017 will assist states to give us the knowledge on why our country’s Mothers are dying and how to help put an end to such tragedy. That knowledge may have saved Kira’s life.

ADDENDUM:

4Moms4Kira Campaign

How Judge Hatchett's Son Is Coping After His Wife's Childbirth Death: 'I Take It Day by Day'

Maternal Mortality: an American Crisis

Too many mothers are dying after childbirth. A hospital hopes to save them.

Charles Johnson shares Kira's story at the March for Moms Washington DC

<https://www.youtube.com/watch?v=05uBCBfrY4g>

Attached :copy of Johnson family complaint for damages. Outlining the timeline of the events that lead to Kira Johnson's death.

Attached: photos of Kira Dixon

CONFIRMED COPY
ORIGINAL FILED
Superior Court of California
County of Los Angeles

Sherri R. Carter, Executive Officer/Clerk
By: M. Soto, Deputy
Moses Soto

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF LOS ANGELES

Plaintiffs Charles Johnson, IV, Charles Johnson, V, a minor, by and through his Guardian ad Litem, Charles Johnson, IV, and Langston Johnson, a minor, by and through his Guardian ad Litem, Charles Johnson, IV, allege as follows:

///

FIRST CAUSE OF ACTION FOR WRONGFUL DEATH BY
PLAINTIFFS CHARLES JOHNSON, IV, CHARLES JOHNSON, V
and LANGSTON JOHNSON AGAINST ALL DEFENDANTS

1. Kyira Adele Dixon was born on June 26, 1976. Kyira was married to Charles Johnson, IV. Their first son, Charles Johnson, V, was born on September 18, 2014 by primary cesarean section delivery. Plaintiff Charles Johnson, IV had been present at the cesarean section delivery of his first son. Kyira Adele Dixon was a healthy, vibrant, fun, loving wife and mother.

2. In 2015, Kyira became pregnant again. She, her husband and son relocated to Los Angeles to pursue business and other opportunities. Once here, her pre-natal care was transferred to Defendant Benham Kashanchi, M.D. Defendant Benham Kashanchi, M.D. followed her through her pre-natal care. However, before her planned elective cesarean section, her care was transferred to Defendant Arjang Naim, M.D. Both Defendants Arjang Naim, M.D. and Benham Kashanchi, M.D. were in the Defendant Cedars-Sinai Medical Center's operative suite at the time of the delivery described herein.

3. The facts leading up to the death of Kyira Adele Dixon taken from the medical records, and with approximate times, include, but are not limited to, the following:

(A) Kyira was 39 years-old;

(B) Kyira, accompanied by her husband, Plaintiff Charles Johnson, IV, presented to Defendant Cedars-Sinai Hospital on April 12, 2016 at approximately 12:30 p.m. for a repeat elective cesarean delivery. The delivery was performed by Defendant Arjang Naim, M.D. and assisted by Defendant Benham Kashanchi,

1 M.D. Plaintiff Charles Johnson, IV, was present in the operating
2 room;

3 (C) Kyira was taken to the operative suite at 2:00 p.m. A
4 foley catheter was inserted at 2:15 p.m. The delivery started at
5 2:31 p.m. Langston Johnson was born at 2:33 p.m. The procedure
6 was completed at or about 2:48 p.m. At 3:00 p.m., Kyira was out
7 of the operating room and taken to the Post Anesthesia Care Unit
8 (PACU). Plaintiff Charles Johnson, IV, continued to be present
9 with his wife. At 3:04 p.m. Kyira was "skin to skin" bonding
10 with their baby;

11 (D) At 4:45 p.m., Kyira's fundus¹ had risen from +2 to +4
12 cms above the umbilicus. This may be associated with failure of
13 the uterus to contract after delivery, a condition called uterine
14 atony. Atony can lead to or be a symptom of a potentially
15 life-threatening condition known as postpartum hemorrhage;

16 (E) Shortly before 5:00 p.m., blood tinged urine was seen
17 in Kyira's foley catheter;

18 (F) By 5:24 p.m., Kyira's foley catheter was draining bright
19 red blood. The records indicate that a resident physician was
20 called by a nurse "to evaluate the rising fundus and concern for
21 excessive bleeding.";

22 (G) Shortly thereafter, the foley catheter was removed for
23 "bloody urine." It was replaced at 5:30 p.m. Defendant Dr. Naim
24 was made aware of his patient Kyira's situation;

25 ///

26 ///

27

28 ¹ The fundus is the upper rounded extremity of the uterus
above the openings of the uterine tubes.

1 (H) At 5:38 p.m., Kyira's fundus continued to be at +4 and
 2 frank red blood was still present and seen in Kyira's foley
 3 catheter;

4 (I) 7 minutes later Kyira's foley catheter was draining
 5 "complete red blood." A bedside ultrasound showed a 6 cm (2.3
 6 inches) heterogenous fluid collection posterior to bladder/
 7 anterior to uterus compressing the bladder suspicious for large
 8 hematoma². Uterotonics, Pitocin and Cytotec, were ordered for
 9 apparent uterine atony;

10 (J) Defendant Dr. Naim was again notified;

11 (K) Kyira was given Dilaudid for pain. She was also given
 12 an intravenous fluid bolus of 500 ml.;

13 (L) At 6:12 p.m., labs were ordered. Kyira's results
 14 showed:

- 15 • White Blood Count abnormal at 19.1 (normal
 16 range: 4-11 1000 UL);
- 17 • Red Blood Count abnormal at 3.01 (normal
 18 range: 3.6-5.11);
- 19 • Hemoglobin abnormal at 9.2 (normal range
 20 12-16.0 G/dl); and
- 21 • Hematocrit abnormal at 27% (normal range 36-47%).

22 In addition, the records reflect that Dr. Kashanchi also
 23 ordered a separate hemoglobin and hematocrit blood test. The
 24 results showed:

- 25 • Hemoglobin abnormal at 9.2; and
- 26 • Hematocrit abnormal at 27%.

27 _____
 28 ² A hematoma is a mass or abnormal collection of clotted blood
 within the tissues.

1 A fibrinogen³ blood test at about the same time showed a result
 2 of 228 which is on the low end of normal (normal range is 200-400
 3 mg/dl);

4 (M) At 6:44 p.m., a "stat" CT of Kyira's abdomen and pelvis
 5 and CT urogram were ordered by Stuart Martin, M.D. The records
 6 indicate the "reason for stat/expedite: surgical emergency." The
 7 records also document that Kyira had "intractable" abdominal pain
 8 and frank blood per foley catheter. The order comments also
 9 state: "Please add imaging, i.e. CT abd/pelvis with IV contrast
 10 as needed to fully evaluate the patient's post op abdomen and
 11 pelvis; high concern for pelvic hematoma but uncertain regarding
 12 injury to bladder and ureters.";

13 (N) Kyira's bleeding continued. At 7:13 p.m., Dr. Sharma
 14 noted that Kyira had not had any urine output after 5:00 p.m.
 15 Dr. Sharma performed another ultrasound. It showed the hematoma
 16 had enlarged. Kyira and her husband were told that although the
 17 hematoma appeared "stable" there was concern regarding the "blood
 18 in foley with little to no urine output. Will obtain STAT
 19 imaging of pelvis and lower urinary tract to ensure
 20 integrity...". Dr. Naim was made aware;

21 (O) More fluids were provided via IV infusion. Labs
 22 reported between 7:35 and 8:01 showed:

- 23 • White Blood Count abnormal at 21.5;
- 24 • Red Blood Count abnormal at 2.58;

25 ///

26

27 ³ Fibrinogen is a protein in the plasma that originates in the
 28 liver. It is converted to fibrin during the blood clotting process
 (coagulation).

- Hemoglobin abnormal at 7.6;
- Hematocrit abnormal at 23.7%; and
- Fibrinogen abnormal at 186.

(P) At 8:00 p.m., Kyira was seen by Dr. Churchill. She had still only produced little to no urine despite having been given fluids. There was still blood in her foley catheter. Kyira's hemoglobin and hematocrit were noted as continuing to drop and her heart rate was tachycardic.⁴ The estimated blood loss was about 1500 cc's. "This suggests symptomatic acute blood loss anemia and decision made to proceed with 2 units of PRBC" [packed red blood cells]. "Proceeding also with CT urogram to evaluate kidneys/ureters/bladder given frank blood in foley"; Kyira's situation was discussed with Dr. Naim and Dr. Sharma;

(Q) Although packed red blood cells were started at 8:41 p.m., plasma, which provides blood clotting proteins including fibrinogen, was not ordered until 11:21 p.m.;

R) At 8:47 p.m. the records document that Dr. Naim was at the bedside examining Kyira in the PACU. Dr. Naim knew at that time that Kyira continued with "bloody urine," had an abnormal hemoglobin of 7, that her heart rate was consistent with tachycardia and that she had a "possible hematoma.";

(S) At just about 9:00 p.m., Kyira was holding her baby in the PACU where she had remained and still had not been transferred to post partum;

///

///

⁴Tachycardia is a resting heart rate of at least 100 beats per minute.

1 (T) At 10:44 p.m., that the CT scans that had been ordered
2 "stat" 4 hours earlier still had not been done. In fact the
3 records do not reflect these scans were ever performed;

4 (U) At 10:55 pm the nurse notified the doctors that Kyira's
5 blood pressures were in the 70's/50's. Dr. Churchill and another
6 doctor were at the bedside to assess Kyira. Even after changing
7 the blood pressure cuff, Kyira's blood pressure was 82/53;

8 (V) At approximately 11:25 p.m., Dr. Naim was notified with
9 a concern "for active internal bleeding." Despite blood in the
10 foley, no urine output, abnormal labs, symptoms suggesting acute
11 blood loss, enlarging hematoma, it was not until approximately
12 11:30 p.m. and thereafter that a surgical discussion was held and
13 consent provided for surgery;

14 (W) At 11:42 p.m., Dr. Churchill and Dr. Sharma were at the
15 bedside. Kyira felt "a little more groggy then before", her heart
16 rate was 120 at rest and her blood pressure was 90/70. Dr. Sharma
17 performed a repeat ultrasound. The ultrasound "found expanding
18 hematoma and now free fluid." Dr. Sharma and Dr. Churchill
19 recommended taking Kyira to surgery to identify the source of the
20 bleeding. Yet Dr. Naim, who was also at the bedside at this
21 time, and in the face of these abnormal findings as previously
22 set forth, wished "to continue expectant management at this
23 time.";

24 (X) Shortly thereafter, the massive transfusion protocol was
25 initiated on Kyira. Massive Transfusion Protocol means packed
26 red blood cells, platelets and plasma given in "massive"
27 quantities to support circulation and coagulation during massive
28 hemorrhage;

1 (Y) Kyira was taken to surgery around 12:30 a.m. on April
2 13, 2016. During surgery Kyira was found to have 3 liters of
3 blood in her abdomen;

4 (Z) Kyira did not survive the ongoing massive blood loss.
5 Kyira was pronounced dead at 2:22 a.m. on April 13, 2016; and

6 (AA) The autopsy stated that the cause of "death was due to
7 hemorrhagic shock, due to acute hemoperitoneum," status post
8 cesarean section.

9 4. The surviving heirs of Kyira Adele Dixon, deceased
10 (hereinafter referred to as "decedent") are Charles Johnson, IV
11 (husband), Charles Johnson, V (son) and Langston Johnson (son).
12 There are no other heirs that Plaintiffs are aware of.

13 5. Defendants DOES 1 through 10, inclusive, are potential
14 heirs of decedent and entitled to bring this action pursuant to
15 C.C.P. Section 377.60, and they are named as Defendants in this
16 action as their true names and capacities as potential heirs are
17 presently unknown to Plaintiffs herein.

18 6. The true names, identities or capacities, whether
19 individual, associate, corporate or otherwise of Defendants DOES
20 11 through 100, inclusive, are unknown to plaintiffs who
21 therefore sue said defendants by such fictitious names. When the
22 true names, identities, or capacities of such fictitiously
23 designated defendants are ascertained, Plaintiffs will ask leave
24 of court to amend this Complaint to insert the true names,
25 identities and capacities together with the charging allegations.

26 7. At all times herein mentioned, Defendants and each of
27 them, were the agents, servants, employees and joint venturers of
28 each other and of their said codefendants, and were acting within

1 the purpose and scope of their employment, agency or joint
2 venture.

3 8. Plaintiffs are informed and believe and thereon allege
4 that each of the Defendants sued herein as a DOE (except DOES 1
5 through 10, inclusive) is responsible in some manner for the
6 events or happenings herein referred to, thereby proximately
7 causing the injuries and damages to their decedent Kyira as
8 herein alleged.

9 9. That all of the facts, acts, events and circumstances
10 herein mentioned and described occurred in the County of Los
11 Angeles, State of California.

12 10. That at all times herein mentioned, Defendants Arjang
13 Naim, M.D., Kathryn Sharma, M.D., Sara Churchill, M.D., Stuart
14 Martin, M.D., Benham Kashanchi, M.D. and DOES 11 through 30,
15 inclusive, were and now are physicians and surgeons, holding
16 themselves out as duly licensed to practice their professions
17 under and by virtue of the laws of the State of California, and
18 were and now are engaged in the practice of their professions in
19 the State of California.

20 11. At all times mentioned herein, Defendants Arjang Naim,
21 M.D., Kathryn Sharma, M.D., Sara Churchill, M.D., Stuart Martin,
22 M.D., Benham Kashanchi, M.D. and DOES 11 through 30, inclusive,
23 held themselves out to the public at large and to Plaintiffs
24 herein as qualified physicians and surgeons duly licensed to
25 practice their professions by virtue and under the laws of the
26 State of California, with expertise, specialized knowledge,
27 training, education, learning skill, techniques and expertise in
28 certain specialities of medicine.

1 12. That holding themselves out as experts and specialists
2 in specialized fields of surgery and medicine, possessing skills,
3 learning and experience in said specialties, Defendants herein,
4 at all times mentioned herein, represented to Plaintiffs that
5 they would, at all times, exercise and use skill, prudence,
6 learning and experience in said specialties. Defendants herein,
7 at all times mentioned herein, represented to Plaintiffs that
8 they would at all times exercise and use the skill, prudence,
9 learning, knowledge and expertise in the care and treatment of
10 decedent in accordance with the standard of practice among
11 competent, reputable and prudent physicians practicing their
12 specialties in the State of California.

13 13. At all times herein mentioned, Defendants Arjang Naim,
14 M.D., Kathryn Sharma, M.D., Sara Churchill, M.D., Stuart Martin,
15 M.D., Benham Kashanchi, M.D. and DOES 11 through 30, inclusive,
16 held themselves out to the public at large and to Plaintiffs as
17 duly qualified physicians and surgeons, duly licensed to practice
18 their profession by virtue of and under the laws of the State of
19 California, and exercising prudence, reasonable judgment and care
20 in the selection, employment and control of qualified, trained,
21 experienced nurses, nursing personnel, assistants, aides and
22 employees, performing services and caring for patients,
23 including, but limited to decedent, under their supervision,
24 control, direction, responsibility and authority.

25 14. At all times herein mentioned, Defendants Cedars-Sinai
26 Medical Center and DOES 31 through 50, inclusive, were business
27 organizations, form unknown, organized and existing under the
28 laws of the State of California.

1 15. At all times herein mentioned, Defendants Cedars-Sinai
2 Medical Center and DOES 31 through 50, inclusive, were and at all
3 times herein mentioned are, a partnership. Defendants DOES 11
4 through 20, inclusive, are, and at all times herein mentioned
5 were, members of the foregoing named partnership and are sued
6 herein individually and by said common name pursuant to the
7 provisions C.C.P. Section 369.5.

8 16. At all times herein mentioned, Defendants DOES 51
9 through 60, inclusive, were and are registered nurses, nurse
10 practitioners, licensed vocational nurses, practical nurses,
11 registered technicians and other paramedical personnel, holding
12 themselves out as duly licensed to practice their profession
13 under and by virtue of the law of the State of California, and
14 were and now are engaged in the practice of their profession
15 under and by virtue of the laws of the State of California.

16 17. At all times herein mentioned, Defendants DOES 61
17 through 70, inclusive, were aides, attendants, technicians,
18 nursing or medical students, acting as agents, employees or
19 servants of some or all of the other defendants, within the
20 course and scope of said agency or employment.

21 18. Defendants Cedars-Sinai Medical Center and DOES 71
22 through 80, inclusive, were at all times herein mentioned, duly
23 organized California corporations and partnerships existing under
24 and by virtue of the laws of the State of California. Said
25 defendants, and each of them, owned, operated, managed,
26 controlled and administered a general medical facility, hospital
27 or 24-hour care facility within said County, State of California,
28 and held themselves out to the public at large and to Plaintiffs

1 herein as properly equipped, fully accredited, competently
2 staffed by qualified and prudent personnel and operating in
3 compliance with the standard of care maintained in other properly
4 equipped and efficiently operated and administered accredited
5 general medical facilities, hospitals and outpatient clinics in
6 said community, offering full, competent and efficient hospital,
7 emergency, clinical, medical, surgical, laboratory, x-ray,
8 anesthesia, paramedical services and outpatient clinics to the
9 general public and to decedent herein. Plaintiffs are informed
10 and believe and thereon allege that said defendants, and each of
11 them, administered, governed, controlled, managed and directed
12 all the necessary functions, activities and operations of said
13 general medical facility, hospital or 24-hour care facility,
14 including its nursing care, intern, resident and house staff,
15 physicians and surgeons, medical staff, x-ray, intensive care,
16 recovery room and emergency room departments and clinics,
17 including but not limited to personnel, staff and supplies of
18 said facilities and clinics.

19 19. Plaintiffs are informed and believe and upon such
20 information and belief allege that at all times herein mentioned,
21 Defendants, and each of them, were the agents, servants,
22 employees and copartners of their said codefendants, and as such,
23 were acting within the course and scope of such agency,
24 partnership, and employment at all times herein mentioned; that
25 each and every defendant, as aforesaid, when acting as a
26 principal, was negligent in the selecting, hiring and maintaining
27 of each and every other defendant, as its agents, servants,
28 partners and employees.

1 20. At all times herein mentioned, Plaintiffs' decedent
2 Kyira was in the exclusive custody and control of Defendants, and
3 each of them.

4 21. Prior to April 13, 2016, decedent Kyira, who was
5 pregnant, consulted defendants, and each of them, for the purpose
6 of obtaining her medical care and treatment and employed
7 defendants to care and do all things necessary in caring for her.
8 Said Defendants undertook the employment and understood and
9 agreed to diagnose, care and treat decedent and do all things
10 necessary and proper in connection therewith, and said
11 defendants, and each of them, thereafter entered into such
12 employment, individually, and by and through their employees,
13 employers and agents.

14 22. At all times herein mentioned, and prior and subsequent
15 thereto Defendants Cedars-Sinai Medical Center and DOES 71
16 through 80, inclusive, and each of them, so negligently and
17 carelessly failed to properly ensure the character, quality,
18 ability and competence of individuals treating patients in said
19 centers, hospitals and clinics, that Plaintiffs were caused to
20 suffer and did suffer, the injuries and damages hereinafter
21 alleged.

22 23. Plaintiffs name the defendants herein, and each of
23 them, because plaintiffs are in doubt and do not know from which
24 of said defendants plaintiffs are entitled to redress and whether
25 the injuries and damages to the plaintiffs herein alleged were
26 caused by the combined negligence of all of the defendants, or
27 one or more of them. For that reason, Plaintiffs name all of
28 said defendants and ask that the Court determine liability of

1 each and all of the said defendants in this action as to what
 2 extent and what responsibility falls upon each of said defendants
 3 either jointly or severally as may be found liable.

4 24. From and after said times, defendants, and each of
 5 them, so negligently examined decedent Kyira and diagnosed and
 6 failed to diagnose her condition and so negligently treated and
 7 cared for decedent while she was in the exclusive control of said
 8 defendants, and so negligently operated, managed, maintained,
 9 selected, designed, controlled and conducted their services,
 10 activities and equipment in connection with the care and
 11 treatment of decedent such that as a proximate result thereof,
 12 decedent Kyira died on April 13, 2016. The negligence of the
 13 Defendants, and each of them, includes, but is not limited to:

- 14 • Failing to appreciate and properly manage Kyira's post-
- 15 partum hemorrhage in a timely manner;
- 16 • Failing to return Kyira to surgery in a timely manner;
- 17 • Among other acts and omissions.

18 25. Plaintiff Charles Johnson, IV is the husband of
 19 decedent Kyira and Plaintiffs Charles Johnson, V and Langston
 20 Johnson, are the sons of decedent Kyira.

21 26. At or about the time of the filing of this complaint,
 22 Charles Johnson, IV, the father of Plaintiffs Charles Johnson, V,
 23 a minor (DOB: 09/18/2014) and Langston Johnson, a minor (DOB:
 24 04/12/2016), was appointed to serve as the Guardian Ad Litem for
 25 both Charles Johnson, V and Langston Johnson.

26 27. As a direct and proximate result of said negligence of
 27 the defendants and the death of decedent, Plaintiffs have been
 28 and will continue to be deprived of the love, companionship,

1 comfort, affection, society, solace, moral support, care,
 2 counsel, physical assistance, services, financial support and
 3 protection of decedent Kyira, and have thereby sustained
 4 pecuniary loss in a sum according to proof in the jurisdiction of
 5 this Court.

6 28. As a further, proximate result of the negligence of
 7 Defendants, and each of them, and the death of decedent,
 8 plaintiffs have incurred expenses for the funeral, cremation
 9 and/or burial of decedent Kyira, in a sum to be proven at the
 10 time of trial.

11 29. That prior to the filing of this action, three years
 12 had not elapsed from the date of the death, and a period of less
 13 than one calendar year had elapsed after Plaintiffs first
 14 learned, or had a reasonable opportunity to learn, of the fact
 15 that the injuries and death suffered and complained of herein
 16 were a proximate result of the negligent acts or omissions to act
 17 on the part of the Defendants.

18 SECOND CAUSE OF ACTION BY PLAINTIFF CHARLES JOHNSON, IV
 19 FOR NEGLIGENT INFLECTION OF EMOTIONAL DISTRESS

20 30. Plaintiff repeats and realleges paragraphs 1, 2, 3, 6,
 21 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 23, 24 and
 22 29 of the allegations contained in the first cause of action as
 23 though each were set forth and incorporated herein in full.

24 31. At all times herein mentioned, Plaintiff Charles
 25 Johnson, IV was the lawfully wedded husband of decedent Kyira
 26 Adele Dixon.

27 ///

28 ///

1 32. Plaintiff Charles Johnson, IV was present and with his
2 wife Kyira from the time she was admitted to give birth to their
3 son until Kyira was taken to surgery on April 13, 2016.

4 33. Plaintiff Charles Johnson, IV was seated on the side of
5 his wife where the bag collecting her urine was located.
6 Plaintiff Charles Johnson, IV saw Kyira's foley catheter bag
7 tinged with blood, saw the bag begin to turn red, called the red
8 colored foley catheter bag to the attention of Kyira's nurses,
9 saw the foley catheter bag get redder and redder with blood, saw
10 the heightened activity of the health care staff as they became
11 aware of the bright red blood in Kyira's foley catheter bag, saw
12 the foley changed, and then again saw bright red blood fill
13 Kyira's foley catheter bag, saw the health care staff perform an
14 ultrasound on Kyira and state that there appeared to be a
15 hematoma in her pelvis/abdomen, understood that a hematoma was a
16 collection of blood, saw the health care providers perform
17 another ultrasound and was advised that it still showed hematoma
18 or blood clot, discussed with Kyira and her health care providers
19 that the bright red blood in Kyira's foley catheter bag was
20 "concerning" and due to Kyira actively bleeding, advised by the
21 health care providers that a "stat" CT scans had been ordered and
22 understood it was needed and necessary to identify the source of
23 Kyira's bleeding, was advised by Kyira's health care providers
24 that further confirmation of the fact that Kyira was continuing
25 to actively bleed were her blood count values which were
26 continuing to decline, asked why the "stat" CT scans ordered for
27 Kyira and necessary to identify the source of her bleeding had
28 not been performed, observed Kyira continue to get pale and

1 understood that Kyira's pallor was due to the continuing loss of
2 blood, observed the health care providers provide Kyira with
3 fluids and blood and understood that such fluids and blood was
4 due to the Kyira's continuing loss of blood, repeatedly asked
5 again why the "stat" CT scans ordered for Kyira and necessary to
6 identify the source of her active bleeding, understood that
7 despite the passage of hours since the bright red blood he
8 observed in Kyira's foley catheter bag the health care providers
9 had still not done anything to identify the source of the active
10 bleeding and had not done anything to stop the active bleeding
11 which he knew was continuing and causing Kyira's condition to
12 continue to deteriorate, continued to express concern progressing
13 to demanding information why his wife was continuing to
14 deteriorate without any intervention improving her condition and
15 continued to ask and then demand why the "stat" CT scans ordered
16 for Kyira had not been done. The events described in this
17 paragraph took place over approximately seven (7) hours.

18 34. Because of what he observed, what he heard and what he
19 was told by the health care providers, Plaintiff Charles Johnson,
20 IV, knew that Kyira's continued active bleeding caused a serious
21 risk of harm to her. Because of what he observed, what he heard
22 and what he knew, Plaintiff Charles Johnson, IV, was
23 contemporaneously aware and understood that the inadequate
24 actions of the health care providers over a period of
25 approximately seven (7) hours were causing harm to Kyira because
26 the source of her active bleeding had not been identified, the
27 bleeding had not stopped, Kyira's condition was deteriorating to
28 the point where she was experiencing pain, Kyira was pale and

1 | groggy, and Kyira had and was continuing to lose blood which the
2 | health care providers were unable to sufficiently replace with
3 | fluids and blood products.

4 | 35. As a direct and proximate result of the failure of the
5 | Defendants to properly and timely respond to his wife's symptoms
6 | and the inadequate treatment provided to her by defendants, and
7 | each of them, Plaintiff Charles Johnson, IV did suffer serious
8 | and severe emotional disturbance, distress and shock and injury
9 | to his nervous system, all of which has caused, and continues to
10 | cause, and will cause in the future, serious mental and emotional
11 | suffering, in an amount in excess of the minimum jurisdiction of
12 | this court.


13 | WHEREFORE, Plaintiffs pray for judgment against the
14 | Defendants, and each of them, as follows:

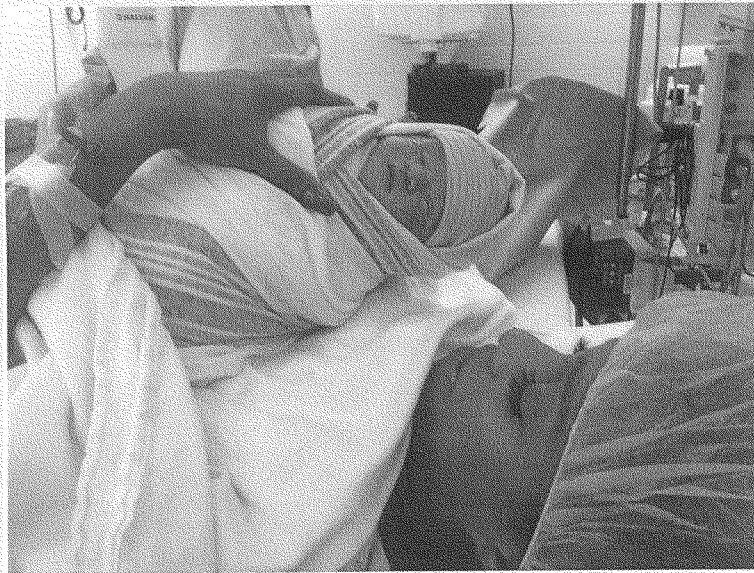
15 | FOR THE FIRST AND SECOND CAUSES OF ACTION:

- 16 | 1. General damages according to proof;
17 | 2. Special damages according to proof;
18 | 3. Funeral and burial expenses according to proof;
19 | 4. Prejudgment interest;
20 | 5. For all costs of suit herein incurred; and
21 | 6. For such other and further relief as the Court may deem
22 | just and proper.

23 | DATED: March 20, 2017

LAW OFFICES OF MICHAEL L. ORAN

24 |
25 | BY: 
26 | MICHAEL L. ORAN, ESQ.
27 | Attorneys for Plaintiffs
28 | CHARLES JOHNSON, IV,
 CHARLES JOHNSON, V and
 LANGSTON JOHNSON



Mr. BURGESS. Mr. Johnson, we do sincerely appreciate your testimony and as a committee I will say we are terribly sorry for your loss, but grateful for your courage to be here today and present your testimony to us. Thank you, Mr. Johnson.

Ms. Stewart, you are recognized for 5 minutes.

STATEMENT OF STACEY STEWART

Ms. STEWART. Thank you, Mr. Chairman.

Mr. BURGESS. I know, he is tough to follow.

Ms. STEWART. Very hard to follow that so—and I am known by my family to be one of the biggest crybabies, but it is for good reason.

So thank you for inviting me to testify at this very important hearing today. I am Stacey Stewart. I am President of the March of Dimes. March of Dimes is leading the fight for the health of all moms and babies. And I would like everyone in this room to take a look at this blanket. Just about everyone that has had a child will never forget the very moment when a doctor placed a precious baby boy or baby girl into our arms wrapped into one of these blankets.

More than 700 times a year, beautiful babies are wrapped into these blankets, in one just like this one, but unfortunately there is no mother to hold a child that is wrapped in that blanket. So that is not just a statistic. There are 700 mothers that die every single year and almost and over 50,000 who experience dangerous complications that could have killed them, making the U.S. the most dangerous place in the developed world to give birth.

And we think and we know that you agree that this situation is completely unacceptable. Our nation is in the midst of a crisis of maternal and child health. Across this nation, virtually every measure of the health of pregnant women, new mothers, and infants is going in the wrong direction. The number of babies born premature is rising in this country. In many communities, infant mortality, rates of infant mortality exceed those in developing nations. Nations such as Slovenia and French Polynesia have better infant mortality rates than here in the United States.

Women are tragically dying, women like Kira, from pregnancy-related causes and are suffering from severe health consequences like infertility. While other countries have reduced their infant mortality rates, the number of women who die from pregnancy-related causes in the U.S. has doubled in the last 25 years. And as we have heard this morning already, black women are three to four times more likely to die from pregnancy-related causes than white women, which is a truly shocking and appalling disparity.

Maternal mortality is also significantly higher in rural areas where obstetrical providers may not be available and delivery in rural hospitals is associated with higher rates of postpartum hemorrhage. March of Dimes will release a report in the coming weeks that will show that maternity care deserts exist in this country and in these deserts pregnant women face serious challenges in receiving appropriate care.

The state of maternal health in the United States is dire, but there are things we can do and we must do. Many factors are contributing to the maternal health crisis in this nation and our work

to address it is important and it must be equally multifaceted. The bill before the subcommittee today is a critical step towards preventing death or serious health outcomes for pregnant women and new mothers.

The discussion draft of H.R. 1318, the Preventing Maternal Deaths Act, would provide grants to states and tribes to help establish or improve maternal mortality review committees or MMRCs. MMRCs are interdisciplinary groups of local experts that come together in maternal, infant, and public health to investigate the cases of maternal death, identify those systemwide factors that contributed to these deaths, and then develop recommendations that would help prevent future cases.

MMRCs are unique in that they identify solutions. Not just collect the data, but then identify solutions that are targeted to the needs of pregnant women and mothers in specific states, cities, and communities. The discussion draft of H.R. 1318 would also establish a demonstration project to determine how best to address disparities in maternal health outcomes.

Mr. Chairman and members of the subcommittee, while this bill is extremely important, maternal mortality is not a single problem with a single solution. The causes of maternal mortality and severe maternal morbidity are diverse. They include physical health, mental health, social determinants, and much more. They can be traced back to the issues in our healthcare system including the quality of care as we just heard so passionately from Charles, systems problems, and of course the issue of implicit bias that exist in our healthcare system. They stem from factors in our homes, our workplaces, and our communities.

Mr. Chairman and members of the subcommittee, thank you for recognizing the urgency and the magnitude of this public health crisis. Our nation's mothers and babies cannot wait any longer. We must act now to save the lives and the health of pregnant women, new mothers, and their babies. Thank you.

[The prepared statement of Ms. Stewart follows:]

**TESTIMONY OF STACEY D. STEWART
PRESIDENT, MARCH OF DIMES**

**BEFORE THE ENERGY AND COMMERCE SUBCOMMITTEE ON HEALTH
HEARING
“BETTER DATA AND BETTER OUTCOMES: REDUCING MATERNAL
MORTALITY IN THE U.S.”**

SEPTEMBER 27, 2018



Thank you, Mr. Chairman, for this opportunity to testify today before the Energy and Commerce Subcommittee on Health at this hearing, “Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S.” I am Stacey D. Stewart, President of March of Dimes, and I would like to commend you for holding this important hearing. March of Dimes is leading the fight for the health of all moms and babies.

Imagine, if you would, a classic hospital receiving blanket. It’s made of soft white flannel, with a pastel blue and pink stripes on each end. Any of us with children will never forget that first moment when the doctor placed our precious baby boy or girl in our arms, wrapped warmly in one of these blankets. More than 700 times a year, a beautiful baby is wrapped up in a blanket just like this one -- but there is no mother to hold that child. That is not just a statistic; 700 mothers die every year, and over 50,000 others experience dangerous complications that could have killed them — making the U.S. the most dangerous place in the developed world to give birth. This situation is completely unacceptable.

Our nation is in the midst of a crisis in maternal and child health. Across our nation, virtually every measure of the health of pregnant women, new mothers, and infants is going in the wrong direction. Preterm birth rates are rising. In many communities, infant mortality rates exceed those in developing nations. Nations like Slovenia and French Polynesia have a better infant mortality rate than the U.S.

Striking disparities exist among the health of mothers and babies of different racial and ethnic backgrounds. Black children face the highest child mortality rate among racial/ethnic groups — more than 2 times higher than the rate for Asian children and 1.5 times higher than the rate for white children.¹ There are dramatic variations in key measures like well-visits for women and infants among different racial and ethnic groups as well as geographic areas.



Maternal Mortality and Severe Maternal Morbidity Are a Public Health Crisis

Across the United States, women are tragically dying or suffering serious consequences from pregnancy-related causes. Despite the fact that many countries around the world have successfully reduced their maternal mortality rates since the 1990s, the U.S. rate is still higher than most other high-income countries,ⁱⁱ and the U.S. maternal mortality rate has doubled in the past 25 years.ⁱⁱⁱ A significant racial and ethnic disparity in maternal mortality exists in the U.S., with black women being three to four times more likely to die from pregnancy-related causes compared to white women.^{iv,v}

Maternal mortality is also significantly higher in rural areas, where obstetrical providers may not be available,^{vi} and delivery in rural hospitals is associated with higher rates of postpartum hemorrhage.^{vii} March of Dimes will release a report in the coming weeks that will show these “maternity care deserts,” where pregnant women face serious challenges in receiving appropriate care.

Approximately 700 women die each year in the U.S. as a result of pregnancy or pregnancy-related complications.^{viii} The Centers for Disease Control and Prevention (CDC) estimates that up to 60% of these deaths are preventable.^{ix,x} For every maternal death, there are about 100 episodes of severe maternal morbidity (SMM) affecting more than 50,000 women in the United States every year.^{xi}

According to the CDC, pregnancy-related deaths are those that occur during pregnancy or within the following year due to pregnancy complications, because of a chain of events initiated by pregnancy, or because of an unrelated condition that was aggravated by pregnancy.^{xii} Severe maternal morbidity includes unexpected outcomes of labor and delivery that result in significant short or longer term consequences to a woman’s health.^{xiii}



Causes of maternal deaths include cardiovascular conditions, hypertensive disorders of pregnancy (preeclampsia/eclampsia), infection, hemorrhage, suicide and drug overdose. Identifying and treating medical conditions before, during and after pregnancy are essential to preventing maternal morbidity and maternal mortality, as part of the continuum of care for all women of childbearing age. This requires a commitment to high-quality clinical care and enhanced maternal quality improvement and safety initiatives in hospitals, particularly those that address disparities, structural barriers to care, differential care experienced by women of color, and provider implicit racial bias.^{xiv}

March of Dimes supports efforts to eliminate preventable maternal mortality and SMM and the unacceptably large disparities in rates experienced by black women. To achieve this, March of Dimes:

- Encourages every state to have a maternal mortality review committee that investigates each death of a pregnant woman or new mother to understand causes and recommend interventions for the future.
- Supports efforts to improve ways to collect data on maternal mortality and SMM, research into their causes and prevention, and promotion of proven ways to keep all mothers healthy.
- Supports ensuring access to inpatient obstetrical facilities and qualified obstetrical providers in rural settings.
- Supports state perinatal quality collaboratives working with hospitals to identify and review cases of SMM and implement hospital based quality improvement initiatives to improve care and promote patient safety.
- Supports efforts to ensure that all women have quality, affordable health insurance and health care to include but not limited to postpartum depression screening, mental health treatment,



substance use treatment, affordable contraception, including long-acting reversible contraception (LARC), and access to health care providers who understand and meet their health needs before, during and after pregnancy.

- Supports improving the social and economic conditions and quality of health care at all stages of a woman's life.
- Encourages acceleration of policies and programs shown to provide preventive and supportive care for women during pregnancy, including group prenatal care.

The Preventing Maternal Deaths Act is a Critical Step Forward

The state of maternal health in the U.S. is dire, but there are things we can and must do. Many factors are contributing to the maternal health crisis in our nation, and our work to address it must be equally multi-faceted. The bill before the subcommittee today represents a critical step toward preventing death or serious health outcomes for pregnant women and new mothers.

The discussion draft of H.R. 1318, the Preventing Maternal Deaths Act, sponsored by Representatives Jaime Herrera Beutler (R-WA), Diana DeGette (D-CO) and Ryan Costello (R-PA) mirrors S. 1112, the Maternal Health Accountability Act, as recently passed by the Senate Committee on Health, Education, Labor and Pensions. would provide grants to states and tribes to help establish maternal mortality review committees (MMRCs) – interdisciplinary groups of local experts in maternal, infant and public health – to investigate cases of maternal death, identify system-wide factors that contributed to the deaths, and develop recommendations to prevent future cases. MMRCs are unique in that they identify solutions targeted to the needs of pregnant women and mothers in specific states, cities and communities. The discussion draft of H.R. 1318 would also establish a demonstration



project to help ascertain how best to address disparities in maternal health outcomes. Together, these provisions will help us obtain the information and recommendations we need to prevent women from dying or experiencing serious health consequences of pregnancy. Congress should pass this important legislation as quickly as possible.

Our nation cannot prevent maternal mortality if we lack data about where and why it takes place. This legislation will fill significant gaps in our current knowledge by ensuring we have nationwide data on maternal mortality rates as well as information about causes. It will provide states and tribes with new resources to gather information and ensure their maternal mortality review committees operate according to best practices. Finally, it will protect the privacy of women and their families by ensuring strong confidentiality processes are in place to prevent the unauthorized release of information.

Mr. Chairman and members of the subcommittee, while this bill is extremely important, maternal mortality is not a single problem with a single solution. The causes of maternal mortality and severe maternal morbidity are diverse; they include physical health, mental health, social determinants, and much more. They can be traced back to issues in our health care system, including quality of care, systems problems, and implicit bias. They stem from factors in our homes, our workplaces, and our communities. The effort to save women's lives can't just end with one hearing and one bill. I urge Congress to launch a series of hearings into the root causes of maternal mortality and to pass additional measures to improve maternal and child health, because every mom and baby deserve a healthy start.



In conclusion, I would like to thank you, Mr. Chairman and members of the subcommittee, for recognizing the urgency and magnitude of this public health crisis. Our nation's mothers and babies cannot wait any longer. We must act now to save the lives and health of pregnant women, new mothers and their infants. Piecemeal efforts are not enough; moms and babies are dying. We need blanket change. March of Dimes stands ready to assist you in working to protect and improve the health of all women and babies.

ⁱ America's Health Rankings Health of Women and Children Report. March 2018. United Health Foundation. Available at https://assets.americashealthrankings.org/app/uploads/ahr_hwc_2018_report_summary_022818a.pdf

ⁱⁱ WHO. Trends in Maternal Mortality 1990-2015. Available at: <http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/>

ⁱⁱⁱ CDC. Pregnancy Mortality Surveillance System. Available at: <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html>

^{iv} Creanga AA, Berg CJ, Syverson C, Seed K, Bruce FC, Callaghan WM. Pregnancy-related mortality in the United States, 2006-2010. *Obstet Gynecol* 2015;125(1):5-12.

^v Callaghan WM. Overview of maternal mortality in the United States. *Semin Perinatol* 2012;36(1):2-6.

^{vi} Faron, Dina. Maternal Health Care is disappearing in rural America. *Scientific American*, February 15, 2017.

^{vii} Kozhimannil KB, Thao V, Hung P, Tilden E, Caughey AB, Snowden JM. Association between hospital birth volume and maternal morbidity among low-risk pregnancies in rural, urban, and teaching hospitals in the United States. *Am J Perinatol* 2016 May;33(6):590-9.

^{viii} MMRIA. Report from Nine Maternal Mortality Review Committees. February 2018. Available at: <https://www.cdcfoundation.org/building-us-capacity-review-and-prevent-maternal-deaths>

^{ix} Berg CJ, Harper MA, Atkinson SM, et al. Preventability of pregnancy-related deaths: results of a state-wide review. *Obstet Gynecol* 2005;106(6):1228-1234.

^x MMRIA. Report from Nine Maternal Mortality Review Committees. February 2018. Available at: <https://www.cdcfoundation.org/building-us-capacity-review-and-prevent-maternal-deaths>

^{xi} CDC. Severe Maternal Morbidity in the United States. Available at: <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html>

^{xii} CDC. Pregnancy Mortality Surveillance System. Available at: <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html>

^{xiii} CDC. Severe Maternal Morbidity in the United States. Available at: <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html>

^{xiv} Jain JA, Temming LA, D'Alton ME, et al. SMFM Special Report: Putting the "M" back in MFM: Reducing racial and ethnic disparities in maternal morbidity and mortality: A call to action. *Am J Obstet Gynecol* 2018;218(2):B9-B17.



Mr. BURGESS. Thank you, Ms. Stewart.

Dr. Coslett-Charlton, you are now recognized for 5 minutes, please.

STATEMENT OF LYNNE COSLETT-CHARLTON

Dr. COSLETT-CHARLTON. Chairman Burgess, Ranking Member Green, Chairman Walden, Ranking Member Pallone, and distinguished members of the Energy and Commerce Subcommittee on Health, thank you for inviting me to speak with you today on behalf of the American College of Obstetricians and Gynecologists at this hearing entitled, Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S.

ACOG, with a membership of more than 58,000, is the leading physician organization dedicated to advancing women's health. Today's hearing will focus on a discussion draft of H.R. 1318, the Preventing Maternal Deaths Act, sponsored by Representatives Jaime Herrera Beutler, Diana DeGette, and Ryan Costello. I want to extend a special thank you to the bill sponsors for working so diligently on this bipartisan legislation, a critical first step in improving maternal health outcomes for women in this country.

A special thanks also to you, Dr. Burgess, my colleague OB/GYN, for your leadership highlighting this critically important issue and making maternal mortality a top priority.

As many of you know, the United States has a maternal mortality crisis. Too many women die each year in the United States from pregnancy-related and pregnancy-associated complications. We have higher maternal mortality rates than any other developed country. At a time when 157 of 183 countries in the world report decreases in maternal mortality, ours is rising. Black women are disproportionately affected and are three to four times more likely to lose their lives than white women. And for every maternal death in the United States there are a hundred women who experience severe maternal morbidity or near misses.

This is all unacceptable and the time for action is now. We know that over 60 percent of maternal deaths are preventable. Common causes include hemorrhage, cardiovascular and coronary conditions, cardiomyopathy, or infection. Overdose and suicide, driven primarily by the opioid epidemic, are also emerging as the leading causes of maternal mortality in a growing number of states including my own. If we have a clear understanding of why these deaths are occurring and what we can do to prevent them in the future, we can save women's lives.

The Preventing Maternal Death Act assists states in creating or expanding maternal mortality review committees through the Center of Disease Control and Prevention. MMRCs are multidisciplinary groups of local experts in maternal and public health as well as patient and community advocates that closely examine maternal death cases and identify locally relevant ways to prevent future deaths. While traditional public health surveillance using vital statistics can tell us about trends and disparities, MMRCs are the vehicle best positioned to comprehensively assess maternal deaths and identify, most importantly, opportunities for prevention.

As ACOG's Pennsylvania Section Chair and incoming District III Legislative Chair and a practicing physician for over 20 years, ad-

addressing maternal mortality is of critical importance to me. As an OB/GYN, seeing a woman die while pregnant or after delivering a baby is something that sticks with you for life and has stuck with me throughout my career. Preventing that kind of tragedy and ensuring the health and safety of the women we care for is central to our mission.

When I took over as ACOG's Pennsylvania Section Chair, Pennsylvania did not have MMRC, though the city of Philadelphia did. And over the past 2 ½ years I have worked diligently to organize the campaign with other OB/GYNs and other advocates in my state and the Department of Health to urge the state legislators to pass legislation to form our first statewide MMRC. Finally, on May 9th, Governor Wolf signed the Maternal Mortality Review Act. Our first meeting is next week. Enthusiasm like this for MMRCs is growing all over the country. Today, approximately 33 states have MMRC and as many of those 33, including Pennsylvania, are brand new this year.

But states like ours need help. The CDC plays a vital role in assisting these states to ensure their MMRCs are robust, multidisciplinary, and using standardized reporting, which is why it is important to have this federal legislation as mechanisms. The Building U.S. Capacity to Prevent Maternal Deaths Initiative, a partnership between the CDC's National Center for Chronic Disease Prevention and Health Promotion, the CDC Foundation, the Association for Maternal & Child Health Programs, and Merck for Mothers has made tremendous progress giving technical assistance to states to help them establish MMRCs or ensure established MMRCs are operating with evidence-based practices.

In Pennsylvania we need to ensure that this type of technical assistance is amplified so that we can get our MMRC off the ground and working correctly. Once MMRCs are up and running they lead to opportunities for quality improvement. For example, to participate in the Alliance for Innovation on Maternal Health, or AIM, a state must first have an MMRC. AIM convened under ACOG's leadership is a national alliance of clinicians, hospital administration, patient safety organizations, and patient advocates that work to reduce maternal mortality and severe morbidity by creating condition-specific bundles which are evidence-based toolkits to improve maternal outcomes. Some of these bundles include severe hypertension, maternal mental health, obstetric care for women with opioid use disorder, obstetric hemorrhage, and racial disparities in maternity care. To participate in AIM, a state must first have MMRC. The data recommendations from MMRCs instruct states where they need to invest to address specific conditions that affect women in their community and ensure proper appropriate targeting of limited resources.

For us to clearly understand why women are dying from preventable maternal complications across the country and make lasting improvements, every state must have a robust MMRC. The Preventing Maternal Death Act will help us reach that goal and ultimately improve maternal health across this country. Thank you very much for the opportunity to speak to you about this pressing issue and in support of this very important legislation.

[The prepared statement of Dr. Coslett-Charlton follows:]

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Written Testimony

Of

The American College of Obstetricians and Gynecologists

Submitted by:

Lynne Coslett-Charlton, MD, FACOG

Before the

House Energy and Commerce Subcommittee on Health

Regarding the Subcommittee Hearing

Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S.

September 27, 2018

Chairman Burgess, Ranking Member Green, Chairman Walden, Ranking Member Pallone, and distinguished Members of the Energy & Commerce Subcommittee on Health, thank you for inviting me to speak with you today on behalf of the American College of Obstetricians and Gynecologists (ACOG) at this hearing entitled, “Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S.” ACOG, with a membership of more than 58,000, is the leading physician organization dedicated to advancing women’s health. Today’s hearing will focus on a discussion draft of H.R. 1318, the Preventing Maternal Deaths Act, sponsored by Representatives Jaime Herrera Beutler, Diana DeGette, and Ryan Costello. I want to extend a special thank you to the bill sponsors for working so diligently on this bipartisan legislation – a critical first step in improving maternal health outcomes for women in this country. Special thanks also to you, Dr. Burgess, a colleague ob-gyn, for your leadership highlighting this critically important issue and making maternal mortality a top priority.

As many of you may know, the United States has a maternal mortality crisis. Too many women die each year in the United States from pregnancy-related or pregnancy-associated complications.ⁱ We have a higher maternal mortality rate than in any other developed country. At a time when 157 of 183 countries in the world report decreases in maternal mortality, ours is rising.ⁱⁱ Black women are disproportionately affected and are three to four times more likely to lose their lives than white women.ⁱⁱⁱ For every maternal death in the United States, there are 100 women who experience severe maternal morbidity, or a “near miss”. This is all unacceptable, and the time for action is now.

We know that over 60 percent of maternal deaths are preventable.^{iv} Common causes include hemorrhage, cardiovascular and coronary conditions, cardiomyopathy, or infection. Overdose and suicide, driven primarily by the opioid epidemic, are also emerging as the leading causes of maternal

mortality in a growing number of states.^v If we have a clear understanding of why these deaths are occurring, and what we can do to prevent them in the future, we can save women's lives.

The Preventing Maternal Deaths Act assists states in creating or expanding maternal mortality review committees (MMRCs) through the Centers for Disease Control and Prevention (CDC). MMRCs are multidisciplinary groups of local experts in maternal and public health, as well as patient and community advocates, that closely examine maternal death cases and identify locally-relevant ways to prevent future deaths. While traditional public health surveillance using vital statistics can tell us about trends and disparities, MMRCs are best positioned to comprehensively assess maternal deaths and identify opportunities for prevention.

As ACOG's Pennsylvania Section Chair, incoming ACOG District III Legislative Chair, and practicing physician for over 20 years, addressing maternal mortality is of critical importance to me. As an ob-gyn, seeing a woman die while pregnant or after delivering a baby is something that sticks with you for life. Preventing that kind of tragedy and ensuring the health and safety of the women we care for is central to our mission. When I took over as ACOG Pennsylvania Section Chair, Pennsylvania didn't have a maternal mortality review committee, though the city of Philadelphia did. Over the past two years, I have worked diligently to organize a campaign with other ob-gyns and advocates to urge the state legislature to pass legislation to form a statewide MMRC. Finally, on May 9, 2018, the governor signed the Maternal Mortality Review Act.

Enthusiasm like this for MMRCs is growing all over the country. Today, approximately 33 states have an MMRC – and many of those 33, including Pennsylvania, are brand new this year.^{vi} But states like ours need help. CDC plays a vital role in assisting these states to ensure their MMRCs are robust,

multidisciplinary, and using standardized reporting mechanisms. The Building U.S. Capacity to Prevent Maternal Deaths initiative – a partnership between the CDC’s National Center for Chronic Disease Prevention and Health Promotion, the CDC Foundation, the Association for Maternal & Child Health Programs, and Merck for Mothers – has made tremendous progress giving technical assistance to states to help them establish MMRCs or ensure established MMRCs are operating with evidence-based practices. In Pennsylvania, we need to ensure that this type of technical assistance is amplified, so we can get our MMRC off the ground and working correctly.

Once MMRCs are up and running, they lead to opportunities for quality improvement. For example, to participate in the Alliance for Innovation on Maternal Health, or AIM, a state must have an MMRC. AIM, convened under ACOG’s leadership, is a national alliance of clinicians, hospital administrators, patient safety organizations, and patient advocates that work to reduce maternal mortality and severe maternal morbidity by creating condition-specific “bundles” – evidence-based toolkits to improve maternal outcomes. Some of these bundles include: severe hypertension, maternal mental health, obstetric care for women with opioid use disorder, obstetric hemorrhage, and racial disparities in maternity care.

To participate in AIM, states must have an MMRC. The data and recommendations from MMRCs instruct states where they need to invest to address specific conditions that affect women in their community and ensure appropriate targeting of limited resources.

For us to clearly understand why women are dying from preventable maternal complications across the country and make lasting improvements, every state must have a robust MMRC. The Preventing

Maternal Deaths Act will help us reach that goal, and ultimately improve maternal health across this country.

Thank you for the opportunity to speak to you about this pressing issue and in support of this important legislation. I'm happy to answer any questions.

ⁱ Building U.S. Capacity to Review and Prevent Maternal Deaths. (2018). Report from nine maternal mortality review committees. Retrieved from http://reviewtoaction.org/Report_from_Nine_MMRCs

ⁱⁱ Lu MC. Reducing Maternal Mortality in the United States. JAMA. Published online September 10, 2018. doi:10.1001/jama.2018.11652

ⁱⁱⁱ Pregnancy Mortality Surveillance System. Centers for Disease Control and Prevention. Available at: <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html>

^{iv} Building U.S. Capacity to Review and Prevent Maternal Deaths. (2018). Report from nine maternal mortality review committees. Retrieved from http://reviewtoaction.org/Report_from_Nine_MMRCs

^v Ibid.

^{vi} Ibid.

Mr. BURGESS. Thank you, Dr. Charlton.

Dr. Crear Perry, you are recognized for 5 minutes, please.

STATEMENT OF JOIA CREAR PERRY

Dr. PERRY. So, thank you fellow ACOG member, Dr. Burgess.

Mr. BURGESS. And if you will suspend for a moment, in the interest of full disclosure I am a dues-paying member of the American College of Obstetricians and Gynecologists.

Dr. PERRY. Here we go.

Mr. BURGESS. And I am current on that. And I don't do the emeritus stuff, I pay the full freight. You may proceed.

Dr. PERRY. And Ranking Member Green, thank you as well, and to my fellow colleagues on the panel. I really feel like going last is always a great way to go because you can hear what the gap might be in explaining this.

I get to work with the 33 states who are doing the MMRCs. As an organization we provide technical assistance. We also get to work in places like Philadelphia. We have been doing it for awhile. So a concrete example would be in Philadelphia they had a lot of women who were dying from cardiomyopathy, which sounds really medical, right, because your heart fails, it won't pump as well. When they actually reviewed the deaths, many of the women had heroin addiction, right, so it was something you could prevent if you actually put in mental healthcare services for addiction. So it is important for us to have a broader view.

Someone brought up California, which is really important. So California has decreased their deaths, but they still have a racial disparity. Still, in California despite having these great outcomes, they have had increased deaths for black women. So what they are doing now is really going back to look at implicit bias that was mentioned, making sure that their providers are culturally cognizant and having really some rules around what does it mean if you don't value a woman and she is not seen for several hours, how does that system respond to that and what can we do differently to ensure that people are seen in an appropriate amount of time.

So just wanted to give some teeth to how important this is and how having the ability to actually look at the deaths individually and to talk to family members and to have mental health there really can help us to get to some answers.

So now I want to tell you a little bit of my own story, because every woman's story needs to be heard and this is what the MMRC allows you to do. So when I was a third-year medical student in my home of Louisiana after attending Princeton for undergrad, my then-husband and I were expecting our planned second child. At about 5 ½ months pregnant, my water broke. My mother, who is here and a pharmacist, still recounts how panic-stricken she was when she was counseled by my physician about the risk of infection to my son and I that included death.

I had access to excellent health care for him provided by my health insurance coverage, but the stress of racism was my only risk factor for the premature birth of my son. The hospital where I was training was named Confederate Memorial just 20 years prior to this. Luckily, my 22-year-old son and I survived, but the sad reality is that my 25-year-old daughter has a higher risk of

dying in childbirth than I did when I had her. The same is true for all of us who have daughters in the United States. We are failing our daughters, especially our black daughters who are dying at three to four times the rate of their white counterparts.

So, ultimately, what we are asking for this bill, when you think about what Charles said and what all of us have said, is we can no longer delay acting. This bill has been reiterated many times in Congress and I am excited to hear that maybe we can have it done by the end of this year, because it is important for us to say that we as a country—I got to testify at the U.N. about this very issue—the world is watching us. The world sees us. I get flown to Geneva to talk about how important it is for the United States to actually value women and to pay for and look at why women are dying, so this is an opportunity for us to say yes, we do value women and yes, we do want to see what is actually happening to them.

So ultimately what women, especially black women, in the United States need is accountability. We need to know that our lives are valued. We need to know that this accountability might be difficult, it might be complicated, but government still has an obligation to act. Accountability is a value that all Americans can agree upon, yet racism, classism, and gender oppression are killing all of us from rural to urban America. This is not about intentions. Lack of action is unintentionally killing us. It is a human rights imperative. We just ensure that prevention efforts and resources are being directed towards the areas of greatest need and be willing to name the problem directly.

Much can be accomplished through improving monitoring and data collection.

Me and my big writing because my eyes are getting bad, I am getting old.

H.R. 1318 is a tremendous step forward in showing that we do recognize, yes, black mamas matter. That is it.

[The prepared statement of Dr. Perry follows:]

September 25, 2018

TESTIMONY
OF
JOIA CREAM - PERRY, MD
FOUNDER and PRESIDENT
NATIONAL BIRTH EQUITY COLLABORATIVE
ADVISORY BOARD MEMBER
BLACK MAMAS MATTER ALLIANCE
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON ENERGY AND COMMERCE
U.S. HOUSE OF REPRESENTATIVES
“BETTER DATA AND BETTER OUTCOMES: REDUCING
MATERNAL MORTALITY
THE U.S.” 10:00 a.m., FRIDAY, SEPTEMBER 27, 2018

Testimony of Dr. Joia Crear-Perry

Founder National Birth Equity Collaborative

In Support of H.R. 1318: Preventing Maternal Mortality Act of

2017 “BETTER DATA AND BETTER OUTCOMES:

REDUCING MATERNAL MORTALITY IN THE U.S.” U.S.

House Energy and Commerce Subcommittee on Health September
27, 2018

Good Morning Mr. Chairman, Ranking Member Green, members of the House Committee on Energy and Commerce Health Subcommittee for allowing me, Dr. Joia Crear-Perry, to testify at this Better Data and Better Outcomes: Reducing Maternal Mortality in the US hearing representing the National Birth Equity Collaborative and the Black Mamas Matter Alliance.

H.R.1318 will support states in their work to save and sustain the health of mothers during pregnancy, childbirth, and in the postpartum period. Of vital importance to my reproductive justice peers and I, it will work to eliminate disparities across maternal health outcomes for pregnancy-related and pregnancy-associated deaths. H.R. 1318, working with groups such as ours, will also identify solutions to improve health care quality and health outcomes for mothers.

As you may be aware, the United States is the only developed country in the world where maternal mortality is on the rise. Further, Black women in the U.S. die at 3 to 4 times the rate of their white counterparts. Despite clear evidence of this inequity, policymakers, and as a consequence, government had not, until now, addressed this urgent public health and human rights issue. The Centers for Disease Control defines Pregnancy Related death

as the death of a woman while pregnant or within one year of the end of a pregnancy – regardless of outcome, duration or site of the pregnancy – from any cause related to or aggravated by pregnancy or its management. Based on that definition, the CDC found in their surveillance, 2,726 women died in the United States between 2011 and 2014 and of those 1,010 or 38% were Black. As a Black woman from the Deep South, who is an obstetrician and a mother, my strong desire to end this inequity is amplified every time I look into the faces of my daughter and patients.

As a Black mother, I cannot buy or educate my way out of dying at 3 to 4 times the rate of a white mother in the United States. The inequity in maternal mortality rates persists regardless of our income or education status. A White woman with less than a high school education has a better chance to live in childbirth than a Black woman with a college degree. The legacy of a hierarchy of human value based on the color of our skin continues to cause differences in health outcomes, including maternal mortality. Racism is the risk factor – not Black skin. There is no “Black” gene.

Maternal mortality extends beyond the period of pregnancy or birth. Nine months of prenatal care cannot counter underlying social determinants of health inequities in housing, political participation, transportation, education, food, environmental conditions, and economic security; all of which have racism as their root cause. We have data that shows that a Black woman who initiates prenatal care in the first trimester has a worse outcome in birth than a white woman with late or no prenatal care.

Good maternal health outcomes depend upon implementation of all sexual and reproductive rights, from comprehensive sexual education to access to all forms of birth control. We know that Medicaid Expansion is critical to ensuring that Maternal Mortality rates improve across our great nation. We have data that shows that this investment in states, such as my own great state of Louisiana,

saves money and lives. Even if women are insured, coverage of sexual and reproductive health services is too often not comprehensive. Receiving the full range of reproductive options ensures safe healthy births for moms and babies. Reproductive life planning in schools, health facilities, community organizations and homes, reinforces the tools our future generations need to make healthy choices about when, how and if, they want to have children to optimize their physical, emotional and fiscal health in order to build a stronger, more secure nation.

Closures of hospitals and maternity units create barriers to services and information. This lack of a safety net for poor and rural Americans produces gaps in access along the reproductive life span. This includes closures of rural hospitals from Texas, Kentucky, Michigan, Illinois, Tennessee, Ohio, Washington, New Jersey, Virginia, Florida, Missouri, Indiana, Oklahoma, North Carolina, Georgia, Oregon, New York, California, Maryland, New Mexico, Massachusetts, and Colorado. All of us are impacted when we make choices to defund Critical Access facilities and disinvest in communities that we deem not economically viable. As someone who grew up in rural America, I watched my best friend have her baby in the car on the way to the hospital that was an hour away. That child has severe cerebral palsy. What is the value of these often forgotten communities and families? What are we saying about how we value them in our policy and funding priorities?

I am the founder of the National Birth Equity Collaborative and on the Advisory Committee for the Black Mamas Matter Alliance. The National Birth Equity Collaborative envisions a world where every Black baby lives to their first birthday with their family. The Black Mamas Matter Alliance serves as a national voice and coordinating entity for stakeholders advancing maternal health, rights, and justice, and intentionally centers Black women's leadership. BMMA has a network of organizations with the reach,

relationships and capacity to support an intergenerational movement. BMMA organizes around four core strategies which aim to 1) advance policy that addresses black maternal health inequity 2) cultivate innovative research methods, 3) enhance holistic and comprehensive approaches to the care of black mamas, and 4) shift culture of the narratives of black motherhood by amplifying black women's voices.

The Maternal Mortality Review is a process by which a multidisciplinary committee at the state or local jurisdiction level identifies and reviews cases of maternal death within one year of pregnancy. Review Committees often include representatives from the areas of public health, obstetrics and gynecology, maternal-fetal medicine, nursing, midwifery, forensic pathology, mental health and behavioral health. Review Committees have access to multiple sources of information that provide a deeper understanding of the circumstances surrounding the death and develop action recommendations to prevent future deaths. According to the CDC, currently at least 36 states and 3 Cities have or are forming a Maternal Mortality Review Committee. Very few are fully functioning due to lack of fiscal support.

Data availability and transparency is important. While making the reports available to the Centers for Disease Control ensures data quality and that we are able to look at national trends in maternal mortality and morbidity, state and local level entities and advocacy organizations also need access to data and reports to inform maternal health programs and services. Additionally, timely availability of reports equips these advocates with critical information to influence policy decisions that are impacting their communities directly.

I applaud the expanded focus of the bill to include severe maternal morbidity. While maternal mortality in the U.S. is on the rise, data reflects that severe maternal morbidity is 100 times more

common, impacting even more women and families. To acknowledge women experiencing a severe maternal morbidity is to recognize that there are women suffering, at times, life-long consequences and medical complications as a result of pregnancy and childbirth.

I also applaud the bill's recognition of the value of community engagement and inclusion in the maternal mortality review process. Mandating that by a state's participation in the program, the maternal mortality review committee shall include "individuals and organizations that represent the populations ...most affected by pregnancy-related deaths or pregnancy-associated deaths and lack of access to maternal health care services" is critical. We must hold states accountable to this mandate. The individuals and communities impacted by this issue must have a seat at the table when discussing programs and policies that directly impact their health and access to health care services.

Ultimately, what Black women in the U.S. need is accountability. We need to know that our lives are valued. This accountability may be complicated, but government still has an obligation to act. Racism, classism and gender oppression are killing all of us, from rural to urban America. This is not about intentions. Lack of action is "unintentionally" killing us. It is a human rights imperative. Throughout the bill, there is no mention of race, racism, or racial disparities. The inability to name this as a key focus to reduce RACIAL disparities in maternal mortality and morbidity will continue to exacerbate the problem. We must ensure that prevention efforts and resources are being directed toward the areas of greatest need and be willing to name the problem directly.

Much can be accomplished through improved monitoring and data collection. H.R.1318 is a tremendous step forward in showing that we do recognize...Yes, Black Mamas Matter.

Mr. BURGESS. Thank you, Dr. Perry, Dr. Crear Perry. I appreciate your testimony and appreciate all of our witnesses for being here.

I will move to the question part of the hearing and I will recognize myself 5 minutes for questions. And Dr. Coslett-Charlton, let me ask you as a—we have heard the stories and yes, the review committees are important, legislation is important. But honestly, doctor to doctor, it is decisions that are made at the bedside and I honestly don't know how you legislate correct decisions to be made at the bedside.

So as part of this effort and as a fellow member in the American College of OB/GYN, it is really incumbent upon our professional societies, medical societies, our specialty society. This is where the rubber meets the road. We have to be—I don't know how I can legislate something that stops what Mr. Johnson went through. I just don't know how I can do that. Here was a situation where all the signs and symptoms pointed to exsanguination and he describes unfortunately in very painful detail what the natural consequence of exsanguination is, and I don't know how I write legislation to stop that from happening. That is on us as a profession, right?

Dr. COSLETT-CHARLTON. I totally agree. And I think that is why we are here and that is why we are sitting beside Mr. Johnson because those stories, I think, affect. And I know, Dr. Burgess, because you practiced for so long, I look at my intern year, I was on my internal medicine critical care rotation, probably the second month of rotation and I was called for a code for one who had a very rare condition called an amniotic fluid embolism, which I don't know if you have seen one in your career, but I was like what could this be—one in 300,000—and she died in front of me.

I was an intern observing, I wasn't actively participating in the care at that time, but I seriously questioned whether or not I wanted to go into this field at that time because—and I am so glad I did, because the joy of being an OB/GYN far outweighs the unfortunate things that happen to patients sometimes. But I think seeing that, if we can prevent one death, if we can educate our members, and really the best way to do that is to understand where the problems lie.

And the AIM programs are a great success story and if we are able to roll them out across the country and really see where we can use best practices to prevent things from happening that couldn't otherwise, and really obstetric hemorrhage is a perfect example where having the beauty of the AIM program is that it is, really, readiness first, so the four Rs, readiness and then recognize that there is a problem. So the readiness includes things like having suture available, having medication available on the labor floor so that you are not calling a pharmacist to come, I need this medicine now not an hour from now while you approve it.

So being ready, being able to recognize that there is a problem and educating staff members. Not just physicians, but also people that are on the front lines caring for the patients first. And also the response and having protocols for response that are appropriate, having blood products readily available for women when they are in transfusion protocols we have shown to be effective.

And, finally, reporting, because when we talk about maternal mortality and we talk about the deaths that is very important, but also the near misses are equally devastating and equally important that we know how to identify them. And not only, we are seeing the iceberg, if we can really get to the crux of that where we are truly going to improve the way we care for women in this country and I am positive we are going to see fewer maternal deaths.

Mr. BURGESS. Well, and that is what is critical about this. Maternal mortality review committees, I think that is an excellent idea. I am all in favor of that. I will just say in the 1970s at Parkland Hospital it was called grand rounds. And you didn't ever want to present at grand rounds. That probably meant your patient hadn't done well, but what it really meant was you weren't going to do well for the next couple of hours. And Dr. Jack Pritchard was the head of the department back then. He was pretty critical and had a way of asking those insightful questions that exposed any perhaps weakness in your clinical judgment or your thought process as you worked through a complicated issue.

Let me just ask you, have we gotten away as a profession from that type of introspection that you probably were exposed to in residency? I know I was.

Dr. COSLETT-CHARLTON. No, I think if you speak to any residents those processes still happen, but they happen mainly in academic centers. And really a part of this problem is that we have to better reach the communities. I practice in a small community hospital right now and it is very different. I think and educating practitioners in the community hospitals we know is equally as important, and access to care obviously as we have spoken to is equally important.

So I think being able to collect the data, being able to see where the deficiencies and having a mechanism and a vehicle and support nationally down to the state levels and the tentacles that can get the boots on the ground to make sure that none of these things happen anywhere in the United States is critical.

Mr. BURGESS. Well, Mr. Green gets extremely critical of me if I run over, so I will yield back my time and recognize the gentleman from Texas for 5 minutes for questions.

Mr. GREEN. I just ask equal time, Mr. Chair. I want to thank all our witnesses. And, Mr. Johnson, being a father of two children and now a grandfather, I just, and as the chair said, I don't think there is anything we can do. Of course there is no shortage. We have a lot of doctors in Congress but we also have a lot of lawyers. And so people say well, you can go to the tort system, and but that is not going to bring back your wife or your second baby. And it just, how do you do that? But we understand, those of us who have children and I know physicians particularly.

So I want to thank all of our witnesses today being here and discussing the U.S.'s maternal mortality rate, which I would be remiss if I didn't acknowledge my home state's maternal mortality crisis as well. As widely reported in 2016, published in Obstetrics & Gynecology found the Texas maternal rate was doubled between 2010 and 2012. The study's authors acknowledge these statistics were unexplainably high.

In the wake of this report, Texas' Maternal Mortality and Morbidity Task Force underwent review of all pregnancy-related deaths in Texas to determine the accuracy of these findings. What the task force found was that data collection errors and lack of standardization in reporting has resulted in varying statistics. If we can't depend on the research, that is a problem.

Dr. Coslett-Charlton, can you explain why the standardization of data collection is so critical when discussing maternal death rates?

Dr. COSLETT-CHARLTON. That is a very important question, Representative Green. And I think the crux of the issue is that the vehicles of looking at vital statistic records we are able in the pregnancy checkboxes, if someone pregnant within a year or 42 days in Texas of delivery that those measures certainly can identify and are inherent to error.

But the important thing and why we are here today is to make sure that all of those deaths are reviewed so that we can have accurate data. And that is why these maternal mortality review committees are essential, because not only are they going to review the deaths but they are going to be able to determine if they could have been preventable deaths and that is where the impact truly could be made.

Mr. GREEN. What can we learn from this study in Texas, and tell me Texas is not the only state that has that kind of statistics that you can't depend on. Is it other states, in Pennsylvania, or other states in the country?

Dr. COSLETT-CHARLTON. Well, in Pennsylvania we have had the checkbox for the past 5 years and I think that in Philadelphia there has been a small community that they have been able to focus on that data. But I think like I was saying, the essential part of this is that having accurate data is really, really, truly important and the Texas studies truly exemplify that how important these MMRCs are.

The Texas committee at that time was not as sophisticated as it is now and their means of collecting aren't as sophisticated, so I think that going forward it is a perfect example of why this is essential.

Mr. GREEN. The Texas Maternal Mortality and Morbidity Task Force put out a series of recommendations on ways to improve maternal health and prevent pregnancy-related complications. Just this last month, the task force released its joint biannual report for our Department of State Health Services. Their first recommendation is we increase access to healthcare services to improve the health of women, facilitate continuity of care, and enable an effective care transitions and promote safe birth spacing.

Dr. Crear Perry, would you agree with the recommendation to improve maternal health we must improve the access to care?

Dr. PERRY. Sure. And I want to also piggyback on the last question a little bit about the data because it is important that we—it is a common phenomenon across the country, so it is not just Texas and it is not just Pennsylvania. A lot of states need this money to help with collect more accurate data, it would be really helpful.

And as far as access it is a big barrier. We see that places where closing rural hospitals in Texas, in Georgia, that when women have

to travel an hour to have a baby they are more likely to hemorrhage. They are more likely to have a heart attack. They are more likely to have these medical conditions. So if you don't have a systemic review you can't look at the match between where your access is being denied and where women are also dying in the same place. So having a more robust review of the deaths will allow you to look at that.

Mr. GREEN. From my perspective coming from Texas, one way to improve access to care is expanding access to Medicaid and ensuring low-income individuals have the care that they need. And do you agree with that?

Dr. PERRY. Sure. I am from the great State of Louisiana and so we have seen actual data since Louisiana expanded Medicaid. We are one of the few deep southern states that expanded Medicaid where we have had improved outcomes. Our governor, really it was important for him to ensure that we had access to Medicaid expansion. Women are getting preventive services so you know that you have diabetes before you become pregnant and you don't show up at the hospital pregnant with uncontrolled blood sugars. So it is important that we have expanded Medicaid.

Mr. GREEN. And in my last 9 seconds, there is no replacement for prenatal care and having a mother who has a relationship with their doctor and that is why we need to have that access no matter who pays for it—Medicare, private sector or whatever.

So, Mr. Chairman, thank you for your time.

Mr. BURGESS. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from Kentucky, Mr. Guthrie, the vice chair of the committee, 5 minutes for questions.

Mr. GUTHRIE. Thank you, Mr. Chairman, and I appreciate everybody being here.

Mr. Johnson, I appreciate you coming here and being willing to share your story. I know that a lot of times we have policy developed and things develop because people went through tragic things and they are willing to bring that to our attention and share. And I know it is difficult to do, but it is one way that they live on and it is a way that it actually changes what is going on in the country, so we appreciate that.

And this is something that has been on the mind of the committee, I know the chairman, I know from his background, but also I remember being in a meeting earlier and we were trying to just get down to the policy that needs to happen. And your story, I remember one of the roundtables that the chairman has talking about the—it is not just access to care. It sounds like your wife was in a fantastic hospital situation and everything and it seems C-sections were something that could be common.

And we are the most, it is not that people aren't getting care. A lot of people are getting C-sections. And my wife has had—I have three children, we have had three, so it really made me cringe when I heard that in your story, because it seems the second or third or whatever, C-sections seem to be something that is something we need to address in moving forward and that gets to just finding the right data.

And Dr. Coslett-Charlton—Charlton or Charlton? Charlton. I know you are with ACOG and in this bill today we are looking at data and how to move data. I know ACOG has endorsed—a number of medical societies and ACOG has endorsed this bill and it is my hope that we can get sound data to see exactly the actions that we need to take. So can you speak to ACOG's perspective on the role of data in your efforts to reduce maternal mortality?

Dr. COSLETT-CHARLTON. So I think to some degree when you are speaking about specific situations like C-section rates and talking about, you know, once a woman has a first C-section, second C-section, third C-section, we know each time that a woman has a C-section risk can increase with subsequent pregnancies. And those are important reasons why, number one, we need access to good care.

But also, the part of the AIM bundles where we talk about preparedness or readiness is that when we know a woman has a third C-section, knowing that you could—if she has the ability to have important prenatal care to recognize the potential complications and be ready for those complications, that is critical and essential.

And the last thing, if we talk about the AIM bundles, one of the bundles is looking at how to improve primary Caesarean section rates so that is something that is good data that is coming out of California that we hope can translate, sharing data across state lines. Women are women in Pennsylvania the same as in Arizona. So, it really isn't rocket science. We should be able to share data and establish best practices and the way to do that is to have the vehicle or the mechanism to accurately be able to identify and look through that data.

Mr. GUTHRIE. It just seems standard—not being a physician at all, I am a manufacturing person—but it just seems to be standard now that if somebody is having their second or third C-section that the symptoms your wife showed seems to be clear from what you said that maybe there should be a team waiting to see if something happens and being ready for any type of those. I would love if you wanted to comment.

Mr. JOHNSON. Absolutely. I think that the astronomical C-section rates are something that needs to be examined. When we talk about Kira's case, there was a C-section, indeed, but it wasn't the C-section that led to her ultimate passing. And I will share this with the committee and I didn't share—what I had shared earlier was a very condensed version of what was happening to Kira.

But what we found subsequently when we go back and look at the medical records, which I shared as part of my record, is that in Kira's case she was exceptionally healthy, she went in for a routine scheduled C-section. And from what I understand, and Dr. Burgess and some of the medical people here, is what I understand is that for a woman who is having a Caesarean section, the cut timing and the time that they make the incision until the time that the baby is born, for a healthy woman and the baby is not under stress should be between 12 and 15 minutes. Is that fair, Dr. Burgess? OK. And in a situation where a woman has had a previous Caesarean you should add another 3 to 5 minutes so that you can cut around the scar tissue.

Mr. GUTHRIE. The problems with scar tissue in the second or third, Dr. Burgess explained that to me.

Mr. JOHNSON. Yes. So this is the point I would like to make is, so we are talking about between 15 to 20 minutes, ballpark, for a woman that is healthy, second Caesarean section, the baby is not in distress. When we received the medical records from Cedars-Sinai Hospital, the cut time on the delivery for my second son, Langston, was less than 2 minutes. Less than 2 minutes. And in the process of him rushing he lacerated her bladder.

But once again, and so the way that has been described is that this was not a medical tragedy, this was a medical catastrophe meaning that everything that could have gone wrong did go wrong.

So let's talk a minute about AIM which is a phenomenal program. And I want to salute ACOG for the work that they are doing in conjunction with AIM and being rolled out in various states. California, where we were where my son was delivered, is one of the trademark states for AIM and what they have done to reduce the maternal mortality rate with their hemorrhage bundle. But as long as we have these tools that are a suggestion and they are not a protocol, women are going to continue to pass away.

So the AIM bundle was available in Kira's case. It is one of the—it is ground zero for the wonderful work they have done reducing the maternal mortality rate in California, but they just chose to ignore it and I continued to beg and plead while her condition deteriorated.

So Caesareans are a challenge, but in Kira's—

Mr. GUTHRIE. Different.

Mr. JOHNSON. She was extremely healthy and they just let her continue to deteriorate. So we have got to have a fundamental standard of care that is not just a suggestion as AIM, as it is in the situation with AIM—and it is phenomenal—but if we can make a fundamental standard of care across the board that will make a big difference.

Mr. GUTHRIE. Thank you. Thank you for sharing and my time has expired. I yield back.

Mr. BURGESS. Thank you, Mr. Guthrie.

Mr. CÁRDENAS, you are recognized for 5 minutes, please, for questions.

Mr. CÁRDENAS. Thank you very much. And to Mr. Johnson, it is just amazing and incredible that you are doing what you are doing and thank you so much. You are saving lives and I appreciate that very much and so does everybody in this country and the world who will benefit from hopefully good decisions that we make, all of your efforts.

First, I would like to ask some questions if the doctors would—I recently read about a program in California that has been very successful since both the March of Dimes and the College of Obstetricians and Gynecologists are part of the California Maternal Quality Care Collaborative. I am hoping that both Dr. Coslett-Charlton and Ms. Stewart can tell us more about this program.

But in California's private-public partnership it was stressed that it was because of the views from a diverse panel of experts that they could avoid missing important details on women's deaths. And one of the things that I think it is important for us to under-

stand is—I have been given a chart about the red line shows the mortality rate across the country while the highlighted yellow line actually shows California's. And we see a dramatic drop since 2007 when California has implemented the process of teaching each other, learning from each other, sharing data. And you are looking at California that has a mortality rate of 7.3 per 100,000 and across the country it is still up at 22.

So what I would like to see happen is we as Congress and those of us who are involved, or those of you who are involved on the day-to-day process that we can come together and create a national best practices, and I hope that that is the outcome not only at this hearing but of this Congress.

Dr. Coslett-Charlton and Ms. Stewart, if you can, can you talk a bit about how the diversity of these panels has changed and improved the maternal outcomes?

Ms. STEWART. Well, let me just start with a couple of points, which is I think that it is notable that California has had so much success, obviously, and I think the idea of the committee that has been formed, the way they have come together to look at data, to design interventions, identify where the problems are within the state and really design interventions that have made a meaningful difference has been important. And that is important to say at a high level, but again when it comes down to each individual person who still may be affected by the gaps in the system like Charles and like his wife Kira, then we still have a problem.

I want to say one thing about diversity in general and the importance of how this issue shows up and the disparate outcomes that many women of color experience as a result of the gaps in the system. And I agree with the chairman we can't legislate morality, but what we can do is ensure that we are tracking the performance of the system, we are tracking those women that are impacted disproportionately by the system, and that we are intentional in designing interventions that will make a difference.

The gaps in the system don't just start though when women show up in the hospital. They start well before then. We know that for example to make sure that we have healthier babies it doesn't just happen in the 9 months of pregnancy. And I am not a physician. I am not an OB/GYN, but I think I have known that in my own experience having had two babies and leading the March of Dimes, which is the leading organization in the fight for the health of moms and babies.

The same is true for healthier mothers. We have got to make sure that women have access to health care before they are pregnant especially if they have chronic diseases, chronic health challenges that might risk their health or the health of their baby. We have got to make sure they have access to good affordable care during pregnancy and what we know now is that it is important that women have access to excellent care after.

And it is especially important and we have had research and studies to show that women of color also feel less trust and less well-served by the system. They feel less listened to and respected in terms of their symptoms when they articulate those symptoms. And these are women that are not only low-income women of color, these are women that are affluent women of color, women that are

highly educated who simply have reported—and again studies show this—that their needs are not being met at the same level at the same rate as white women and other women.

So I just want to say that I think this issue of diversity is really important not just in the panels but across the board in listening to the issues of disparate outcomes that we see across all communities.

Mr. CÁRDENAS. So best practices are something that we can improve and hopefully will become more prolific so we can have the outcomes that you just described. My time is limited, but hopefully during the testimony some of you can talk about the toolkits and how these toolkits are free.

But a quick, quick question to Mr. Johnson is since you have lost Kira, it has been 2 years, how has this affected you and your family, if you could describe that for us, so we can understand the true responsibility that we have and we can make sure that this happens less and less and less. Thank you.

Mr. JOHNSON. Well, this has been the most challenging experience that I could ever—even more challenging than anything that I could ever comprehend. That being said, the true blessing in all of this is the two tremendous gifts that Kira left us and that is my son Charles and my son Langston. They really, truly are what keeps myself, my mother who is seated behind me, all of us going.

And, it is difficult as they mature and as they are, now 2 and just turned 4 years old, their ability to process and understand the absence of their mother evolves. And like I said, when you talk to a 2 year old he wants to know why his mommy is not coming home. And you explain to him, well, your mother is in heaven and she is doing important work with God. And he tells you, well, I want to go to heaven too.

And so there is nothing that I can prepare for, there is nothing that I can do to fix that and I hope that over time that—the heart is saying to just be completely honest with you is I am proud to be here representing these families, but at the end of the day I am just a father that whose heart aches for his sons and a husband that misses his wife desperately. And so while there is every day I search for answers and how to support these amazing gifts, what I am clear about is that what I have to do is, although there is nothing I can do to bring Kira back I have to do everything that I can whenever I can to make sure that I send other mothers home with their babies.

And that if I can prevent another father from going through this, if I can prevent another child from having to understand why his mother isn't showing up at school—and I will share this with the committee. This is something that I have never even shared with my family, is when a 3-year-old asks you, Daddy, is Mommy mad at me? I want Mommy to come home. Why won't she come home? And I have never shared that with anybody because it is just too painful for me to articulate.

But I am clear that the work that we are doing here is going to prevent this to continue to happen to other women and it is going to make sure that other women get to go home with their babies.

Mr. CÁRDENAS. Mr. Chairman, if you will allow me a few seconds to thank Mr. Johnson, my time has expired. Thank you so much.

Thank you for your courage, your strength, and your commitment to community and to others and God bless you and your family. And know that your wife is doing good work in heaven, but you are doing tremendous work on earth. Thank you. I yield back.

Mr. BURGESS. The chair thanks the gentleman. The gentleman from California referenced the California Toolkit to Transform Maternity Care. I did print off a copy of that and at the conclusion of the hearing I will ask unanimous consent to make that as part of the record.

The chair now recognizes the gentleman from Ohio, Mr. Latta, 5 minutes for your questions, please.

Mr. LATTI. Thank you very much, Mr. Chairman. And thanks so much for our panel of witnesses and for being with us today because it is so important for the work that you are doing in getting this message out.

Ms. Stewart, if I could start my questioning, I am also concerned for soon-to-be mothers and new moms that live in our rural areas of our country. The national data indicates that more than half of all rural U.S. counties are without hospital obstetric services. With an increase of women dying due to pregnancy-related complications, how does access to care and hospital services affect pregnancies and postpartum recovery and is this issue exacerbated for women in our rural communities?

Ms. STEWART. Thank you very much. It is a very serious issue and thank you for the question. And as I mentioned in my statement earlier, the March of Dimes is working currently on a report that would really show this issue of maternity care deserts. The issue of the closing of community hospitals in rural areas has been well documented.

One of the things that we are missing is that it is not just the closing of hospitals. It is the closing of hospitals compounded by the lack of obstetrical services and OB/GYNs, the lack of midwives and doulas in areas, the distance that women often have to travel just to receive care, and it is particularly acute not just—in rural areas there is a major challenge, but one of the things we are looking at is even where in urban areas there can be maternity care deserts as well.

I will give you a good example of this. Here in the District of Columbia there is no hospital that provides obstetrical services east of the river in Wards 7 and 8. So east of the Anacostia River, tens of thousands of women who live there who have no hospital to go to, who then have to travel. If they have no transportation they have to go on the Metro often an hour or more to even go to a prenatal visit. If you are a high-risk pregnancy or you have a high-risk pregnancy, the complications that are then exacerbated or the complications that can result because of that distance, because that lack of access is increased significantly.

So one of the things that we really need to talk about in the system is the fact that even in the District of Columbia, for example, where there may be the number of beds may be sufficient for the number of women, that doesn't mean that those beds or that care is available to all the women that need it when they need it, and that is a very significant problem.

So I think one of the things that we are doing in the March of Dimes is to try to work with our friends in health care, our partners—ACOG has been a longtime partner of ours—working with hospitals and others to make sure that services are available.

The last thing I will just mention is that because all these issues that we are talking about today really just disproportionately again impact women of color. Women of color, African American women, are three to four times more likely to die as a result of childbirth. We also need to look at other ways in which services can be provided. We know that African American women, for example, are far more likely to want to receive services and care from a doula working within the formal healthcare system. And we have got to make sure that those services are also available so that women have places they can go they can trust. They know they go to places that will listen to them and that will respond to their needs and that will deal with their situation if they have high-risk needs as well. And what we are seeing today is that there are significant gaps in rural areas as well as in urban areas too.

Mr. LATTA. Dr. Coslett-Charlton, our country is facing an opioid epidemic and especially in the State of Ohio we are, unfortunately, about the third worst in the country. And while Congress and especially this committee has done a lot of work and we have passed a lot of bills trying to reverse this devastation, I can't help but think of the pregnant women and the new mothers who struggle with addiction.

And how prevalent is opioid abuse in maternal deaths?

Dr. COSLETT-CHARLTON. Well, I would comment that it is very significant and that is why it is so important that these maternal mortality review committees include diverse members including mental health professionals, substance abuse professionals and I know when we established our panel in Pennsylvania it was imperative that we had representatives from communities where—because that is a very significant issue and I know Philadelphia has seen a large increase. That they have done a good job of looking at their data, almost a doubling of maternal deaths over a short period of time related directly to the opioid abuse process.

And ACOG really appreciates all of the work that government is doing to make sure that—pregnant women are a special population that sometimes have different needs, so the pregnant addicted mother, number one, it is a great population to invest in because women that are pregnant that have opioid use disorders are often motivated to get better. You have a reason to get better. Not that everybody doesn't, but a pregnant woman is a special population.

And the other thing that we have seen is that doing, not only paying attention to different prescribing needs as we are limiting prescriptions, I see in my state things like that to make the special considerations for pregnant women that may have difficulties with access and need and to make sure that they continue on treatment during pregnancy and postpartum.

The last thing is that there are special pilot projects that are coming out of these committees looking at the special population of pregnant women, and like soft landing centers where we are not separating moms and babies, and, very importantly, not making punitive decisions based on maternal care and that because we

know that women, the fear of losing their child or going into a system are not going to seek prenatal care and how imperative that is for the health of the woman and the child that she is carrying. So those are all things that ACOG is working very passionately on to try to improve the health care of women related to opioid use disorder.

Mr. LATTA. Well, thank you very much. And, Mr. Chairman, my time has expired and I yield back.

Mr. BURGESS. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentlelady from Colorado, Ms. DeGette, 5 minutes for questions, please.

Ms. DEGETTE. Thank you so much, Mr. Chairman, and I want to thank all of our witnesses, but especially you, Mr. Johnson. I just can't even imagine what it must be like raising those two boys and I am glad your mom is here to help you. But, I want to come over and help myself, but I am not sure what I—and I think probably most of us feel that way if there is anything we can do.

I think the first thing we can do is pass this bill. And I have been working with my co-sponsor, Representative Herrera Beutler, to try to get this bill passed by the end of the year and I think your testimony is what will bring us over the line. So if people wonder, does it make a difference that answer would be yes, so thank you.

I want to ask you—am I pronouncing it correctly, Crear Perry? Crear Perry, OK. I want to ask you, Doctor, according to the CDC, the Nation's maternal mortality rate rose by 26 percent between 2000 and 2014; is that correct?

Dr. PERRY. Yes.

Ms. DEGETTE. One of the most striking aspects that I have been researching of this uptake is that African American women are nearly four times as likely to experience a pregnancy-related death than other women; is that right?

Dr. PERRY. It is. In some places it is higher.

Ms. DEGETTE. It is higher in some places?

Dr. PERRY. Yes. In New York City it was 12 to 1.

Ms. DEGETTE. Wow. And can you explain to me why this is? But it goes across—

Dr. PERRY. It does.

Ms. DEGETTE [continuing]. Socioeconomic lines, which is stunning. Can you explain a little bit about that for me?

Dr. PERRY. Well, and I think, for me, Charles' story really reflects this idea, right.

Ms. DEGETTE. Yes.

Dr. PERRY. Like in general in the United States we have not really grasped the idea that women, when they are pregnant, are special populations and it is important that we value them. So to have someone in the hospital for a long time without evaluating them, it means there is a fundamental lack of valuing them as a person and wanting to come and check on them. And saying she is not a priority right now and what we don't do when we just look individually at the doctor, it wasn't just the doctor. So a lawsuit, when you have an entire system and a structure—

Ms. DEGETTE. Just the whole hospital.

Dr. PERRY. And it is the whole structure. So how do we get to a space where black women and women in general, right? Because

the reason that the gap is high in New York and not in Texas is because white women in Texas are dying. So it is not so much that black women are doing so great in Texas, so in general across this country.

Ms. DEGETTE. There is just fewer of them.

Dr. PERRY. Right, exactly. So across this country we don't value women. We don't have paid leave. We have to go back to work really quick, but we don't have child care so all those things impact our ability to have a healthy pregnancy. So how we then get into the hospital and need to rush out or if someone is doing something quickly, it makes it more difficult for us to live. So that happens really acutely for women of color and so you see that impact of implicit bias.

So what you can legislate is rules around training on implicit bias. What you can legislate is accountability for the entire system to look at every death and make sure that all the structures that they need to have in place are put there so there is not just one individual nurse or doctor but it is the entire structure.

Ms. DEGETTE. Yes, yes.

And Ms. Stewart, many nations have actually been able to cut the rate of maternal mortality in half. I talked about that in my opening statement. I wonder if you can give us some ways that they have been able to do that, that we can model our own behavior on in the U.S.

Ms. STEWART. Well, in many of those countries, Congresswoman, all of the outcomes relative to moms and babies are far better than they are here in the U.S. So one of the things about what is going on here in the United States is we are focusing on maternal mortality today as we should and maternal morbidity as we should. But if you look at all the outcomes around moms and babies, whether it is around premature birth, infant mortality, our outcomes are far worse than many other, most other developed countries in the world.

Ms. DEGETTE. And many underdeveloped countries too.

Ms. STEWART. And some in many underdeveloped, emerging countries. I mentioned in my opening statement our maternal mortality rates are worse than even countries like Slovenia and—

Ms. DEGETTE. So what are some of the things these countries have done?

Ms. STEWART. So I think it starts at the highest level of a policy environment and an environment that respects and cares for and prioritizes women and women's health and women and babies. So when you look at certain countries, Scandinavian countries for example, there are a range of policies that are far more supportive of women having a healthier lifestyle before being pregnant, having healthier pregnancies, and then having the kind of support even after pregnancy to make sure that they recover from their pregnancies well, that they feel supported, that they don't feel overwhelmed.

And we know the issues of stress in this country. Chronic stress, for example, can have a devastating impact on the health of women and the health of moms that impact not only them but their babies as well. So I think it starts with making sure that women have the healthcare coverage that they need, have access to the care we

need. We have talked about that. Half of the pregnancies in this country are covered by Medicaid. We need to make sure that all women have the kind of coverage they need. We need to make sure there are services in their communities that are accessible as we mentioned earlier around the deserts that exist.

And then I think we need to make sure that postpartum, Medicaid doesn't stop within 60 days of delivering the baby. That it extends so that moms have the kind of care and health care and support that they need even as they recover from their pregnancies.

Ms. DEGETTE. Thank you. Thank you so much. I yield back, Mr. Chairman. Thanks to all of you.

Mr. BURGESS. The chair thanks the gentlelady. The chair recognizes the gentleman from Virginia, Mr. Griffith, 5 minutes for your questions, please.

Mr. GRIFFITH. Thank you very much, Mr. Chairman, and I thank our panelists for being here.

Mr. Johnson, I am just so sorry. Nobody should have to go through that. And of course I am sitting there while you are testifying thinking about my wife, her C-section with my first son. So I am very, very sorry. And as Ms. DeGette said, if there is anything that we can do I am sure we would try including passing this bill.

So here is a question for you all. I like the bill, and I like the bill because it will have us looking at it from a national perspective. If we just do it on a state perspective it may not work. Because I represent the corner of Virginia that is outside Appalachia and the Allegheny Highlands and so, I border four states.

The Bristol Herald-Courier did a series of articles last year on neonatal abstinence syndrome because we have a high number at the hospital in Tennessee, but those are my constituents even though they are going to a hospital in Tennessee. I believe that hospital serves at least three states. And so if you are looking at it from a state perspective, Virginia is going to look a whole lot better on substance abuse and other things than Ohio. But if you compare Ohio just with my section of the state, we are probably in pretty good similarity. We are in sync along with West Virginia because we have similar problems and similar backgrounds. And I have got to have some of the deserts on your map because I have an area that two of my counties have lost their hospitals.

And so, I want to see this data from a regional perspective not just a state perspective because my part of Virginia is not like Arlington or even Virginia Beach or Richmond. It is completely different and if you are just looking at it from a state perspective you get a skewed picture from my region. So I like the bill.

So then the questions become, do we overload the bill, and you don't want to do that. Sometimes you can put too much on it. Do we overload it by trying to include prenatal and neonatal care into the study? If we don't and if Ms. Beutler is in agreement, I would say expand it. If it is going to overload it and we might not get it passed by the end of the year, let's get this one passed and do something else.

But how, Ms. Stewart, how do we fix it? I am a big advocate of telemedicine. Obviously can't deliver the baby by telemedicine, but maybe some prenatal or pre-birth care, some neonatal care could be done that way. What do you think of that?

Ms. STEWART. Yes. Actually, we think the prospects of telemedicine especially for prenatal care can be very exciting and very productive. There have been several studies to show that women in rural areas, in urban areas, low-income women are very comfortable actually receiving care. And we also know that in the postpartum, we have some programs going on right now in the postpartum stages where uploading data, checking, taking blood pressure at home, uploading that data has actually reduced maternal deaths significantly in places like Philadelphia and can do the same in rural areas.

So we think the aspect of telemedicine in this space can be extremely helpful to overcome some of the gaps and barriers that we have. I will say that we, for sure, believe very strongly that this area and the period of time postpartum is the most critical period for this bill and for these issues that we are talking about. So whatever we can do to make sure that women have the care they need during that period.

We are measuring maternal deaths up to a year, so we need to make sure that women have the support they need after the baby. We are rightfully so, and we still need to focus prenatal, but what we are talking about now is the care postpartum that is now so critical and is contributing to so many of these deaths. So thank you for raising these issues.

Mr. GRIFFITH. Thank you all for being here. I think as technology moves forward we may have different answers, but I do think we have to embrace everything we can for those areas that are underserved or have deserts as you call it. And I appreciate you all being here. Thank you all so much for what you do and I yield back.

Mr. BURGESS. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for questions, please.

Ms. CASTOR. Well, thank you, Mr. Chairman, for holding this very important hearing on maternal mortality. And I really want to thank my colleague, Diana DeGette, and Congresswoman Herrera Beutler, for their work on the Preventing Maternal Deaths Act. And thank you to all of the witnesses who, you all have all devoted your careers to this, and Mr. Johnson, I take your story to heart especially.

This is a long overdue hearing and I do hope that this is just a start on an important focus on policy regarding maternal health because I don't believe that most people in the United States of America today understand that we are not doing so well. That women in the United States are more likely to die from childbirth or pregnancy-related causes than women in other parts of the developed world. That is not acceptable and the racial disparities are particularly disturbing. In Florida, we have our Pregnancy-Associated Mortality Review committee. In Tampa we are home to at the University of South Florida, the Lawton and Rhea Chiles Center for Healthy Mothers and Babies, and I have some wonderful experts there who help me. They have shared with me the latest Florida pregnancy-related mortality rates.

Since 1999, Florida's pregnancy-related mortality rate has been flat with no significant trend. How can that be that since 1999 things have not gotten better? I just, I think that is outrageous.

The committee found that hemorrhage-related deaths are the leading cause of pregnancy-related deaths in Florida by far. And of course we know that more than half of these deaths are preventable. Florida's most recent review committee has the statistics for 2016. They have identified 157 pregnancy-associated deaths, 21 died during the postpartum period. That has been the focus of many of your remarks.

Dr. Coslett-Charlton, I understand in May that ACOG released a number of recommendations on ways to optimize postpartum care for mothers including that new moms should have contact with their OB/GYN or other obstetric care provider within 3 weeks postpartum in a comprehensive, postpartum visit no later than 12 weeks after birth. Why is focusing on that fourth trimester or postpartum period important for the health of new moms and what are the barriers? We talked a little bit about it, but let's go into greater detail. What are the barriers that you and your colleagues see to prioritizing the fourth trimester? Transportation, child care—give us a little update on that.

Dr. COSLETT-CHARLTON. So that is a wonderful question and that is one of the exciting things that ACOG has developed, like you said, over the past several months is reevaluating the fourth trimester or postpartum care. And we know that when we look at preventable deaths that about half of those preventable deaths occur within that year within delivery.

So it is really important that we continue to engage patients on the importance of postpartum care and also reduce those barriers that you are discussing. Number one being access, number two being, in Pennsylvania I am fortunate to practice in a state that I did residency and medical school and practice in Pennsylvania, and in Pennsylvania when you are pregnant you are covered. And I cannot imagine a woman not being covered during pregnancy. But that coverage for Medicaid patients ends at 6 weeks postpartum and we know that things can happen afterwards.

And it isn't just the issues with—I have had plenty of women have preeclampsia or hypertensive disorders that need very close follow up. I have seen women seize 6 weeks after delivery in the emergency room related to preeclampsia. So those identification of patients that are at risk, number one. Number two, having important communications in a manner such as telemedicine within the first several weeks after delivery and especially in high-risk patients is critical.

And also, we talk a lot about postpartum depression and mental health disorders and how important it is that we screen women adequately and continue screening and keeping them within that period and also educating patients of the importance of the postpartum period. And we think that that might come during the prenatal period and that we need to do work to emphasize the importance of postpartum to women when they are having their babies because, I am a mother of four children.

I am embarrassed to say it. I don't know if I went back for a postpartum visit. I know I am an obstetrician and I know that, are privy to knowing the signs, but I was caring for children and having important maternal and parental leave, it is very important having the transportation. So there are so many policy things that

are exciting and that, going forward hopefully we can look to all of you to make those favorable changes a reality.

Ms. CASTOR. Yes. One of the major gaps I see in my state and other states, Florida is in the minority of states that did not expand Medicaid. And I worry about the continuity of care for young families, for young women especially if they are not taking care of themselves early on and then they reach a gap after they have their baby. Has Medicaid been expanded long enough for there to be any studies on the differences on maternal mortality in states that have expanded Medicaid and states that have not, do you all know?

Dr. PERRY. I know for health in general, but not specifically maternal mortality and that is why this bill will be really helpful for us to be able to drill down on more details on maternal mortality.

Ms. CASTOR. Thank you very much and I yield back.

Mr. GRIFFITH [presiding]. The gentlelady yields back. The gentleman from Missouri, Mr. Long, is recognized for 5 minutes.

Mr. LONG. Thank you, Mr. Chairman. And I have heard a lot of testimony over my years on the committee here and, Mr. Johnson, I don't know that I have ever heard any more heartfelt or any more important testimony that what we heard from you here today. So thank you for being here and I know it is hard to do, and but hopefully your voice will add a voice and will garner more attention to this, so thank you for being here.

A quick question for you, your first son, was that—I understand that was a C-section also?

Mr. JOHNSON. Yes, sir. That was a C-section.

Mr. LONG. Was that a planned C-section like the next one or an emergency?

Mr. JOHNSON. No, that was not. So that was an emergency C-section so we went in for, we didn't expect it and so that was part of the reason that the C-section was recommended during the delivery of Langston, our second son.

Mr. LONG. OK, OK. Because I am curious, but yes, I am a little familiar with the emergency part of that situation, so yes.

Ms. Stewart, I just want to thank you for what you do at March of Dimes and the big event you hold every year here in Washington, D.C. The cook-off I call it. What is the official name of it?

Ms. STEWART. It is called a Gourmet Gala.

Mr. LONG. That is what I was going to say if you hadn't interrupted me.

Ms. STEWART. It is a lot of good food there.

Mr. LONG. Gourmet Gala.

Ms. STEWART. Gourmet Gala.

Mr. LONG. It is a dandy and it raises a lot of money every year for March of Dimes and I appreciate that.

Ms. STEWART. Absolutely. And we appreciate all of your support for that. Thank you.

Mr. LONG. Right. Dr. Coslett-Charlton, as you note, only 33 states have a maternal mortality review committee, many of which are newly created. Could you talk about the important role the Centers for Disease Control and Prevention is giving technical assistance to states to either help them establish MMRCs or ensure that they are operating effectively and getting appropriate data?

Dr. COSLETT-CHARLTON. I would be happy to speak of that. As the state that has a very newly formed committee, I mentioned earlier that our MMRC is meeting for the first time at the end of October and I am very excited to see the outcomes of our getting together and being able to collect this data effectively. The CDC Foundation has actually reached out to us and has been integral in not only determining the makeup of the committee and working well with our Department of Health and members of the committee, but also ensuring again standardization and by knowing best practices from other states. So having that cooperation is essential.

The other thing is that through the CDC there are data collecting tools, the MMRIA, collecting tools which will standardize the reporting part of the MMRCs so that we would be able, if the reports are looking different from every state it is a difficult task to try to come to a consensus. So we keep talking about the importance of making sure we keep standardization and the support through the CDC with the MMRIA application is an excellent example of that.

Mr. LONG. OK. In your testimony you discuss Pennsylvania's efforts to establish MMRC this year. What has been your experience so far in getting it up and running?

Dr. COSLETT-CHARLTON. Well, fortunately we have an extremely supportive Department of Health for this issue and some of it has been similar to our efforts here is recognizing that there is a problem. And some of the national attention to the problem has really given some interest to members that have been very interested in participating in this bill.

Our bill was supported unanimously—House, Senate, and by the Governor's Office. So this was an easy ask at this time, but it really, it was more momentum initiative and a lot of the reports coming out that this truly is a problem that, you know, opened the eyes of many and we realized that we need to tackle this. And it is not a hard thing to tackle if you do it the right way and there are best practices already established.

Mr. LONG. And getting data on why pregnancy-related deaths are happening is essential of course, but what can we do to improve outcomes once we receive that data and can you talk about the role MMRCs have once that data is collected?

Dr. COSLETT-CHARLTON. So some of collecting the data is important so that we can use it to see where it needs not only nationally but also in communities. And we talk about these perinatal collaboratives that the CDC and the national effort to collect data will be the mothership and hopefully we will be able to send out the tentacles to go out in the communities and find where there is deficiencies and where there is disparities and do better to be able to connect patients and meet those needs and to hopefully a realization where access really is an issue.

Maternity care is difficult to deliver and, we talk even about Philadelphia that has closed half of its maternity hospitals in the past decade. The only hospitals that are delivering right now are university institutions because a lot of hospitals find the reimbursement not adequate for the care and liability exposure and a multitude of things which is not for the conversation here.

But it is really important that we are able to identify where these deserts are—I think that is wonderful—in care and be able to improve upon that.

Mr. LONG. OK, thank you. And once again thank you all very much for being here. I appreciate your time in taking time out of your day and week to come up here and testify. And, Mr. Chairman, I yield back.

Mr. BURGESS. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentlelady from Illinois, Ms. Schakowsky, 5 minutes for questions, please.

Ms. SCHAKOWSKY. Thank you. I want to join my colleagues who have thanked you so much for this, all of you. I want to thank you, Mr. Johnson, for turning this tragedy into something positive. It took a lot of courage and probably a lot of time away from being a dad. And so I just want to express my appreciation to all of you and just mention that in particular.

I think that the WHO and the CDC reports, et cetera, were really a wake-up call for people. I have been aware of communities near me, in Milwaukee for example, where we have seen this rise in maternal mortality, infant mortality as well, and it has really been unacceptable that we in a country, the richest country in the world, would see these kinds of results. It is really, it is absolutely shameful.

So I wanted to—and I think there are a lot of ways that we are failing mothers and children, especially African American women who are three to four times more likely to die from childbirth. We just simply have to do better. But I am concerned about the new proposals, the Trump Public Charge Rule that puts maternal and infant health in grave danger. By targeting legal taxpaying immigrants in this country, this rule seeks to discourage immigrants from using the government services that pay for—that are paid for with their tax dollars—Medicaid, CHIP, SNAP, WIC, and the Earned Income Tax Credit, just to name a few.

So let me ask Dr. Coslett-Charlton and Dr. Crear Perry, women who qualify for Medicaid that would cover pregnancy care and labor and delivery may face the impossible choice of jeopardizing their legal immigration status in this country or go without needed care. And let me just add that right now in my very diverse district, we are finding that people who qualify are not signing up for benefits, right now, because they are so fearful. So if women are forced to go without needed prenatal care, what could that mean to her health and risk of maternal mortality?

Dr. PERRY. So it is an opportunity for us to use the same empathy we have when we talked earlier about with the opioid addiction moment we are having where we don't want to criminalize moms who are addicted to opioids so we ensure that they have access to health care. If we criminalize women for using SNAP or Medicaid, we are also harming their ability to have a healthy pregnancy.

So we should be able to use that same feeling of empathy for all mothers that everyone who is in the United States deserves to have a healthy pregnancy and a healthy baby and so how do we make sure that they don't miss their prenatal care? For example, in Louisiana we didn't for a long time cover immigrant mothers and after Katrina it was a big push of new immigrants.

Ms. SCHAKOWSKY. This is even legal.

Dr. PERRY. Yes. And so we had to add that to the bill when we got more citizens coming because it was important for us to ensure that the babies had access and the babies had care. We saw an up-tick in baby——

Ms. SCHAKOWSKY. But this would prohibit even citizen children of those parents from getting the benefits.

Dr. PERRY. Right. So we have to think about what are value is, right, so if we don't value citizen children, what do we value? If we don't think it is important for them to have treatment from a physician then what are we asking for as a country. So it is just we have to think about our own values as a country.

Ms. SCHAKOWSKY. I agree.

Yes, Doctor.

Dr. COSLETT-CHARLTON. And I would just like to add, ACOG strongly opposes any efforts to provide any barriers to any kind of care for pregnant women and postpartum and prenatal, and this rule obviously would do such. So and as a practitioner too, the woman is going to deliver the baby no matter what, so she is going to deliver. No matter what she is going to deliver. And, it is common sense that she needs prenatal care or, for fear of having rising morbidities and mortalities related to this.

Ms. SCHAKOWSKY. Yes, go ahead.

Ms. STEWART. I was going to say, Congresswoman, we have made a strong statement against that Public Charge Rule as well.

Ms. SCHAKOWSKY. Thank you. And I yield back. Thank you so much, all of you.

Mr. BURGESS. The chair thanks the gentlelady. The gentlelady yields back. The chair recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for your questions, please.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it. Thanks for holding this very important hearing.

Ms. Stewart, as a parent I remember the birth of my children was such a joyful event. The idea that rates of maternal mortality are on the rise is horrifying as far as I am concerned. In our state it is on the rise. I read that women are dying from hemorrhage complications in the State of Florida. How does the Preventing Maternal Deaths Act help reverse the trend of women who are losing their lives to these typical medical complications?

Ms. STEWART. Well, I will defer to my medical colleagues to describe the issues around hemorrhage and how it is contributing, but I will say that what this bill is designed to do is to establish across the country maternal mortality review committees that are designed to collect data on every maternal death and to make sure that every state understands the underlying causes of death for each woman that dies as a result of childbirth.

But even beyond that what it is designed to do is to not just collect the data but to help states and to help the participants and the healthcare system design interventions that can actually eliminate deaths in the future. And that is one of the things that is really important about this bill is not only collecting the data, but then designing interventions.

And of course if we collect data consistently across the country and if the sharing of interventions can also be shared we can cer-

tainly accelerate our ability to reduce and even eliminate maternal deaths. I will give you a couple of examples of how collecting data in MMRCs has been really helpful.

In Colorado, for example, data was collected and what was found is that women that experienced maternal death had also been experiencing suicide and depression and they were, in Colorado, able to find and identify where there were gaps in mental health services and actually close those gaps and give more mental healthcare services to women where they needed it.

In Ohio, they actually did something, which I think is really important, which is do additional training for hospital staff beyond just the doctors themselves, hospital staff where they went through simulations of training in obstetrical emergency situations so that they could actually be more responsive in the event of an emergency situation.

So MMRCs are not only about collecting the data, but actually putting into action the things that can actually eliminate maternal deaths. And that is why this bill is so important and that is why a national bill and a national effort is also so important, so the data can be consistent, can be collected, we can see the data, we can actually track the interventions more successfully.

Mr. BILIRAKIS. Thank you very much for that answer.

Dr. Coslett-Charlton, according to the Centers for Disease Control and Prevention, it lists indicators. Severe maternal morbidity has steadily been increasing in the years. What are the key drivers of this increase and how can it be addressed?

Dr. COSLETT-CHARLTON. Well, some things are recognizing and be able to maintain proper prenatal care and care of women throughout their reproductive years and identifying comorbidities such as, we talk about obesity and smoking cessation and where we see a rise in comorbidities with heart disease. So having active interventions before a pregnancy we find is critical to having a healthy labor and delivery for all women.

Mr. BILIRAKIS. So you feel that they are increasing. In this day and age with all the technology we have or is it just that we are getting more data on this or there definitely are increases in maternal deaths?

Dr. COSLETT-CHARLTON. Well, so far that is part of the purpose of this review is so that we were talking earlier about the accuracy of the data. So some speculation has been made that perhaps because for the past 5 years we were actually recording on death certificates whether or not a woman was pregnant when she died, or within a year after delivery whether or not that has caused a rise in the actual numbers that we are seeing. But when comparing to other countries that have had similar checkboxes on their certificates where they have seen a stabilization or a decrease, we have actually seen an increase.

So these committees are really imperative to really, exactly what you are saying, really know and be able to assess and accurately determine if those disease entities as well as maternal death if there is a change and make sure that we have accurate data so that we can successfully portray appropriate interventions.

Mr. BILIRAKIS. Yes, exactly. So, whether it is increasing or what have you, we have to focus on the issue. There is no question.

And, Dr. Johnson, you have my sympathies. I was in the VA Committee so I didn't get a chance to hear your testimony, but I know how difficult it must be for you.

Let's see, Dr. Crear Perry, please, our maternal mortality data has been described again as limited, unreliable, and even embarrassing by top researchers. Do you agree with these characterizations? And I know, let's expand upon this. Are there concerns with the research community regarding the integrity of the data being collected in states? What are those concerns and how might they be addressed federally?

Dr. PERRY. That is me. That is OK. Hi.

Mr. BILIRAKIS. Oh, you are over here. I am sorry.

Dr. PERRY. And so it is important, Dave Goodman and the folks at CDC are doing a great job of doing the data. They have been doing it for a very long time. They have dedicated their life to it. And they have looked at if the increase is due to error in data versus if it is an increase, that is true, and all the studies so far have come back saying no, there is an increase and it is from the data.

And so the robustness with which the CDC is working on to look at this issue is something that we should all value. And if they are part of this bill, they are not here testifying, but CDC is really integral to getting this work done and it is important that we understand that they are—that yes, there have been researchers that have given us pushback around the data over the years, but we have gotten better and better and this is just another way to get even more clear about how women are dying, because beginning at a granular level and look at the hospital level what is happening.

So yes, there have been a lot of articles about the data, but we truly know through the CDC that the rates are increasing and that we can do something together to do it better with this bill.

Mr. BILIRAKIS. Very good. Thank you and I yield back, Mr. Chairman.

Mr. BURGESS. The chair thanks the gentleman and the gentleman yields back.

The chair would just make the observation that I believe it was Dr. Callaghan from the CDC who came and spoke at one of our roundtables about a year ago. And you are correct. They are very thorough and they have been at this for a long time. They have a lot of good insights.

The chair recognizes the gentleman from Massachusetts, Mr. Kennedy, 5 minutes for your questions, please.

Mr. KENNEDY. Thank you, Mr. Chairman. I want to also thank you for your obviously lifelong and personal dedication to this issue given your profession before coming to Congress and still the work that you do. I want to also thank Representative Herrera Beutler who was here earlier and obviously our distinguished panel for joining us.

Mr. Johnson, excuse me. I will apologize. I have been in and out. Your words are extremely powerful, sir. Kira sounds like quite a woman. I have two kids under 3. I was in a delivery room about 9 months ago. Thoughts are with you and your family, sir.

In 2018, the United States of America has the highest rate of maternal deaths in the developed world. Every single year we

mourn roughly 700 mothers who are lost to complications during their pregnancy, and at least 350 of those deaths are preventable. Most alarmingly, profound racial disparities exist in these statistics. Black women today are three to four times more likely to die of pregnancy or delivery complications than white women.

Before we try to explain that away on socioeconomic terms, just access to care, access to education, and higher income, we have to be clear that even when you control for those factors a wealthy black woman with an advanced degree is still more likely to die or to have a baby die than a poor white woman without a high school diploma. In the United States, a black woman is 22 percent more likely to die from heart disease than a white woman, 71 percent more likely to die from cervical cancer. Those are haunting statistics, but they still pale in comparison to the one we discussed here today, for black women are 243 percent more likely to die from pregnancy or childbirth-related causes: 243 percent. So we can't have a discussion about how to address a larger crisis in maternal mortality without having a discussion about how to confront the pervasive, systemic inequities that are buried deep within our system of health care in America.

And the last point I have to make is this, that there are, as we speak, 20 Republican Attorneys General that are attempting to repeal the Affordable Care Act in our court system after most of my Republican colleagues have voted to do the very same thing more times than I can count. So let's remember 9.5 million. That is the number of previously uninsured women that gained healthcare coverage including maternity care which is an essential health benefit under the Affordable Care Act. Coverage for women of color grew at more than twice the rate of women overall in 2013 to 2015. So to have a conversation about maternal mortality at a time when my Republican colleagues are using every tool in the book to roll back access to guaranteed maternal care and maternal coverage is a bit much.

And with that I want to direct my questions to Dr. Crear Perry and by the work that you have done, Doctor, in discussing how we need to move away from seeing race as a risk factor in maternal health and call the real risk factor what it is: racism. So can you extrapolate that a bit for the committee and, specifically, what do you believe to be the leading cause of those racial disparities I mentioned in maternal mortality rates?

Dr. PERRY. So we have done quite a bit of focus groups and work in hospitals around how patients feel disrespected and not heard and not listened to and not valued. And, a great example of that is Serena Williams, right. She gives an amazing story around how she had symptoms. She knew who she was. She is a very wealthy and healthy person as well and she still was not heard or valued.

So what we miss in this country is really being honest about when you don't see someone as being fully equal to you, you are less likely to think about their care in a very serious manner. You are less likely to address their issues in a serious manner, and you are less likely to spend the time that they need ensuring that they are healthy.

And so what we have to be able to do is have some truth around that conversation first and not act as if that is not a true—

Mr. KENNEDY. And so is there data that you would point to on this or is this something that is a bit bigger than fits into an Excel spreadsheet and a pie chart and how—

Dr. PERRY. This is going to be both a policy fix and a cultural shift, right. Like we have had policy shifts. We have had the civil rights movement, we have a lot of things of policy we can have, but as long as the culture still believes that black people are less valuable or inferior, and women, we are going to keep having the same conversations over and over and over again. So we have to have both a policy conversation and a culture shift.

Mr. KENNEDY. Anybody else want to comment on that? Mr. Johnson?

Mr. JOHNSON. So just talking about this from a personal experience and having an African American, extremely vibrant woman who was not in good health but in exceptional health at one of the top hospitals in the world, and to be quite honest with you, when this first happened and I was asked a question, do you think that this would have been different if your—do you think this is because your wife was black, or do you think the outcome would have been different if your wife was Caucasian, I was in so much pain I couldn't process that and the thought that the color of my wife's skin contributed to her death?

But what I am clear about is that she was not seen or valued as human. She wasn't. And the people who were responsible for her care that I trusted with her care failed to look at her in the same way that they would their daughter or their sister or their mother. And the reality of the situation is I am asked the question and people sometimes, and, the more I have spent with wonderful groups like Black Mamas Matter and the more I look at the data, people—and I am very clear about this issue of implicit bias and the contributing factors or racism. And people say you are making it a racial issue. I didn't make it a racial issue, the statistics did.

So what we have got to do is figure out how these women are valued and looked at as human, because what I said at night, thinking about my wife and I have to think about that question about would she be here today if she was Caucasian? Let me be clear that this is an epidemic that affects all families from all backgrounds and all walks of life, and unfortunately I know that personally because I have talked to these families and I have become very close to some of these fathers and some of these families and they are from all walks of life.

But we cannot address this issue without head-on facing the way that it is disproportionately and horrifyingly affecting African American mothers.

Mr. KENNEDY. Thank you, sir.

Chairman, thank you for the extra time. Thank you all for being here.

Mr. BURGESS. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from Georgia, Mr. Carter, 5 minutes for your questions, please.

Mr. CARTER. Thank you very much, Mr. Chairman, and thank all of you for being here. And, Mr. Johnson, thank you for your efforts and your work on this especially, and I echo the comments of all of my colleagues here today. We appreciate your courage.

Mr. Chairman, I believe this hearing was set for another time and I requested and I am sure others did that it be delayed so that we could have it. It is important to me and I am sorry if it disrupted any of you all or inconvenienced you.

But I am from the State of Georgia. In 2010, there was an Amnesty International report that flagged Georgia as being the number one state in maternal mortality. And that is why I expressed to the chairman, Mr. Chairman, I want to be at this hearing because this is real to me. In fact, when I served in the Georgia State Legislature and we passed Senate Bill 273 that created the MMRC and put it into the Georgia Department of Public Health.

And I wanted to ask you, Dr. Perry, because when we created that, you know, we followed the guidelines and we did what we were supposed to do. But I believe that your group was involved in a study, When the State Fails: Maternal Mortality and Racial Disparity in Georgia; so you are familiar with that?

Dr. PERRY. Yes, sir.

Mr. CARTER. I know you are. And I had the chance to look at it and study it and one of the things that it pointed out was the racial disparity in Georgia was the fact that even though the four categories—access to and quality of care, insurance access and pricing funding, and accountability around data analysis and use, even though we had those in there we are still failing on those, particularly access.

And my question is, what can we do? Tell me what I can take back to my state because this is important to me. I served in legislature. I was in Health and Human Services, vice chair of that committee, and I helped with this legislation. If, and the point has been made by my colleagues today, what can we do legislatively, but what can I do? What can I take back to the State of Georgia?

Dr. PERRY. Thank you so much. And I do work with Dr. Lindsay and the folks at Grady around the Georgia work and they are specifically trying to look at their mental healthcare service structure. So supporting mental healthcare services in Georgia is important. Supporting Medicaid expansion in Georgia is important. Supporting rural hospital closures in Georgia is in support and like supporting support systems that include midwives and doulas in Georgia is important.

All the social structures that we see, all the states where we allow for us to disinvest in women honestly have poor outcomes. Even though you can look and do the study and see, we are working on things inside of hospitals because you have some great doctors in Georgia. You have some phenomenal people and some nurses and midwives. But until we build a structure that holds the entire state together, right, like from rural Georgia from—then we are not going to be able to see an improvement and we are being separated around ideals that don't allow us to come together. And it is important that we know we value all the moms in Georgia, rural moms, urban, they all need access to insurance.

Mr. CARTER. Well, thank you for mentioning that because as you well know, knowing the state we have a disparity between rural and urban.

Dr. PERRY. Exactly.

Mr. CARTER. I mean to say Georgia is Atlanta and everywhere else. So it really is.

Dr. PERRY. Exactly.

Mr. CARTER. Well, another part of that study that I was very interested in, because I am a big advocate of this, is the proposition that the state could develop ways to help religious organizations in leadership engage and advocate for quality health education and services.

And I am really big with wanting to include the religious community. And can you give me examples of how we can do that or examples of how that has worked before?

Dr. PERRY. Including, because if you think about mental health it is a great example, right, so a lot of religious organizations have access to therapy, access to group places where women can come to make sure they have grievance counseling.

So there has been a lot of work that religious organizations are there to be a safety net and a support for women. They can't replace medical care, but they can serve as a safety net. They can provide transportation. They can help with child care. Like all these other things that we are looking for that a community provides, because we know that women who have access to a community and to each other, the connectedness, have better outcomes.

So how do we create connectedness and community across this country and across Georgia.

Mr. CARTER. Right. And one last question and this could go to just about any of you. But the thing that I am wondering here is I know we are accumulating the data and we are, and I believe you said earlier the data is going to CDC. Are they crunching the science of it? Can we tie anything into this genetically, regionally?

Ms. STEWART. I will try and then others. CDC has had a surveillance system in place for a number of decades and thankfully we are able to collect a lot of data mainly coming from death certificates. And just recently now, death certificates now include whether or not a woman was pregnant within the last year, and so that information has been helpful.

But what we don't get from all of that—and by the way that voluntary system, CDC asks states around the country to voluntarily submit the data. There are epidemiologists that then review the data and we learn as much as we can from death certificates. But what we don't understand is that a death certificate does not necessarily tell the full story of how a woman may have died and what were the underlying causes and what were the potential interventions that could have been in place to prevent that.

And that is what this is about is taking the data we collect, improving it, improving the collection, making it consistent, having committees that then can design interventions and having them well-funded so that they can actually see meaningful improvement over time. So that is the difference.

Mr. CARTER. Good. Again, thank all of you. And, Mr. Johnson, thank you and God bless you.

Mr. JOHNSON. And I would just like to say that I am actually a native of Georgia and currently—

Mr. CARTER. Did this happen in Georgia?

Mr. JOHNSON. It actually happened in California but I am a native of Georgia.

Mr. CARTER. OK.

Mr. JOHNSON. Kira grew up in Decatur, Georgia and I grew up in East Point and we are back living in Georgia.

Mr. CARTER. Right.

Mr. JOHNSON. So we look forward to working together with you—

Mr. CARTER. Absolutely.

Mr. JOHNSON [continuing]. To see how we can help out too.

Mr. CARTER. Can I ask you, was your wife originally from Georgia?

Mr. JOHNSON. Absolutely. Decatur, Georgia. Born and raised.

Mr. CARTER. OK, see this is the point I am getting at here. We are the Cardiac Belt. Has anybody looked at any of this to kind of try to tie this into it?

Ms. STEWART. There is a lot of work being done on what is going on that is that are sort of the underlying causes to why so many women of color especially are dying, and there are a bunch of issues. I will mention one of them. By the way I am from Atlanta too. Don't hold that against me.

Mr. CARTER. I see a pattern here.

Ms. STEWART. We have known each other a long time.

Look, there is a very important study and we could go through a laundry list of things, but there is a very important study that has really helped all of us understand what are some of the underlying causes to why we see so many disparities among African American women in particular.

A study that was done by a researcher who is now at the University of Michigan but she started this study in New Jersey, I believe, where she started to look at this as your weathering. The fact that African American women's health tends to, and African American women tend to have more challenges the older they get, challenges in pregnancy, challenges in childbirth, challenges maybe post childbirth may be due to this issue of weathering, which is that the impact of chronic stress that may be coming from racism and discrimination over a long period of time.

This issue of weathering which tends to deteriorate one's health may be a big contributor why we see so many disparities. The fact that women are getting, are older as they are getting pregnant and the fact that if black women are older having babies and they are experiencing this impact from this weathering effect that that could explain in part why we are seeing so many outcomes.

Having said that, we still need to address the fact that we don't specifically have to accept that that is the case, we can actually do something about it. We can actually address those issues. We can actually deal with the underlying stress that exists. We can actually deal with the systems that may be creating the stress in the first place, and we can make sure that we understand when interventions are really effective across all communities.

Mr. CARTER. Thank you, Mr. Chairman. I yield back.

Mr. BURGESS. As the gentleman's time has expired, the chair recognizes the long-suffering Mr. Engel from New York, 5 minutes for your questions, please.

Mr. ENGEL. Thank you, Mr. Chairman. I appreciate those words, thank you.

Thank you, Mr. Chairman, for holding today's hearing. Just in listening, it is just shocking that right here in the United States women are dying from preventable pregnancy-related complications. That alone is shocking, but that women are more likely to die from those complications here than in other parts of the developed world, that is shocking. And the fact that this risk is three to four times higher for black women than white women, that is shocking.

So it is a tragedy and it is an emergency, and thank you, Mr. Johnson, for sharing your story with us.

I want to thank my colleagues, Congresswoman Herrera Beutler and Congresswoman DeGette, for introducing the Preventing Maternal Death Act legislation which I am a proud co-sponsor of. And I hope that after today our committee can move forward on solutions to this problem that we really need to move more quickly. It is long past time we acted to reverse this horrible trend once and for all.

So let me ask this question. I have long supported investments in family planning and reproductive health and I am particularly interested in the impact that such investments can have on maternal mortality. As the ranking member of a House Foreign Affairs Committee, I have seen that impact on a global scale. In fiscal year 2016 alone, U.S. investments in family planning worldwide provided contraceptive services and supplies to 27 million women and couples, which in turn helped to prevent 11,000 maternal deaths.

So let me ask Drs. Crear Perry and Coslett-Charlton, would you each explain why meeting unmet need for contraception helps to prevent maternal deaths?

Dr. PERRY. So there has been some data that shows that the safety and security you get from having access to family planning and not having to worry about if you are going to get pregnant again because you are not planning to be pregnant at that moment really decreases your stress and your weathering and ensures that you have a healthier pregnancy.

We know that we have looked at the states that have more supportive policies around family planning also have better infant mortality rates and better maternal mortality rates. So it is not a coincidence that when you invest in family planning and when you invest in infrastructure for moms and babies, you actually create a safety net where people can live longer and be healthier. So it is important that these policies that are created in this House improve the ability for moms and babies to live.

Dr. COSLETT-CHARLTON. And I would certainly echo that response. But also it has been shown that women that are able to plan their pregnancies by spacing intervals between pregnancies and having access to adequate contraception that it improves the safety. There is very clear data to show that it improves outcomes in pregnancy and delivery also.

Mr. ENGEL. So thank you. But along those lines, let me ask you if either of one of you would explain why women in the United States specifically have unmet need for contraception. By that I mean they want to use modern contraception but are not currently.

Dr. PERRY. Well, it is a state and local issue, usually, around access to family planning and reproduction and because when we allow that to be made state-based wide people's personal, you get gaps in what states pay for, things like sex education, what states allow for, things like having birth control inside of high schools.

Once again I will say for my great State of Louisiana, we struggle with getting sex education in the schools. We struggle with getting access to family planning for the people who actually need it very desperately. So I think in an attempt to make for a safe environment for our state sometimes we mislabel what safety looks like. Safety looks like having access to choice when it comes to your reproduction. And when you have that access to choice and information, you can have a safer pregnancy and a safer outcome.

Mr. ENGEL. Well, thank you. Obviously there is a lot more work to do on this front. Let me mention this. A December report from the Guttmacher Institute estimated that globally, "fully meeting the unmet need for modern contraception would result in an estimated 76,000 fewer maternal deaths each year." That is 76,000.

So I want to ask either one of you doctors to please, if you agree is it fair to say that improving access to contraception for American women could help address the rates of maternal death in the United States?

Dr. PERRY. Yes.

Dr. COSLETT-CHARLTON. Yes.

Mr. ENGEL. That is a loaded question, but I wanted to put it out on the record. I want to also take this opportunity to briefly talk about legislation. I have introduced with Congressman Stivers, the Quality Care for Moms and Babies Act. The legislation would bring together diverse stakeholders to identify care quality benchmarks for women and children in Medicaid and CHIP as well as fund new and existing maternity and infant care quality collaboratives.

These collaboratives bring together local stakeholders such as doctors and nurse midwives to best share the best practices in improved care for patients, and I am grateful to both the ACOG and March of Dimes for supporting this legislation.

And let me ask you, finally, both—let me ask perhaps Ms. Stewart. I will ask you this. Wouldn't you agree that we should be measuring and evaluating performances of Medicaid and CHIP caring for America's moms and babies as well as investing in perinatal quality collaboratives which work to implement maternal mortality review committee recommendations at the state level?

Ms. STEWART. Congressman, we are very involved across the country in perinatal collaboratives and they are very effective and we would very much support them. And I would just add at this point which is that 60 percent of all births are covered by Medicaid and that is a lot of women and a lot of babies.

And whatever we can do to make sure that the quality of care exists for those women as it does for women in the private insurance market to make sure we are collecting the kind of data to understand what is effective and what is not and that we are sharing that data across states, we would firmly support that.

Mr. ENGEL. Thank you. Thank you very much. Thanks, Mr. Chairman.

Mr. BURGESS. And the gentleman's time has expired.

Seeing no additional members wishing to ask questions, I want to thank all of our witnesses again for being here today. I have some documents I need to read into the record, a statement for the record from Sean Blackwell, M.D.; momsrising.org; and Alexis Joy Foundation. I also have the September report for the Maternal Mortality and Morbidity Task Force from the state of Texas¹; a letter from Dr. Gary Hankins who participated in one of our roundtables—Dr. Hankins is from the University of Texas Medical Branch in Galveston; and Dr. Cárdenas had mentioned the Obstetric Hemorrhage Toolkit in California² and I do have a copy of that I am going to submit for the record.

Also, documents from the March for Moms; Postpartum Support Virginia; Association of Maternal & Child Health Programs; Heart Safe Motherhood; Massachusetts Child Psychiatry Access Program; a letter signed by 1,000 Days and other patient groups; Americans United for Life; Alexis Joy Foundation; Nurse-Family Partnership; Preeclampsia Foundation; Society for Maternal and Fetal Medicine; a letter from Timoria McQueen Saba; American College of Surgeons; KSM Consulting³; more California PPH; SAP America; and Forbes Insight Study.

[The information appears at the conclusion of the hearing.]

And just to end on a somewhat positive note, my grandfather was an OB/GYN, an academic OB/GYN at McGill University in Montreal and practiced obstetrics during the decade of the 1930s when the maternal mortality fell from all-time highs to all-time lows, certainly indicative that if we put our minds to it, it has happened before, it can happen again.

Pursuant to committee rules, I remind members they have 10 business days to submit additional questions for the record. I ask the witnesses to submit their responses within 10 business days upon receipt of the questions. Without objection, the subcommittee is adjourned.

[Whereupon, at 12:23 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

¹The information has been retained in committee files and can be found at: <https://docs.house.gov/meetings/IF/IF14/20180927/108724/HHRG-115-IF14-20180927-SD022.pdf>.

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MomsRising.org

Where moms and people who love them go to change our world

MomsRising HR 1318 Preventing Maternal Death Acts Hearing Testimony

Hello, my name is Smita Nadia Hussain. I am the Maternal Justice Campaign Director at MomsRising, a national organization of over a million members, with members in every state in the country, who organize and advocate around issues that impact mothers, children, and families. As Director of our Maternal Justice campaign, I work on grassroots organizing and advancing policy efforts to address the maternal mortality/morbidity issues in our country, concentrating on the disparities Black women experience. In fact, Black women, no matter their education or income level, are 3-4 times more likely to experience maternal mortality and morbidity, one of the widest disparities in all of women's health.

I urge you to move HR 1318 The Preventing Maternal Deaths Act forward in today's Subcommittee on Health hearing to enable this important piece of legislation to go to a vote by the House of Representatives.

Why is this legislation important? The ability to protect the health of mothers and babies in childbirth is a basic measure of a society's development. Yet, currently, the United States holds the worst record for maternal and infant mortality in the developed world, and maternal mortality continues to rise. Every year in the U.S., 700 to 900 women die from pregnancy or childbirth-related causes, and some 65,000 nearly die.

American women are more likely to die from pregnancy-related complications than women in 45 other countries including the United Kingdom and much poorer nations like Libya and Kazakhstan. Additionally the data reveal major racial disparities in maternal mortality rates: Black women are three to four times more likely to die from pregnancy complications than white women, independent of age, parity, or education in our nation.

This legislation would establish a program to help states review maternal deaths; establish and sustain a maternal mortality review committee; develop a plan for health care provider education to improve maternal care, and improve information collection on maternal deaths to provide public disclosure of information on maternal mortality. It will help enable health systems to address the factors leading to the disproportionate deaths of Black mothers and put recommendations in place to begin addressing racial disparities that have been present and unchanged for decades.

These are some of the critical solutions needed to address our nation's maternal mortality and morbidity crisis.

We can fix this; women don't have to die from childbirth. According to a recent analysis by the CDC Foundation, nearly 60 percent of maternal deaths in the U.S. are preventable. Sixty-percent. If we are able to decrease that number by even a fraction, thousands of mothers' lives could be saved.

At MomsRising, we have repeatedly heard the stories of women who've almost lost their lives and from those who've lost loved ones to childbirth related causes. Stories such as Carissa, from Olympia, WA.

"After 40 hours of labor and 6 hours pushing, [my daughter] was in fetal distress and I had to have an emergency c-section. If we hadn't had access to a good doctor, and appropriate care, we both would have died. As it is, she is my miracle, and I am so thankful we are here! Good prenatal care and access to the childbirth center are not optional. We live in the wealthiest country in history, and there is no excuse for moms and babies to die needlessly."

We can and must do better to ensure that births are as safe and healthy as possible for all mothers. We must all work to ensure that the health of women and their children are made a priority. Thank you very much for your time.



September 17, 2018

Chairman Michael C. Burgess, M.D.
Ranking Member Gene Green
Subcommittee on Health
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

RE: "Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S."

Dear Chairman and Ranking Member Green:

I write to you on behalf of the upcoming hearing scheduled for September 27, 2018 on Maternal Mortality. I lost my wife Alexis Joy in 2013 due to postpartum suicide, and I deeply believe that Congress needs to be aware of this ongoing crisis.

On August 30th, 2013 my wife Alexis and I had our first child, a beautiful healthy baby girl we named Adriana Joy.

August 30th, 2013 was supposed to be the happiest day of our lives. Rather, it was the most challenging, eye opening, brutal reality we had never been prepared for. Our daughter's delivery was a code blue delivery. This was the beginning of the end of our perfect life as I knew it. Alexis was diagnosed with PTSD from the delivery. Breastfeeding proved way more challenging than either of us would have thought. Baby Adriana cried, a lot. This did not help our situation.

Alexis was diagnosed with PTSD. She started worrying over everything. "Our perfect baby might be damaged", Alexis thought. Alexis was convinced Adriana had brain damage and we took the baby in for testing on her brain. She was fine. This was an answer my wife couldn't accept. Her fears seemed to grow daily. Each day she became more irrational, paranoid, and cried more. She would push food around on her plate but never took a bite.

She had been calling her ObGYN, psychiatrist, and pediatrician during this entire period of time. Each one said "Don't worry, it's just the baby blues. It will pass. You're fine. Just relax and enjoy this time."



I watched my wife lose nearly 50 pounds in 30 days. One doctor in an emergency psychiatric unit pulled me aside and said "Your wife's not crazy. She will be fine. She just needs her family and friends. But, just in case there's only two ways women as pretty as her commit suicide. They either asphyxiate themselves in the garage or overdose on pills. Just get rid of the car keys at your house and any prescription pills she could take. Women like her would never commit suicide in a "sloppy" way. They would never want to be remembered not looking their best."

In our struggles to find help for my wife Alexis, **we went to 7 different hospitals or crisis centers in her last 13 days.**

On the morning of October 8th, 2013 I woke up to our Maltese puppy named Lucy, frantically barking to wake me up. Something seemed off. The air was stale, it was almost as if time had stopped. It's a feeling you have to experience to really know. In that moment I knew. I jumped out of bed. Ran downstairs screaming Alexis name. No response. I could hear my daughter crying. I ran down to the kitchen, no Alexis. The dining room, family room, office- no Alexis. Outside on the deck, not there either. Downstairs to the garage, not there. In the basement, not there either. By this point I'm literally crazed, panicking screaming at the top of my lungs. I run back upstairs to find my daughter strapped to her changing table and crying. Still no Alexis. I run back downstairs to look again. As I look to the back of the basement there was my beautiful, perfect, love of my life. Lifeless hanging by TV cable from my basement ceiling. I called 911 screaming for them to help me save her. I remember going through the chest compressions and mouth to mouth bargaining with God please, please bring her back. Suddenly, paramedics and cops were everywhere. They pulled me from her and started working on her. This was only probably 7 minutes. The craziest 7 minutes nobody should ever go through.

These 7 minutes that paled in comparison to the 5 1/2 weeks of hell my wife had to endure. 7 minutes that pale in comparison to the eternity I will spend missing my best friend. 7 minutes that pale in comparison to the lifetime my daughter will spend wondering who her mom was. 7 minutes that pale in comparison to the times I spend coming up with answers to my daughter's questions about why her mommy died. Will my daughter blame herself someday? Will she do the same thing when she has a baby someday? Will she even want to have a baby someday? 7 minutes that pale in comparison to the anxiety I get when my reality sets in that I have to do this parenting thing all alone.



All of this for no good reason.

Since my wife lost her battle with postpartum suicide, Pittsburgh has decided to not wait for another tragedy and to do something about it. Moms in Pittsburgh can now see a psychiatrist in under 48 hours because of Allegheny Health Network and Highmark Blue Cross Blue Shield and the Alexis Joy Foundation. I'm confident in the near future it will be under 24 hours.

PPD is not a women's health issue, it is a family health issue. I firmly believe we owe it to our children to fix this preventable and treatable problem. I know I will do my part to make sure my daughter gets the care she deserves if needed, someday.

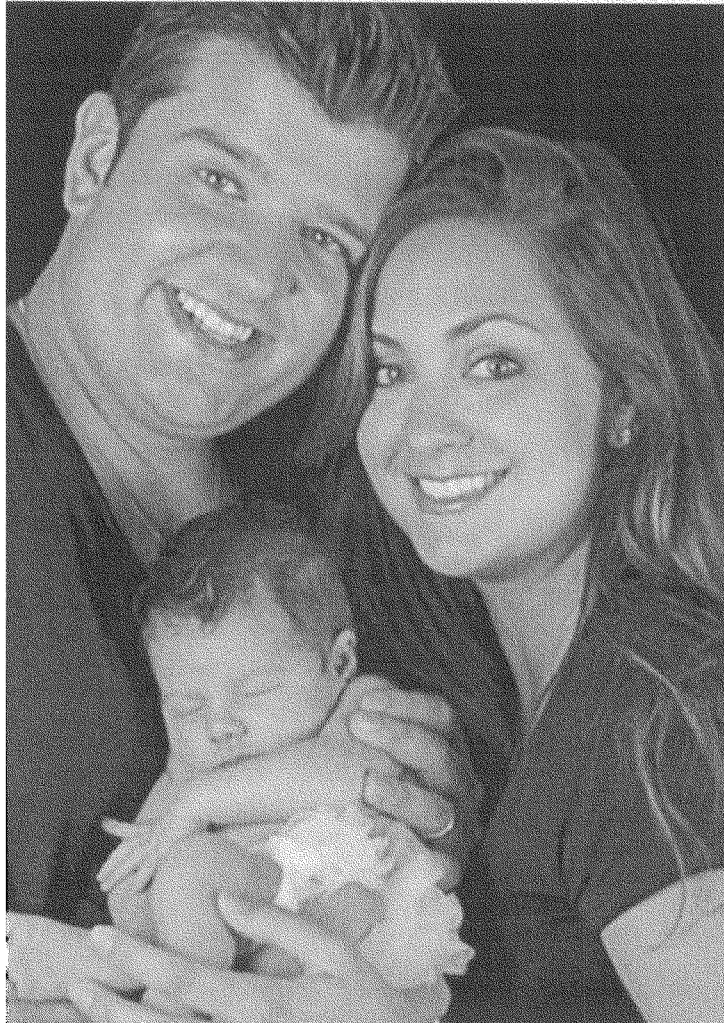
As Congress takes into consideration the escalating rise in maternal mortality and the need to figure out "Why are Mothers dying in this great country", I implore Congress to take a look at the mental health aspect of this issue. Perhaps if there was enough information on maternal mental health, its risks and evidenced based treatment options, my wife would be here with me and our daughter, today.

I thank you for your time.

Sincerely,

Steven D'Achille

Steven D'Achille, Founder
The Alexis Joy Foundation
2010 Lake Marshall Drive
Gibsonia, PA 15044
www.alexisjoyfoundation.org
412.606.0065





September 17, 2018

Chairman Michael C. Burgess, M.D.
Ranking Member Gene Green
Subcommittee on Health
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

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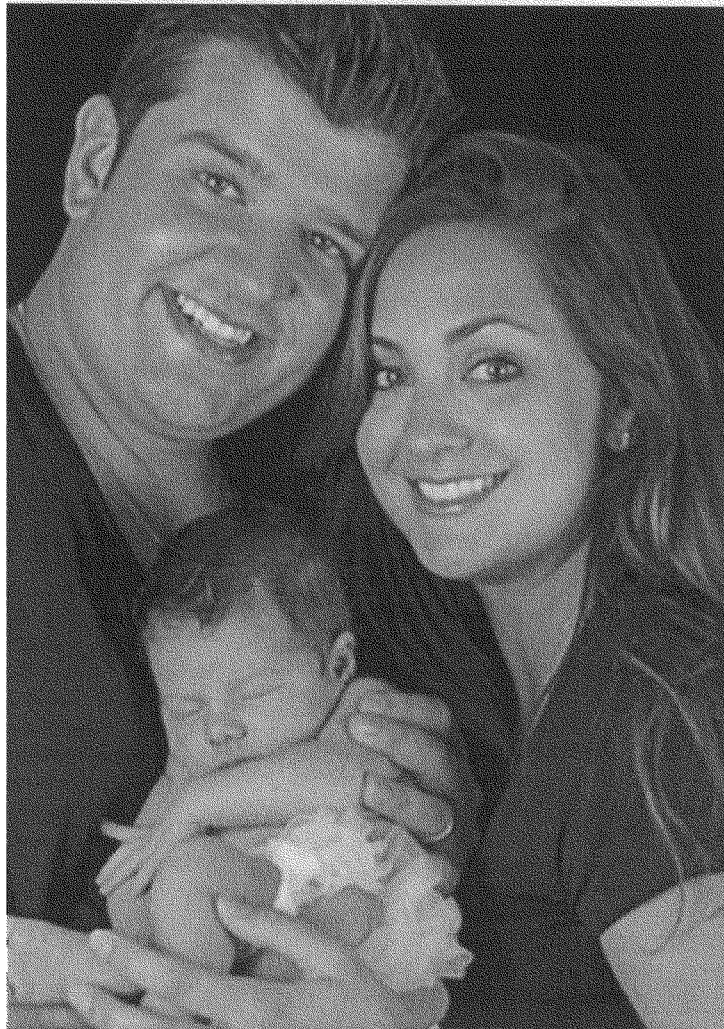
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Statement for the Record

September 27, 2018

House Energy & Commerce Committee

Health Subcommittee Hearing

Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S.

Submitted by:

Sean Blackwell, MD

President, Society for Maternal Fetal Medicine

409 12th Street SW Suite 601

Washington, DC 20024

Contact: Katie Schubert, Chief Advocacy Officer (202) 517-6122 | kschubert@smfm.org

Thank you for the opportunity to provide a statement for the record in support of bipartisan efforts to reduce a rising national maternal mortality rate in the United States. I submit this statement for the record on behalf of the Society for Maternal-Fetal Medicine, or SMFM.

SMFM was founded in 1977 as the medical professional society for high-risk obstetricians. Maternal-fetal medicine specialists treat high-risk pregnant women – women who have underlying medical conditions and become pregnant, women who develop life-threatening medical conditions as a result of becoming pregnant, or women whose fetuses do not develop normally and, in some cases, may become unviable. MFMs are obstetricians who have an additional three years of training and are on the front lines of these complicated pregnancy cases. Because we see these cases every day we are deeply concerned with our country's rising maternal morbidity and mortality rates.

Unfortunately, there is still much we do not know about why so many women are dying in childbirth or as a result of or following pregnancy. What we do know is that maternal mortality is just the tip of the iceberg and as many as half are potentially preventable. For each maternal death, there are numerous other women who suffer serious complications, what we refer to as severe maternal morbidities. We are working to understand more and do more to prevent these tragic outcomes.

What we do know is that we can do better. Despite advances in obstetrical care, the United States still trails the developed world in its maternal mortality rate. While the rate of maternal mortality has fallen in most developed nations, it is rising here. In a 2015 study, the United States had the highest maternal mortality rate at 26.4 deaths for every 100,000 live births, followed by the United Kingdom at 9.2 deaths for every 100,000 live births. That translates into 2 to 3 women dying each day in the United States at a time that should be one of the happiest in their lives and the lives of their families.

When obstetrical care is standardized – when all women receive certain interventions when faced with complications – outcomes improve. The state of California has demonstrated remarkable improvements in pregnancy outcomes by reviewing the death records of pregnancy and postpartum women and standardizing care and working systematically to implement standardized care based on what they learned. Specifically, the California Maternal Quality Care Collaborative, via the use of state-wide outreach collaboratives, has been able to reduce severe maternal morbidity by 20.8 percent between 2014 and 2016 among the hospitals that participate in maternal hemorrhage and preeclampsia best practices.¹ The United Kingdom has long had what is known as the Confidential Inquiry into Maternal Deaths. As a result of that program, standardized interventions were developed and implemented that have had a dramatic impact on reducing maternal deaths from conditions like venous thromboembolism.

We also know that with standardized data collection and review of maternal death cases, we can improve care and save lives. To assist with this, in September 2016, SMFM and the American College of Obstetricians and Gynecologists (ACOG) published an Obstetric Care Consensus outlining a process for identifying maternal cases that should be reviewed. We need better, more standardized data surrounding maternal mortality so that we can accurately attribute its causes

¹ <https://www.cmqcc.org/qi-initiatives/obstetric-hemorrhage/hemorrhage-collaboratives>

and prevent it wherever possible. There are some new tools available to share knowledge – for example, with the support of the CDC Foundation, the Association of Maternal and Child Health Programs (AMCHP) created a web portal highlighting performing maternal mortality reviews so that states that have maternal mortality review committees can share information about best practices with states that are interested in setting up review committees. The National Network of Perinatal Quality Collaboratives sponsored by the Centers for Disease Control and Prevention and the March of Dimes was recently launched to provide support to state Perinatal Quality Collaboratives so that they can improve maternal and infant health outcomes. However, to accomplish this, they need more information about the problem that they are attacking.

Once we have data it will be important to translate that data into actionable recommendations that can be implemented on a state level. This last piece is critical if we truly want to move the needle on reducing maternal morbidity and mortality in the United States and ensuring healthy births, moms and babies. With technical assistance and support from the CDC, as provided for in HR 1318, the Preventing Maternal Deaths Act, states can expertly create and sustain maternal mortality review committees.

There is more that we can do together to reduce maternal mortality and severe maternal morbidity as healthcare providers. The establishment of maternal mortality review committees is just the first step. As an example, a focus on care coordination and the importance of considering social determinants of health in all of our solutions cannot be stated enough.

SMFM has endorsed HR 1318 and appreciates Representatives Herrera Beutler, DeGette and Costello's leadership on this important issue. With the bipartisan support and further leadership of Chairman Burgess, Ranking Member Green and the entire Health Subcommittee, as well as Chairman Walden, Ranking Member Pallone and the full Energy and Commerce Committee, we can take the first step in reducing maternal mortality.

No woman goes into pregnancy fearing a significant complication or death. Having a child should be a joyous time – but far too often complications arise and these impact not just the woman—but also her baby and her entire family. We can do more, and we must do more. With a state-based review process, better data, actionable recommendations and a focus on policies that are informed by findings from state-based review process and evidence, we can and will make a big difference. We urge you to support HR 1318 and move it forward to House floor action. Thank you again for providing me the opportunity to speak and for shining a light on this important issue.



SCHOOL OF MEDICINE
DEPARTMENT OF OBSTETRICS & GYNECOLOGY

Gary D.V. Hankins, MD
Garland D Anderson, MD
Distinguished University
Chair in Obstetrics and Gynecology
Professor and Chairman

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MEMORANDUM

Date: September 12, 2018
To: Congressman Michael Burgess
From: Gary D.V. Hankins, MD
Chairman, Department of OB/GYN

RE: Maternal Mortality Testimony

I greatly appreciate Congressman Michael Burgess providing me the opportunity to submit written testimony to the Health Subcommittee of the United States Congress. By way of introduction, I am currently the Chairman of Obstetrics and Gynecology at the University of Texas Medical Branch in Galveston, Texas where I have practiced for the last 22 years. Prior to coming to UTMB I was on active duty in the United States Air Force for 22 years, again serving a practicing obstetrician gynecologist. I am trained both as an OBGYN physician as well as having subspecialty training in Maternal Fetal Medicine and in Critical Care medicine. Additionally, I most recently served as Vice Chair for the state of Texas Maternal Morbidity and Mortality Review Committee.

Having spent considerable time looking at maternal mortality in the United States, it is clear that substantial improvement is needed and should be accomplished. The mortality within the United States is more than twice that in other areas of the industrialized world and greater than 6 times that in Sweden. While it is unlikely that we could ever achieve the maternal mortality in the United States that can be achieved in a country as small as Sweden, it is clear to me that concentrating in the three areas that I will detail below, would substantially (I estimate by at least 50%) reduce maternal mortality in the United States.

1. Interpregnancy care; The provision of healthcare to many pregnant women within the United States, particularly those on government programs such as Medicaid, is episodic. That care begins only with the diagnosis of pregnancy and ends within a relatively short period following the conclusion of pregnancy. As such, women often enter into the pregnancy with uncontrolled or only partially controlled diabetes, hypertension, thyroid disease, and many other medical conditions. It is these complications of pregnancy which translate not only to a poor outcome for the women but also a poor outcome for the baby, often to include potential fetal malformations

as well as premature deliveries. The cost burden of not providing pregnancy care and control of these chronic conditions is staggering and would greatly exceed the cost to control these diseases and conditions before the woman ever enters into pregnancy. As a specific example, failure to control Diabetes Mellitus carries a substantial risk that the fetus will have either a midline CNS developmental defect i.e., cleft lip, cleft palate, spina bifida, or a cardiac anomaly. These fetal malformations can be reduced to near zero if the diabetes is controlled prior to pregnancy. This is but one example of where dollars could be very well spent. The return on investment on quality of life and a reduction on long-term expenditures are very substantial.

2. **Regionalization.** The fact that regionalization of medical care to concentrate getting the patient to the appropriate level facility works has been demonstrated by the pediatricians and neonatologists for at least 30 years. It is largely through regionalization that the neonatal survival rates have been markedly increased at the same time that long term morbidity has been decreased for premature infants. This same model is applicable to pregnancy and the transfer of women with substantial complications to regional centers with the appropriate staffing! By way of one example, major maternal cardiac conditions should be sent to centers with specialized ability to provide care for these highly complex and complicated women. Such care is available through the input of teams of physicians with expertise to include maternal fetal medicine specialists, cardiologists, and intensivists to name a few. As an immediate first step towards reducing maternal mortality, the combination of providing interpregnancy care and regionalization of the care system hold the promise of significant immediate improvement in maternal mortality & morbidity.
3. **Mental Health Services.** In the review on the state of Texas Maternal Morbidity and Mortality Committee it was a surprise to me as a clinician that almost half of the deaths occurring were as a result of either a drug overdose or suicides/homicides. In the majority of these cases the women had either not been referred for mental health services or had not gained access to facilities capable of providing mental health services. It was clearly my misperception that the overwhelming majority of maternal deaths were as a result of the classic issues of obstetric hemorrhage, poorly controlled hypertension and/or infection as is still taught in many medical schools. To the contrary, almost half of maternal deaths relate to the mental health of the woman. Accordingly, while the first two strategies that I've outlined above *would* make a significant impact on the actual medical conditions, that would (at max) affect only about half of maternal deaths during pregnancy. Attention to provision of mental healthcare when needed is essential.

I would conclude by briefly addressing the disparity in outcomes based upon race and ethnicity. There can be no debate but that the healthcare outcomes for the Native American population and for the African American population is far worse than for the Caucasian population. Similarly, the outcome for Hispanics, especially if first generation, actually exceeds that of Caucasians in the United States. Accordingly, specific populations are readily identified where a greater impact on the outcome certainly should be able to be achieved. I'd also point out that throughout the United States even in those states with the lowest maternal mortality, this disparity in outcomes persist and sometimes is even worse. Finally & sadly, the disparities in these outcomes based upon race and ethnicity is the absolute worst in our Nation's Capital.

I want to thank Dr. Burgess and the committee for allowing me to express my thoughts on this issue. I commend you for undertaking this difficult task and stand ready to assist you in any fashion I might.

Regards,

A handwritten signature in cursive script, appearing to read "Gary DV Hankins".

Gary DV Hankins, MD



September 11, 2018

TO: US House Energy & Commerce Committee

Written Testimony of the March for Moms Association at a Hearing of the House Committee on Energy and Commerce Subcommittee on Health on the "Maternal Mortality Act" (H.R. 1318)

Dear Committee Members,

On behalf of the March for Moms Association Board of Directors, we value your time and our opportunity to highlight key issues related to maternal mortality in the United States. March for Moms Association, now in its second year, is a growing, multi-stakeholder coalition sharing like-minded urgency to improve the wellbeing of mothers in the US.

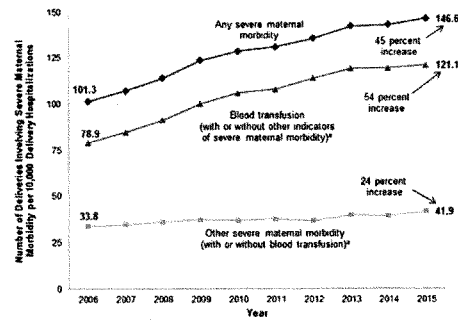
We established March for Moms in 2017 to address a widespread crisis among American families during the universally vulnerable period that stretches from pregnancy through delivery of a baby to early parenthood. Right now, Americans who are starting or growing their families face starkly greater risks than their parents did.

In just one generation, the odds of an American mother dying from a pregnancy-related cause has increased by more than 50%, a risk that is consistently three to four times higher for black mothers than white mothers.

For every death, there are 100 mothers who experience life-threatening injuries. For every injury, there are tens of thousands of mothers who experience avoidable suffering in the form of physical or mental illness, professional disruption, and/or wider societal disempowerment.

Our inclusion of two graphs depict the current state and worsening trend of maternal health childbirth in our country. The first graph published this month from AHRQ illustrates severe maternal morbidity from 2006-2015. Severe maternal morbidity is defined as including unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health. Often called near-misses, deliveries involving severe maternal morbidity generally include life-threatening conditions, such as acute myocardial infarction, pulmonary embolism, or sepsis. ***Severe maternal morbidity disproportionately affects minority and low-income pregnant women, especially non-Hispanic Black women and those with Medicaid coverage.***

Figure 1. Trends in delivery hospitalizations involving severe maternal morbidity, 2006-2015

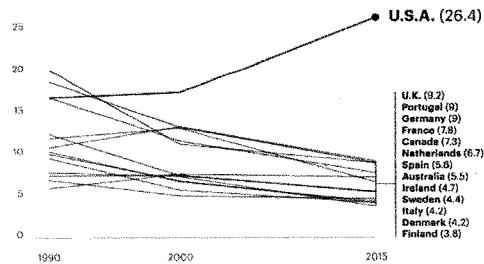


Fingar KF (IBM Watson Health), Hambrick MM (AHRQ), Heslin KC (AHRQ), Moore JE (Institute for Medicaid Innovation). Trends and Disparities in Delivery Hospitalizations Involving Severe Maternal Morbidity, 2006-2015. HCUP Statistical Brief #243. September 2018. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb243-Severe-Maternal-Morbidity-Delivery-Trends-Disparities.pdf.

The next graph depicts maternal death. American women are more than three times as likely to die in the maternal period and six times as likely to die as Scandinavians. *In every other high-income country, many less affluent than the US, maternal mortality rates have been falling. But in the US, maternal deaths increased from 2000-2005, with the CDC estimating nearly 60% of such deaths are preventable.*

Maternal Mortality Is Rising in the U.S. As It Declines Elsewhere

Deaths per 100,000 live births



Notes

*Global, regional, and national levels of maternal mortality, 1990–2015: a systematic analysis for the Global Burden of Disease Study 2015. The Lancet. 2015; The Lancet. 2015; 386(10000):1084–1094.

Source: The Lancet

Going forward we envision a society where every person can start or grow their family with dignity by accessing childbirth care that is safe, supportive and empowering. In the current state, maternal health is dangerously fragmented and riddled with inequity. The quality of care for women and moms can swing wildly from one woman to the next based on the accident of her geography, the color of her skin, or the size of her paycheck. Families, healthcare providers and policy makers must come together to shed light on where we are failing and how we can do better.

We are pleased H.R. 1318 enjoys bipartisan support in the House and Senate. We applaud the Senate HELP Committee for advancing S. 1112, the Maternal Health Accountability Act this past June, and for taking a significant step toward fighting maternal mortality and improving maternal health. This legislation will help reverse our country's rising maternal mortality rate by assisting states to establish or improve multidisciplinary committees that will track, analyze and identify local solutions to prevent maternal deaths. These are known as maternal mortality review committees (MMRCs). And we are also pleased they raised the funding level available for these state MMRCs from \$7 million to \$12 million each year for five years. This increased investment will allow the CDC to robustly support state MMRCs so they can provide a comprehensive picture of why these deaths are occurring, and come up with actionable solutions.

Advancement of H.R. 1318 today shows House leadership in addressing this public health crisis, a first step in ending preventable maternal mortality.

Thank you for your consideration of this legislation on September 14th, 2018. We urge this Subcommittee and House to pass without delay. Feel free to contact either of us with any questions.

Respectfully,



Ginger Breedlove, PhD, CNM, FACNM
President, March for Moms
maternitycaremarch@gmail.com

Dr. Neel Shah, MD, MPP, FACOG
Vice-President, March for Moms
neel@post.harvard.edu



September 12, 2018

House of Representatives
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington DC 20515

Dear Members of the Committee,

Having a new baby is supposed to be the happiest time in a woman's life. Not always.

New mothers in the United States are dying at increasing numbers. In fact, the United States has the **highest rate** of maternal mortality than any other developed country, and this rate continues to rise in our country as it declines elsewhere around the globe.

**What is going on in the United States? Why are at least 700 new mothers dying each year?
Why has the rate of maternal mortality in the United States DOUBLED since 2000?**

The only way to answer these questions is to review each and every maternal death through statewide maternal mortality review committees (MMRCs), groups of maternal-child health experts and advocates who identify, review, and analyze maternal deaths and then disseminate information and act on the findings. Unfortunately, not all states have MMRCs, nor do the existing MMRCs gather data uniformly and consistently.

One of the leading causes of death for women in the first year after having a baby is SUICIDE. The United Kingdom and Japan both report suicide as the LEADING CAUSE of maternal mortality. Because we don't track this information in the United States, we are not sure of the suicide rate. But we know that postpartum depression and related mental health issues affect at least 1 in 5 women during pregnancy or first year postpartum. And we know that women like Shelane Gaydos, Allison Goldstein, and Brittany Butts (see next page for more about each of these lovely young mothers) are taking their lives. We need better systems to help these women and to identify why and how new mothers are dying.




Please vote for full funding of maternal mortality review committees in all 50 states.

Why? Because children need their mothers.

Sincerely,

Adrienne Griffen
Founder and Executive Director

Sample -- Maternal Deaths By Suicide

 Shelane Dawn Gaydos 6/12/2015	<p>Shelane was a strong, energetic, intelligent and warm woman. She had a hearty, infectious laugh and a bright smile. She was a loving and supportive wife to her husband, Brian, and a devoted mother to her three beautiful daughters, Nadia (7), Sofia (5) and Olivia (2). She truly lived for her girls and dedicated a lot of time and energy into making their lives extra special. On that beautiful sunny afternoon, after she made sure all the girls were safely at home and comfortable watching the T.V. she made an irreversible split minute decision to go into the next room, close the door and end her life.</p> <p><i>Shelane was a Fairfax County police officer. Her family launched Shelane's Run 5K and Kids Fun Run in 2016 to raise awareness about PMADs. Learn more at www.shelanesrun.org.</i></p>
 Allison Mathews Goldstein 6/28/2016	<p>No star shone brighter, no smile was sweeter than Allison Goldstein. She was a wonderful Mother, a devoted wife, and remarkable daughter and sister, a special aunt to two nephews and a niece, five cousins and countless friends. Amidst all the joy and love she shared with the world, Allison silently suffered from postpartum depression. Allison is survived by her loving husband, Maj. Justin Goldstein, and her infant daughter, Ainslee Parker.</p> <p><i>Allison's family has taken on the issue of maternal suicide through a foundation they launched named Allison's Reach and by speaking publicly and openly about their loss. Allison's story has been featured in local news outlets and shared worldwide via social media.</i></p>
 Brittany Julianna Butt 11/12/2014	<p>Brittany loved being on the sled running with her Siberian Huskies, or showing them in the conformation ring. Mother to her son Teige, with husband Jeff, she was aspiring to be a sports veterinarian. Brittany was the spark in the room that made lasting impressions with everyone. She was loved by her family and friends. Yet none of us really knew the depth of her despair or the many questions that would be left unanswered.</p> <p><i>Brittany's mother, Natalie Velasquez, participated in PMAD Advocacy Day in 2016. Natalie is a psychiatrist who lived in Northern Virginia for many years and now lives in Alaska.</i></p>

House Energy & Commerce Committee Health Subcommittee Hearing on
Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S.

September 27, 2018

Testimony for the Record

Submitted by Susan Chacon, MSW, LISW

President, Association of Maternal & Child Health Programs (AMCHP)

Chairman Burgess, Ranking Member Green and distinguished members of the subcommittee, thank you for this opportunity to submit testimony in support of H.R. 1318, the Preventing Maternal Deaths Act. I would also like to especially thank Representatives Jaime Herrera Beutler (R-WA) and Diana DeGette (D-CO) as well as their staff for their diligent work to introduce and refine this bill.

My name is Susan Chacon and I currently serve as the President of the Board of the Association of Maternal & Child Health Programs (AMCHP). For 16 years, AMCHP has collaborated with national partners to build the capacity of state- and jurisdiction-based teams to conduct maternal mortality and morbidity surveillance, including establishing and sustaining maternal mortality review committees. As an organization representing state maternal and child public health leaders, many of our members directly oversee the maternal mortality review committee process in their own states.

I am proud that my state of New Mexico, where I currently serve as the Children and Youth with Special Health Care Needs Director, has been conducting maternal mortality review in some form since 1980 and by a multidisciplinary committee since 1993. The mission of our maternal mortality review committee is to identify and review maternal deaths caused by pregnancy complications and other factors, to identify remediable problems contributing to maternal deaths, and to develop interventions to reduce these deaths.

This process is time consuming and resource intensive. Currently there is no dedicated federal source of funding for maternal mortality review committees and therefore most states cobble together funding from a combination of their Title V Maternal and Child Health Services Block Grant, fluctuating state funding allotments, private grants and volunteered time. Today, only 35 states (as well as 3 large cities) have maternal mortality review committees, which means they have the capacity to understand why mothers are dying and what can be done to prevent these tragedies. This capacity is fragile and easily influenced by shifting state public health priorities and funding constraints and must be nurtured to ensure adherence to best practices. The remaining one-third of states are in varying stages of forming a maternal mortality review committee and may be struggling in building political and social will or finding adequate funding and staff support to put a review committee into practice. Because these committees operate independently of one another and are governed by individual state laws and/or regulations, they are also vulnerable to inconsistent methods of collecting, analyzing, and reporting data, thereby hindering our ability to tell a complete national story about maternal mortality in the U.S.

H.R. 1318 would take a critical step forward by providing federal support to build and sustain the work of state maternal mortality review committees and advance efforts to standardize the review process and the collection and analysis of data. With this support, we can continue to work together to turn that data into action in order to save women's lives.

About AMCHP: The Association of Maternal & Child Health Programs is a national resource, partner and advocate for state public health leaders and others working to improve the health of women, children, youth and families, including those with special health care needs.

Heart Safe Motherhood at Penn Medicine (University of Pennsylvania Health System)

Website: <https://healthcareinnovation.upenn.edu/projects/heart-safe-motherhood>

Preeclampsia is a disorder of pregnancy characterized by high blood pressure and high levels of protein in the urine. Hypertension is the leading cause of maternal morbidity and mortality in the U.S., and while risk factors are known, previously no strategy existed for effective, reliable blood pressure surveillance for at-risk patients. With poor maternal outcomes on the rise in Philadelphia and across the country and new guidelines on postpartum care issued by the American College of Obstetricians and Gynecologists this spring, there is a clear call to action and an audience eager for a solution.

A Penn Medicine team, led by providers and researchers in Maternal Fetal Medicine, has designed a common-sense approach to care that answers an important challenge. Their solution, Heart Safe Motherhood (HSM), is an evidence-based care model with real-world data that's bolstering the promise of connected health, and by its focus on convenient care for women, speaks to the growing attention being paid to women as a vital demographic in the dual eras of population health and health care consumerism.

At the start of the HSM project, blood pressure monitoring required patients to attend a one-time, in-person appointment. However, professional association guidelines published by ACOG in 2014 recommended two points of monitoring: 72 hours and seven to ten days post-discharge.

As part of the project, the team developed and tested a text-based intervention for hypertension. They enrolled patients in a remote blood pressure monitoring program during the first seven days post-discharge from the Labor and Delivery floor at HUP.

Over the course of seven iterative pilots, over 30 patients were discharged with digital blood pressure monitors and sent reminders via text message to check their blood pressure twice daily. Once submitted by the patient, blood pressure results were reviewed and responded to by an Ob/Gyn physician.

After the conclusion of the pilot, the team received funding from the Penn PCORI Grant and Penn Presbyterian Harrison Fund to conduct a randomized controlled trial of the intervention. The team was recognized for their leadership with a first prize award in the American Heart Association's Philadelphia Heart Science Forum Innovation Challenge, Digital Health Category, and first place in the Council on Patient Safety in Women's Health National Improvement Challenge on Hypertension in Pregnancy.

Heart Safe Motherhood continues to make postpartum remote blood pressure monitoring easy so that providers can catch rising blood pressure earlier and keep patients safe at home.

Our journey to spread Heart Safe Motherhood has just begun. Heart Safe Motherhood can become a national model for reducing the burden of preeclampsia on maternal morbidity and mortality. Through text message-based remote monitoring, we have transformed our ability at one hospital to provide high quality, convenient, and safe care for women with pregnancy-related hypertension in the immediate postpartum period. We have developed knowledge about how to identify and enroll patients for engagement and how to capture and act on blood pressure remotely for clinical impact, providing the right care to the right patient at the right time. We have learned to think outside conventional medicine

and listen to our patients. In fact, the American College of Obstetrics and Gynecology recently acknowledged our work in their May, 2018 Committee Opinion on Redefining the postpartum visit.

Through Heart Safe Motherhood, we can transform our ability to monitor hypertension remotely. The Heart Safe Motherhood program allows us to provide patient-centered postpartum care for women with preeclampsia who are at risk of devastating complications while simultaneously engaging them in their future health.

Program Results:

Nine months ago, the team implemented Heart Safe Motherhood for patients with known pregnancy-related hypertension at the Hospital of the University of Pennsylvania. Since then, they have been able to obtain blood pressures remotely at the two time points recommended by ACOG in 80 percent of patients, intervene and start medications from home before development of morbidity, and continue to have strong patient and provider satisfaction. The team's readmission rate has dropped from 5 percent for postpartum patients monitored for hypertensive issues prior to Heart Safe Motherhood to 1 percent with the program at scale. Hypertension is no longer the leading cause of seven-day obstetrical readmissions at the Hospital of the University of Pennsylvania.

Additional proof points and tangible results include:

- Results of the pilot program showed there were no seven-day readmissions among enrolled patients, compared to a 5 percent readmission rate among women monitored through in-person visits. The percent of patients to report at least one blood pressure reading in the first week post-discharge jumped from 15 percent pre-intervention to 84 percent among all enrolled patients.
- The percent of patients to report blood pressure readings on five of seven days in the first week post-discharge jumped from 0 percent pre-intervention to 69 percent among all enrolled patients.
- At the conclusion of the RCT, the team saw the platform's ability to meet ACOG guidelines on postpartum blood monitoring leap from 0 percent to 82 percent compared to in-person office visits and seven-day readmissions from hypertension drop from 3 percent to 0 percent.

Heart Safe Motherhood is now the standard of care for obstetrics patients at HUP with plans to scale to other Penn Medicine locations in 2018. The team is also partnering with health systems, payers, and vendors to evaluate the ability to scale the program for national impact.

September 27, 2018

The Honorable Greg Walden
Chairman
Committee on Energy & Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
Committee on Energy & Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Michael Burgess
Chairman
Subcommittee on Health
Committee on Energy & Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Gene Green
Ranking Member
Subcommittee on Health
Committee on Energy & Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Walden, Ranking Member Pallone, Chairman Burgess and Ranking Member Green:

Our organizations commend you for holding today's hearing, "Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S." We would like to express our support for the discussion draft of H.R. 1318, the Preventing Maternal Deaths Act, sponsored by Representatives Jaime Herrera Beutler (R-WA), Diana DeGette (D-CO) and Ryan Costello (R-PA) that is being considered today, which mirrors S. 1112, the Maternal Health Accountability Act, as recently advanced by the Senate HELP Committee.

Our nation faces a growing crisis in maternal health. More women die from pregnancy-related complications in the United States than in any other developed country, and the rate of maternal deaths continues to rise. Major disparities in maternal mortality exist, with black women three to four times more likely than white women to die during pregnancy or shortly after birth. Moreover, for every maternal death that occurs, an estimated 100 other women suffer severe complications of pregnancy or childbirth. We must act now to reverse this trend and save mothers' lives.

We urge the Subcommittee to address maternal mortality by supporting the work of state maternal mortality review committees (MMRCs) through the Centers for Disease Control and Prevention (CDC). MMRCs are multidisciplinary groups of local experts in maternal, infant, and public health that examine cases of maternal death. Maternal mortality review is a cyclical process that does not end by simply counting and characterizing deaths, but must be followed with action by putting the recommendations of the committee to work in hospitals, communities, or policies.

While these efforts take place at the state or jurisdiction level, federal support will accelerate progress toward ensuring that every state has a high-functioning MMRC. This legislation will also advance efforts among states to standardize the collection and analysis of data. With better data and information, we can develop a national understanding of why mothers are dying and what we collectively can do to reverse this tragic trend.

We look forward to continuing to work together to see this bipartisan bill move forward in Congress and enacted into law.

Sincerely,

1,000 Days
 2020 Mom
 AFE Foundation
 American Academy of Family Physicians
 American Academy of Pediatrics
 American College of Nurse-Midwives
 American College of Obstetricians and Gynecologists
 American College of Physicians
 American College of Surgeons
 American Medical Women's Association
 American Psychological Association
 American Public Health Association
 American Society for Reproductive Medicine
 Amnesty International USA
 APS Foundation of America, Inc.
 Association for Prevention Teaching and Research
 Association of Maternal & Child Health Programs
 Association of Public Health Laboratories
 Association of Schools and Programs of Public Health
 Association of State and Territorial Health Officials
 Association of State Public Health Nutritionists (ASPHN) MCH Nutrition Council
 Association of Women's Health, Obstetric and Neonatal Nurses
 Children's Defense Fund
 Choices in Childbirth
 Every Child By Two
 Every Mother Counts
 Genetic Alliance
 Hand to Hold
 HER Foundation
 Heroes for Moms
 Lamaze International
 March of Dimes
 Maternal Safety Foundation
 Medicines360
 MomsRising
 NAPHSIS
 National Association of County and City Health Officials
 National Association of Nurse Practitioners in Women's Health

National Association of Pediatric Nurse Practitioners
National Association of Perinatal Social Workers
National Black Women's HIV/AIDS Network
National Blood Clot Alliance
National Health Law Program
National Partnership for Women & Families
National Perinatal Association
National WIC Association
New York State Birth Center Association
Nurse-Family Partnership
Organization of Teratology Information Specialists
Patient Safety Movement Foundation
PCOS Challenge: The National Polycystic Ovary Syndrome Association
Power to Decide, the campaign to prevent unplanned pregnancy
Preeclampsia Foundation
Premie World, LLC
Safe States Alliance
Save the Mommies Inc.
Society for Maternal Fetal Medicine
Society for Public Health Education
Spina Bifida Association
The 2 Degrees Foundation
The National Accreta Foundation
The National Alliance to Advance Adolescent Health
The Shane Foundation
The Tara Hansen Foundation
The Tatia Oden French Memorial Foundation
Trust for America's Health
United Methodist Women
ZERO TO THREE



**Written Testimony of Catherine Glenn Foster
President and CEO, Americans United for Life
Regarding the Subcommittee Hearing
Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S.
Submitted to the House Energy and Commerce Subcommittee on Health
Thursday, September 27, 2018**

Chairman Burgess, Ranking Member Green, and distinguished Members of the Committee:

Americans United for Life (AUL) urges the Committee to recognize that not all maternal mortality is the same and to include specific statistical data collection and reporting on abortion-related mortality in the Preventing Maternal Deaths Act of 2018. Founded in 1971, Americans United for Life, the legal architect of the prolife movement, is a national law and policy nonprofit organization with a specialization in abortion and bioethics law.

The current United States system for reporting abortion-related maternal mortality is deeply flawed, and there is currently no reliable source of data. For the sake of women's health, this Committee should take steps to remedy that problem.

Abortion data reporting in the U.S. is entirely voluntary. This skews both the statistics and resulting analysis. For the reporting that does occur, maternal mortality due to abortion is often underreported as many maternal deaths are attributed to some other cause—like “sepsis,” or “infection”—rather than the true underlying cause, termination of the pregnancy. This means that most studies are based on abortion “estimates” and “reported” deaths.¹ Additional studies show that 1 out of 16 women who have an abortion will visit an emergency room within six

¹ See, e.g., Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 *Obstetrics & Gynecology* 215 (2012).

Page 2 of 3

weeks after the abortion,² which, due to data collection methodology, should be considered a floor and not a ceiling.

Abortion-related maternal deaths are not systemically collected. There are two national reporting organizations: the Alan Guttmacher Institute (AGI) and the Centers for Disease Control and Prevention (CDC). AGI collects its data from abortion providers that report voluntarily. The CDC collects its data from the states, which report data haphazardly. For example, California—where reportedly one-third to one-half of all abortions in the U.S. are performed—has not reported its data to the CDC for several years. The numbers of annual abortions reported by AGI and the CDC differ by 15% or more.

The deeply flawed state of abortion-related maternal health data collection and reporting is a direct risk to the health of women. It deprives doctors of accurate data, which in turn prevents them from providing accurate information about abortion-related maternal mortality and morbidity to women. This is even more problematic considering the vast majority of abortions are elective and not medically indicated.

With the current data and reporting regime, it is impossible for a woman considering undergoing an abortion to receive the information she needs to voluntarily consent. Women need more than “estimates” or “guesses” on abortion-related maternal mortality to make an informed decision. They need complete and accurate data, and the U.S. has a responsibility to care for women’s health by providing this data through public health reports.

Such a dysfunctional system of abortion-related maternal health data collection and reporting in the U.S. is unnecessarily substandard. In contrast, the collection and reporting of births and other gynecological procedures in the U.S. is systematic and thorough. Unlike

² Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 *Obstetrics & Gynecology* 175, 175 (2015).

Page 3 of 3

maternal mortality from natural causes, abortion-related maternal mortality can be directly linked to either an invasive surgical procedure or a chemically-induced response. Given that this unnatural impact to pregnancy is man-made, it stands to reason that there should exist a robust methodology to track its impact. Currently, there is not.

In conclusion, this Committee should add data collection and reporting on abortion-related maternal mortality specifically in the Preventing Maternal Deaths Act of 2018.

Sincerely,



Catherine Glenn Foster, M.A., J.D.
President and CEO
Americans United for Life



1900 Grant Street, 4th Floor / Denver CO 80203 / 866.864.5226 / nursefamilypartnership.org

September 26, 2018

The Honorable Michael Burgess
United States House of Representatives
Washington D.C. 20515

Dear Chairman Burgess,

As a board member of Nurse-Family Partnership (NFP), I write in strong support of H.R. 1318, the *Preventing Maternal Deaths Act of 2017*. NFP is an evidence-based community health program with a core mission of improving the lives of at-risk moms and their children, and we thank you for your attention and steadfast commitment to improving maternal health outcomes.

Each day, NFP nurses work in their local communities to transform the lives of at-risk, first-time mothers. The program partners mothers with a registered nurse at a pivotal moment — beginning early in pregnancy with a first child — and provides ongoing nurse home visits that continue through her child's second birthday. Their relationship begins with a focus on the mother — their personal goals as well as their overall health — which leads to healthier outcomes in both the mother and child after birth. Specifically, a 20-year follow-up study of an NFP randomized controlled trial in Memphis, TN found that NFP is effective at reducing all-cause mortality among mothers and preventable-cause mortality in their first-born children living in highly disadvantaged settings. This study showed that mothers who did not receive nurse home-visits were nearly 3 times more likely to die from all causes of death than nurse-visited moms.

We believe that H.R. 1318 stands to greatly improve how we address maternal mortality in this country, by providing needed federal support for Maternal Mortality Review Committees (MMRCs). These committees bring together stakeholders to focus on locally-relevant, preventative solutions that work and investing in those that are effective, like NFP.

We are so grateful for your continued leadership on this critical issue. Please let us know if we can be a resource to you as you work to advance this legislation.

Sincerely,

Fred Cerise
CEO, Parkland Health & Hospital System





**House Energy & Commerce Committee Health Subcommittee Hearing on
“Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S.”
September 27, 2018
Testimony for the Record
Submitted by Eleni Tsigas
Chief Executive Officer, Preeclampsia Foundation**

Chairman Burgess, Ranking Member Green, and distinguished members of the subcommittee, thank you for holding today’s hearing to address “Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S.” I am Eleni Tsigas, Chief Executive Officer of the Preeclampsia Foundation, and I am so pleased for the opportunity to submit testimony for this hearing in support of the discussion draft of H.R. 1318, the *Preventing Maternal Deaths Act*. I would also like to recognize the hard work of Representatives Jaime Herrera Beutler (R-WA) and Diana DeGette (D-CO) for their efforts to address the crisis of maternal mortality in the U.S. and to introduce and advance this important legislation.

Preeclampsia is one of the leading causes of mothers dying from pregnancy-related issues. It is a hypertensive disorder of pregnancy characterized by high blood pressure, protein in the urine, and sometimes failure of the kidneys, liver and other organs. It can affect up to one in 12 pregnancies, and there is no cure, only management.

Nineteen years ago, I held the still warm body of my baby daughter in my arms and kissed her desperately, trying to will her back to life. My kidneys had failed. I had lost half of my body’s blood volume when I delivered her because of an undetected placental abruption due to



preeclampsia, and I almost died. So many other women like me have faced similar circumstances, but sadly, many of them did not survive and cannot offer their testimony here today.

As an organization, the Preeclampsia Foundation is focused on educating patients, their families and health care providers to recognize the preeclampsia warning signs and ensure that timely care is provided so no woman dies during pregnancy, delivery, or during the postpartum period. Moving this agenda forward has required solid data proving that a lack of patient knowledge of preeclampsia is a factor in a large percentage of preventable deaths. We have been able to obtain much of this data from existing state maternal mortality review committees, but much more data is needed. The data from state maternal mortality review committees is utilized to ensure healthcare providers accept and adopt the Preeclampsia Foundation's call to action to educate women about the signs and symptoms of preeclampsia and appropriately respond with timely diagnosis and accurate clinical management when they do.

Thanks to the work of existing maternal mortality review committees, the Foundation is sending out hundreds of thousands of pieces of patient education materials every year that are used in hospitals, and often in prenatal care settings. We strive to push out millions of educational materials, and women should be getting them at every prenatal visit, but unfortunately, too many states have not yet been able to - or understood how to - appropriately collect and assess their maternal mortality data that is linked to hypertensive disorders of pregnancy or other pregnancy-related complications.



The Preeclampsia Foundation ultimately strives to prevent maternal mortality and severe maternal morbidity and help states and communities establish protocols that save lives. We view this as a data-to-action initiative. There is so much to be learned from maternal mortality reviews that can improve healthcare practices today. For example, in Florida, based on their maternal mortality reviews, the state found that hospitals were taking too long to treat pregnant women that had severe high blood pressure. These women were dying from stroke and other preventable sequelae. Armed with data, new standards and protocols were set. In less than a year, 90 percent of women with persistent new onset severe hypertension were treated within one hour in hospitals using a new hypertension in pregnancy protocol. Before that time, only 20 percent were being treated within one hour.

Another example of where data can impact care is in addressing postpartum preeclampsia. One of the most common myths associated with this disorder is that “delivery is the cure for preeclampsia.” This is not true. Women are still at risk from preeclampsia and related hypertensive disorders following delivery, sometimes for weeks, particularly as most care is directed to the baby. Analyses from some states’ data has reinforced this by reviewing the number of mothers that die after they have returned home post delivery. We need far better postpartum surveillance, and we need to train emergency departments for when these women present with signs of preeclampsia-related distress. We cannot let up after delivery. There are states to learn from that have successfully begun to address postpartum preeclampsia. The legislation the Committee is reviewing here today would do much to support this type of information exchange to share best practices with other states.



Preeclampsia costs the U.S. health care system \$2.18 billion dollars a year — about half due to maternal health care costs and half for the care of the infants born to those mothers. To put that into perspective, these preeclampsia-related costs comprise about 1/3 of the costs for these entire pregnancies in just one year. The long-term costs associated with prematurity and long-term maternal health consequences are not included in these numbers.

A long time health activist, Mary Lasker, once said, “Research is expensive, but disease is more!” In the case of maternal mortality reviews, the research that is collected, assessed, and released by the state committees almost immediately leads to health care improvements and is nowhere near as expensive as the health conditions and complexities we would otherwise face. There are system factors, patient factors and provider factors that contribute to maternal mortality and severe morbidity today. We can do so much more with a small investment of time and resources for states and ultimately improve outcomes for thousands of lives. This must be a public health priority. Maternal health is the building block upon which all other health issues are based. We need compelling, instructive data to move healthcare providers and institutions to action and to support patient and family engagement in their health care.

Support the H.R. 1318 Discussion Draft

Mr. Chairman, Ranking Member Green and members of the Subcommittee, the discussion draft of H.R. 1318, *The Preventing Maternal Deaths Act*, sponsored by Representatives Jaime Herrera Beutler (R-WA), Diana DeGette (D-CO), and Ryan Costello (R-PA) mirrors S. 1112, the



Maternal Health Accountability Act, as recently passed by the Senate Committee on Health, Education, Labor and Pensions.

This legislation will help support state efforts to get at solutions – affordable and actionable efforts that can save lives. The bill, with the support and expertise of the Centers for Disease Control and Prevention (CDC) will help states understand how to identify local problems that contribute to rising rates of maternal mortality and derive local solutions. It will also help states that have been unable to get a maternal mortality review committee launched or operating. Despite the pockets of successful committees, the fact remains that today no state has a fully functioning maternal mortality review committee; even the best of them are handicapped by inadequate information, resources or know-how. For too many, the investment that has been made to date in databases, training, and tools will have been wasted if we cannot create a sustainable maternal mortality review system and thereby demonstrate what we value most: our mothers.

The Preeclampsia Foundation believes the discussion draft of H.R. 1318 will work to put an end to the rising rate of maternal mortality in the United States, protecting our mothers and saving health care resources. On behalf of the Foundation and all of the families we represent, we urge the Committee to prioritize this legislation and for Congress to pass it this year.

September 24, 2018

Statement
OF Timoria McQueen Saba

Survivor of a near fatal postpartum hemorrhage, Commissioner for the Commonwealth of Massachusetts, Senator Ellen Story Special Commission on Postpartum Depression

BEFORE THE SUBCOMMITTEE ON HEALTH COMMITTEE ON ENERGY AND
COMMERCE U.S. HOUSE OF REPRESENTATIVES

"BETTER DATA AND BETTER OUTCOMES: REDUCING MATERNAL MORTALITY IN
THE U.S."

Dear Mr. Chairman, Ranking Member Green, members of the committee: My name is Timoria McQueen Saba.

I am an African-American mother of two daughters, Graison Joyce and Harper Elle. I've waited many years to see a bill like this get passed. On April 19, 2010, I started hemorrhaging after giving birth to Graison. My uterus wouldn't contract after the birth, known as a uterine atony. Doctors told me that they would try to save my uterus and ovaries by performing a procedure called an embolization. If that was not successful, they would have to give me a hysterectomy. If the bleeding continued after receiving a hysterectomy, I was told that I would die.

My pregnancy with Graison can best be described as "normal". I had no pre-existing conditions and am fortunate to have great health insurance. I had a relatively easy, but long (twenty-seven hour) labor. Once I was fully dilated, delivery was fast and easy — I remember thinking it was almost *too* easy. Ten pushes and twenty minutes

later, my beautiful daughter was born. As I held Graison in my arms for a few moments, I could feel a shift in the mood of the hospital staff in the room. Before I knew it, the serenity of the room was tainted by the sounds of warning beeps from the machines I was hooked up to. Next, the room became flooded with strangers.

Enter emergency personnel. My husband, Robert, and Graison were rushed out of the room and taken into the nursery. I watched blood pour out of my vagina through the reflection from an overhead television screen. My body was weak, and I struggled to keep my eyes open, feeling deep down that if I allowed them to close they would never open again. After a three-hour long surgery (during which I was fully conscious), I was left in critical condition. Instead of staying in intensive care alone, my Ob/Gyn insisted that I be reunited with Graison and Robert in the labor and delivery ward.

I was told not to move a muscle, which included nursing or holding my new baby. I lay awake all night in pain. I was afraid to sleep, afraid to move, afraid that every breath I took might shake loose whatever was keeping me together. I stared at Graison all night. Her big, round, brown eyes peered through the bassinet. I made a promise to her that I would be live — she would *not* be a motherless child. I survived and the three of us went home five days later.

I was diagnosed with PTSD (Post Traumatic Stress Disorder) several weeks after giving birth. Because of what happened, I was afraid to leave the house. This was a very new feeling to me. At the time, I was a professional make-up artist and loved traveling with my clients to destinations near and far. I had never been afraid to go

anywhere! After the traumatic birth, I was easily startled and wrought with anxiety that something might happen to me, my daughter or my husband.

It became increasingly difficult to sleep at night. Every time I closed my eyes, I saw the blood pouring from my body and other reminders of the ordeal I had suffered through. Due to the demands of motherhood, I tried to push my negative feelings aside. I was excited to be a mom and savored the days I spent with Graison. I challenged myself to get out of the house. I joined a hospital support group for new moms and signed up for "Mommy and Me" baby music classes. As I met more new moms I felt a common bond among us as we talked about breastfeeding, sleep schedules and baby gear. We also shared intimate details of our lives that you would never think possible to share with strangers. I made great friends through joining that group. Despite my outgoing nature and positive outlook on life, deep inside I remained a traumatized victim of a near fatal postpartum hemorrhage. No other mom I met back then had experienced a postpartum hemorrhage. My feelings about the hemorrhage and the surgery never went away. My emotions cycled through anger, guilt, fear and sadness.

Thirteen months after Graison was born, I had a miscarriage which resulted in another hemorrhage. This occurred in front of several people while I was in a frozen yogurt shop. The miscarriage triggered the difficult emotions from the hemorrhage I suffered the year prior. I underwent an emergency D & C and returned home the next day. Yet again- I was sad, angry and afraid that I might bleed to death at any moment.

I knew that I could not be the *only* woman who experienced these types of harrowing birth and pregnancy complications. While looking for answers, I realized that resources and support for mothers and families who had survived a near miss or lost a loved one due to a birth or pregnancy complication, were scarce. I began sharing my story publicly in 2012 and have since connected with thousands of women across America who have experienced similar birth and pregnancy complications; and the lingering psychological effects. With the help of a therapist who specializes in postpartum mental health and birth trauma, I was able to heal. I gave birth to Harper Elle in March 2014. I'm happy to report that my birth experience the second time around was perfectly "normal."

I am now a full-time maternal health advocate, speaker and writer with a focus on mental and physical trauma due to childbirth and pregnancy. I am also the coordinator of resources and support for Postpartum Support International (PSI) in the Boston Metro West and Central areas. In this role, I connect women suffering from postpartum mood disorders and their families to local therapists and support groups. I'm also a member of the PSI President's Advisory Council. Twice per month, I facilitate a free peer-to-peer mother's support group, *Emotional Wellbeing After Baby*, at Milford Regional Hospital in Milford, MA. In 2017, I was honored to be appointed by MA State Rep. James O'Day (D-14 Worcester) to a House chair seat on the Senator Ellen Story Special Commission on Postpartum Depression.

Every day I think about how fortunate I am. I survived two hemorrhages due to birth and pregnancy complications. Statistics show that black mothers die during childbirth at three to four times the rate of white mothers.

Statistically speaking, I shouldn't be alive.

But because I survived, it is my duty and a privilege to be a voice for mothers who struggle to cope with the mental and physical effects of a near fatal birth trauma, and also honor those who tragically, have died.

Passing HR 1318: Preventing Maternal Mortality Act of 2017 is imperative to the health of all mothers and families in the United States. Individual states will be able to learn the exact causes of deaths due to childbirth and pregnancy complications, therefore helping healthcare providers to identify the proper preventions or the best emergency response plans.

It is our responsibility to care for *all* mothers in America. Legislators, healthcare providers, advocates and patients must work together to give mothers the healthcare they deserve. By passing this bill and working together to understand the disparities in outcomes, we will prevent mothers from dying and save entire generations from suffering.

Thank you for allowing me the opportunity to share my story with you.

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June 27, 2018

The Honorable Jaime Herrera Beutler
U.S. House of Representatives
1107 Longworth House Office Building
Washington, D.C. 20515

The Honorable Ryan Costello
U.S. House of Representatives
326 Cannon House Office Building
Washington, D.C. 20515

The Honorable Diana DeGette
U.S. House of Representatives
2111 Rayburn House Office Building
Washington, D.C. 20515

Dear Representatives Herrera Beutler, Costello, and DeGette:

On behalf of the more than 80,000 members of the American College of Surgeons (ACS), I would like to express our support for the *Preventing Maternal Deaths Act*, H.R. 1318. This bipartisan legislation is an important step in addressing disparities in pregnancy-related mortality and identifying ways to make pregnancy safer.

The U.S. is the only industrialized nation with a rising maternal mortality rate. The U.S. saw a 26% increase in the maternal mortality rate from 18.8 deaths per 100,000 live births in 2000 to 23.8 in 2014¹. Considerable racial disparities in pregnancy-related mortality exist. According to the Centers for Disease Control and Prevention's Pregnancy Mortality Surveillance System, during 2011–2013, the pregnancy-related mortality ratios were 12.7 deaths per 100,000 live births for white women compared to 43.5 deaths per 100,000 live births for black women.

According to the CDC Foundation, the leading causes of pregnancy-related death include seven causes accounting for 72.2% of all pregnancy-related deaths. The leading underlying causes of pregnancy-related death are hemorrhage, cardiovascular and coronary conditions, cardiomyopathy, infection, embolism, mental health conditions, and preeclampsia. Variations amongst the leading causes exist among states, race-ethnicity, and age. Determining methods to address

¹ MacDorman, M., Declercq, E., Cabral, H., Morton, C., "Is the United States Maternal Mortality Rate Increasing? Disentangling trends from measurement issues: Short title: U.S. Maternal Mortality Trends." *Journal of Obstetrics and Gynecology*. September, 2016



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disparities amongst different populations by providing high quality care will help to improve health outcomes.

Currently, 33 states are studying local maternal death cases through maternal mortality review committees (MMRCs) to identify opportunities for prevention and ways to make pregnancy safer for all women. The authorization of a Department of Health and Human Services (HHS) grant program through the Centers for Disease Control and Prevention (CDC) for states to establish, maintain, or expand MMRCs is critical for improving health outcomes and reducing disparities in pregnancy-related care.

The ACS also strongly supports the provision directing HHS to research disparities in maternal health outcomes and expand access to health care services that improve quality and outcomes of maternity care for vulnerable populations. The establishment of a demonstration project to compare the effectiveness of and implement effective interventions to reduce disparities in maternity care is vital to efforts to reduce preventable pregnancy-related mortality.

Again, thank you for your leadership in introducing the *Preventing Maternal Deaths Act*. We look forward to working with you as this important legislation moves through Congress.

Sincerely,

David B. Hoyt, MD, FACS
Executive Director, American College of Surgeons

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The Honorable Michael C. Burgess, MD
Chairman
Subcommittee on Health
Committee on Energy & Commerce
U.S. House of Representatives
Washington DC 20515

The Honorable Gene Green
Ranking Member
Subcommittee on Health
Committee on Energy & Commerce
U.S. House of Representatives
Washington DC 20515

September 28, 2018

RE: Submission Request for the Record of the Health Subcommittee's hearing entitled "Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S.," being held on September 27, 2018

Dear Mr. Chairman and Ranking Member Green:

On behalf of SAP America Inc. (SAP), I write to respectfully request this letter and its accompanying attachments be entered into the Record of the Health Subcommittee's hearing entitled "Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S.," being held on September 27, 2018.

SAP is the world's largest provider of enterprise application software serving over 400,000 customers and 100,000 partners in 180 countries. We develop and produce software for a wide range of customers, in both the public and private sectors, around the world. Seventy-seven percent of all global commercial transactions run through SAP software.

The extraordinary growth in the amounts of data available to governments presents both great challenges and significant opportunities. SAP has significant experience in translating those challenges to successful outcomes allowing governments to take advantage of the opportunities data and the analysis of the wealth of data at governments' fingertips present. Weaving together publicly held data sets holds great potential for making government more effective at serving the public.

In March 2014, then-Governor Pence of Indiana established the Indiana Management Performance Hub (MPH). Among the purposes of the MPH is to collect data from all Indiana state agencies and analyze the data to produce "continuous process improvements" by providing recommendations to the Governor on "[o]pportunities to use data . . . to drive innovation and efficiency" See Goldberg, "Analytics Paves the Way for Better Government," *Forbes Insights*, Sept. 2014, enclosed with this letter. SAP provides the software that performed the data analysis conducted by the MPH.

Of direct relevance to the Subcommittee's hearing on maternal mortality is the initial area of inquiry conducted in 2014 by the MPH. That initial study was focused on reducing infant mortality in Indiana. The report produced as a result of the study by KSM Consulting, entitled "A Summary of Findings and Quantitative Investigation Targeted at: Reducing Infant Mortality in Indiana," is attached for the Subcommittee's review and consideration, insofar as it may be relevant to the related subject of this hearing, the reduction in maternal mortality.



The Honorable Michael C. Burgess, MD
The Honorable Gene Green
September 27, 2018
Page 2

As a result of the data analysis performed in connection with the MPH's review of infant mortality, Indiana was able to develop a set of predictive algorithms and put in place programs to address identify the most at-risk populations and ensure the delivery of services to this population by the Indiana State Department of Health.

SAP believes that programs like the Indiana MPH can and should be established at the state and local levels with federal support. The wider establishment of programs like the MPH can be a basis for the widespread improvement nationally on addressing maternal mortality rates.

The potential for emerging technologies to enable data-driven policy and practice is well articulated by the Commission on Evidence-based Policymaking: "...the Commission envisions a future in which rigorous evidence is created efficiently, as a routine part of government operations, and used to construct effective public policy. Advances in technology and statistical methodology, coupled with a modern legal framework and a commitment to transparency, make it possible to do this while simultaneously providing stronger protections for the privacy and confidentiality of the people, businesses, and organizations from which the government collects information. Addressing barriers to the use of already collected data is a path to unlocking important insights for addressing society's greatest challenges" ¹

SAP would be pleased to brief the Subcommittee members and staff on the MPH and the potential for data analytics in tackling many of government's most pressing problems.

Respectfully submitted,

A handwritten signature in black ink that reads "Kevin Richards". The signature is written in a cursive, flowing style.

Kevin M. Richards
Vice President, Head of US Government Relations
SAP America, Inc.

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Enclosures

¹ Commission on Evidence-based Policymaking (<https://www.cep.gov/content/dam/cep/report/cep-final-report.pdf>).



Analytics Paves the Way for Better Government

The State of Indiana is applying data-driven insights to improve outcomes for citizens and make public sector performance more transparent.

BY MICHAEL S. GOLDBERG

1. Chui, Michael, Diana Farrell and Kate Jackson, "How Government Can Promote Open Data and Help Unleash Over \$3 Trillion in Economic Value," McKinsey & Co., April 2014. <http://goosgl/vuvv99>.

SEPTEMBER 2014
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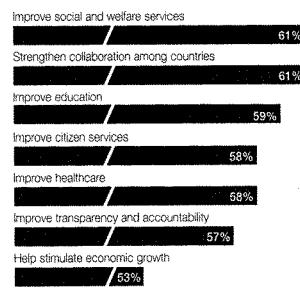
Managing state government often requires impassioned debate about the best way to allocate resources, deliver services to citizens and build budgets that reflect elected leaders' and citizens' priorities. The State of Indiana is bringing data-driven insights to these discussions through its use of analytics.

Public sector organizations globally are fertile ground for policymakers' vision of more effective, timely decisions. Every agency, department and bureau has years' worth of data that has been collected in compliance with documented procedures, subject to oversight and accessible via information systems. Citizens, in fact, increasingly expect government agencies to manage and analyze their voluminous data sets in ways that benefit the public and enable government transparency.

Government leaders, from the European Commission to the White House, have called for investment in big data analytics capabilities to modernize government services and aid their economies. Deeper insights from government data offer more than the possibility for better-informed policy decisions. Businesses may also use these insights to create new data-driven products and services using government data (see Figure 1, "Data That Serves the Public"). In fact, McKinsey & Co. estimates that by digitizing information, disseminating public data sets and applying analytics to improve decision-making, governments around the world can act as catalysts for more than \$3 trillion in economic value.¹

In the State of Indiana, data is at the center of Gov. Mike Pence's long-term vision for improving the management and effectiveness of government

FIGURE 1 Data That Serves the Public



Base: 100 IT decision-makers in state public sector organizations
Source: TechAmerica Foundation, "Big Data and the Public Sector," February 2013. <http://goosgl/Xecl0h>

Improvements to social services and collaboration are the top benefits to using big data. (percent of respondents)

programs and making Indiana a leader in data-driven decision-making. In March 2014, a year after taking office, Pence ordered state agencies to share data and partner with the state Office of Management and Budget (OMB, which oversees state finances and agency performance management), the Indiana Office of Technology (IOT) and outside experts in a centralized effort "to improve and strengthen services, maximize the utilization of available resources and ensure that state services are available to all." As in many public sector settings—where systems and tools have become available to more easily analyze large, diverse data sets—data sharing had not, until recently, been a common practice in states.

Overseen by the OMB, the data-sharing mandate is setting the stage for an enterprisewide solution that will put key performance indicators (KPIs) in front

By augmenting existing research efforts, analytics have the potential to uncover new approaches to stubborn problems.

of decision-makers and the public. The solution will also apply both descriptive and predictive analytics to critical problems.

DATA SHARING SERVES POLICY GOALS

Indiana's initiative aligns with the administration's six-pronged roadmap that emphasizes economic growth, education and the well-being of families (see Figure 2, "Data-Driven Progress"). "This project is enabling state government to service those goals and achieve outcomes," says OMB Director Chris Atkins.

Each of Indiana's 92 agencies and departments has a role to play. Using Gov. Pence's data-sharing order as a lever, Atkins and his colleagues are working with the IOT and the other agency heads to collect data for analysis. Part of Atkins' job is communicating the end-goal. "We're trying to help the agencies see the value in this project," he says. "A culture of data-sharing means a more successful enterprise."

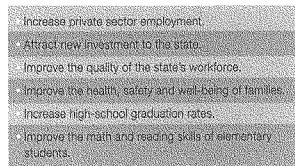
Data sharing is more than a technical issue, as laws and regulations restrict the handling of certain types of data. So another essential element for Atkins was to hire several legal experts who could answer questions about the rules for using different data sets. Federal or state privacy laws may require agencies to remove personal information, for example. "We hired counsel to help the agencies work through these data security issues so they don't have to task their own legal teams," he says. "We're doing it for them, in concert with their leadership" (see Figure 3, "Breaking Down Barriers").

ANALYTICS FOR SAVING LIVES

The data collection effort supports a four-point program to deliver more insights to government policymakers and the public. One segment, recently begun, targets a vital public policy problem: the rate of infant mortality in Indiana, which at 7.6 percent in 2010 ranked higher than the national average of 6.1 percent.

The project pilots Indiana's recently acquired in-memory computing platform, which supports predictive analytics capabilities. An in-memory

FIGURE 2 Data-Driven Progress



Source: Indiana Management and Performance Hub. <http://goo.gl/15u6y>

Insights from analytics will help Indiana pursue six public policy goals.

platform enables organizations to consolidate extremely large volumes of data from multiple sources into one database and answers any question almost instantly. Indiana is now able to collect data sets from many different state agencies for rapid-fire, iterative queries. That ability, in turn, enables analysts to test out hypotheses and answer questions using a range of techniques and algorithms.

By scrutinizing combinations of these data sources—and adding new data sources to the mix—analysts are working to identify correlations that provide signals about the possible causes of the infant mortality problem. The signals may relate to demographics, mothers' health conditions or unexpected relationships among other variables that influence babies' health.

The pilot so far is demonstrating the value of both the cooperation of state agencies (the shared data sets are useful in the predictive models) and the in-memory platform that provides fast response times to analysts' queries. Atkins says the work to date has shown promising results, but it's not finished. "We know as we add more data, we will see more results," he adds.

The findings are expected to drive the development of new programs or the updating of existing ones, so that the state can improve Indiana's performance—and reduce the number of infant deaths in Indiana. Charlie Brandt, managing director at KSM Consulting, a technology, management and data analytics consultancy that has been working with the state, says predictive analytics has the potential to elevate public policy decision-making as leaders are provided

"A culture of data-sharing means a more successful enterprise."

—CHRIS ATKINS,
DIRECTOR,
INDIANA OFFICE
OF MANAGEMENT
AND BUDGET

knowledge of drivers of transformation instead of reports sharing insights on past performance.

By augmenting existing research efforts, analytics has the potential to uncover new approaches to stubborn problems. "People have been trying to improve performance and outcomes related to the public sector, and in particular, in areas like human services," continues Brandt. They do research, take the best of it and use it to model policy changes. "Analytics gives us the opportunity to show that data is a powerful component to be used," he says, "to make decisions and to improve outcomes."

Atkins says the state is now developing additional predictive analytics projects related to achieving the goals that Gov. Pence set out in his roadmap.

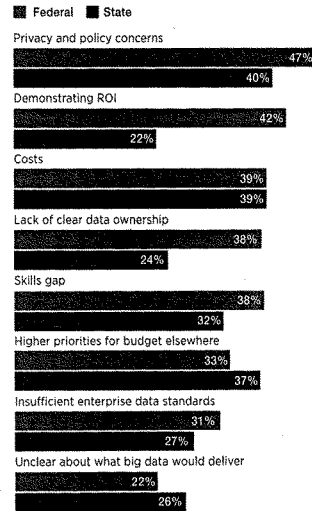
TRANSFORMING SERVICE DELIVERY

Three other projects in the state's data analytics program aim to improve transparency, so that policymakers and the public alike are able to more easily see government performance. Indiana is using the in-memory platform and data visualization tools to make data more visible. For one project, the OMB is working with agency leaders to collect data for specific KPIs tied to each state agency's performance. Another involves developing an executive dashboard system that will enable state leaders to scan these metrics and know when they change.

A related project includes the launch, in July 2014, of an online Management and Performance Hub (MPH) to share performance data in sectors tied to Gov. Pence's roadmap, including private sector employment, elementary students' reading skills and the percentage of children who are at risk of going hungry. The measures are posted on the MPH Web site, with graphs and charts that set baselines for comparison as data is added or updated.

Taken as a whole, these moves have attracted the attention of government innovation watchers like Stephen Goldsmith, a former Indianapolis mayor who is a professor at Harvard's Kennedy School of Government. Goldsmith writes: "With the launch of MPH and strong

FIGURE 3 Breaking Down Barriers



Base: 198 IT decision-makers in federal and state public sector organizations
Source: TechAmerica Foundation, "Big Data and the Public Sector," February 2013. <http://goo.gl/KaLdth>

U.S. technology officials view privacy and other policy issues as a top obstacle to using big data. (percent of respondents)

central leadership, Indiana stands to become a model for other governments looking to embed data throughout their operations and tap the power of data analytics to save money and transform service delivery."²

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Bruce Rogers
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2. Goldsmith, Stephen, "How Indiana Is Supercharging Data for Efficiency," *Governing*, June 18, 2014. <http://goo.gl/Kc4gn1c>

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CASE STUDY

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STATEMENT

**"We're unlocking
the true potential
for innovation
through new
business
processes and
models: real-time
innovation."**

**—STEVE LUCAS,
PRESIDENT,
PLATFORM
SOLUTIONS, SAP SE**

Real-Time Organizations Make Decisions in the Moment

Forbes Insights interviewed Steve Lucas, President, Platform Solutions, SAP SE, about transforming operations with real-time insights.

What does it mean to be a real-time organization?

Being a real-time organization means being aware of the key factors that will impact your decisions and being able to make a decision in the moment that matters. In most public sector agencies today, decision-makers have to wait for batch processes to run. When batch technology is replaced with real-time processing, however, organizations can obtain in-the-moment policy insights instantaneously. They can use those insights to improve performance, deliver services to constituents more efficiently and develop innovative approaches to policy goals. That is why the SAP HANA platform exists: to enable organizations do business in the moment.

Where do you see the most value for different organizations?

The value comes from three main drivers. First, we reduce the complexity of the systems required to produce your existing results. This was one of the key motivations in designing SAP HANA: massive IT simplification. You can use the platform to feed data from all different sources into one system. Second, we enable agility by giving customers the ability to get real-time insight for decision-making. Third, we're unlocking the true potential for innovation through new business processes and models: the real-time innovation.

As you look ahead, what new ways of serving constituents do you envision?

Our SAP HANA platform not only can enable customers to make decisions for today, but it also provides a powerful predictive engine. Most organizations make decisions by looking in the rearview mirror. But the rearview mirror is tiny compared to the windshield looking forward. Organizations will start to build forward-looking decisions into their operating models.

What is your best advice to organizations that want to start their real-time transformation?

It is not just about the technology. SAP HANA is extraordinarily innovative, but the first thing we do is look at where the opportunities are to transform business processes. Then we spend time with customers rethinking how those processes are designed, and how to remodel them. You have to start at zero: What would you do if you didn't have to wait for information? If you don't have to wait, there's an opportunity for massive reinvention and value creation across industries.

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September 27, 2018

The Honorable Greg Walden
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Walden,

I am writing to you on behalf of Johnson & Johnson in support of the *Preventing Maternal Deaths Act* and to thank the Energy and Commerce Health Subcommittee for holding the hearing, "Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S.," to call attention to this complex and wide-ranging problem. We believe this hearing is a positive step forward to help address a worsening health crisis affecting families across the country.

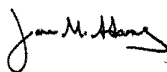
In just 14 years (2000 to 2014), America has suffered a staggering 26 percent increase in its maternal mortality rate, many of which occur from mostly preventable causes like preeclampsia and obstetric hemorrhage. Of nations with advanced economies, the United States stands alone in experiencing increases in mortality rates. Other countries also seeing increases are South Sudan and the Democratic Republic of the Congo.

Along with the American College of Obstetricians and Gynecologists, the American College of Nurse-Midwives, and the March of Dimes, Johnson & Johnson believes that a crucial part of the U.S. solution to this problem includes utilizing higher quality data, and expert review of maternal death cases by effective maternal mortality review committees (MMRCs). MMRCs study local maternal death cases with the goal of identifying ways to make pregnancies safer, prevent loss of life, and ultimately save families from this tragedy.

Congress can advance the health of mothers and families by working for swift passage of the Preventing Maternal Deaths Act, which will commit \$58 million through the Public Health Service Act to support states and to establish and improve maternal mortality review committees helping to prevent pregnancy related deaths and reduce disparities in care.

We are pleased to support this legislation, because Johnson & Johnson is committed to changing the trajectory of health for humanity and believe good health is the foundation of vibrant lives, thriving communities and forward progress. That's why for more than 130 years, Johnson & Johnson has aimed to keep people well at every age and every stage of life. Today, as the world's largest and most broadly-based health care company, we are committed to using our reach and size for good. Working together, we can work to reduce the number of maternal mortality deaths in the U.S. Please don't hesitate to reach out to me for further information.

Sincerely,



Jane M. Adams
Vice President, U.S. Federal Affairs