Statement for the Record

September 27, 2018

House Energy & Commerce Committee

Health Subcommittee Hearing

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

Submitted by:

Sean Blackwell, MD

President, Society for Maternal Fetal Medicine

409 12th Street SW Suite 601

Washington, DC 20024

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

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

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

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

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

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

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

[1] https://www.cmqcc.org/qi-initiatives/obstetric-hemorrhage/hemorrhage-collaboratives

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

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

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

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

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