BIRTHING WHILE BLACK: EXAMINING AMERICA'S BLACK MATERNAL HEALTH CRISIS

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BIRTHING WHILE BLACK: EXAMINING AMERICA'S BLACK MATERNAL HEALTH CRISIS

Thursday, May 6, 2021

HOUSE OF REPRESENTATIVES,
COMMITTEE ON OVERSIGHT AND REFORM,
Washington, D.C.

The committee met, pursuant to notice, at 11:12 a.m., in room 2154 of the Rayburn House Office Building, Hon. Carolyn Maloney [chairwoman of the committee] presiding.

Present: Representatives Maloney, Norton, Connolly, Raskin, Khanna, Mfume, Ocasio-Cortez, Tlaib, Porter, Bush, Wasserman Schultz, Welch, Johnson, Sarbanes, Kelly, DeSaulnier, Gomez, Pressley, Comer, Foxx, Gibbs, Keller, Clyde, Mace, Franklin, LaTurner, Fallon, and Donalds.

Chairwoman MALONEY. Welcome, everybody, to today's hybrid hearing. Pursuant to House rules, some members will appear in person and others will appear remotely via Zoom.

Since some members are appearing in person, let me first remind everyone that pursuant to the latest guidance from the House attending physician, all individuals attending this hearing in person must wear a face mask.

Members who are not wearing a face mask will not be recognized. For members appearing remotely, I know you are all familiar with Zoom by now, but let me remind everyone of a few points.

First, the House rules require that we see you, so please have your cameras turned on at all times.

Second, members appearing remotely who are not recognized should remain muted to minimize background noise and feedback.

Third, I will recognize members verbally, but members retain the right to seek recognition verbally, and regular order members will be recognized in seniority order for questions.

Last, if you want to be recognized outside of regular order, you may identify that in several ways. You may use the chat function to send a request, you may send an email to the majority staff, or you may unmute your mic to seek recognition.

We will begin the hearing in just a moment when they tell me they are ready to begin the live stream.

The committee will come to order. Without objection, the chair is authorized to declare a recess of the committee at any time. I now recognize myself for an opening statement.

Our nation is facing a maternal health crisis. Across the globe, our maternal mortality rate ranks the absolute worst among simi-

larly developed nations and 55th overall, and the danger of giving birth in the United States is not equally distributed.

The Centers for Disease Control and Prevention estimates that Black women are more than three times as likely to die during or after childbirth as a white woman. Black Americans experienced higher rates of life-threatening complications at every stage of childbirth, from pregnancy to postpartum.

It doesn't have to be that way. The CDC estimates that 60 percent of these deaths are preventable. So, how does one of the most medically advanced nations in the world continue to fail Black birthing people at such high rates?

To understand, we have to take the blinders off our history and acknowledge that our healthcare system, including reproductive health care, was built on a legacy of systemic racism and the mistreatment of Black people and that that legacy continues today.

Our current health care system is rife with implicit bias and structural barriers that put Black people at an inherent disadvantage before, during, and after their pregnancies.

Thankfully, Black women leaders here in the halls of Congress and across the country have developed policies to systemically shift the way we approach health care for birthing people of color and promote programs and resources that are proven to reduce the rates of maternal mortality in these communities.

I am honored that several of these leaders are with us today to discuss policies they have written and championed and that Congress needs to implement to protect the health and well being of Black people and Black families.

These include bills like Congresswoman Kelly's MOMMA's Act, Congresswoman Pressley's Healthy MOMMA's Act, and Congresswoman Underwood and Adams' Black Maternal Health Momnibus bill.

We are also joined today by experts and individuals who have firsthand experience with the ways that our healthcare system fails Black people in birth settings.

I urge all of my colleagues to consider today's testimony and recommendations carefully. Health equity for Black birthing people is attainable as long as we address racial disparities with the urgency, empathy, and focus that this issue requires.

I believe that this is a historic hearing that, together with my colleagues, we will work to have similar hearings and all of the seven different committees of jurisdiction and that we will pass these bills out of the House and to the Senate and send them to the president for his signature.

I now want to introduce my co-chair for this hearing, Congresswoman Robin Kelly. From the moment she set foot in Congress, Ms. Kelly has championed efforts to turn the tide on this crisis.

Her efforts recently led to a groundbreaking provision in the American Rescue Plan that allows state Medicaid programs to cover new moms for a full year postpartum.

Ms. Kelly, it is my privilege to share the gavel with you today and you are now recognized for your opening statement.

Ms. Kelly?

Ms. KELLY. [Presiding.] Thank you, Chairwoman Maloney, for inviting me to co-chair this very important hearing as we take action to address the Black maternal mortality crisis within our Nation.

To Ranking Member James Comer and my colleagues on both sides of the aisle, thank you for your attentiveness and efforts to address the maternal health crisis. The maternal mortality rate in the United States is an issue that reaches into communities across our Nation, but it is especially concerning for communities of color.

Black women are three times more likely and indigenous women are more than twice as likely to die from pregnancy-related causes as non-Hispanic white women. Recently, the Center for Disease Control and Prevention released a report which showed that maternal mortality continues to rise.

The rate continues to rise. Even worse, more than two-thirds of the deaths are preventable. For every maternal death in the United States, there are approximately 100 women who experience severe maternal morbidity or a near miss. This is all unacceptable and the time for action is now.

The Federal Government has a critical role to play in addressing the crisis and the unacceptable racial inequities in health care delivery and outcomes.

Specifically, the Federal Government should support access to and the provision of patient-centered data-driven quality maternal care, enhance coverage and support for birthing people during the postpartum period, and address social determinants of health including structural and systemic inequities in the country's health care, economic, social, and criminal legal systems.

I have been advocating for evidence-based solutions for the legislation to address maternal mortality for a long time, as the chairwoman said. Despite all the hard work to address this issue, there is still a long way to go in preventing maternal deaths.

In the recently passed American Rescue Plan, language from my Healthy Moms bill was included, which provided states the option of expanding postpartum coverage from 60 days to one full year after giving birth.

Let me explain why this is such an important step forward. The American College of Obstetricians and Gynecologists recommends that women have access to continuing health coverage to increase preventive care, reduce avoidable adverse health outcomes, and increase early diagnosis of disease and reduce maternal mortality rates.

There are major risks associated with becoming uninsured shortly after experiencing pregnancy. Lapses in insurance coverage is one of the continuing factors in the maternal mortality crisis, with one-third of all pregnancy-related deaths occur as late as one year after delivery.

Women of color are disproportionately affected by disruptions in insurance coverage. Nearly half of all non-Hispanic Black woman had discontinuous insurance from pre-pregnancy to postpartum, and half of Hispanic Spanish-speaking women became uninsured in the postpartum period.

Earlier this year, I led my colleagues in a letter urging HHS Secretary Becerra to approve Illinois' waiver to allow for additional Medicaid coverage beyond the current 60-day allowance. Secretary

Becerra approved the waiver, making Illinois the first state that allows women to receive the postpartum care they deserve.

Additionally, I reintroduced my supporting best practices for Healthy MOMMIES Act. This bill would require CMS to publish guidance for hospitals and other maternal care providers on ways to reduce maternal mortality and morbidity under Medicaid and the Children's Health Insurance Program.

In the next few weeks, I will introduce my key maternal health legislation, the Mothers and Offspring Mortality and Morbidity Awareness Act, also known as the MOMMA's Act.

This bill will help standardize data collection, provide grants that improve maternal and infant health, and establish regional centers of excellence, which will improve how our health care professionals are educated in implicit bias and delivering culturally competent health care.

As we go into Mother's Day weekend, let us recommit our efforts and support to ensure that every birthing person across this Nation is empowered and feels safe when making that wonderful and exciting decision to become a mother.

This hearing is a testament to the hard work of advocates and researchers and my other colleagues who have fought so long to elevate this issue.

I look forward to hearing from the witnesses. Thank you so much.

Chairwoman MALONEY. [Presiding.] I now recognize the distinguished ranking member, Mr. Comer, for an opening statement.

Mr. Comer?

Mr. COMER. Thank you, Madam Chair. I want to thank all of our witnesses for being here to share your stories and expertise with us here today.

According to the CDC's most recent available data, the maternal mortality rate in the U.S. for 2018 was 17.4 deaths per 100,000 live births. Maternal mortality for Black women is 2.5 times the ratio for white women and three times the ratio for Hispanic women.

We all agree that that is unacceptable. The United States is one of the most advanced healthcare systems in the world. We can and should have lower mortality rates. There are a range of factors contributing to this crisis, from lack of access to proper care to the maternal mental health crisis, which takes the lives of so many mothers.

I hope today we can explore innovative solutions to ensure that maternal mortality rates in the U.S. decline. Historically, this issue has been approached in a bipartisan manner. I hope we can continue that posture today.

This hearing is about what we can do right now to save the lives of women and their babies. I look forward to hearing from our witnesses on the amazing work they are already doing to solve this problem, as well as exploring suggestions for what we can do better.

With that, I yield the remainder of my time to Dr. Foxx and then Congresswoman Mace for their opening statements.

Chairwoman MALONEY. The gentleman yields back.

I now recognize Dr. Foxx for an opening statement.

Ms. FOXX. Thank you very much, Madam Chairman, and thanks, Ranking Member Comer, for your participation in the hearing today.

As the ranking member stated, the situation regarding maternal health is unacceptable and we must work together to determine the proper response.

Historically, data collection on the maternal mortality rate in the United States has been incomplete. In order to target relief in a manner that can actually affect positive outcomes, we need better information.

Shining a light on the data will, we hope, improve the health outcomes of mothers and their newborn children. I look forward to hearing from the witnesses today on how we can gather better data for better outcomes.

As the ranking member of the Education and Labor Committee, today I hope we can address the impending shortage of OB/GYN care providers and the lack of proper education for some in the health care industry.

Currently, the U.S. and Canada have the lowest overall supply of midwives and obstetrician/gynecologists, or OB/GYNs, relative to comparable countries. There is expected to be a shortage of between 3,000 to 9,000 physicians by 2030.

We must act now to ensure this shortage does not get worse. Further exacerbating this problem is a lack of education for care providers on early warning signs of life-threatening complications. I know many of our witnesses here today are working tirelessly to provide best practices for physicians, nurses, midwives, and other care providers to ensure these preventable deaths do not occur.

One potential way to address the shortage of caretakers now is to use nonphysician clinicians such as midwives, nurse practitioners, and physician assistants, especially for low-risk pregnancies.

Expanding access to midwife care can improve access to maternity care in under resourced areas, reduce interventions that contribute to the risk of maternal mortality and morbidity, and lower the cost of care.

Incorporating nonphysician clinicians as part of a health care team, led by an OB/GYN, has shown to improve outcomes for both the mother and baby.

Implementing these patient teams and best practices for care is something hospitals can start doing right now, which can have an immediate impact on lives.

I look forward to hearing more from our witnesses today about solutions we can implement to address this.

I now yield to Representative Mace for her opening remarks.

Chairwoman MALONEY. I know——

Ms. MACE. Thank you, Congresswoman.

Chairwoman MALONEY. I now recognize Ms. Mace for an opening statement.

Ms. MACE. Thank you, Chairwoman Maloney and your co-chair, this morning, Congresswoman Kelly. I want to thank Ranking Member Comer and Dr. Foxx as well.

I echo the statements of my colleagues this morning. This maternal health crisis is unacceptable in our advanced society today. It

is entirely unacceptable that Black women are nearly three times more likely to die during childbirth than white women.

I hope among the many important topics of discussion today that we hear about we can address the mental health and substance abuse crisis which also afflicts so many mothers out there today.

Opioid use and suicide combined are the leading cause of death for mothers in the postpartum period. Data shows that one in five women experience maternal mental health conditions. About 75 percent of those go undiagnosed and untreated.

All childbearing women should be educated about and screened for postpartum mental health conditions throughout the relevant timeframe and have access to quality treatment options.

Personally, with my firstborn, I didn't have postpartum mental health issues. But with my second, I experienced those firsthand and I cannot imagine for those women that don't have the resources or the ability to access health care professionals to access those who could provide resources in a time of tremendous need. Those are things that we have all got to address and I hope will be addressed today.

Having check-ins and subsequent care before and after childbirth are essential to any mother's maternal health for that and her child. To the mothers out there who are struggling to hold down a job and educate your children at the same time, we see you.

We are working to shine a light on your plight and the challenges that you face today. They are real, and we want to be there and provide the resources we can at every level—national, state, and local.

There are national and local organizations and providers, a few of which are represented here today and that we will hear from, who are ready and willing to help you.

Please do not be afraid to reach out for help if you are struggling. I also feel it is important to note that this maternal health crisis has been further exacerbated by the pandemic. I would be remiss if we didn't mention the needs are so much more—are so much greater today than they were even just a year ago.

While we won't have hard data on the effect of COVID–19 on maternal mortality for some time yet, we know generally that opioid use, intimate partner violence, domestic violence, and mental health crisis have been exacerbated.

They have increased exponentially due to the pandemic, due to lockdowns, due to children being unable to be at home—I mean, be at school and be at home.

We also know women have borne the brunt of this pandemic from job loss to childcare responsibilities. Recent studies show that pregnant women and new moms are experiencing anxiety and depression at levels three to four times the levels or the rate prior to the pandemic.

This increased stress increases the likelihood of pregnancy-related complications. The problem is real. Perhaps the only good thing that has come out of this devastating pandemic is the increased access to telehealth, the expanded telehealth use, which studies have shown improve outcomes for pregnant women.

A recent study from the University of Texas Southwestern Medical Center found that prenatal doctor visits conducted over the

phone or with video technology encouraged more women to make and keep their appointments during the pandemic, particularly among vulnerable populations, and resulted in similar pregnancy outcomes compared with women who were able to come in in person.

The telehealth options should continue to be utilized and, perhaps, even expanded, not just now but at a high rate even after return to some sense of normalcy post-COVID–19 pandemic.

What telehealth appointments have shown us that they are especially helpful for rural communities and women who are unable to get to an appointment in person physically due to transit or financial or other limitations to get to a doctor for face-to-face check-ins.

As the number of pre-and post-natal care appointments go up, the risk for maternal mortality goes down. I hope today we can continue to explore additional innovative options for care for these women who are exponentially hurt greater in pregnancy and postpartum.

I want to thank the chairwoman for your time today and I yield back.

Chairwoman MALONEY. The gentlelady yields back.

We have two panels today and our first panel is a member panel, so I would like to introduce them first.

Our first witness today is Congresswoman Ayanna Pressley from Massachusetts. Since 2019, Congresswoman Pressley has been a powerful voice for equity on this committee.

She has introduced numerous bills to improve Black maternal health outcomes and address structural racism as a public health crisis, including the Healthy MOMMIES Act, which, among other things, extends Medicaid coverage to birthing people for one year postpartum, the COVID–19 Safe Birthing Act, and the Anti-Racism in Public Health Act, which would empower the CDC to address structural racism in public health.

We are lucky to have her as a part of our committee and as a part of our panel.

Following her, we have Congresswoman Cori Bush from Missouri. She recently shared her story about giving birth as a Black woman in America. Like many Black birthing people, doctors ignored and dismissed her pain, which led to her son's premature birth.

She has worked in Congress to protect Black maternal health and Black babies. She is a strong part of this committee, and we thank her for sharing her story with us today.

We will then hear from Congresswoman Alma Adams from North Carolina. Ms. Adams is co-chair of the Black Maternal Health Caucus. The caucus has introduced the Black Maternal Momnibus Act, a sweeping proposal to comprehensively address the country's maternal health crisis.

She has tirelessly championed policies to systematically address Black maternal health, and we thank her for her passion and for appearing here today.

Last but not least, we will hear from Congresswoman Lauren Underwood from Illinois. She is the other co-chair of the Black Maternal health Caucus and has led efforts to pass the Momnibus and

comprehensively address every dimension of the Black maternal health crisis.

She has been a bold leader for a more equitable America since she first set foot in Congress.

I want to thank all of them for their extraordinary work. We are all deeply grateful for their leadership.

Without objection, your written statements will be made part of the record, and with that, Congresswoman Pressley, you are now recognized for your testimony.

STATEMENT OF HON. AYANNA PRESSLEY, REPRESENTATIVE, CONGRESS, MASSACHUSETTS

Ms. PRESSLEY. Thank you, Madam Chair. This hearing is historic, and I am honored to participate alongside my sisters in service, my colleagues who are committed to achieving maternal health justice.

Today, we will likely hear a consistent drumbeat of sobering statistics which underscore the often life-threatening, too often fatal experience of birthing while Black.

Now, while some may be tired of hearing these alarming data points, they should know that Black people are tired of living them, and more accurately, tired of losing loved ones.

My paternal grandmother, who I never had the blessing to know, died in the 1950's giving birth to my father's youngest brother, sending my father and his five siblings into a downward spiral of great trauma and hardship.

And decades later, the Black maternal mortality crisis is still killing our loved ones and destabilizing our families. My family's history is not unfamiliar for many Black folks who have heard mothers, grandmothers, aunties, and partners recount tragic losses or their own harrowing birth experiences.

Black people have been vocal about this pain, but that pain has fallen on deaf ears or been delegitimized for generations. It is now incumbent upon this body to hear this Black pain and to legislate solutions.

Today, in partnership with Senator Booker, we reintroduced our MOMMIES Act, which would ensure that every state allows Medicaid-eligible pregnant people to remain covered for at least a full year postpartum, and this coverage is comprehensive and not limited to arbitrarily selected pregnancy-related services. We are demanding the type of responsible accessible person-centered care that is required to save lives.

This bill would also mandate the collection of critical information on the coverage of and barriers to receiving doula services. One bill alone will not end this crisis. That is why I am proud to support the Black Maternal Health Momnibus Act of 2021, which includes my legislation to provide care and dignity for pregnant people in the criminal legal system.

The Justice for Incarcerated Moms Act would end the practice of shackling people who are pregnant, an unconscionable practice, fund diversion programs as alternatives to incarceration, and create maternal health initiatives for pregnant people behind the wall, including access to doulas, healthy food and nutrition, mental health and substance use counseling.

These bills were developed in close partnership with Black women who are leaders in maternal and reproductive health care.

I testify today not to remind Black people of our plight, but instead, to demand the action and the meaningful change that we deserve. The policy is ready.

What we need now is a commitment from our colleagues that Black maternal health, that Black mamas, that Black babies, that Black lives are, indeed, a priority.

Birthing while Black should not be a death sentence, and if we believe in health care justice, as we espouse that we do, then we should legislate like it.

Thank you. I yield.

Chairwoman MALONEY. Thank you.

Congresswoman Bush is here in person and we now recognize your testimony.

STATEMENT OF HON. CORI BUSH, REPRESENTATIVE, CONGRESS, MISSOURI

Ms. BUSH. Thank you.

First of all, let me just say that I think it is disgusting that we have colleagues on this hearing who won't acknowledge Black women suffering, that there are stark differences in our pain.

But St. Louis and I thank you, Chairwoman Maloney and Congresswoman Kelly, for your leadership in convening this all-important hearing. It is an honor to join my sisters in service—Congresswomen Pressley, Underwood and Adams—as part of today's panel.

I sit here before you as a mother, a single mother of two. Zion, my eldest child, was born at 23 weeks gestation versus what is considered a normal pregnancy of 40 weeks. When I was early in my pregnancy with him, I didn't think that there could even be a possibility that there could be a complication.

I became sick during my pregnancy. I had hyperemesis gravidarum, which was severe nausea and vomiting. I was constantly throwing up for the first four months of my pregnancy.

Around five months, I went to see my doctor for a routine prenatal visit. As I was sitting in the doctor's office, I noticed a picture on the wall that said, if you feel like something is wrong, something is wrong. Tell your doctor.

I felt like something was wrong so I—so that is what I did. I told my doctor. I told her that I was having severe pains, and she said, oh no, you are fine. You are fine. Go home, and I will see you next time.

So, that is what I did. I went home. One week later, I went into preterm labor. At 23 weeks, my son was born one pound, three ounces. His ears were still in his head. His eyes were still fused shut. His fingers were smaller than rice and his skin was translucent. A Black baby, translucent skin. You could see his lungs. He could fit within the palm of my hand. He was—we were told he had a zero percent chance of life.

The chief of neonatal surgery happened to be in the hospital that morning and saw my case on the surgical board and she decided to try to resuscitate him. It worked, and for the first month of his life as Zion was on a ventilator fighting to live, for four months he was in the neonatal care unit. The doctor who delivered my son

apologized. She said, "You were right and I didn't listen to you. Give me another chance."

Two months later, I was pregnant again. So, I went back to her. At 16 weeks I went for an ultrasound at the clinic and saw a different doctor who was working that day. I found out again I was in preterm labor.

The doctor told me that the baby was going to abort. I said, no, you have to do something. But he was adamant. He said, "Just go home. Let it abort. You can get pregnant again because that is what you people do."

My sister, Kelly, was with me. We didn't know what to do after the doctor left. So, we saw a chair sitting in the hallway. My sister picked up the chair and she threw it down the hallway. Nurses came running from everywhere to see what was wrong.

A nurse called my doctor and she put me on a stretcher. The next morning my doctor came in and placed a cerclage on my uterus and I was able to carry my baby, my daughter, my angel, who is now 20 years old. My son who was saved is now 21 years old.

This is what desperation looks like, that chair flying down a hallway. This is what being your own advocate looks like. Every day Black women are subjected to harsh and racist treatment during pregnancy and childbirth. Every day Black women die because the system denies our humanity. It denies us patient care.

I sit before you today as a single mom, as a nurse, as an activist, and as a Congresswoman, and I am committed to doing the absolute most to protect Black mothers, to protect Black babies, to protect Black birthing people, and to save lives.

Thank you, and I yield back.

Chairwoman MALONEY. Thank you for your very moving testimony.

Congresswoman Adams, you are now recognized for your—for your testimony.

Congresswoman Alma Adams?

STATEMENT OF HON. ALMA S. ADAMS, PH.D., REPRESENTATIVE, CONGRESS, NORTH CAROLINA, CO-CHAIR, BLACK MATERNAL HEALTH CAUCUS

Ms. ADAMS. Thank you, Madam Chair, Chairwoman Maloney, Ranking Member Comer, Congresswoman Kelly, and to other distinguished colleagues serving on the Oversight Committee.

Thank you for the opportunity to join you today for this historic hearing in the House Oversight Committee on maternal mortality and the disparate and unacceptable outcomes that Black women and birthing persons face.

As the founder and co-chair of the Black Maternal Health Caucus, I want to just take time to speak about the Black maternal health crisis in America. Black mamas are disproportionately and needlessly dying.

The U.S. is one of 13 countries in the world where the rate of maternal mortality is worse than it was 25 years ago, and even more disturbing is that across the country Black women from all walks of life, regardless of socioeconomic status and education, are dying from preventable pregnancy-related complications at three to four times the rate of non-Hispanic by women.

And the shocking fact is that 60 percent of maternal deaths are preventable. Research also suggests that the cumulative stress of racism and sexism undermines Black women's health, making them more vulnerable to complications that endanger their lives and the lives of their infants.

Unfortunately, current healthcare practices are insufficient in addressing the health consequences of living with this stress. In fact, the healthcare system often fails Black women, providing inadequate and culturally insensitive care that is plagued by bias, racism, and discrimination.

This crisis demands urgent attention and serious action to save the lives of Black mothers and women of color and other marginalized women across the country, which is why Congresswoman Underwood and I crafted and introduced a comprehensive package of nine bills called the Black Maternal Health Momnibus Act, and this February we introduced an updated package of 12 bills with Senator Cory Booker.

You know, the Momnibus will comprehensively address every dimension of the maternal health crisis in America to save lives and end racial and ethnic disparities in maternal health outcomes.

The bill makes investments in social determinants of health, increasing maternal vaccinations, improving our national response to pandemics with respect to maternity care, the growth and the diversification of the perinatal work force, improvements in data collection and quality measures, digital tools like telehealth and innovative payment models.

It focuses on environmental justice, because recent studies have reinforced the linkage between man-made climate change and the toll that it takes on pregnant women and their infants.

And very importantly, the Momnibus provides critical funding for community-based organizations, perinatal workers, doulas, and midwives, and lactation consultants who are doing the work right now to save Black mamas and babies, especially in communities of color.

We know the solutions that our communities need, and I am fighting hard every day in Congress to speak up and stand up to make sure that my colleagues understand what Black women need and what they must have.

The Momnibus is a bold and compassionate solution that unequivocally says Black mamas matter. That is why I am calling today for the Momnibus to be included in the American Families Plan, which is a once in a generation investment in health—healthcare and education and childcare.

Inclusion of the Momnibus would build on the Biden's administration American Rescue Plan, a bold and compassionate relief bill that included a provision to extend Medicaid coverage for up to 12 months.

In 1962, Malcolm X said that the most disrespected person in American is the Black woman. The most unprotected person in America is the Black woman. The most neglected person in America is the Black woman.

Sadly, that continues to be true and evident in the health and economic outcomes that we continue to face. The pandemic has re-

vealed these disparities all too well and it has further exacerbated them.

In 1966, Martin Luther King declared of all other forms of inequality and injustice, injustice in healthcare is the most shocking and most inhumane.

Including the Momnibus in the American Families Plan is a key way to address long-standing health injustices and to ensure that our moms and our babies have the resources they need to not only survive, but to thrive.

It doesn't matter what side of the aisle you are on. Either you have a mother or you are a mother or you know women who are moms. If we raise the tide for Black women who are who are among the most marginalized and the most vulnerable, we ultimately raise the tide for all women.

All moms deserve equal access to quality maternal care without bias. Passing the Momnibus, we can begin to take action now to truly hold ourselves, our health systems, and our society accountable.

I urge my colleagues to support the Momnibus. Our Black women and our mamas deserve better. I yield back, Madam Chair. Thank you so very, very much.

Chairwoman MALONEY. Thank you for your important leadership on this issue.

Congresswoman Underwood, you are now recognized for your testimony.

Congresswoman Underwood?

STATEMENT OF HON. LAUREN UNDERWOOD, REPRESENTATIVE, CONGRESS, ILLINOIS, CO-CHAIR, BLACK MATERNAL HEALTH CAUCUS

Ms. UNDERWOOD. Chairwoman Maloney, Ranking Member Comer, and members of this committee, thank you for holding this hearing on the urgent topic of Black maternal health.

Two years ago this month, I joined Congresswoman Alma Adams to co-found the Black Maternal Health Caucus, a bipartisan group of 115 members united in our commitment to ending our Nation's maternal mortality crisis.

My colleagues have shared the alarming statistics about maternal health outcomes in the United States, and behind every one of these statistics is a story, stories like my friend, Shalon.

Dr. Shalon Irving was a graduate school classmate of mine at Johns Hopkins University. She went on to become a lieutenant commander in the U.S. Public Health Service Commission Corps, utilizing her dual Ph.D.

She was also a CDC epidemiologist. She was a talented photographer, a chef, an author. She traveled the world and she was so excited to become a mom.

But we still lost her. Three weeks after giving birth to her beautiful daughter, Soleil, Shalon died due to complications from her pregnancy. I couldn't believe it. But while Shalon's story is devastating, it is not unique. Too many families have stories of their own of loss or near misses.

It was with these stories in my heart that my team and I committed to developing a comprehensive set of data-driven evidence-

based policies that would build on existing legislation to address every driver of maternal mortality, morbidity, and disparities in the United States.

The result was the Black Maternal Health Momnibus Act, which I introduced with Congresswoman Adams and then Senator, now Vice President Kamala Harris in March 2020.

This Congress, I reintroduced the Momnibus with Senator Cory Booker, and now more than 140 co-sponsors between the House and Senate, including many members of this committee.

The Momnibus has wide support, including Speaker Pelosi who said last month that we, quote, "Must pass the Momnibus."

The Momnibus is a suite of 12 bills that include bipartisan policies to save lives, end racial and ethnic disparities, and achieve true equity and justice for all mothers and birthing people.

As the Congress considers proposals for the American Families Plan, I urge my colleagues to support the policies in the Momnibus, which are even more important in response to a pandemic that has both underscored and intensified the need to make robust investments in high-quality care.

At the heart of these investments is the principle that in America every family has the right to thrive, a principle that begins with a safe and healthy pregnancy and birth.

To realize this promise for every mother, the Momnibus includes investments in community-based organizations, funding to grow and diversify the perinatal work force, data collection improvements, expanded access to maternal mental health care, and programs to address social determinants of health, like housing, nutrition, and environmental risks.

These are necessary investments that will save lives and support families.

I look forward to working with my colleagues to get the Black Maternal Health Momnibus Act included in the American Families Plan and signed into law.

We don't have any time to wait. Our moms are worth it. Our families depend on it and this moment demands it. Thank you, and I yield back.

Chairwoman MALONEY. Thank you for your powerful testimony and for your continued leadership on this critically important issue.

The first panel is now excused and we will pause for a moment while we get the second panel ready.

[Pause.]

Chairwoman MALONEY. Now I would like to recognize my co-chair for this hearing, Congresswoman Kelly, to introduce the witnesses on our second panel.

Congresswoman Kelly?

Ms. KELLY. [Presiding.] Thank you again, Madam Chair.

Our expert witnesses today have all seen or felt the tragic impact of our Nation's Black maternal health crisis up close.

Tatyana Ali is an actress, advocate, and mother who confronted the consequences of systemic racism during her own 2016 delivery of her first son. She was left traumatized and feeling alone at the questionable decisions and missteps by her health care providers, culminated in an emergency C-section, an outcome that unneces-

sarily put her life at risk and was entirely divorced from her original birth plan.

Charles Johnson is the founder of the maternal health advocacy organization 4Kira4Moms. Mr. Johnson's wife, Kira, was an extraordinarily accomplished woman in perfect health when her planned C-section resulted in severe internal hemorrhaging.

Charles and Kira's pleas for help were ignored by hospital staff for 12 hours while her abdomen filled with blood. She died only 12 hours after giving birth.

Dr. Veronica Gillispie is a board-certified obstetrician and gynecologist, an associate professor for Oschner Health in New Orleans, Louisiana, and the medical director at the Louisiana Perinatal Quality Collaborative and Pregnancy Associated Mortality Review for the Louisiana Department of Health. She leads initiatives to improve birth outcomes for all birthing persons in Louisiana and eliminate health disparities.

Dr. Joia Crear-Perry is the founder and president of the National Birth Equity Collaborative, which focuses on creating solutions that optimize Black maternal and infant health through training, policy advocacy, research, and community-centered collaboration. She is a mother, OB/GYN, activist, and thought leader around racism as a root cause of health inequalities.

Dr. Jamila Taylor is the director of healthcare reform and senior fellow at the Century Foundation where she leads TCS work to expand access to affordable health care by focusing on the structural barriers to access to health care, and the racial and gender disparities in health outcomes.

And Dr. Tamika Auguste, who serves on the board of directors for the American College of Obstetricians and Gynecologists. Dr. Auguste is a practicing OB/GYN at MedStar Washington Hospital Center and a renowned physician expert on issues of Black maternal and infant health.

I want to thank all of our witnesses for joining us today.

Ms. Ali, you are now recognized for five minutes for your opening statement.

STATEMENT OF TATYANA ALI, ACTRESS AND ADVOCATE

Ms. ALI. Thank you for inviting me to share my story. I hope I can honor the mamas and babies who are no longer with us.

I had a very healthy pregnancy, and when it came time I was laboring and dilating normally. When my husband and I got to the hospital, it was like we were on a clock that kept very close track of the hours.

I remember them trying to get me to take an epidural though it wasn't in my birth plan, interrupting me again and again in the midst of my labor pains, making it seem imperative until, finally, we relented.

I wanted to get onto my hands and knees to push because I could still feel my legs. But every time I tried, five of the 10 people in the room, all screaming at me at the top of their lungs, would push me back down. They pinned me down by my feet.

I could feel my baby's wet hair because he had been crowned for hours. One doctor climbed up onto the side of the bed and pushed

his forearm into my belly and squeezed downward, like my baby was two-faced. I could still feel the pain days later.

Then when my husband and I yelled no to the forceps, they use suction, a plunger. I screamed stop because they were aggressively popping it off of his head again and again four times. Then, without warning, one doctor pushed my baby all the way back inside me. I screamed in pain. My body started shaking uncontrollably. Then I lost consciousness.

When I woke I heard my baby cry. That is our baby, I told my husband. Don't let them hurt him. Go. Go and get him and he went, and then I went unconscious again.

I remember the warmth that washed over me when I finally got to hold him. I remember two nurses in particular in the maternity ward who were kind and gentle with me.

He spent four days in the NICU. The head pediatric urologist explained to us that it would take time for our baby to urinate on his own because of the traumatic nature of his birth, and our prayers were answered when he did and we could leave.

When we found out we were pregnant again, we vowed to find another way. The first time we met our midwife I felt like I had met her before. She is a brilliant Black woman with a beautiful smile. Her laugh reminds me of my very own cousin, Valerie. I remember her spending hours with us visiting in our home, helping my eldest as he was just learning to walk up the stairs on his own.

I remember her asking for permission every time she touched my belly and never used a speculum or did an intervaginal check like my OB/GYN did at every appointment.

We decided to have a home birth VBAC. She gave us choices and was a reservoir of information, never too busy to take a call or answer a text. Last minute, my youngest changed his position and went lateral so I had to have another C-section. But we had planned so thoroughly that we knew exactly which hospital would respect our team.

When I broke down weeping after the anesthesiologist said I would feel nothing from the chest down again, my midwife prayed while she held my feet. My midwife knew my story and prepared me for the time when the trauma of my first birth might return, and she also knows that I believe in prayer. She knew me that well.

She suggested that I walk into the OR instead of being put on a gurney in order to feel a sense of agency and autonomy that had been taken from me previously. I got to hold my youngest right after he entered the world and he latched right away.

During postpartum visits with our midwife, she provided lactation support. She checked in on my baby's growth, my physical wellness, my nutrition, my mental and emotional well being, and how we were adjusting as a family.

Both of my babies were born via C-section, but the experiences could not have been more diametrically opposed. My eldest and I were not safe. My youngest and I, cared for by a Black midwife, were. The birth of my oldest was my first experience of a kind of institutionalized racism and paternalism that can kill.

Throughout my advocacy efforts, I have heard firsthand stories of people in pain being dismissed, threatened, called drug seeking.

I have heard stories of the sheriff's department coming to homes in the middle of the night because families refused to take elective tests.

I have heard stories of Child Services being called moments after babies are born because the parents seem unfit. The similarities amongst Black families and the treatment and similar outcomes for indigenous families and queer families and disabled families and incarcerated birthing people are stunning and they all have similar root causes.

We are being mishandled, ignored, sterilized, and completely disrespected. Many are now scared to start families because they know we are dying in hospitals. There are groups on the ground providing the support that we need, but they need the resources to scale their efforts.

We need more Black midwives, Black doulas, culturally competent birth workers, and they need to be supported in their work. They need to be covered by all health plans so that adequate care ceases to be a luxury. We need to demedicalize birth.

We need redress with hospitals that fail us so completely. We need racial bias and trauma training, postpartum and lactation support. We need to be heard and believed. All pregnant and birthing people deserve to be treated with loving patient-centered care.

Thank you for this time.

Ms. KELLY. Thank you so much, Ms. Ali.

And now we will turn to Mr. Johnson. You are now recognized for your testimony.

STATEMENT OF CHARLES JOHNSON, HUSBAND OF KIRA JOHNSON AND FOUNDER OF 4KIRA4MOMS

Mr. JOHNSON. We are going to jump right into it.

I was fortunate enough to meet a woman that absolutely changed my life, and so when we talk about my wife, Kira, we are talking about truly sunshine personified. We are talking about a woman who raced cars, who ran marathons, who spoke five languages fluently, and really challenged me to be a better man in every single aspect of my life.

I have always wanted to be a father, and so I was ecstatic when we found out. We welcomed our second son, Charles the V in September 2014, and Kira and I always talked about how cool it would be to have back to back boys. They would grow up, just being rambunctious, best friends. And so we were absolutely over the moon when we found out we were welcoming our second son, Langston, in April 2016.

And the painful irony of what I am going to share with you this afternoon is that as a father and as a husband, you want the best for your family. You want the best for your wife.

And so we made the decision to give birth at Cedar Sinai Medical Center in Los Angeles, California, because it was our understanding that this hospital had what was supposed to be a sterling reputation, particularly in the area of obstetrics and delivery.

And so on April 12 of 2016, we walked into Cedar Sinai Hospital in Los Angeles for what we expected to be the happiest day of our lives and walked straight into a nightmare.

It is important to understand that throughout Kira's entire pregnancy she was not only in good health, Madam Chairwoman, she was in exceptional health. All signs pointed to both her and our new son, Langston, being extremely healthy.

And so at our doctor's recommendation we went in for what was supposed to be a routine scheduled C-section. Langston was born perfectly healthy, 10 fingers, 10 toes, and we were just overwhelmed with joy welcoming this tremendous gift into our lives.

Shortly after birth, we were taken back to recovery, which is standard in a Cesarean delivery, and as we were there in the recovery room, and Kira is resting and I am watching her rest, and Langston is in what I called a little toaster, the little incubator thing, and I am just soaking all of this in, all the pride of being a father for the second time and our family was finally complete.

And then things began to take a turn for the worse. As I am sitting there watching Kira rest, I look and I see by her bedside the catheter coming from her bedside begin to turn pink with blood. Now, keep in mind, this is around 4 o'clock in the afternoon and so I brought it to the attention of the doctors and the staff at Cedars Sinai.

They came and they examined Kira physically. They took her vitals, they drew blood, and they did an ultrasound, and very early on they can see that her abdomen is beginning to fill with fluid. And very quickly they ordered a CT scan that was supposed to be performed stat and by stat, for everybody on the committee, what does that mean to you all? Immediately.

Five o'clock came, no CT scan. Six o'clock came. Seven o'clock came, no scan. By 7 o'clock, my wife is shivering uncontrollably because she is losing so much blood. Eight o'clock comes, no scan. I am begging and pleading, please do something. Help her. Nine o'clock, nothing.

At around 9 o'clock, I pulled a nurse aside and I asked her, please help me. My wife isn't doing well. She is weak. She is in pain. She is losing color. Please help me. And she responded to me, sir, your wife just isn't a priority right now. Your wife isn't a priority.

Ten o'clock came. Eleven o'clock came. It wasn't until after 12:30 a.m. that they finally made the decision to take Kira back for surgery. When they took Kira back to surgery and they opened her up, there were three and a half liters of blood in my wife's abdomen from where she had been allowed to bleed and suffer needlessly. For 10 hours while myself and my family begged and pleaded for them simply to just help us, and our cries for help fell on deaf ears.

And as I said when I was here in 2018 in support of the Preventing Maternal Deaths Act, I am going to say it again, you are going to hear from brilliant people, many of whom I look up to tremendously. They are going to tell you about the statistics.

But there is no statistic that can quantify for what it is like to tell an 18-month-old that his mommy's never coming home. There is no point on your data collection that can begin to measure the impact of what it is like to try and explain to a son that will never know his mother just how amazing she is.

And what I want to say is this. I am going to share with this committee a harsh truth, and that truth is for all the wonderful

work that you are doing you cannot legislate compassion. You cannot legislate compassion, and it was lack of compassion and lack of humanity that failed my wife and is failing Black mothers time and time again.

It was not my wife's race that was a risk factor. She did everything right. It was racism. That was the risk factor. And so we must do better, and while you cannot legislate compassion and humanity, what you can do is you can take bold steps like the Momnibus Bill to invest in community-based care models.

You can make sure that every woman in this country that wants access to a doula has it. You can make sure that we diversify the perinatal work force. You can make sure that women have the resources that they need to thrive and survive before, after, and during childbirth.

And as we approach Mother's Day, my heart is heavy as I sit here representing the thousands upon thousands of families that have been impacted.

And so, Madam Chairwoman, let me share with you on behalf of those families what our expectation is, what my expectation is, of this committee, of this Congress, and of our leadership.

My expectation is that this committee will come together in a bold bipartisan fashion to stand in solidarity and sound—and send a loud definitive message that mothers and babies and Black birth and people are important and will make the investments and legislate as such.

What I will share with you is this in closing. These are my sons, Charles and Langston. My wife, Kira, won't wake up to breakfast in bed this Mother's Day because she gave birth in a country that didn't see her, that didn't value her. We must do better.

This is Amber Rose Isaac. Her son, Elias, won't have the chance to spend his first Mother's Day with his mother. Elias deserves better.

Shamony Gibson should be here with her son, Khari, and her daughter, Anari. She deserves so much better.

Tahmesha Dickey should be here this Mother's Day with her son, Muhsin. She deserved better.

Tamara Johnson Thompson should be here—should be here with our daughter, Ryan Rose.

Dr. Shalon Irving should be here with her daughter, Soleil. Precious Triplett Strokes should be here with her son, Jacob.

Yolanda Kadima, a doula—a doula—should be here with Jamayla, Zaden, Armand, Alanna, Zaire, Qashar, Shivran and Yavin, her eight children, this Mother's Day.

I refuse to allow my children, these children, and the children and families affected by this maternal crisis—maternal health care crisis to inherit a world where they fear that their wives or that their selves may meet the same fate as their mothers. We must and we can do better.

Thank you for your time.

Ms. KELLY. Thank you so much for sharing your words and your testimony. We really appreciate it.

Dr. Auguste, you are now recognized for your five minutes of testimony. Thank you.

STATEMENT OF TAMIKA AUGUSTE, M.D., BOARD OF DIRECTORS, AMEREICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS; CHAIR OF THE OBSTETRICIAN AND GYNECOLOGIST CLINICAL PRACTICE COUNCIL, MEDSTAR HEALTH

Dr. AUGUSTE. Thank you.

Good afternoon, Chairwoman Maloney, Chairwoman Kelly, Ranking Member Comer, and members of the House Oversight and Reform Committee. Thank you for inviting me to speak with you today on behalf of the American College of Obstetricians and Gynecologists, or ACOG.

It is an honor to join this esteemed panel. As an obstetrician/gynecologist practicing in Washington, DC, I have dedicated my career to ensuring patients have happy and healthy pregnancies and births.

I currently serve as a member of ACOG's board of directors and as vice chair of the Council on Patient Safety and Women's Health, an effort convened by ACOG to improve patient safety, promote equity, and drive culture change in women's health care.

Confronting our Nation's rising maternal mortality rate, which disproportionately impacts Black and indigenous women, is one of ACOG's paramount priorities. ACOG recognizes its position as the leading medical organization dedicated to women's health and treats this responsibility with reverence and humility.

We also recognize the need and are committed to changing the culture of medicine, eliminating racism, and racial inequities that leads to disparate health outcomes, and promoting equity in women's health and health care.

As members of the committee are aware, the U.S. is the only industrialized nation with a maternal mortality rate that is on the rise, with unacceptably high rates among Black and indigenous birthing people.

Additionally, data indicates that the COVID–19 pandemic is disproportionately affecting communities of color, and maternal health experts caution that it may be exacerbating the maternal mortality crisis.

This is a multi-factorial crisis that requires multi-factorial solutions. The list of programs and initiatives critical to improving Black maternal health is long. In the interest of time, I will highlight only some of the evidence-based quality improvement programs that are helping us make progress in moving the needle.

In order to fully confront this crisis, we must recognize that race is a social construct, not biologically based, and that racism, not race, impacts healthcare, health, and health outcomes.

Systemic and institutional racism are pervasive in our country and in our country's healthcare institutions, including the fields of obstetrics and gynecology.

We must invest in quality improvement initiatives that standardize care and improve the provision of respectful and culturally congruent care. We must increase the access to care, including telehealth in rural communities.

We must address social determinants of health and we must ensure that all pregnant, birthing, and postpartum people have access to the care they need.

One initiative key to this work is the Alliance for Innovation on Maternal Health, or AIM program. AIM provides technical assistance, capacity building, and data support for the adoption of evidence-based patient safety practices, or bundles, which address issues like obstetric hemorrhage, hypertension, and safe reduction of primary Cesarean birth.

Ongoing work of AIM includes the development of a new bundle on cardiac conditions and incorporating equitable and respectful patient care into each of the existing bundles.

Continued investment in this program is necessary to achieve implementation of patient safety bundles in every birthing facility across the country. Perinatal Quality Collaborative and Maternal Mortality Review Committees also play an important role in improving maternal health outcomes.

Together, the AIM Program, Perinatal Quality collaborative, and Maternal Mortality Review Committees make up an infrastructure key to our efforts to promote high-quality respectful care and eliminate preventable maternal mortality and inequities in outcomes.

To simplify, Maternal Mortality Review Committees make recommendations for preventing maternal deaths. The AIM program provides tools and resources and the Perinatal Quality Collaboratives provide the networks to facilitate system wide implementation of these best practices.

Last, I would like to emphasize the critical need to close the postpartum coverage gap in Medicaid. Medicaid covers nearly half of births nationwide and we see alarming postpartum coverage gaps in both expansion and nonexpansion states.

As we learn more about the timing of maternal death, it is clear that continuous coverage of people who rely on Medicaid is critical to confronting this crisis. We urge Congress to do more to incentivize every state to provide 12 months of continuous postpartum coverage in Medicaid.

I am heartbroken every time I see a Black patient who comes to me for prenatal care, and says, Doc, please just let me die. This happens far too often.

No one should have to experience this type of fear. In the most highly resourced country in the world, people should not be dying from what should be the happiest times of their lives.

Thank you for the opportunity to be part of this urgent conversation and to help inform the critical work ahead to end preventable maternal deaths and improve Black maternal health.

Ms. KELLY. Thank you so much, Dr. Auguste, for your testimony.

We will now hear from Dr. Gillispie. You are now recognized for five minutes for your testimony.

STATEMENT OF VERONICA GILLISPIE-BELL, M.D., FACOG, M.S., MEDICAL DIRECTOR, LOUISIANA PERINATAL QUALITY COLLABORATIVE

Dr. GILLISPIE-BELL. Thank you.

Madam Chairwoman Maloney, Co-Chairwoman Kelly, Ranking Member Comer, and members of the Committee on Oversight and Reform, thank you for inviting me to testify and give my perspective on America's Black maternal health crisis. It is truly an honor.

I am Dr. Veronica Gillispie-Bell. Today, I bring forth my knowledge as an OB/GYN who has practiced in New Orleans for the last 13 years. I also bring the perspective as the medical director of the Louisiana Pregnancy-Associated Mortality Review and of the Perinatal Quality Collaborative, and finally, the perspective as a Black mama.

I bring this knowledge, but I am here today to be the voice of my Black patients, of my Black families. Do you know what it is like to have someone look you in your eyes with fear in theirs and ask, Dr. Gillispie, if you are not there when I give birth, am I going to die?

Our Black persons are afraid and they have every right to be, when 700 mothers, wives, sisters, daughters are lost in childbirth every year, when our chance of dying is three to four times that of our white counterparts.

And as you have heard today, it doesn't matter if we are rich or poor, if we are sick or well, if we are educated or not. The chance we will experience a severe maternal morbidity or a death is increased by one factor, race. And for those who think that being Black is the problem, let me be crystal clear.

Race is a social construct, not a biological condition. Four hundred years of systemic racism has created a world where we, as Black women, are two steps behind before we even emerge from the womb. False narratives have shaped biases that have led to inequities in the care that we receive.

But I came today to not only discuss the problem but also the solutions. We need congressional support for state Perinatal Quality Collaboratives. The Louisiana Perinatal Quality Collaborative, by using improvement science to implement equitable care delivery processes in birthing facilities, has seen a 35 percent reduction in severe maternal morbidity related to hemorrhage, a 49 percent reduction in our Black birthing persons, and a 12 percent reduction in severe maternal morbidity related to hypertension.

Evidence-based patient safety bundles like the AIM bundles tell us what to do. Improvement science tells us how to do it. It takes 17 years for evidence-based medicine to be implemented at the bedside without improvement science. With the improvement science, it takes only three years.

We need state Perinatal Quality Collaboratives to help teach our birthing facilities the how. We need congressional support for state Maternal Mortality Review Committees. Through the Louisiana Pregnancy-Associated Mortality Review Committee, we review all maternal deaths to quantify the drivers of maternal mortality.

This data is used to drive improvement. Funding is needed to secure the resources of time and people to support these committees in every state so they are able to locally identify the drivers of maternal mortality.

We need congressional support to ensure the extension of Medicaid postpartum coverage to one year. The year after birth is a crucial critical time to optimize medical conditions and provide an opportunity for family planning.

Through the American Rescue Plan Act, Congress took an important step to incentivize states to extend postpartum Medicaid cov-

erage to 12 months after the end of pregnancy. Even with those incentives, not all states will choose to extend Medicaid.

We need to ensure all Medicaid individuals have coverage through the critical postpartum period. We need congressional support for systems that ensure pregnant women receive the appropriate level of care based on the complexity and the acuity of their medical issues.

The American College of Obstetricians and Gynecologists and the Society for Maternal Fetal Medicine have established a classification system that standardizes the maternity facility capabilities and personnel to facilitate patients receiving risk-appropriate maternal care.

Not all states have adopted this system. As I have led the work to adopting this system in Louisiana, it is also apparent that states will need resources to meet these requirements, especially for hospitals in smaller and more rural communities.

We need congressional support for infrastructure to ensure telehealth is available to all. The benefits of telehealth with remote home-monitoring devices are well noted in the obstetric population.

Through our Connected Mom program at Oschner, I have diagnosed someone with preeclampsia with severe features between her regularly scheduled visits because she was able to take her blood pressure more frequently than in traditional care.

Telehealth has the potential to really improve outcomes, but it also has a potential to exacerbate barriers if we do not address infrastructure and access to home broadband.

We need to create and support programs to increase diversity within the physician work force, such as the Summer Health Professions Education Program. I am the result of that program when it was called the Minority Medical Education Program. We must support the development of minorities with a desire to pursue careers in healthcare.

I would like to thank you for the opportunity to share my perspective on the causes and solutions for the Black maternal health crisis, and I want to leave you with one thought.

Privilege should not be the gateway to equitable safe care. It is a right of everyone and our Black mothers deserve better and we can be better.

Thank you so much.

Ms. KELLY. Thank you so very much, Dr. Gillispie, for your powerful testimony.

Now I would like to introduce Dr. Crear-Perry. You are now recognized for your testimony for five minutes.

Thank you.

STATEMENT OF JOIA ADELE CREAR-PERRY, M.D., FACOG, FOUNDER AND PRESIDENT, NATIONAL BIRTH EQUITY COLLABORATIVE

Dr. CREAR-PERRY. Good afternoon, Chairwoman Maloney, Congresswoman Kelly, Ranking Member Comer, and members of the House Committee on Oversight and Reform.

My name is Dr. Joia Crear-Perry and I am an OB/GYN by training and serve as the founder and president of the National Birth

Equity Collaborative, where we create global solutions that optimize Black maternal, infant, sexual, and reproductive well being.

We shift systems and culture through training, research, technical assistance, policy, advocacy, and community-centered collaboration. In the United States, the legacy of devaluing Black women's lives is directly linked to today's Black maternal health crisis. Slavery as an institution and white supremacy as a framework have had a direct impact on the maternal mortality crisis among Black birthing people in the United States and around the globe.

From the stories told by Black women regarding the lack of respect for maternity care received in their birthing experiences as well as recent occurrences received in their—I am sorry, forced sterilization of women in ICE detention centers, it is clear that the very systems in place today that perpetuate harm are keeping the legacy of eugenics and population control alive and well. From Lucy, Betsey, and Anarcha to Kira, Shalon and Amber Rose, Black mamas deserve better.

The structure of our American society causes poor maternal health outcomes for Black people, not individual choices or genetics. Structural forces include our political, economic, justice, and education systems, as well as racism, immigration status, classism, gender oppression. All are reinforcing systems of oppression that cause harm and death.

In the last five years, at least 48 Black women have been killed by police and zero officers have been convicted. In order to end the Black maternal health crisis, we need to center Black women's lives and experiences, and that means addressing interlocking systems of oppression.

So we must, first, infuse a reproductive justice lens into policymaking, as demonstrated with the Black Maternal Health Momnibus Act of 2021. The Momnibus Act advances reproductive justice by joining once fragmented issues like racism within the healthcare system, implicit bias training, veterans, substance use disorder, climate change and environmental justice, criminal justice, and medical technology by censoring the most marginalized Black and indigenous birthing people.

No more silos. No more toolkits and drills as the solution. Health is a right and reproductive justice is the pathway to codify that right. We must establish the White House Office of Sexual and Reproductive Health and Well Being.

Sexual and reproductive health and well being are a key component of people's overall health and quality of life. We need to reproductive health equity. Efforts related to maternal and child health are siloed. Family planning services and social supports are disinvested in and have their roots in eugenics and population control in the United States and abroad.

We don't need a plan. We need power. A permanent infrastructure is needed to develop a Federal strategy for promoting sexual and reproductive health and well being through a human rights and racial equity lens and to better coordinate the many—the work of the many departments and agencies whose actions impact our well being.

Since I can breastfeed and have abortion on the same day, the Federal structures that support me should work together to support the full personal bodily autonomy of all people.

The establishment of the office can drive change and foster accountability by developing a national strategy for integrating sexual and reproductive health equity into established Federal processes.

And we have to reckon with the effects of COVID–19 on maternal health. The COVID–19 pandemic has disproportionately affected Black women and exacerbated inequities in maternal health outcomes.

Black women are more likely than white women to be essential workers, thus, increasing the likelihood of exposure and contraction of COVID–19. These physicians tend to have lower wages and they don't come with benefits like employer-sponsored insurance or paid sick leave. Without these coverage—without insurance coverage, routine maternal care visits are delayed or disrupted. Barriers to providers are heightened.

To address the impact that COVID–19 has had on Black maternal health, funding should be allocated to Black women-led community-based organizations to support the delivery of care in person or via telehealth through the Centers for Medicare and Medicaid that should support hybrid models of healthcare by providing guidance, incentives, and promoting telehealth and birth center services.

Congress should pass the COVID–19 Safe Birthing Act to promote birth equity during the pandemic and after. Further, we must increase health insurance coverage by mandated Medicaid postpartum coverage to be extended for at least one year.

The American Rescue Plan grants states the option to extend Medicaid postpartum coverage between the typical 60 days to at least 12 months. However, allowing the states to have the option to opt out of providing continuous coverage does not go far enough to address the maternal mortality crisis, an additional barrier for Black and indigenous women to access high quality and affordable health insurance. We applaud Illinois, but we worry about our sisters who live in Florida and Texas and other places.

Last, we must increase the pathways for birth workers of color. There are not enough Black workers of color, leaving Black birthing people with limited autonomy or opportunity to receive racially concordant care, which is associated with improved maternal health outcomes for Black mamas and babies.

Community-based birth workers such as doulas, midwives, lactation consultants, and community workers, and my colleagues who are members of the Black Mamas Matter Alliance, are essential to improving maternal and infant health.

Medicaid and private insurance can reimburse and cover, but most states have not. Requiring Medicaid reimbursement for all types of perinatal birth workers will help to rebuild and repair community trust and lead to reduction of health disparities in noncentered communities where health—holistic healthcare plays an essential role.

Further, we should invest in midwifery schools at historically Black colleges and universities as a pathway to increase the num-

ber of Black midwives and increase investment in pipeline programs for Black physicians, including OB/GYNs like myself.

Data shows that cultural concordance matters for Black births. I am committed to Black justice, liberation, and joy, and yes, liberation and joy can even be part of birth. They are core tenets of sexual and reproductive well being that values more than just mere survival or the absence of disease, but the ability to thrive.

So, that is what birth equity is all about. Thank you, and I look forward to your questions.

Ms. KELLY. Thank you so much, Dr. Crear-Perry. And now I would like to introduce our last witness, Dr. Taylor.

You are now recognized for your testimony.

STATEMENT OF JAMILA TAYLOR, PH.D., DIRECTOR OF HEALTH CARE REFORM AND SENIOR FELLOW, THE CENTURY FOUNDATION

Dr. TAYLOR. Good afternoon.

Chairwoman Maloney, Ranking Member Comer, and members of the committee, thank you for the opportunity to testify on structural racism and Black maternal health.

I serve as the director of health care reform and senior fellow at the Century Foundation, a 100-year-old progressive think tank that conducts research, develops solutions, and drives policy change to make people's lives better.

According to the CDC, Black women are dying of pregnancy-related causes more than any other racial or ethnic group. We are also most likely to experience severe maternal morbidity.

Poor maternal health outcomes among Black women cannot solely be attributed to social determinants such as poverty or educational attainment. Rather, structural racism is the main culprit.

Racism cannot be understood as simply interpersonal bias and animus. It is a powerful social condition that has its roots in a centuries-long system of oppression and devaluing of Black people and Black women in particular.

It not only persists today in our healthcare policies and practices; it has real significant impacts on people's health. According to the Aspen Institute, structural racism is defined as a system where public policies, institutional practices, and cultural representations work to reinforce and perpetuate racial inequity.

Much of American history and culture in which whiteness is privileged and color is disadvantages squarely fits this definition. The Aspen Institute also affirms that structural racism has been a mainstay in the social, economic, and political systems in which we all take part.

Healthcare is one of those systems. Throughout history, Black women have endured abuses by some in the medical profession. Enslaved Black women were forced to undergo experimental surgeries to advance the study of obstetrics and gynecology. Low-income Black women have been subject to forced sterilization. Our bodily pain has been diminished or outright ignored.

There are too many examples to list. These events have lasting implications for the health care challenges Black women face today. Harmful institutional practices and negative cultural representa-

tions have led to trauma inducing pregnancy and birthing experiences, and even death for some women.

This has to change, and, fortunately, it can be done. For one, healthcare providers should be trained in ways that afford them the opportunity to recognize and address racism and bias in their interactions with Black patients.

Practitioners should be equipped to ensure safety protocols that offer quality care that respects and values Black life. Public policy which can also perpetuate racial inequity needs to change as well.

The groundbreaking report on equal treatment published by the Institute of Medicine in 2003 asserted that health disparities not only emerged from how healthcare systems operate, but also from the legal, regulatory, and policy climate within which health is delivered.

One example of this is how some policy decisions make it harder for Medicaid enrollees, a program that disproportionately serves women of color, to access the health care they need. Almost half of all births in this country are covered by Medicaid. But for women who enroll in pregnancy only Medicaid, coverage ends just 60 days after giving birth.

The American Rescue Plan Act takes steps to remedy this shameful policy by giving states a time-limited option to extend coverage for new mothers up to one year. The Act also incentivizes Medicaid for states that have yet to do so, states which are, largely, concentrated in the South, where about half of African Americans live.

And while both of these provisions are progress, we desperately need long-term fixes to support the health care needs of Black women and birthing people. This means all states expanding Medicaid, mandatory extension of postpartum coverage to at least one year, and passage of the Black Maternal Health Momnibus.

Failure to take these steps will only further limit coverage for women of color and perpetuate racial inequity. We all have a role to play in dismantling structural racism, which is a key contributor to racial disparities in maternal health.

It is past time to implement policies and healthcare practices to ensure quality care that is equitable and respectful of Black women and birthing people.

In addition to my testimony, I will be submitting my article, "Structural Racism in Maternal Health Among Black Women," as published in the Journal of Law, Medicine, and Ethics, for the record.

Thank you for the opportunity to testify today, and I look forward to your questions.

Ms. KELLY. Thank you so very much, Dr. Taylor, for your testimony, and at this time, I would like to turn it back over to Madam Chair Maloney for questions.

Chairwoman MALONEY. [Presiding.] Thank you, Co-Chair Kelly, and thank you for your moving testimony. I now recognize myself for five minutes.

Ms. Ali and Mr. Johnson, thank you for sharing your stories with us this morning. They are heartbreaking, and I am sorry that our health system—that our American health system harmed you and your families.

Addressing our Black maternal mortality crisis will require a systemic shift in our approach to maternal health care and targeted data-driven policies. But right now, we simply don't have the tools to collect the data we need to inform good policy.

So, Dr. Taylor, let me start with you. How is the Federal Government's data collection on adverse Black maternal health outcomes lacking?

Dr. Taylor?

Dr. TAYLOR. Yes. Thank you so much for your question, Chairwoman Maloney.

You know, right now, we still have a fragmented system in terms of collecting data in this country and so, you know, the best that we can use or what we see coming out of the CDC is, basically, an estimate.

You know, you have heard a lot today from our colleagues about the need to advance and ensure better funding for maternal mortality review committees, and that is going to be key to make sure that we have more accurate data.

The Preventing Maternal Deaths Act was passed in, you know, 2018 and that bill allocated additional funding for states to develop and start maternal mortality review committees. But we still don't have them in every state, and so until we do that, you know, then we will have more accurate data, both in terms of race and ethnicity.

And we also need to know what the impacts are on these communities, both from a qualitative level as well as a quantitative level.

Chairwoman MALONEY. Thank you. There are a number of bills that have been introduced in the House that would improve data collection. For example, Congresswoman Kelly's MOMMA's Act would standardize Federal data collection and reporting on maternal mortality rates, and the data for MOMMA's Act, part about Momnibus package championed by Congresswomen Underwood and Adams, would foster improvements in data collection practices and promote diversity and community engagement in maternal mortality review committees.

So, Dr. Crear-Perry, how would better data collection reduce Black maternal mortality and morbidity in the United States?

Dr. CREAR-PERRY. Thank you. So, we know that during the COVID pandemic there was a highlight of the need for data, right. We were sending resources to places based upon bias. We were hearing words like it is the Chinese virus and all those biased, and so that made our infrastructure shift.

It is the same thing that happens when it comes to Black maternal health. If you don't have the actual information, you are going to create solutions not based upon what is really happening.

The beauty of us having, finally, the data released by the CDC after the testimony that Charles and I were able to give to increase funding for the CDC to help support states for recording show that, you know, Black birthing people were still five times more likely to die in childbirth, despite having an advanced degree.

That is the kind of thing that you need in order to be able to then say, so don't just blame them and say go to school and your outcomes will become better, because we go to school and we still die.

So, we need to have data so they don't operate out of bias when we create policies and strategies and investments just like we had to do during the COVID pandemic.

Chairwoman MALONEY. Thank you for your excellent answer.

I was pleased to join my colleagues on the Oversight Committee and in the Black Maternal Health Caucus earlier this week in asking the Government Accountability Office for three new reports that were crafted from the Momnibus legislation, and these are the three reports that we have requested.

The first will examine how the coronavirus pandemic has exacerbated America's Black maternal health crisis and how our efforts to build back better are impacting these outcomes.

The second will analyze the state of our country's perinatal work force, including barriers to assessing care by midwives and other maternity care professionals.

And the third will evaluate how America's Black maternal health crisis disproportionately harms people who are incarcerated.

In each of these requests we asked GAO to assess how limitations in data collection inhibit their abilities to draw conclusions. This will help us to understand what we still do not know.

Mr. Johnson, let me end by asking you what do you hope will come out of this hearing today?

Your mic is not on.

Mr. JOHNSON. Anybody? There we go. OK.

Chairwoman MALONEY. Now we hear you.

Mr. JOHNSON. OK, here we go.

So, thank you, Madam Chairwoman. Let me, first, say, as I expressed earlier, that although the statistics and the stories that we are hearing are devastating, what I want you to understand and I want all the members of this committee to understand is on behalf of the families that have been impacted by this crisis, legislation like the Momnibus gives us hope. It gives us hope.

And day in and day out, I talk to families who are grieving, families that are devastated, fathers that are trying to find their way in their new reality, and to be able to tell them that we understand your loss.

And there are people in the highest offices of power who are making the sacrifice of their loved one a priority and who are working tirelessly to make sure that it does not continue to happen.

So, my hope is that this committee, this Congress, will come together in a bipartisan fashion the likes of which we have never seen. Because the reality of the situation is, as I have said before, is that there are two types of people in this country—either you have a mama or you are one. It is that simple, and we have to make this a priority.

And I hope that people will begin to realize what this is. This is not a Black issue. This is not a Black women's health issue. This is a human rights issue. It should be a fundamental human right to deliver a healthy child in this country and live to raise that child. That is my hope.

Chairwoman MALONEY. Well, I hope they will be able to deliver on your hope by coming together in a bipartisan way and working collectively to change the system and to pass the over 15 bills that were under consideration today.

And thank you for sharing your story and your pain and your loss with us, and it will inspire all of us to work harder to help you and families like yours.

Mr. JOHNSON. Thank you very much.

Chairwoman MALONEY. I want to thank all of our witnesses for sharing their very powerful and personal perspective with the committee today, and I want to thank my colleagues for lending their outstanding leadership and expertise to today's hearing.

In the United States, it should be a national scandal anytime a parent is lost during childbirth, and we should not rest, any of us, until we turn the tide on this crisis.

I now recognize the gentlewoman from North Carolina, my Republican colleague, Ms. Foxx from North Carolina, for five minutes, after which the leadership will return to my co-chair, Ms. Kelly, for the duration of this hearing.

Again, I thank all of the participants and I look forward to everyone's questions.

Ms. Foxx, you are now recognized for five minutes.

Ms. FOXX. Thank you, Madam Chairman, and I thank our witnesses for being here today also.

The questions I have are all for Dr. Auguste. The U.S. and Canada have the lowest overall level of midwives and obstetrician/gynecologists, between 12 and 15 providers per 1,000 live births respectively.

In contrast, all other countries have between two and six times more midwives and OB/GYNs. How does this lack of providers impact expectant mothers?

Dr. AUGUSTE. Thank you, ma'am, for the question.

So, I think that this contributes—the lack of these providers around midwives contributes to the lack of work force that we are seeing that contributes to the lack of attention that is given to all of our mothers, particularly Black women.

So I think that, like many of the other panelists have mentioned, you know, being able to make sure that midwives are part of the healthcare delivery team will absolutely help and assist with the improvement of Black maternal health outcomes. Access to——

Ms. FOXX. Let me ask you—let me ask you to add to that. What can we do to encourage more people to enter birthing helper professions?

Dr. AUGUSTE. Thank you again for that question.

I think that it starts earlier on. I think we have to make this more of a awareness of the type of medical care that people can offer being midwives. Again, include them as part of the team to deliver healthcare. Make this more of the conversation. Have it well known and understood that the improved outcomes with this entire team—a physician, midwives, and doulas—will help on maternal health efforts.

Ms. FOXX. Well, we think—you agree that having midwives and other nonphysician partners can help decrease the risk for mothers. Is that correct?

Dr. AUGUSTE. Access to nonclinical support personnel like doulas and midwives is associated with improved outcomes for women in labor. I have worked alongside both for my entire career and I ap-

preciate and extremely value the care that they provide for the patients of a low-risk nature. Absolutely.

Ms. FOXX. Great. The COVID–19 pandemic seems to have forced care providers to increase telehealth options, which has increased the likelihood that pregnant women receive prenatal care. How does an increase in prenatal care impact the potential outcome for the mother?

Dr. AUGUSTE. Thank you. Yes, you are correct. Telehealth will increase the impact and the occurrence of prenatal care. Entering and adhering to prenatal care enriches the conversation and the relationship between the patient and the providers.

It allows time for the patients and the providers to discuss concerns, again, based on that relationship that they develop, have the women be heard and to have all their questions and concerns answered.

So, I think this is just a win-win situation in terms of solidifying the relationship between patients and their providers.

Ms. FOXX. A lot has been said today about the need to increase care for rural communities, and we all know it is difficult to get physicians of all kinds to live in rural communities.

But talk a little bit about the impact of increased telehealth services on rural communities.

Dr. AUGUSTE. Sure. So, I think that in rural communities we have to very clearly understand that studies have found that pregnancy-related mortality ratios rise with increasing rurality.

So, again, the lack of access to high-quality maternal services in rural communities is a result of many factors and telehealth can very much help.

So, again, being able—we cannot forget to have those resources available to the rural communities so that we can improve the access and the adherence to prenatal care.

Ms. FOXX. Great. I have 39 seconds left. Is there anything you wanted to say that you have not been able to say in your testimony so far in my questioning?

Dr. AUGUSTE. Thank you for that opportunity.

I just wanted to say that with all of the panelists here, it highlights the fact that this crisis is multi-factorial and that we have to work together on this.

All the panelists here bring together a different point of view, but this is all very important. It is multi-factorial problems. We have to have a multi-factorial solution, and all the panelists here are bringing that together, along with all the members of this committee in Congress. Thank you.

Ms. FOXX. Thank you, and thank you, Chairwoman Kelly, for allowing me the time to ask questions. I yield back.

Ms. KELLY. [Presiding.] Thank you, Representative. The gentlelady yields back.

And now the gentleman from Virginia, does he have his camera on? Congressman Connolly?

Mr. CONNOLLY. Yes.

Ms. KELLY. You have five minutes, sir.

Mr. CONNOLLY. I don't know why my camera went off. I am sorry.

Thank you, Chairwoman Kelly, and thank you, Chairwoman Maloney. This—I can't imagine a more important and gripping hearing we have had in recent history than this.

Mr. Johnson, your testimony goes to everybody's heart. What you and your family have gone through and suffered no American family should ever have to go through or suffer, and I can only assure you your words matter. You sharing your experience is going to matter, and this is an issue we won't let go of in the U.S. Congress and, hopefully, in a strong bipartisan fashion, as you suggest.

Dr. Taylor, we heard from Ms. Ali and we heard from Mr. Johnson stories of blatant indifference to, you know, women who were suffering, who were in pain, who were going through a difficult experience, and it cost one woman her life.

How in the 21st century is it possible that the medical profession is still capable of that kind of gross negligence and indifference to any patient, white or Black? And help us reflect on that. I mean, what does that say about hospitals and medical care in America?

Dr. TAYLOR. Thank you for your question, Mr. Connolly.

You know, I think it is important to note here, you know, there is a reason why this hearing has a theme about racism, right, and when we talk about racism in a structural sense or when it is institutionalized, sometimes it can be harder to see.

You know, it could be more in covert forms instead of overt forms. And we have also heard today that there is this of legacy of oppression and white supremacy that has really been—you know, was first instituted during when African Americans or Black people were enslaved and it has followed us until where we are now.

And when you hear in those stories the fact that women's pain has been ignored, they have not been listened to, that is a manifestation of racism within the healthcare system. And, you know, from my perspective, that also dates back to slavery where women were abused, you know, used for the experimentation of surgeries in the study of obstetrics and gynecology. Their pain was ignored.

You know, there is this perception that Black people have thicker skin. They may not feel pain in the same ways that white people do, and so that is being institutionalized in the healthcare system and it has led to, you know, the grave challenges that we have seen in terms of Black women, Black birthing people, and their experiences.

And so, I think, for us to move beyond this issue and really see change, we really have to deal with these racist perceptions of pain in the Black body.

Mr. CONNOLLY. Thank you.

Dr. Gillispie, would you like to comment on that?

Dr. GILLISPIE-BELL. Yes, thank you so much. I echo what Dr. Taylor has said. When we look, historically, especially in obstetrics and gynecology, and we look at the racism in medicine, just starting back to Marion Sims, who was known as the father of modern gynecology, who performed his procedures on slave women without anesthesia, even though anesthesia was available at the time.

What got perpetuated and what that published in the textbooks is that Black individuals don't feel pain in the same way, and in a recent study that was done at a medical school where they inter-

viewed over 200 white residents and white medical students, they believed that Black individuals have thicker skin and that our nerve endings are not the same so that we don't feel pain in the same way.

They also found in this study that the higher their disbelief was about Black individuals and their pain tolerance, the more likely they were to not prescribe appropriate pain medications.

And so what has been perpetuated through history has to be corrected, and I am speaking about pain. But there are hundreds, hundreds of biases that have formed the way we educate our medical students and our residents to then go and practice medicine.

And so we have got to start to undo these biases and we have to diversify the work force so that we have providers that are bias interrupters to be able to bring truth to the way medicine should be performed and the way that we—that we respect all birthing persons.

Mr. CONNOLLY. Thank you. In my brief—my time is up but I just want to conclude by observing we not only have to look at the huge inequities in terms of access to health care, we also have to look at how healthcare is practiced.

Thank you so much, all of you, for the courage of being here today and for riveting and enlightening testimony.

Thank you, Chairwoman Kelly.

Ms. KELLY. The gentleman from Virginia yields back.

And now the gentleman from Ohio, Congressman Gibbs, has five minutes.

Mr. GIBBS. Thank you, Madam Chair.

First of all, I would like to say the birth of a child that should be for the family—for celebration and excitement and look forward to a bright future, and it is sad to hear when there is problems, obviously.

Well, I am going to start off, first, and ask Mr. Johnson a question. Obviously, that was tragic what happened, the loss of his wife and child.

Was there anybody held accountable or any legal action taken for the unacceptable behavior that you can't tolerate, Mr. Johnson?

Mr. JOHNSON. Certainly. Thank you for that question, and extremely unfortunately there has been zero accountability in my wife's case, for multiple factors.

In the state of California, they have a set of caps on medical malpractice recovery that limit the value of human life to $250,000. So, what happens is, oftentimes, doctors who are perpetual bad actors are not held accountable. Not only that, the medical systems and the hospitals are not forced to be transparent.

So, the anniversary of my wife's death was five years on April 13. To this day, the doctor who was mainly responsible for taking her back to surgery and was found grossly negligent in her death by the California Medical Board is still practicing medicine.

He was disciplined with only three years probation after being found grossly negligent not only in Kira's death, but in the death of, I think, six other women, right. So, there has been zero accountability. There has been zero transparency, which adds insult to injury to families like mine. And I could go on and on and on——

Mr. GIBBS. Let me interrupt. I don't want to run out of time. But the medical board did hold him accountable, but then they didn't really hold him accountable. They just said he was grossly negligent, and that is an issue that should be addressed either through the legal system or, obviously, the legislature, too.

We shouldn't let bad actors, if it is bad doctors, bad police, bad anybody, they should be—they should be held accountable and removed from their positions.

So, I know about racism, right, and I struggle a lot with that, knowing that, you know, in our society, you know, in the medical community, we have lots of Black nurses and doctors and same thing in the police and in the cities where we have—and some of the written testimony there was talk about police brutality. I am sure it happens.

But in these areas where we have—in these urban centers the leadership is Black, in most cases, in a lot of cases, and elected—and some elected officials. I just want to mention that. So, there are some things that are hard to reconcile with.

I will also say that, you know, I think we have—poverty, you know, these people in our inner cities the Black community has been trapped in poverty, in housing, mental health issues, drugs, suicides.

We have all heard of that—heard about that, and one of the reasons they are trapped in poverty is because our education system has totally failed our Black community and they don't have a choice to get out or get to a better opportunity.

We have loss in the Black community, a lot of families with the fathers not there. So, there is a lot of other issues that go into this, too, I believe.

And so economic opportunities—on the last Congress, we passed opportunity zones targeted to these areas to provide jobs and opportunities and also criminal justice reform, a bipartisan bill.

Hopefully, that will help address some of these issues.

In my district here in Ohio in my largest county, Stark County, with a program called Thrive that helps especially with the Black community, safe, affordable housing.

They have mentoring programs for fathers. They also supply baby supplies, food, and diapers, and those—you know, obviously, those programs are helpful and help people lift out of poverty, because I think poverty is a—is a root cause of this issue.

Voice. My God.

Mr. GIBBS. Pardon? OK. Somebody was just—so unmuted there.

Anyways, I want to ask Ms. Auguste—Dr. Auguste, has there ever been any studies done that you know that determine the correlation between infant mortality and opioids and drug abuse in the—you know, I guess, in the Black community, or any community, for that matter?

Dr. AUGUSTE. Sure. Thank you very much, sir, for that—for that question. There are very clear links to opioid use and increased opioid use with both maternal and infant mortality. So yes, there definitely are.

So, I think that it is important that those issues as well need to be addressed.

Mr. GIBBS. OK. And I think some of the other—as I mentioned. I am out of time so I have to yield back. But I think we do need to address the poverty issue, especially how it is affecting the education system and the lack of opportunities, especially in the African-American community.

I yield back.

Ms. KELLY. The gentleman from Ohio yields back.

And now I would like to recognize the gentleman from Maryland, Congressman Raskin.

Mr. RASKIN. Thank you, Madam Chair, Congresswoman Kelly, Congresswoman Pressley, Congresswoman Maloney. This is truly an extraordinary hearing and it has got history-making potential, depending on what we do with it, and I just want to thank you all for arranging such an extraordinary panel of witnesses.

Dr. Gillispie-Bell, let me start with you. You stated that one factor stands out when you control for all of the variables, and I want to be very clear about this.

You are saying that African-American women suffer disproportionately negative outcomes regardless of income or wealth. So, that even within the category of affluent African-American women, they—we are still seeing racial disproportion. Is that right?

Dr. GILLISPIE-BELL. That is absolutely correct. Thank you so much for recognizing that. Yes, we find that looking specifically at severe maternal morbidity that a Black woman with a college degree is twice as likely to experience a severe maternal morbidity when compared to a white woman with less than a high school diploma. And so, again, as you have already said, and that is a testament to addressing—for addressing education, addressing those socioeconomic factors and still having adverse outcomes.

Mr. RASKIN. And you are citing studies that have isolated all kinds of variables that refute different theories about biological differences, physiological differences, all of it.

It comes down, as Dr. August or Auguste—forgive me, I missed the original pronunciation—but, Dr. Auguste, let me come to you. It comes down to what you say is not race, but racism.

And I love this point, Dr. Auguste, because you have made a point I think several of the panelists have also echoed, which is that race itself is a social construction. The whole concept of race was a construction of racism, the ideology of racism that in America was put to service for enslavement and oppression and exploitation of people. And so you blame it, generally, on race. It makes it sound like there is nothing we can do about it.

But if you identify specific structures of racism, that is something that we can actually change. We have got the power to change that, and it is so moving to hear these doctors come in and say that.

So, Dr. Auguste, let me ask you, what are some of those specific manifestations of racism in our medical practices, in our medical system, that we can alter by being conscious of this and intervening?

Dr. AUGUSTE. Thank you very much for the question.

So yes, as you can see from the conversation that we are having here, it highlights that there is racism at all levels and, unfortunately, we know that racism is structural and institutional, and

implicit bias on our healthcare providers contribute to the racial and ethnic disparities that we are all talking about and have contributed to this poor outcome.

So, organizations like ACOG are committed to addressing the issues around racism in medicine, particularly at the base of structural and institutional racism, and we want to be able to partner and are glad to partner with Congress in correcting these.

I just want to say that, you know, in my experience, healthcare providers, physicians, don't enter the profession with intention of providing inequitable health care. It is—it is the fact of the implicit bias on part of our healthcare professionals that needs to be addressed.

Mr. RASKIN. Very nice. OK.

Dr. Taylor, I want to ask you, quickly, if I could, how has insurance coverage been shown to improve health outcomes for women who are delivering? And I say this because Medicaid, I think, and Medicaid coverage can be a critical part of the answer here. So, does it—how does expanding health insurance coverage work to improve outcomes, Dr. Taylor?

Dr. TAYLOR. Thank you for that question, Representative Raskin.

Absolutely. Health insurance coverage is essential to not only ensure that women can keep up with their medical appointments, you know, support—it also supports, you know, the health of the infant as well. When mom is healthy, the infant is also healthy.

So, the continuum of care is critical, and that goes hand in hand with having insurance coverage.

Mr. RASKIN. Thank you so much.

Finally, Mr. Johnson, your testimony just broke my heart, and I want to thank you for being out there speaking up for your wife, your kids' mom and for all of those moms.

And I wonder if you would just say a word about the importance of making this an issue not just for women, but for men, too.

Mr. JOHNSON. So absolutely. So, thank you—thank you for your comments. It is critically important that as we are fighting to protect mothers that we are doing everything that we can to also empower their partners, if that means a father, if that means a support person, if that means whatever—however they are coming to their birthing experience, that they are informed, they are empowered about potential warning signs, that they understand how to advocate for them if their partner can't advocate for herself.

But it is also critically important that we reform systems in a manner in which these voices are heard and they are not dismissed, and a Black man such as myself, who is advocating for his wife at her most vulnerable point, is seen and heard and not seen as a threat.

That is what we must do, moving forward.

Mr. RASKIN. Thank you so much. I yield back, Madam Chair. Thank you for your indulgence.

Ms. KELLY. The gentleman from Maryland yields back.

And I now recognize the gentleman from Pennsylvania, Congressman Keller.

Mr. KELLER. Thank you, Madam Chairwoman. Every mother and newborn child in America deserves access to high-quality

healthcare before and after delivery. Far too many rural communities do not have a qualified childbirth provider.

Healthcare providers such as midwives must work around scope of practice requirements, licensing laws, and regulations surrounding physician supervision.

Dr. Auguste, to what extent are Federal restrictions surrounding midwives contributing to these work force challenges?

Dr. AUGUSTE. Thank you, sir, for the question.

So, I am a clinical expert and am not exactly familiar with all the legislative and Federal restrictions. However, I think the key takeaway point here is that there is a known shortage of healthcare providers in these rural areas.

So, we are talking about midwives and physicians. There is also a maldistribution of where those health providers are. So, we can look at those sort of—look at those sort of issues and really help to bring them into the communities where they are needed.

Some programs, like the National Health Service Corps, will help to bring those needed maternal health providers to some of those rural areas and urban areas where they are needed.

Mr. KELLER. So, that would be one of the steps. Would there be any other steps that could be taken to ease the regulatory burden on midwives or other in order to recruit more providers to the profession?

Dr. AUGUSTE. Sir, but I do apologize, I am not qualified to speak on the regulatory burdens on midwives. But our organization like ACOG and our legislative department can and will happy to get back to some of those.

Mr. KELLER. I appreciate that. A study done by the Harvard Chan School found that as many as 36 percent of post-delivery deaths are caused by suicide. While even a single suicide is unacceptable, these statistics tragically illustrate the need for continued maternal care after birth.

Dr. Auguste, how could an increase in telehealth availability help new mothers experiencing mental health challenges in rural areas of America?

Dr. AUGUSTE. Thank you, again, for that question.

Maternal mental health is one of the most common medical complications during pregnancy and, particularly, in the postpartum period that affect many women.

ACOG's guidance has been very clear. We have actually just put out new clinical guidance recently on optimizing the postpartum care that really does have a large focus on the mental health conditions. ACOG is also a supporter of telehealth modalities in this space as well.

ACOG works with having a working group on telehealth. It is important to understand that it is not—telehealth, that it is not just video but also audio. All of these modalities of telehealth are going to help all of our women particularly in the postpartum period.

If they have multiple children in addition to a newborn, it may be more feasible for them to use a telehealth modality to contact their health provider, and that point of contact, regardless if it is in person, by video, or by phone is going to be critical in preventing any further maternal mortality or morbidity.

Mr. KELLER. Thank you. I appreciate that. And also, would there also be a telehealth that would be helpful before delivery that might help some of the mothers take care—you know, get that kind of help that maybe before delivery that would help a more positive outcome, you know, for childbirth?

Dr. AUGUSTE. Absolutely. ACOG provides the guidance to obstetricians to continuously monitor and ask about a woman's maternal mental health throughout the course of pregnancy.

Telehealth can be used during the whole course of pregnancy. It is—again, as many of the other panelists have mentioned, it is now expected to be part of prenatal care and health delivery.

So, utilizing telehealth, perhaps, for a quick check-in when someone may not feel well or they feel like something's amiss, to have that connection point with a health care provider is critical.

Mr. KELLER. And I think it is just as critical prior to delivery throughout the pregnancy, and I think if we look at that would you agree that if we make sure people have that access to telehealth for mental health and emotional issues that might create a more positive outcome and not as many mothers would have problems during delivery or after?

Dr. AUGUSTE. I think—yes, I think that telehealth, in person, addressing mental—maternal mental health will make a difference in terms of our maternal mortality.

Mr. KELLER. Thank you, everyone, for your testimony and attention to this extremely important subject. Congress needs to remain committed to decreasing the maternal mortality rate so that more American families can get the care they need and lead healthy lives.

Thank you, and I yield back.

Ms. KELLY. The gentleman from Pennsylvania yields back and now I would like to recognize the gentleman from California, Congressman Khanna.

Mr. KHANNA. Thank you, Madam Chair, and thank you for your extraordinary leadership for many years on this issue. Thank you to my colleagues who testified so powerfully this morning, and thank you to the distinguished panel.

This hearing is long overdue and I am really grateful to all of you for helping educate us on this and spur us to action. As we work to enact policies to make childbirth safe, we must ensure that every single patient is listened to and supported, as we have heard from a number of the panelists, and one way we can do this is expanding access to doulas and midwives.

In fact, my understanding is there are multiple studies showing that integrating midwives into the healthcare system is associated with better outcomes for both mothers and babies.

Dr. Crear-Perry, if I could start with you. Could you please, briefly, explain the role of doulas and midwives for pregnant people?

Dr. CREAR-PERRY. Yes, thank you for that question. So, it is important for us to realize that midwifery was decimated in this country when we ended grand midwifery, which Black women were birthing babies around—Black and white babies when this country was founded.

And so undoing the racism and the harm means acknowledging that and ensuring that we have a full spectrum of access to birth

workers. Doulas provide social support and safety. My colleagues, as OB/GYNs, we understand that. When it comes to high-income patients, we expect them to have social support.

What we have not been able to grapple with is the need and the desire for people who are less centered to have social support and sometimes that we are not capable or we are not—we have not gotten to being able to appreciate how that is important as well.

So, it is important for us to be able to broaden our view and make room for all the people and who—to support birthing people, and we recognize that birthing people want doulas and midwives.

In every other country that has better birth outcomes than we do, that is who delivers those babies. And so instead of us—and we know we have maternity deserts. So, it is not a fight. It is not pie. There is room for all of us. We need more Black doctors but we also need more Black midwives and more Black doulas.

Mr. KHANNA. Thank you, Dr. Crear-Perry. In fact, a study published in the Journal of Perinatal Education found that people who use doulas were four times less likely to have a low birth weight baby and two times less likely to have a complication.

Dr. Taylor, maybe I could turn to you. How could access to these resources improve outcomes specifically for Black birthing people?

Dr. TAYLOR. Sure. Absolutely. I mean, you have already gone over the stats. I mean, for Black birthing people having access to doulas and midwives is essential, particularly if those doulas and midwives look like them.

Research also shows that for doulas and midwives that focus on having care models that center their patients and their lived experiences, they have better birth outcomes.

And so this also means—we have talked a lot about today, you know, ensuring the pipeline of a diverse work force and so that means we do have to make sure that we are creating opportunities, particularly for people of color, to be in those professional pipelines to get their certifications, to get their trainings, and to get the education that they need in order to support Black families and meeting them where they are. In most times, they are the ones that are on the front lines, meeting their needs, again, that is consistent with their lived experiences.

Mr. KHANNA. Thank you. One of the things many of us believe in this body is that we need universal health care. We need Medicare for all. We need equal resources.

But what I am hearing from you and some of the panelists is that that is not enough to deal with racism, that even if you have health care as a human right, even if you have Medicare for all, even if you have everyone having the same amount of access to doulas, you still have a problem of race. You still have a problem of discrimination that is leading to disparate outcomes.

I wonder, Dr. Taylor or Dr. Crear-Perry, if you can talk to us about what we need to do as we craft a Medicare for all bill or other bills of universal health care to deal specifically with the issue of race?

Dr. TAYLOR. Well, I can start. Oh, go ahead, Dr. Perry—Crear-Perry.

Dr. CREAR-PERRY. Oh, I am sorry. I was just going to say that you can never do race-neutral policies to end racist policy. So, we

created Medicare and Medicaid in a racist strategy. You know, Medicaid is a states' rights issue, and you see that play out over and over and over again.

So, when you do Medicare for all or any kind of universal health care coverage, you have to actually explicitly undo the racist harm that is currently being done by the current policies that we have.

Mr. KHANNA. Dr. Taylor, did you have any comment? And then I think my time is up.

Dr. TAYLOR. I would just say I agree with that. You know, I think you said it precisely. Coverage is not enough. So, you know, my opinion is that we need to not only fix our health care policies and ensure that health care is accessible and affordable to all families.

We also need to address the racism that is systemic within a restructure in this country and that is going to have to go hand in hand with the fixes for the—for health insurance.

Mr. KHANNA. Thank you. Thank you so much to the entire panel.

Ms. KELLY. The Congressman from California yields back.

And now I would like to recognize the Congressman from Kansas, Congressman LaTurner.

Mr. LATURNER. Thank you, Madam Chairwoman. I want to thank you for holding this critical hearing to help the committee explore the causes of the unacceptable high maternal mortality rate in the United States, especially among Black, American Indian, and Alaska Native women.

While the U.S. has one of the most advanced health care systems in the world, we are lagging behind several other developed nations in the area of maternal mortality rate. Nearly 700 women die every year in the U.S. because of pregnancy-related complications, and an additional 25,000 women will suffer from unintended health consequences due to pregnancy.

The worst part is that, according to the CDC, nearly two-thirds of every pregnancy-related death is preventable. We must take action to fix this immediately. I do want to point out some important solutions in this area that were—that were provided by the previous administration to achieve what everyone in this hearing desires, fewer deaths and health complications due to pregnancy in America.

Last December, then HHS Secretary Azar released a 184-page report entitled "Action Plan to Improve Maternal Health in America," which sets forth a comprehensive well-thought out plan to achieve demonstrable targets by 2025.

Madam Chairwoman, I would like to submit a copy of the action plan for the record.

Ms. KELLY. Without objection.

Mr. LATURNER. Thank you. It is my strong hope that the Biden administration will not abandon this deeply important effort by the previous administration. We should continue the good work that has already begun in this area and build off of it, moving forward.

Our country already lags too far behind other developed nations when it comes to maternal mortality. We cannot afford to abandon the significant progress this action plan offers and start from scratch.

Before I ask today's witnesses to comment on the plan, let me briefly summarize what the action plan does. According to the 184-page report, HHS provides a roadmap for addressing risk factors before and during pregnancy, improving the quality of and access to maternity and postpartum care, and support a research agenda to fill gaps in current evidence.

The vision behind the action plan is to, quote, "make the United States one of the safest countries in the world for women to give birth," end quote, especially for Black women, who are 2.5 times more likely than white women to suffer a pregnancy-related death or a serious complication.

The action plan includes four goals to help achieve the vision along with three ambitious health outcome targets by 2025. As set forth by former HHS Secretary Azar, the four goals include achieve healthy outcomes for all women of reproductive age by improving prevention treatment, achieve healthy pregnancies and births by prioritizing quality improvement, achieve healthy futures by optimizing postpartum health, and improve data and bolster research to inform future interventions.

By putting our complete focus and resources on these four broad goals, the action plan sets forth three significant maternal health outcomes to be achieved by 2025.

One, reduce the MMR across the board by 50 percent in five years; two, reduce low-risk Cesarean delivery by 25 percent in five years; three, achieve blood pressure control in eight out of 10 women of reproductive age who suffer from hypertension in five years.

Madam Chairwoman, I hope HHS Secretary Becerra, along with Congress, will take the hard look at the previous administration's action plan and choose to buildupon its progress for the sake of American mothers.

With my remaining time, I would welcome any of today's witnesses to share what they know about the action plan and their thoughts on the plan.

Dr. CREAR-PERRY. I will start. This is Joia.

We were working with HHS currently on the C-section work and a continuation of the action plan. With the previous administration it was exciting to see there was a desire to work on maternal health and there was a desire even in this body to pass bills.

What was missing and still—what we hope this can buildupon is an explicit identification of racism as a root cause, because even though we can decrease C-sections and we can improve outcomes when it comes to hypertension, we cannot do those things without addressing the bias that makes people do C-sections unnecessarily or makes people say Black people just have high blood pressure so I won't treat it.

So, it is a both/and so it is important to build on that, but explicitly call out the root cause of racism. So, thank you.

Mr. LATURNER. In the remaining time, would anyone else like to comment on their knowledge of the plan or their thoughts about opportunities to build on it?

Dr. AUGUSTE. Thank you, sir. This is Dr. Auguste, though I may not be familiar with every aspect of the plan, it is very important to know that ACOG and other organizations, but ACOG particu-

larly, continues to support some of the programs outlined, particularly the support for the AIM Program that was mentioned previously in my testimony, the Perinatal Quality Collaboratives, and optimizing postpartum care.

These are all things that many of the panelists have mentioned and ACOG supports as well. So, thank you.

Mr. LATURNER. Thank you, Madam Chairwoman. My time has run out. Thank you for holding this hearing. I appreciate the time.

Ms. KELLY. Thank you. The gentleman from Kansas yields back, and now I would like to recognize the gentleman from Maryland, Congressman Mfume.

Mr. MFUME. Madam Chair, thank you for this opportunity. I want to thank you, Chairwoman Maloney, Ranking Member Comer, and everybody else that has participated in these last two, two and a half hours on what, clearly, is a topic that begs for discussion and cries out for action.

I would—I do want to thank the ranking member for pointing out that this must be and has to be a bipartisan approach to get this done, and I would hope that other members of the House and of the Senate see that and act on it as well.

I do want to say to my colleague, the gentleman from Ohio, that we must be very, very careful when we start suggesting that maladies in a community, whether it is poverty or lack of education or lack of opportunity, contributes to these high death rates.

That is not the case. As has been said over and over again, this affects the most affluent African Americans. It has nothing to do with your status in life. It has everything to do with your race, and all we need to do would be to drive 90 miles from D.C. into Appalachia to see that poverty besets everybody and lack of education is not solely the exclusive domain of one race.

And as Exhibits A and B, I would suggest that Ms. Ali and her husband, and Mr. Johnson and his wife, represent affluent, well-educated, good taxpaying citizens who had a single hope and that was to bring forth a child, and in each case underwent things that we don't want to happen to anybody.

And so when you consider that here we are in 2021, after 200 years of slavery, oppression, deprivation, degradation, denial, disprivilege, that we are still back at the center of the argument and that center of the argument is this whole construct of race, as my colleague from Maryland, Mr. Raskin, pointed out in his comments, and that is what has to be dismantled before we would make any progress.

I do want to say that I don't have questions. I am just spouting out my observations. I have been around this body lots of times, both previously in the 1980's and the 1990's and now again, and I know that sometimes questions don't take the place of how something hits you, and when it hits you, you have an observation that you can't run away from.

And I am hoping that other Members of the Congress get a chance to read this committee's report as well as the report of the other six committees that have joint jurisdiction over this to understand that there is a crisis.

You cannot be the greatest democracy in the world and be 55th in the world in terms of child mortality. You can't have a situation

where one segment of your population, in this particular instance African Americans, tend to be three times more likely to face a deadly situation as it relates to birthing.

We can't ignore the fact that PAs and midwives are the stopgap measures that we have right now until we do something more disciplined to deal with this problem, that we ought to be trying to find a way to support and advance them and others.

I am happy to be a co-sponsor of the Momnibus bill. I have said to a number of people this is not just about women. This is about men as well, which is why I appreciated the testimony earlier from Mr. Johnson, and that we, as men, have to find a way, regardless of whether we are Black or white or anything else, to talk about this with men, even if they are not in the stage of being in a situation where their wife or partner can bear children because of their age. They still have to find a way to help move this effort forward, I think.

I spent a few years back some time as the executive director of the National Medical Association, and I can tell you that Black physicians across the country have been ringing this bell for years and years and decades and decades with early publications going back to the 1930's about how this problem has beset the African-American community and how it has done so in a way out of, again, this construct of race.

So, I just want to commend everyone who has spoken. I think that, clearly, the panel—the first panel of our colleagues—had an effect on me as did the second panel of persons who have undergone these tragedies. I don't know where Representative Bush might be.

But as soon as I see her, I am going to tell her I can't wait to see her son and meet Zion 21 years after the fact, when he was supposed to have been dead had it not been for her advocacy.

I want to thank Ms. Ali for her advocacy to make sure that her son's head was not sucked off by people who were using devices and apparatuses that only could cause problems.

Mr. Johnson, I don't know what to say to you except that, man, it is a tragedy and a nightmare, that I am so honored and pleased and I thank God that I did not go through with the birth of my six sons. I can only imagine your heartbreak, and I just want to pledge to you today personally and man to man that we will find a way to get something done to move this forward, to get it the attention that it needs of the entire House and Senate and to finally create what Jamie talked about as a historic moment in a committee of oversight to do something that will have lasting effects and make real and lasting differences.

Madam Chair, with that I will yield back any time that I might have.

Ms. KELLY. The gentleman from Maryland yields back.

And now I would like to recognize the gentleman from Georgia, Congressman Clyde.

Mr. CLYDE. Thank you, Chairwoman and Ranking Member, for holding this hearing today. I appreciate your shining a light on our Nation's unacceptably high mortality—maternal mortality rate and advocating for upholding the sanctity of life.

As you know, the CDC defines maternal mortality as the death of a woman while pregnant or within one year of the end of pregnancy. The irony is not lost on me that while my Democrat colleagues sit here today to talk about protecting the life of mothers, we cannot forget that mothers are, indeed, the bearers of life, and so we must protect the sanctity of life in its entirety.

Unfortunately, many of my Democrat colleagues have not committed to upholding life at all stages, as their leadership continues to block the Born Alive Abortion Survivors Protection bill, as well as repeated requests from the Republican side of the aisle to ensure taxpayer dollars do not fund abortion providers such as Planned Parenthood.

And so I want to take a second to reflect on that latter point. As it is critical that we work to ensure all communities have access to quality health care, including maternal health care, the bottom line is that Planned Parenthood and other abortion providers do not have any regard for the sanctity of life, and so by no means provide quality health care. In fact, their founder advocated for the exact opposite of life.

It sickens me that the government continues to funnel tax moneys to Planned Parenthood and abortion providers that claim to provide quality care to expectant mothers in several of our communities, including those that need it most, but fail to do so.

While the facts show that Black communities are reeling from high rates of maternal mortality, rural communities such as my district in North Georgia, Georgia's 9th, are also struggling. Just as the COVID–19 does not know racial boundaries, maternal mortality rates, at large, do not either.

And so I do not believe my constituents should be left out of today's conversation just because they do not fit into the racial lens of today's hearing. In fact, Georgia is in the top 10 of the highest maternal mortality rates in the country with 48.8 per 100,000 deaths.

In 2019, the Georgia House of Representatives formed a study committee on maternal mortality and reviewed three years of maternal death rates in that state—in the state. They found that 60 percent of deaths were preventable.

Furthermore, it was found that rural women have a much higher maternal mortality rate than do urban women. While white women—excuse me, white women in rural areas have a 50 percent higher maternal mortality rate than white women in urban areas, and Black women in rural areas have a 30 percent higher mortality rate than their urban counterparts.

To reduce these unnecessary deaths, the state of Georgia created the Perinatal Quality Collaboration—Collaborative, which has been implemented several of the initiatives put together by the Alliance for Innovative Maternal Health.

Specifically, it sets forth the best practices for maternal care and provides recommendations for hospitals, protocols, policies, and a system of date tracking.

Over 60 Georgia hospitals participate in these maternal health initiatives touching 87 percent of all births in Georgia to date.

While ensuring quality maternal health care remains a top issue nationally along with protecting against maternal mortality, I want

to take this opportunity to commend my state leaders and officials for taking steps to protect the life across all communities in the state.

There is more work to be done, and I am committed to looking for ways to support them.

With that said, I turn now to a few of today's witnesses. This question is for Dr. Auguste.

Doctor, thank you for being here today and thank you for your testimony. As you know, 40 percent of all U.S. counties, most of them rural, lack a qualified childbirth provider. Do you believe an increase in quality maternal care providers will positively affect maternal morbidity rates and how so?

Dr. AUGUSTE. Thank you, sir, for that question. Simply put, yes, definitely. I think this is an issue in our rural areas where there is a lack of providers, both physicians, midwives, and I think that there has to be—there has to be efforts to increase that, things like—things like the National Health Service Corps that will aid in providing—putting and placing providers in those rural areas are critical here, utilizing some of the tools.

Some of these providers that are there that are the only providers for hundreds of miles, giving them the tools that they need, things from AIM, from different bundles. Utilizing the Perinatal Quality Collaboratives to make sure that they have the resources that are there for those providers in the rural areas, I think, will be critical.

If we provide the resources and a streamline for increased providers in those rural areas, we should be able to see improvements in maternal mortality.

Mr. CLYDE. Thank you very much, Doctor. I appreciate your answer.

Ms. KELLY. The gentleman from Georgia——

Mr. CLYDE. And I yield back.

Ms. KELLY [continuing]. Yields back, and I would like to recognize the gentlewoman from New York, Congresswoman Ocasio-Cortez, for five minutes.

Ms. OCASIO-CORTEZ. Thank you. Thank you so much, Chairwoman—Madam Chairwoman.

That was just a lot, and I think it is really important that it is addressed very directly right now and in this moment.

First and foremost, I don't want to hear a single person on this committee or outside of this committee talk about what—about valuing life when they continue to uphold the death penalty, when they continue to support policies that disproportionately incarcerate and lead to the deaths of Black men and people throughout this country, and uphold in a—an absolutely unjust medical system that exists for profit that allows people to die because they can't afford to live.

In addition to that, if we want to talk about Planned Parenthood, let us talk about how many lives Planned Parenthood has saved and how many babies have been born because of the prenatal care provided by Planned Parenthood.

And if you don't—if you don't believe it and if you have never met a Planned Parenthood baby, I am happy to let you know that

I am one, and that my mother received and relied on prenatal care from Planned Parenthood when she was pregnant with me.

And so if we are concerned about life, we don't get to talk about anyone else who is not concerned about the full spectrum of that when we are upholding policies that kill people.

Moving on, I would like to submit some incredible testimony from healthcare providers and champions and advocates from my district right here in the Bronx and Queens: Dr. Heather Irobunda, and three midwives—Carmen Mojica, Melissa Enama Bair, and Dr. Anne Gibeau, as well as the testimony from one of my constituents, Bruce McIntyre, who, like Mr. Johnson, lost his love and life partner, Amber Rose Isaac.

Ms. KELLY. Without objection, so ordered.

Ms. OCASIO-CORTEZ. Thank you so very much.

And I want to thank every single one of our witnesses that were here today to share their story, many of which were intensely personal, and it should not be up to us to rely on sharing a trauma that is so personal in order to enact change.

The right thing should just be done without doing—without having to share and relive these traumatic experiences. But you all have chosen to do so and I thank you, particularly Ms. Ali and Mr. Johnson, for sharing that and opening your experiences today. So, thank you.

I would like to start—you know, every single one of these medical providers and people who offer testimony from the—to my office as well pointed to social indicators of health. They said, if you want to protect Black women, we need to talk about housing. We need to talk about livable wages. We need to talk about guaranteed access to health care.

And also, when it came to Mr. McIntyre, we need to talk about medical racism. Because this isn't just about poverty or education at all. This—you could have all the access to the resources of the world and still be subject to medical racism within our system.

In fact, Mr. McIntyre, with his partner, Amber Rose, tried to get family leave approved by their OB/GYN and their OB/GYN didn't believe her. And while she saw white women patients at the same income level and opportunities as her due at a later date routinely get approval for FMLA, she didn't because her pain wasn't believed and her concerns weren't believed.

So, I had—I know I have just a minute left but I wanted to ask two questions, one on midwives and one on that—on the role of men.

So, I wanted to ask Ms. Ali if you felt that perhaps midwifery or doulas in your experience or in experiences that you have seen in your advocacy could help stem or be a protectant against medical racism in having that advocate there by your side, and I also wanted to ask Mr. Johnson about how this system is hurting men and spouses as well.

So, we will start with Ms. Ali. Thank you.

Ms. ALI. Thank you for that question and for what you said earlier as well. You gave my heart some rest.

In the advocacy work that I have done and in meeting a lot of different midwives, you know, and doulas, they kind of—they play more than birth worker roles, in many cases.

They—they are—you know, in some cases, they are often put in positions where they have to defend the rights to autonomy, the rights of their—the people they are seeing, their families, their rights to choice. And, you know, I know—the thing is, though, there is this, you know, OB/GYN-led kind of conversation happening. There are—I have—I know a lot of people where, you know, the doulas don't necessarily have the authority to be able to do what they really can in the hospitals.

So, there is this kind of tug of war that is taking place in the hospital who—you know, what the patients want them advocating for the patients but not really having the power that—or this—the same so to have their choices be heard, have the patients' choices be heard.

I know. I mean, I said it in my statement, but the experience I had with my midwife was completely different. It is a completely different—it is a paradigm shift in the way that they care for you.

My OB/GYN, I only saw him 20 minutes every session. He didn't really get to know me and my family or my desires, and when I even talked about natural birthing positions and, you know, when I had questions to that nature, he made a joke and he told me that I could hang from the lights in the delivery room if I wanted to. And when it came to actually birthing, he wasn't even there. He was on vacation.

And so midwives have a completely different—it is a totally different modality, that it made me feel—she made me feel safe. We felt safe with her, even when we had to go to the hospital.

Ms. OCASIO-CORTEZ. Thank you.

Mr. JOHNSON. So, thank you for that question. First, let me say thank you for uplifting and centering the story of Amber Rose Isaac and the work of Bruce McIntyre, who is a dear, dear friend of mine and I draw inspiration from him daily because he is a champion.

And so with specificity to your question, I think that it is—this maternal mortality crisis is impacting men in ways that are immeasurable. But I want to talk specifically about the layered roles that racism plays in the lived experiences of Black families and, particularly, Black fathers.

So in my situation, when my wife was most vulnerable and I was doing everything I could to advocate for her, Kira, at her most vulnerable state, the thing that she kept saying to me as I was getting increasingly frustrated and angry was, "Baby, just please stay calm. Stay calm." Because Kira knew that if I raised my voice, if I slammed my fist on the table, if I grabbed a doctor by the collar, if I turned over a table, then I would have immediately been seen as a threat as a Black man and been removed from the hospital or the situation.

And every single day, I ask myself the question what is it that I should have done or what could I have done differently, and that haunts me. Should I have yelled? Should I have—I mean, but the reality of the situation as a Black man I did not have the same autonomy to raise my voice, scream, that a Caucasian father would.

And as I look back on April 12 of 2016, the only outcome that I can conceive that could have been worse than what happened to Kira is had I been thrown out of the hospital or detained and then my wife not survived.

But at bare minimum, at bare minimum, I can wake up every day knowing that I was there and I did everything within my power to try and save her.

Ms. OCASIO-CORTEZ. And you continue to do everything in your power to honor her life and her legacy, and to protect so many other women and their partners and birthing people from having to endure the experiences that you have. So, thank you. Thank you so much.

Mr. JOHNSON. Thank you.

Ms. KELLY. The gentlewoman from New York yields back. And now I would like to recognize the gentlewoman from Washington, DC, Congresswoman Eleanor Holmes Norton, for five minutes.

Ms. NORTON. Thank you very much, Madam Chair.

We have been hearing about losing a parent to childbirth and how devastating it is to families, and that too many African-American families are forced to endure this trauma.

So, I thought I should share with—share with you a few stories that I think will drive this home. Dr. Chaniece Wallace worked as a resident physician at Riley's Children's Health Hospital in Indianapolis. She was only 30 years old and died just two days after she and her husband welcomed their first child, a daughter named Charlotte.

Yolanda Kadima from Atlanta had previously worked as a lactation specialist. She died three days after she had a C-section delivery and gave birth to twins. She left behind a husband and five other children.

Mr. Johnson, who has stepped out—I am sorry. That is who my question was for because that is who I had a question for. If I can pause a minute. If we can pause a minute, because that is who I had written a question for.

Ms. KELLY. We can pause.

Ms. NORTON. If we can pause on the hearing just a moment.

[Pause.]

Ms. KELLY. Congresswoman, do you want me to go to the next person and come back to you?

Ms. NORTON. Would you please?

Ms. KELLY. Sure. I would like to recognize the gentlewoman from Michigan, Congresswoman Tlaib.

Ms. TLAIB. Well, thank you so much, Chair Kelly, and thank you so much to all of our panelists for being here. This is an incredibly emotional and personal issue, just as a mother myself and also as a Detroiter, where we see our babies, you know, approximately 15 out of every 1,000 of our babies are not surviving or not getting to their first birthday and we see more of a risk, obviously, among Black mothers who face, you know, obstacles like massive water shut offs, hospital deserts, and other increased stresses, which is experienced every single day due to structural racism in our country.

But, you know, I have been compelled and this question is for you, Ms. Ali, to address this myth that we are hearing in committee. I mean, you are an accomplished actress. What is your opinion on this myth posed during this committee that this is solely a, quote, "income problem" and nothing to do with structural racism?

Ms. ALI. I—how do I react to that? It makes me angry. It doesn't matter. You know, when you are—when you are in the hospital, you are in the same blue gowns, or green, depending on what the hospital puts you in.

You don't have your makeup on. You are stripped down. You are in labor. And your concern is for the safety of your child, you know, even before your own. And so whatever fancy words I learned at the Ivy League school I went to they are not there anymore. You know what I mean?

Those things, they should never matter, which is really problematic about this as an argument to not—as an argument against fixing this. Because it shouldn't matter what—where I went to school or how much money I make or, you know, I was an actor when I was a kid. None of that should matter. I actually—I come from a humble background. You know, I happened to get on a show when I was a kid, and none of that should matter and the truth is, it doesn't.

Ms. TLAIB. I agree with you, Ms. Ali. You know, Black mothers are more likely to suffer from a stroke or a heart attack or given C-sections, which carry a far higher risk of maternal mortality, even during low-risk pregnancies. And so for many of us that have been championing this issue, this is a public health emergency and I truly believe the cause is structural racism.

So, you know, Mr. Johnson, the story of what happened to your wife, Kira, after she gave birth is heartbreaking testament. I couldn't even, you know, stop shaking because I knew what it was going to lead to, but just hearing your pain.

One, you should know that the guilt you might still feeling just as that person, the husband, the spouse, the partner, know this, that we failed you. You didn't fail her. So, I want you to hear that from me.

But you said something that race didn't kill her, but racism did. Can you talk about and explain further what you are—you meant by those words?

Mr. JOHNSON. Absolutely. Thank you for that. So, let me give a very vivid kind of example of where the intersection of policy and legislation and racism intersect specifically in Kira's case.

So, keep in mind that we gave birth at Cedars Sinai Hospital in the state of California. So, some of the people—some of the members of this committee may be familiar with AIM and the work that they have done with their bundles and their obstetric hemorrhage bundles, right.

So, in short, there were policies and procedures in place at Cedars Sinai Hospital that should happen when a woman is showing signs of hemorrhage post-delivery, right. This hospital and the staff had been trained extensively to utilize these toolkits provided by ACOG.

However, in my wife's case, they just chose not to use them. There were tools that were there at their disposal to save my wife's life. Hemorrhage after childbirth is not something that is abnormal and I am sure that the doctors and the experts on this—on this that have been chosen to testify can speak to that.

But when she wasn't prioritized and she wasn't seen as a party, and when her pain was dismissed and when my concerns were dis-

missed repeatedly, that is when the intersection of bias, racism, can—bias and racism can have catastrophic and very oftentimes fatal consequences.

And this is what I say when I have the opportunity to speak to care providers, systems, and medical students. If you are civilian and you hold bias in your heart—we all have bias, right. But if you are a civilian, you have the luxury to work those biases out in your own time or not.

But if you are a care provider who is responsible for the life and well being of families, you have two options, as far as I am concerned. You can identify those biases, take steps to get better, or you need to find something else to do. It is that simple.

Ms. TLAIB. Thank you. And, Chair Kelly, if I may, I would like to submit for the record a letter from Mothering Justice, which states Black maternal and infant death rates force us to acknowledge that bias isn't simply wrong, but it is deadly.

And so I encourage all my colleagues to also read this important letter from Black mothers right in my community. This is an amazing advocacy organization that truly needs to be seen and heard in the halls of Congress.

Thank you so much, and I yield.

Ms. KELLY. Without objection, so ordered.

Ms. KELLY. The gentlewoman from Michigan yields back.

I would now like to recognize again the gentlewoman from Washington, DC, Congresswoman Holmes Norton.

Ms. NORTON. Thank you, Madam Chair.

Mr. Johnson, I had been particularly moved by your experience as a father, and that is why I had shared a few stories that I wanted to lay before you before asking my question.

One was from a physician, a woman who had worked as the resident who was only 30 years old and died two days after she and her husband had a first child. Another was a lactation specialist—you see, nobody is immune from this experience—who had died three days after a C-section and had given birth to twins, leaving five children behind.

These families can never recover from this kind of impact, and you testified about losing your wife, Kira, after a routine C-section just after the birth of your second child.

I would like to hear more about how the loss of your wife impacted you and your family, and whether you have heard from other families about any lasting impacts that they have experienced.

Mr. JOHNSON. So thank you, Congresswoman, for that question. Thank you for centering the impact and the pain of the families in this conversation.

And so my heart is particularly heavy, as it is every year as we approach Mother's Day, and I—we celebrated my son Langston's fifth birthday on April 12, and every year April 13 is the day that Kira transitioned.

And so it has been five years for us and I am still struggling to find understanding. One of the main reasons I am struggling with understanding is there has been zero accountability, if I am being frank. There has been zero accountability, and with all the work

that we are doing, with the tremendous allies that have come to the table in meaningful ways, we are still losing mothers.

We are still losing mothers in an alarming rate, and I have, in fact, heard from and I have talked to families—it almost seems like Groundhog's Day. Almost every day or weekly or biweekly, I am speaking to another father whose world has been devastated, another family who is searching for answers on why a perfectly healthy woman with so much to contribute is no longer here.

And there is nothing that I can do to bring reason or rationale to this because it is—other than we are falling short time and time again.

And so that is why I am here, and although we cannot bring these precious mothers back, we have an opportunity. We have an opportunity for everybody on this committee to do everything we can. We owe it to these mothers and we owe it to these families to do everything we can to make sure we send other mothers home with their precious babies.

Ms. NORTON. Thank you, Mr. Johnson. We needed to hear that.

Mr. JOHNSON. Thank you.

Ms. KELLY. The gentlewoman from Washington, DC, yields back. And now I would like to recognize the gentlewoman from California, Congresswoman Porter.

Ms. PORTER. Thank you so much.

Ms. Ali, thank you for being here today. You wrote in detail about your birthing experience and the racism that threatened your life and the life of your child. I wanted to talk with you today about not just the physical challenges that Black mothers endure in childbirth, but the mental and emotional ones as well.

Would you describe your first birthing experience as traumatic?

Ms. ALI. Yes, absolutely.

Ms. PORTER. And was this trauma something you had to deal with in those first few weeks in motherhood—first few weeks and months of motherhood?

Ms. ALI. I did, while I was, you know, also learning to breastfeed, and I would say I just didn't deal with it. My husband did as well. It is a good thing that we like to talk because we also didn't even realize that what we went through was something that we might, you know, want to talk to somebody about.

It took a good year or so to really unravel everything that happened and that something bad had happened. A lactation consultant that I worked with, I remember telling her—she just asked me kindly, how was your birth? You know, what happened, da, da, da, and I shared a little and the look on her face is what let me know that my feelings were valid.

Ms. PORTER. Now, and I will also—as a mom of three who has gone through some of this herself, it can also—in addition to having an influence on the spouse, if it happens when you already have children in the home, the trauma of the arrival can be a real impact for those other young children who were afraid of their mother being sick, of losing the child, watching her heal.

And, of course, you talked about this going on during the time that you were dealing with breastfeeding, lack of sleep, hormonal changes, physical healing, isolation.

Were you able to get mental health services during that time? You talked a little bit about that lactation consultant. But so often I think people don't know that their birth has been traumatic or that they need those services, in some cases until they go to get pregnant a second time.

And, for me, that was really when I realized that I had had a traumatic first birth. There was this enormous sense of fear and dread that I felt about being pregnant again, and what was supposed to be an incredible joyful thing. It was a planned pregnancy. Can you talk a little bit about your experience with getting mental health services?

Ms. ALI. I think that, very similar to what you just described, when we were planning our—to get pregnant again. You know, we talked about all of the joys of seeing our first baby with a sibling and all of those things. But, really, the big discussion was how do we not let that happen again.

And speaking with my midwife, actually being invited into these birth advocacy spaces, because I actually shared my breastfeeding story online and I was invited into the spaces and this world of advocates and birth workers just opened up for me, and it was a world that I didn't know existed.

And that is—and that is when I really—that education—that is when I was able to seek help for those feelings. And I still—you know, I still go through it.

Ms. PORTER. Well, and I just will echo what you are saying about the way—the level of care and support, that world, when you are in it and you are getting the help that you need to heal versus the level of despair and trauma and isolation, it really does save lives.

And I want to turn to Dr. Crear-Perry to ask you about this. Are perinatal mood disorders, things like postpartum depression or postpartum psychosis, a contributor to maternal mortality—in maternal mortality?

Dr. CREAR-PERRY. Yes. We know—thank you for that question. We know that postpartum anxiety disorder and postpartum depression are huge contributors to maternal mortality and that we have not created a infrastructure to support birthing people so that they can feel safe and heard and valued.

Most places don't even have access to even therapy if you are—or even a social circle. And so we have kind of disconnected our mental health from our physical health in our American healthcare system and it shows up greatly in our birthing—the anxiety—and then we don't provide the social support that people need.

So, we send people off to go back to work, usually within 10 days after having a baby in this country with no pay leave, with no equal pay, with no childcare, and then we say, oh, but don't be nervous. We don't have access for anything for you, right.

And so, like, all the ways that we are creating the nervousness by our policy choices, and then we don't also provide for safety—for mental health for people. So, we are doing a disservice on both ends.

Ms. PORTER. I could not agree more.

Dr. Taylor, I just wanted to ask you, are new Black mothers—how likely are they, more or less likely, to be screened for depression during the postpartum period than white mothers? Can you

talk about is there—is there a disparity and what you think the reason might be?

Dr. TAYLOR. Well, there is, certainly, a disparity in terms of access to the mental health care and services that Black mothers need. You know, there is still a issue—I just want to say this—across the board in terms of accessing mental health care in this country, particularly for communities of color.

We are less likely to have access to mental health providers that look like us, which I think is really critical, especially to ensure that we have, you know, culturally responsive care. Also, too, that even for people that do have health insurance, the costs that can be associated with mental health care is also a barrier for us.

And so, whereas I think it really just comes down to whether or not you have health insurance and then also whether or not the providers that you do have access to are they—do they provide culturally responsive care, which is really critical for Black moms.

Ms. PORTER. I really appreciate that, and my time is about to expire. But I just want to emphasize there are policy things that we can do to address some of this.

Building on what Dr. Crear-Perry said, last year I fought for the creation of a National Maternal Mental Health hotline, and one of my priorities this year is to secure increased funding for the hotline, which provides 24-hour voice and tech support, including culturally and linguistic—to meet individual cultural and linguistic needs.

So, as someone who, you know, went through three children and, you know, was told, we will see you in——

Ms. KELLY. The gentlelady's time is up.

Ms. PORTER [continuing]. We will see you in six weeks, good luck, that is not an appropriate response. That is not what mothers and fathers and kids and parents in this country deserve.

Thank you very much, Madam Chair, for your indulgence.

Ms. KELLY. The gentlelady from California yields back, and now the gentlewoman from Missouri, Congresswoman Bush, and thank you so much for your testimony earlier and sharing your personal experience.

Ms. BUSH. Thank you, and St. Louis and I thank you. Today's conversation is a necessary step in the work to address the Black birthing crisis in our country, a crisis rooted in our Nation's legacy of slavery, let us be clear. A country that did not even recognize Black people as full of people under the law, words that are still written in our Constitution.

America's history is one that too often stripped away the humanity of Black women and Black people. Malcolm X once said the most disrespected person in America is the Black woman. The most unprotected person in America is the Black woman. The most neglected person in America is the Black woman. What a painful truth.

In St. Louis, Black women and birthing people are four times more likely to die during childbirth birth. Four times. Missouri ranks 16th in the Nation for Black infant mortality, and these statistics outpace national averages.

To truly understand what is happening to us today, we must first understand where it begin—where it began. Black enslaved

women, my ancestors, were valued for their ability to increase the wealth for white slave owners, forced to provide strenuous labor and reproduce children that will later be torn from their arms and sold off. Your child born, torn from your arms and sold off, for you to never see them again, possibly, and that was OK with our society back then, and no one wants to really talk about that.

Black enslaved mothers often only received medical care from trained doctors when their lack of fertility or difficulties during childbirth threatened that profitability.

Dr. Taylor, how has the legacy of slavery affected Black maternal health?

Dr. TAYLOR. Thank you, Representative Bush, for that question. You know, as I said in my testimony today, it is absolutely

[inaudible.] I think if you look at, you know, some of the examples that you talked about, as well as others on the panel today, you know, discounting Black women's pain, you know, this focus on replenishing the population of slaves by using Black women's bodies, abusing Black women's bodies.

You know, the pain piece is key because it is hard when we have this conversation, folks don't understand that there is a direct connection to some of the same, you know, situations that we see now, you know, in terms of Black women's pain being ignored or outright diminished in the context of their interactions with healthcare providers.

That is based on negative stereotypes of how Black people feel pain, whether or not we feel pain, we have thicker skin. And so slavery and the barbaric, you know, situations that we saw during that time have a definite connection to some of the same challenges that Black women are going through today.

And I will just say, too, I mean, we can rise above this, right. I mean, we haven't had a conversation today about what we need to do in terms of ensuring that providers have the right training.

First, we need to acknowledge that that history is there and then how do we work with providers to make sure that we root out those racist stereotypes, those mindsets, to the point that it doesn't show up in their interactions with patients.

Ms. BUSH. Thank you. Black people were also used as scientific test subjects for the development of tools and surgical methods and medical procedures, exactly going down the lane you were just speaking about, Dr. Taylor, always without consent and often without anesthesia under the false racist belief, like Dr. Taylor just said, that Black people did not feel pain.

Dr. Crear-Perry, Black women have been begging to be heard when it comes to our pain and our trauma. Can you describe the harm caused on Black birthing people, Black women, when providers dismiss or ignore our pain?

Dr. CREAR-PERRY. Yes, and I think it has been—thank you for that question, Congresswoman. I am so excited to meet you, actually.

Anyway, I think it has been mentioned earlier that there was a study that showed that medical students believed that we had thicker skin. I think Dr. Gillispie mentioned it. The truth is the reason they pick medical students because that is who would answer the question.

But that is not just medical students. That is department chairs, the CEOs, that is everywhere that we go, this idea that we don't feel pain, the way that we have to minimize ourselves, we don't get access to treatment.

There was another study that was done by our colleague at UNC, Dr. Johnson, who showed that we were less likely after having the C-section, a major abdominal surgery where we remove your uterus, place it on your chest, sew you back up—we were less likely to receive the same anesthesia as our white counterparts having the same exact surgery.

So, we have data that shows that this devaluation, this belief that we are superwomen and we are super powerful and we don't feel pain shows up in how we are treated and how we are seen.

We can think about Dr. Susan Moore, who had to fight to live from COVID–19, who said, "I have pain," and they didn't believe her, and she ended up fighting for her life and then dying in a hospital, even as a physician who knew how to advocate and what to do.

And in your place in St. Louis, there is a lot of work that is being done at the birth center and with the networks there to ensure that we increase and improve the outcomes by training providers around racism and the history of the legacy of racism in our field.

Ms. BUSH. Thank you. And, last, I will say, Ms. Ali, I wanted to ask you a question but we ran out of time. I want to thank you for sharing your story. Thank you, and I yield back.

Ms. KELLY. The gentlewoman from Missouri yields back.

And now I would like to recognize the gentlewoman from Florida, Congresswoman Wasserman Schultz. You have five minutes.

Ms. WASSERMAN SCHULTZ. Thank you so much, Madam Chair, and I really want to thank all of the witnesses today. I had an opportunity to listen to the testimony, and thank you so much to our colleagues who testified.

Congresswoman Bush, your story was poignant and impactful, and just so appreciate you sharing that. I know how difficult that must have been.

So, I am a mom. I was—I was pregnant during my first campaign for Congress. Gave birth to all three of my children while serving in office, and I can tell you that I experienced nothing like the stories that I have heard today, and I have heard countless stories like these.

One thing that was important that was said during the testimony earlier was that we can't legislate against racism. So, I would really like to hear from any of the witnesses that would like to—that would like to share a response.

Given all that we have—that we have discussed this afternoon, what can we do to make sure that we can impact Black maternal mortality, that would impact the inherent racism that, clearly exists in the healthcare system, exists among healthcare professionals?

What I haven't really heard so much of, at least not in detail today, is the kind of—training is not the right word because you can't train out racism.

But what can we do to open eyes of healthcare professionals and healthcare institutions so that at the outset, when a Black woman,

a woman of color, presents with a pregnancy that they are cared for equitably all the way through their experience?

Dr. GILLISPIE-BELL. If I may. I agree we cannot legislate racism out, but we can legislate for implicit bias training. There is data that—from social psychologist Patricia Devine that shows that you can teach others to undo their biases.

It is a longitudinal action. It is not a one and done type of training. You have to think—because biases are unconscious it is like undoing a habit. So, just like I am not going to be here today saying, oh, I want to stop smoking and then in two days, I won't stop—I will stop smoking, that habits don't work that way.

And so implicit bias training in the same way is about acknowledging that you have your bias and then doing actionable items to undo those biases.

Now, it can be done legislatively. Every year, as a physician, I have to go in and I have to renew my medical license. So every year, you can require me to be trained to do——

Ms. WASSERMAN SCHULTZ. Right.

Dr. GILLISPIE-BELL [continuing]. To undergo implicit bias training. So, there are things that we can—that we can do legislatively to address biases in the healthcare system.

Ms. WASSERMAN SCHULTZ. Thank you. Do any of the other panelists want to add to that?

Mr. JOHNSON. Yes, I certainly would. So, I think that implicit bias training is critical, as we move forward. But from my perspective, it doesn't go far enough, and the reality of the situation is we cannot legislate the humanity.

And as we are working on structural racism and all the things that are contributing, the reality we have to face is some of these are generational fixes.

So, what we must do immediately if we want to see drastic changes is we need to, first, establish a fundamental dignified care threshold that we can quantify and then we must tie payment to meeting that standard.

That is we must do. So, while we are working on all these issues of color, of what is—of white, Black, and how people are seeing or not seeing and working on those issues, let us make it about green. We should tie performance and payment to medical providers' ability to meet a standard of care for their patients.

Dr. CREAR-PERRY. I just have to say that—he said we can't legislate humanity. But we can legislate anti-racism. Like, it was—racism was built into these policies. You can create policies that say we cannot be racist.

For example, all the hospitals are still just as segregated as they were when we tried to desegregate them by law. So, you can say if you are taking Medicare and Medicaid and you only see two percent Medicaid in your facility that is illegal.

There has to be a threshold so that we don't have a burden of illness on lower-resourced hospitals who only—that is racism that segregates hospital care. That is racism that says we can't open a birth center.

That is racism. All of those things are policies that we can fix in this House, in this hall. You have an opportunity to undo racism.

Ms. WASSERMAN SCHULTZ. Madam Chair, thank you so much for the opportunity to have this discussion. I appreciate being able to elicit the responses that we did.

And I will yield back the time that I don't have.

[Laughter.]

Ms. KELLY. This woman, the gentlewoman from Florida, will yield back the time she doesn't have. And now I would like to recognize the gentleman from Vermont, Congressman Welch, for five minutes.

Mr. WELCH. Thank you very much.

First of all, I want to say thank you to my colleagues who testified in the first panel for doing such a terrific job bringing attention to this incredibly important issue.

And second, I want to thank the witnesses for your excellent testimony.

One of the concerns that I have, and I know we all do, is about work force issues, and I think that is very much integrated into access and the quality of service. And I want to ask Doctors Taylor and Dr. Crear-Perry about the challenges of building a diverse work force as something that I see and I think many of us do that could help in addressing the severe inequities in maternal health and beyond.

Dr. CREAR-PERRY. Dr. Taylor, I was going to let her go first. But so I will go.

So, we know that having culturally congruent providers or providers who look like their patients is actually lifesaving. My colleague, Dr. Hardeman, and her team showed that Black babies who were cared for by a Black provider were five times more likely to survive in a NICU. So, it is critical for us to invest in diversity in our work force.

My colleague, Dr. Gillispie, mentioned the pipeline programs that we all used to participate in that have been decimated, where we could go and do research at LSU and other medical schools around the country, and middle school and high school and college.

When we get rid of those pipeline programs you don't see diversity. When we don't—when we say we are going to invest in Black midwifery but we don't invest in HBCUs that have nursing programs where you can build on them to have nurse-midwives come from Black universities, that is a policy choice, right. There is an opportunity to invest in how we even support birth centers across this country.

And I just want to go back to the conversation earlier about rural. I am from the rural South. I am from rural Louisiana. Rural does not just mean white. There is a diversity in ruralness.

I also grew up in a place that needed work force and we needed access to birth centers. We needed access to doulas. We needed access to midwives in all of America, rural, urban, suburban, because all of it is diverse and rich and beautiful.

Mr. WELCH. Thank you. Go ahead.

Dr. TAYLOR. Hi. Thank you for the question. Just to followup briefly, I agree with everything Dr. Joia Crear-Perry said, and then I will just add, too, that sometimes costs can be a barrier in terms of having access to training and schooling, particularly for the Black community, you know, and again, that also is directly con-

nected to structural racism and income inequality in this country that tends to fall hardest on our communities.

And so, in addition to everything that Dr. Perry said, I think we also need to make sure that we don't have any barriers in place in terms of costs that can keep us out of the pipeline.

Mr. WELCH. Thank you. I want to ask a little bit about telehealth as well. That, in the pandemic, has been a lifesaver for many of us in rural Vermont, and can you speak about telehealth?

I will ask this to Dr. Gillispie and Dr. Auguste. Can you speak about telehealth and what it would provide in Black America before and after birth and if this telehealth would be an essential component of a tool for getting access to quality health care?

Dr. GILLISPIE-BELL. Yes, I think that telehealth has the potential, definitely, to be a tool for access. As I mentioned in my testimony, here at Oschner we have a telehealth program called Connected Mom and it was crucial to making sure I could maintain prenatal care with my patients during the pandemic in a safe way for the visits that they did not have to come to the office for, to be able to—they had home monitoring devices and to be able to still continue that care.

And so I think, definitely, for rural America, urban America, for all people, I think telehealth has the potential to be a benefit. But at the same time, we have to be very careful to make sure we are not furthering our disparities if, in those urban and rural communities, they don't have the infrastructure that they need to be able to maintain those services.

Dr. AUGUSTE. Thank you for that question, and to build on what Dr. Bell said is one of the crux items here is that we have to make sure that telehealth is equitable. We fail to recognize any full potential that telehealth or telemedicine could have if we don't properly implement that. And so we have to prioritize some of those advances in telehealth and particularly around telehealth access.

So, we are talking about increased access to broadband, access, like I said, to audio only visits for those that don't have video capabilities or who aren't comfortable using video, and then coverage for durable, like, medical equipment, like, for remote patient monitoring, like blood pressure cuffs, and scales.

So, I think this needs to be part of the conversation around telehealth in order to make it equitable.

Mr. WELCH. Thank you very much. I yield back.

Ms. KELLY. The gentleman from Vermont yields back.

And now I would like to recognize the gentleman from Georgia, Congressman Johnson, for five minutes.

Mr. JOHNSON. I thank the gentlelady for recognizing me and I thank the Chairwoman Maloney for holding this hearing today.

My home state of Georgia is the most dangerous state in the country for pregnant Black women where the maternal mortality rate is double the national rate, a problem that disproportionately affects Black women in childbirth, in addition to the usual stress, fear, costs, and obstacles faced by all people who give birth in America looking for the best possible medical care. Black people are forced to contend with discriminatory treatment and racial biases in the healthcare system.

And this is a difficult topic and issue for white people, in general, to deal with, particularly my friends on the other side of the aisle. There seems to be a—just a mental block when it comes to the issue of systemic racism when they hear that term used or even just the simple term racism.

It, like, shuts them down, and they start coming up with other reasons. Like, I have heard today, lack of education, poverty, crime, the lack of a male in the household as being reasons for what has been testified to today.

And I even heard one of my colleagues ask you, Mr. Johnson, you know, whether or not you had, you know, filed suit, you know, trying to infer that maybe you are here to—with some kind of financial motive in mind.

And, Mr. Johnson, I am deeply sorry for the loss of your dear wife and the mother of your two children. She was not the victim of a bad education system. She would not have been helped by charter schools or public schools. She was not the victim of lack of economic opportunity. Opportunity zones would not have helped your wife.

She was not the victim of the criminal justice system that would have prevented her from losing her life. The passage of the Tim Scott Justice Act would not have helped your wife. Your wife was not the victim of not having a man at home. Your wife was not the victim of poverty.

Your wife was killed because of exactly what was said and that is that she was not a priority, and the reason why she was not a priority was because of systemic racism. Until we understand that basic concept, there will never be anything that we can do to address the issue.

White folks have to understand that racism is endemic in the soil of this Nation and in the hearts of its people, and until we recognize that we won't be able to root it out.

Black people who give birth are often personally blamed for the systemic failures, compromising their care. Dr. Taylor, why must we ensure that issues such as the denial of healthcare and the mistreatment of Black people who give birth are considered within the context of systemic racism?

Dr. TAYLOR. Thank you for that question. You know, I think we have heard across the board today that it doesn't matter what your socio-economic status is. As a Black person, this is an issue for us, and so I think when it comes to our care, you know, we definitely need to think more clearly about what we can do to at least address some of the issues on the surface in terms of provider training, ensuring that that training is rooted in anti-racism, which will also, in effect, deal with the issues around implicit bias, which I think folks are more comfortable with addressing and talking about.

Mr. JOHNSON. Well, you can call it implicit bias or you can call it just straight out racism, systemic racism. But I will go with implicit bias, if that is what it takes.

Dr. TAYLOR. Yes. I mean, I think for some people, it is—you know, most likely, you know, our colleagues on the right side of the aisle as well as I think white folks in this country, it is more comfortable to talk about it as implicit bias.

But we have to go deeper. I think one of the key things that we have seen, particularly in the last year, around racial reckoning in this country is that we can't address this issue with kid gloves.

You know, as you said, sir, it is a part of every corner of this country and in order for us to address it in a substantive way as well as in a way that is going to root out the needless deaths that we are seeing in terms of maternal mortality for Black women and other women of color, we have to address it head on and we can't just focus on implicit bias.

Mr. JOHNSON. Thank you. I am out of time, Madam Chair.

In 2011, Amnesty International issued a report that identified the inappropriate, disrespectful, and discriminatory treatment of Black women of childbearing age and pregnant women as a human rights violation, and I ask unanimous consent to enter that Amnesty International report into the record.

Ms. KELLY. Without objection, and so ordered.

Ms. KELLY. The gentleman——

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

Ms. KELLY [continuing]. From Georgia yields back.

And now I would like to recognize the gentleman from Maryland, Congressman Sarbanes, for five minutes.

Mr. SARBANES. Thank you very much, Madam Chair, and thank you for the hearing, and to all of the witnesses this was incredibly powerful and moving testimony. And I hope that today will turn out to be transformational in terms of focusing the House of Representatives and Congress, more broadly, on addressing the issues that have been raised.

The question I was going to ask has actually been asked a number of times, and there has been terrific answers—how do we drive the bias out of the medical profession and all those who can impact when it comes to the issues we have discussed today, and there has been good answers about the training on that.

I did want to observe, and maybe it has happened already in the hearing, but as we know, recently the Centers for Disease Control, the head of the CDC, finally declared what has been a long time coming, which is that racism poses a threat to public health, and the CDC is now going to be studying that, collecting data on it, making the connection and drawing that much more clearly.

And, hopefully, that kind of research and study and focus can benefit the issues that we have been addressing today.

And I just invite maybe Dr. Crear-Perry and Dr. Taylor, among others, to observe whether you think that that new focus on the part of the CDC can help with respect to the issues that we are describing and talking about today.

Dr. CREAR-PERRY. Yes, I was super excited to hear about that. That is a continuation of the work of my mentor, Dr. Camara Jones, who back at the CDC years ago asked for us to really focus on racism as a public health emergency.

And when I think about our colleagues in Georgia at the same breath that we are talking about that white women in Georgia are dying, we don't want to understand—while we can't articulate how structural racism is the reason they are dying as well.

When you don't expand Medicaid, when you don't invest in childcare, when you don't invest in paid leave, that also impacts white folks who are in Georgia.

And so what we could do to undo this harm of believing that certain people should have and should not have having a place like CDC really look at the levers and the ways that structural racism harms all of humanity, sucks the resources from all of us.

It deeply harms Black and brown people, but it also harms white folks, right. It is harmful to believe that you should have things just because of your skin color, and so, therefore, you show up and have a insurrection when, really, you are not supposed to have things just because of your skin color, right.

It is important for us to really acknowledge the harm that white supremacy culture causes to folks as well. So, I am excited to see the CDC lean into creating actual real policies and strategies and helping us to understand that racism is not a feeling or an emotion.

It is not calling you a bad name. There is a historic and a current belief of a hierarchy of human value based upon skin color, and we can create solutions to end that.

Mr. SARBANES. Thank you very much. Any other thoughts from the other panelists?

Dr. TAYLOR. I will just followup and say, you know, I also think I was encouraged by the announcement. But we also need investment in a whole of government approach to address the racism issue in this country, and I think that with the CDC proclamation that is just the first step. But we need much more to focus on.

Mr. SARBANES. Thank you very much. Madam Chair, I appreciate the opportunity, and I yield back.

Ms. KELLY. The gentleman from Maryland yields back, and now I finally get five minutes.

[Laughter.]

Ms. KELLY. You know, I have been running this hearing and listening to all the testimony and, Mr. Johnson, he and I have been together a number of times and, you know, I find myself tearing up, angry at some of the things that I heard because I have felt like some victim blaming.

But, you know, I have been working on this for a while, and then Congresswoman Lauren Underwood and Congresswoman Ayanna Pressley came to Congress, and Congressman Underwood represents Illinois and Congresswoman Pressley is a native. And even though we are all working on this, the rates in Illinois are going up. They are not going down, even though we are working on this.

And I want to let you guys know, and I promise you that I have a bill, the MOMMA's Act and in that bill I talked about Medicaid coverage for a year and I wanted it to be—to have to be for every state.

But I could not get it passed. That is why we wound up doing what we did, because I could not get that bill passed. Included in that bill was cultural competency, review committees, best practices, but I could not get that bill passed.

So, I am so glad that everyone is hearing your testimony today so they could see what you are saying, the experts, how very important that this is and we need a lot of different things.

There is not just one answer, and we even do work around—I am the chair of the congressional Black Caucus Health Brain Trust—how do we diversify the healthcare pipeline. And I am so proud that my cousin is a Black OB/GYN in New Jersey.

But and also the other thing is I—not anymore, but I was a proud member of Planned Parenthood. So, I know the services that they bring to the table for men and for women.

But I just actually wanted to give any of you the opportunity. Is there something we haven't asked that you want to say, you want to drive home? I want to give you the opportunity to do that.

Dr. CREAR-PERRY. Well, Congresswoman, I want to thank you for supporting the Office of—White House Office of Sexual Reproductive Health and Well Being. I really want to publicly thank you for leaning in to thinking about something bigger and more important at this moment that Black women have fought to ensure that we got the White House and we got Georgia. We deserve reproductive justice at the White House. And so we just—I just want to thank you. OK.

Ms. KELLY. You are welcome. Anybody else?

Mr. JOHNSON. So, I just also want to thank you, Congresswoman Kelly. I remember that you were the first person to actually bring me to D.C. to give me an opportunity to share Kira's story, and I am grateful. And I just am grateful for your leadership and you continue to be relentless to fight for families.

The point that I want to drive home has been said but I want to make sure that we leave the members with it, is as we work to gain support, particularly bipartisan support, when and if you are asked—well, the first thing—the first point I want to make is, well, why are we making this about race. We didn't make this about race. The statistics did, first.

Second point is that for all the members who were present today, if and when you are asked by your colleagues why we need specific legislation for Black women, the clear response is because if and when we fix this for Black women we fix it for all mothers.

Ms. KELLY. That is such a excellent point and so true. And we keep talking about bipartisanship. I do have a bipartisan bill, H.R. 1350, Senate colleague Senator Brown and Toomey and my House colleague, Bob Latta. It would create the first representative National Advisory Committee on reducing maternal deaths. I will let you read the whole bill. But I hope many of you sign on to the bill.

And I will just leave you with I am a mom and step mom. My husband and I have four kids between us, three adult women and my son. And I have one grandson, I have one on the way due in June and then we have one that is taking her sweet time.

And I pray we get to the bottom of this and we do everything we can do to make sure all women deliver but particularly Black women can deliver healthy babies and can see their healthy babies grow up and have productive lives.

I thank you all so much. It means the world. Yield back.

Mr. JOHNSON. Madam Chair? Madam Chair?

Ms. KELLY. Yes?

Mr. JOHNSON. If I might interject right now. I neglected to commend you for your yeoman's work behind the scenes and in front of the scenes as chair of the CBC's Health Brain Trust.

Ever since you have come to Congress, you—that was the mission and the mantle that you wanted to pick up and you picked it up and you have run with it, and you have gone across the country with it, educating people about issues of health care in the Black community, particularly as it relates to women.

And so I want to commend you for your work, and there is no greater champion in Congress other than you on this issue. Thank you.

Ms. KELLY. Thank you so much, and I yield back.

And I would like to recognize another champion, the gentlewoman from Massachusetts, native Chicagoan Congresswoman Ayanna Pressley.

Ms. PRESSLEY. Thank you, Madam Chair, and thank you to the witnesses, again, for your willingness to share your expertise, an expertise that has been born out of great pain and trauma.

Today, we hold space for that pain. When we know that for centuries Black pain has been ignored and delegitimized. So, we thank you for your dedication to maternal health justice in spite of that deep trauma and adversity that you have faced. You have set an example for Members of Congress to take immediate action and to save lives.

My colleague was talking about how some colleagues might feel uncomfortable. This is not a space for fragility. This is not a space for timidity. The purpose of this hearing has been as investigative as it has been educational, as it has been prescriptive, about how we do the work of saving lives, because Black mamas matter, Black babies matter, Black lives matter.

And although I appreciate the symbolism of plazas that paint that that and enlist that and on the ground—demonstrate on the ground very artfully, I never asked for a plaza.

What this moment requires are policies and budgets that codify the value of Black lives. Those are the only receipts that matter in this moment of reckoning, and as has been stated throughout this hearing but bears repeating, we will never be able to fully address the Black maternal mortality crisis if we do not confront the underlying racism that has created it.

And so while some have wrongfully asserted that racism is only interpersonal—one person hating someone else because of the color of their skin, today's discussion demonstrates that structural racism in our society is pervasive and far more insidious than a single act. In fact, some of the commentary by my colleagues across the aisle bears that out and proves that.

So, again, this hearing is not focused on individual doctors and individual pregnancies. We are discussing a widespread culture of racism within systems and policies that endanger Black pregnant people across our Nation.

And so that is why, because policy is my love language. because we have seen policy, policy violence, create inequities, disparities, racial injustices across every outcome, including health care.

None of that is naturally occurring. So, if we can legislate hurt and harm, we can legislate equity, we can legislate healing, we can legislate justice, and we can, in fact, be actively anti-racist as lawmakers.

And that is why I have partnered with Representative Barbara Lee and Senator Warren to introduce the Anti-Racism in Public Health Act. This is a first of its kind bill that will create a center on anti-racism in health at the CDC.

If we seek to dismantle the racist systems and practices that create inequities that contribute to the Black maternal health crisis, we need robust comprehensive research on the public health impacts of structural racism and policy solutions to bring an end to these disparities once and for all.

And so because I find myself at the unenviable end of this, most of my questions have already been asked and effectively answered. So, I will simply just end here and say structural racism puts Black people giving birth in danger and regardless of personal strength, educational attainment, or even fame or fortune.

As Mr. Johnson so eloquently asserted, this is a matter of human rights. So, Congress has both the obligation and the tools to enact legislation, like the Anti-Racism and Public Health Act, like the Momnibus, all aimed at dismantling the racist policies that put Black people at risk daily.

So, again, I thank our esteemed panel. I thank my sister in solidarity here who has been a teacher and a pacesetter on this issue. I thank our chair here, Robin Kelly, and, of course, our chair, Carolyn Maloney, for bringing us together today for this historic convening.

Ms. KELLY. The gentlewoman from Massachusetts yields back. And now I would like to recognize the gentleman from California, Congressman Gomez.

Mr. GOMEZ. Thank you so much, Madam Chair.

First, let me thank Chairwoman Maloney for holding this important hearing. Also, I want to thank—just thank my colleagues Representatives Adams, Kelly, Pressley and Underwood. Thank you for your tireless work and leadership to secure equitable health outcomes for Black mothers and Black people.

One of the things that—this is an issue that is not new to me. It is something I have been working on regarding just health equity, the health outcomes, and you see these statistics not only on maternal health but also when it comes to cancer outcomes.

We know that a Black woman is more likely to die from breast cancer even though the incidence of breast cancer is higher in white women. This is something that has been not only bothering me but frustrating me and kind of making me angry, and because I tried of compare it to other injustices that we see.

I tell people, if you are angry and you get mad when you hear that somebody is pulled over because of the color of their skin, you should just be as—just as angry and offended that a person, especially a Black woman, is more likely to die at childbirth because of the color of her skin.

I equate them to being similar because it is—it is something that that we can—we can change if we take proactive steps to change it.

It is something that we started talking about in the Ways and Means Committee. I am a member of the Ways and Means Committee. We had a hearing on it—on this issue as well.

And the committee is so interested in trying to undo the inequity that is built into our system from the tax code to the health care system across the board that we have now a Racial Equity Working Group that I am part of with Congresswoman Terri Sewell from Alabama and Congressman Horsford from Nevada.

And we had a speaker last week on one of the symposiums we had. It was Dean Bowen Matthews from the—she is a professor of law at George Washington University, and she was talking about health equity, health outcomes and she mentioned that access is just one part of it, that if you include—increase access, it improves outcome only by about 10 percent. So, she was saying that there is deeper, deeper inequities built into the system.

And so it doesn't mean that we are not going to take care of that access component, but there is something else that we need to take care of.

Dr. Taylor, I wanted to just ask, what are those other things that we can do through legislation? I know we have great pieces of legislation, but what is something that people don't think about when it comes to health outcomes for Black birthing people and Black mothers?

Dr. TAYLOR. Thank you so much for your question.

You know, it is interesting that you mentioned the example about breast cancer, and one of the things that we haven't touched on today is the health impacts of racism.

When I say that, I mean, you know, what if Black folks deal with racist experiences on a day-to-day basis? That actually causes us to have premature death. It causes us to be chronically ill. It causes us to have mental health challenges.

And so that means that when we are in a situation where we do get sick with a disease like cancer or we have issues with our pregnancies, they were already in a—you know, shortchanged, so to say, in a situation where, you know, our defenses are already down and that wear and tear on our bodies due to the racism that we experience on a day-to-day basis impacts our health. It makes us sick.

So, I did want to lift that up because I think that also is directly connected to some of the stats that you lifted up in the conversation just about the health impacts of racism as well.

In terms of policy, I think we have talked a lot today about, you know, issues around ensuring coverage, you know, for everyone, particularly for people of color, for Black women. We have talked about access issues.

But, again, because racism is so ingrained in every corner of this country, meaning that the same woman that has those is going to have those challenges in the context of her pregnancy-related outcomes may also be dealing with income inequality.

She may also be dealing with the wealth gap. She may also be dealing with issues around access to higher education. And even though those things aren't directly related to, you know, her having worse maternal health outcomes because we know it is something that hits every person, every family, across the socio-economic strata, it is a problem and, you know, structural racism is directly connected to those issues as well.

So, for me, I think we have to have a holistic approach in how we address racism. We have talked about legislation like the Momnibus, which is a comprehensive package of bills that address almost every dimension of the Black maternal health crisis.

It deals with some of these other challenges around the social determinants of health and other issues. So, whatever we are putting forth, it needs to be comprehensive and it needs to be a whole of government approach.

Mr. GOMEZ. Thank you so much for your answer. And although I am out of time, I just want to address, you know, I know some folks on the other side of the aisle don't believe this is a real thing.

But I want—you got to look at the statistics. Why are the outcomes just worse for Black women, right, when it comes to health care and health outcomes? Answer the why, and then you—and if everything is equal and that still exists, that means that there is something deeper than just access and what do we need to do to take care of it and reverse that problem, and I believe these bills are a step in that direction.

With that I yield back.

Ms. KELLY. The gentleman from California yields back.

Now I would like to recognize the ranking member, Congressman Comer, from Kentucky.

Congressman?

Mr. COMER. Thank you, Madam Chair. And I have heard a lot of mention of the fact that one of the problems may be the fact that there aren't enough people of color in the medical field.

And I was wondering what—to anyone on the panel, what can we do to change that? What can we do from a policy standpoint, in a bipartisan way, to try to create a situation where we have more people of color in the medical field serving the high minority populations, the underserved populations in the minority districts? And I will let anyone on the panel answer that.

Dr. CREAR-PERRY. Well, I think that the pipeline—this is Joia—the pipeline programs are really important, especially in places like Kentucky, having access to, from elementary school, to middle school, to high school, being able to go to the medical school and see researchers, to see what research is, to be tied to—and, in fact, we have fewer Black men in medical school today than we did in the 1970's and that is because we have disinvested.

And I wouldn't call it affirmative action. It is reparative action, to repair, the things that we need to do to repair the harm that has been caused by generational trauma.

So, investing in pipeline programs, again, would be really critical and that—Congressman Gomez, when he mentioned breast cancer, I just want to give an explicit example of how that shows up in healthcare.

I was trained that breast cancer in Black women was higher because we had higher—just higher rates biologically. Mayo Clinic did a study that made sure that every person had the same access to treatment, had the time off paid, had childcare services, and they were able to debunk this myth that we have a biological basis of higher rates of breast cancer, because we all have different breasts, different pelvises, different kidneys.

So, that is the kind of information that we have to put in to our training schools when we get this pipeline together for ensuring that we have more providers of color.

Dr. GILLISPIE-BELL. And I think if I can add to that, too, and I mentioned in my testimony having the pipeline programs for minorities to show them different careers in medicine, not just physicians or being a physician, but midwifery and physician's assistants, nurse practitioners, midwives, all of all of those different disciplines.

But also, specifically, I can speak from medicine, there is structural racism even trying to get into medical school. The number of hoops and loops that you have to jump through, through tests that have been shown to just be able to take a test.

They are not tests that show your ability to practice medicine, to accumulate the information that you need to be able to practice medicine, and not to even think about the cost that is incurred in going on interviews for medical school positions and, again, being able to take the test.

So, also looking at those financial barriers that prevent people of color from being able to pass the many hoops and loops that we have now created to get into these professional schools.

Mr. COMER. Anyone else want to pop in?

Representative Pressley, are you still on the panel? Would you like to comment on that?

Ms. PRESSLEY. Oh, would I like to comment on that which they just offered?

Mr. COMER. No. What can—what can we do to attract more minority students to the medical profession? That was one of the issues that they said was a problem, that we needed to get more African-American—more people of color involved in the medical profession and medical school, nursing, healthcare?

Ms. PRESSLEY. Well, actually, I am not on this panel. I was on the first panel.

Mr. COMER. Oh, OK.

Ms. PRESSLEY. Yes. So but I—so I co-sign all with—all that which they just offered. I thought it was very specific in enumerating both the challenges, you know, and the opportunities necessary in order to diversify.

Mr. COMER. And I—that is something that I would support and I think we would support, you know, anything that would be able to attract more people of color into the medical profession.

And if there are instances of universities making it harder, discriminating against people of color to try to get into any type of medical profession, I would gladly join with Chairwoman Maloney in a bipartisan investigation into that or any barriers into financial aid to people of color that are trying to get into the medical profession or any other field, for that matter.

So, hopefully, we can try to come up with some solutions to the problem in a bipartisan way, and I think that our side of the aisle—the minority—the minority conference is more than willing to do that.

And we—many of us represent rural districts. I actually live in Appalachia. Appalachia was referred to earlier. I know that when my wife went into labor, we were real nervous because the hospital

is an hour and a half away. You know, you are very spread out in, you know, rural America has challenges in health care.

My local hospital—something was mentioned about Medicaid. My local hospital here, which is the second biggest employer in my hometown where I am sitting right now—is 89 percent Medicaid. That is what the annual rate is for our hospital every year. Eighty-nine percent of the revenue in the hospital, 89 percent of the patients in the hospital are Medicaid patients.

So, you know, and I think there is challenges throughout healthcare. Healthcare is the biggest problem we have in America.

And I just want to close by saying we are more than willing to do anything we can to help with the situation and, obviously, I appreciate today's hearing and acknowledge that there is a problem and would be more than willing to work with any Democrat to try to solve the problem.

So, Madam Chair, thank you for this hearing. And with that, I will yield back.

Ms. KELLY. Thank you.

Chairwoman MALONEY. [Presiding.] Mr. Chairman, I want to thank you for your heartfelt response and willingness to work across the aisle on this critically important issue, to turn what we have learned today—the heart and purpose of this hearing—to turn it into the reality of laws, which can only happen in a bipartisan way. I thank you so much.

I yield to my distinguished good friend and colleague, the great Robin Kelly, for her closing statements, and I also have a closing statement.

Robin, thank you for your leadership today and for, really, your selfless leadership all the time that you have been in Congress toward the goal of passing these bills we are discussing today.

I yield to Robin Kelly.

Ms. KELLY. [Presiding.] Thank you, Chairwoman Maloney.

I would like to thank all of our witnesses for sharing their expertise and heart-wrenching experiences with the committee and thank all of my colleagues for their careful attention to this testimony today.

I also thank our colleagues for speaking on today's first panel. Congresswoman Pressley, Congresswoman Bush, Congresswoman Adams, and Congresswoman Underwood are leaders on this issue and have championed Federal policies to dramatically improve the quality of health care for Black people.

And, finally, I would like to thank Chairwoman Maloney for her leadership in bringing this issue before the full committee and for her continued commitment to supporting legislation that can make a real difference in improving maternal health outcomes for Black people and their babies.

The statistics we discussed today are shocking but not surprising. There is absolutely no justification for Black Americans to face three or four times the risk of dying during or after childbirth than white Americans.

There is no justification for the American healthcare system failing to protect Black families from these, largely, preventable losses. We can and must take an evidence-based approach to root out systemic racism and racial bias in our healthcare system.

We must undo the structural barriers that prevent Black people from receiving the care that they need and deserve. Now is the time to turn the tide on this crisis. Congress needs to enact the policies we heard about today to protect the health and well being of Black people and Black families across the United States.

Before I close, I would like to enter into the record letters and statements the committee received regarding the urgent need to enact comprehensive reforms that will address our Nation's Black maternal health crisis.

These include statements from the American Medical Association, the Blue Cross Blue Shield Association, March of Dimes, the University of Texas Southwestern Medical Center.

And without objection, these materials are entered into the official hearing record.

Ms. KELLY. And just thank you so much, again, Chairman Maloney, and I turn it back to you.

Chairwoman MALONEY. [Presiding.] Without objection, and I also add the UT Southwestern Medical Center to be added to the official record, without objection.

Chairwoman MALONEY. I just must say that I really believe that this hearing is transformational, I feel it is historical, and I feel that it is going to bring lasting change. I really do.

And I feel the way we bring this change is by following up on what we have learned today, which I don't think anyone could listen to this hearing and listen to Mr. Johnson and Ms. Ali and not be moved in fundamental ways, and by the professionalism of our witnesses coming forward with concrete actions, in addition to the excellent hard work of my colleagues and friends in Congress.

I congratulate Congresswomen Underwood and Adams for founding the Black Maternal Health Crisis Committee on which I serve with 140 of my colleagues, and, very importantly, working with Congresswoman Bush and with Congresswoman Kelly and others on a massive group of bills that are a step in the right direction.

And I believe that our next step should be, and I started writing a letter today during this hearing, to the seven other committee chairs that have the real jurisdiction.

Mr. Comer and I do not have the jurisdiction for this material. We decided, or I decided with all of you that we should have this hearing and get it moving.

But if we all reach out to these chairmen, I believe they will very quickly have hearings on this and work with us to report the bills out so that they can be passed.

I learned so much on it but I want to particularly thank Dr. Crear-Perry for some of the ideas that you put out that were new, and I particularly liked your idea of an Office of Reproductive Health and Well Being to develop the Federal strategy for ending this outrageous—I would call it a national scandal—a national scandal—that innocent women like Mr. Johnson's wife would have to suffer for 10 hours without medical treatment as they called for help.

That is a national scandal that we have to stop in America, and your idea of having—you know, to promote the human infrastructure and to look at the human rights and racial equity that is involved.

But something as large as this, it has to be coordinated throughout all of government. It is not a law. It is not one law. It is a coordination with everyone. So, to have a sort of central department that would interact with all of the agencies and Congress members on both sides of the aisle, and to focus on it in a very strategic way, I think, was a very excellent, excellent idea and I have written a bill draft already for this to add to our others.

And all I can say is, you know, it takes a village. This has been a huge effort by a great number of people—doctors, nurses, researchers, scientists, and then my wonderful colleagues in Congress that have moved it forward so carefully and so strategically.

It has to be bipartisan. I also want to thank my like-minded colleagues on the other side of the aisle that are willing, as Representative Comer is, to work in a constructive way to move this idealism and rightful goal off the table and into the ground, from heart and purpose into the reality of strong laws that can be enforced.

I am very grateful to all of my colleagues and all the professionals that made this happen, and I want to thank the staff of the Oversight Committee that put a lot of heart and work into this.

This has been a labor of love on the part of our staff and I thank everyone, and all I can say is on to passage.

Now, without objection, all members will have five legislative days within which to submit extraneous materials and to submit additional written questions for the witnesses to the chair, which will be forwarded to the witnesses for their response. I ask our witnesses to please respond as quickly as possible.

And with that, this hearing is adjourned.

[Whereupon, at 3:04 p.m., the committee was adjourned.]