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Opening Statement
Energy & Commerce Subcommittee on Health
Better Data and Better Outcomes:
Reducing Maternal Mortality in the U.S.
Thursday, September 28, 2018

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

All too often do we read about stories of seemingly healthy pregnant women who are thrilled to be having a child, and to everyone's surprise, suffers severe complications, or death during pregnancy, birth, or post-partum. The death of a new or expecting

mother is a tragic event that devastates everyone involved, but in many cases these are preventable scenarios.

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

This is an issue that we cannot solve without accurate data. There were great efforts in our nation to address maternal and infant mortality in the first half of the 20th Century, and the data showed that

those efforts were successful. Yet, according to the Centers for Disease Control and Prevention (CDC), the U.S. maternal mortality rate was 7.2 deaths per 100,000 live births in 1999, and increased to 18 deaths per 100,000 live births in 2014.

CDC began conducting national surveillance of pregnancy-related deaths in 1986 due to a lack of data on causes of maternal death. In 2003, the CDC National Center for Health Statistics revised standards for certain death certificates, and added a pregnancy checkbox. While this checkbox has led to increased data collection on maternal deaths, it does not provide enough insight into why or how these mothers are dying.

Representative Jamie Herrera-Beutler's discussion draft will address the complex issue of maternal mortality by enabling States to form maternal mortality review committees to evaluate, improve, and standardize their maternal death data. This is a critical step in the right

direction, as physicians, public health officials, and Congress are unable to reach conclusions based upon current data as to what the causes for maternal mortality are. Once we establish what these are, there will be an opportunity to use the data to implement best practices.

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

Additionally, this May, various researchers involved in the review of Texas maternal deaths published a paper in the Green Journal

detailing that unintentional user error and other issues led to inaccurate reporting of maternal mortality. The researchers also concluded that "relying solely on obstetric codes for identifying maternal deaths appears to be insufficient and can lead to inaccurate maternal mortality ratios." The moral of this story is that we must ensure accurate data to accurately pinpoint the clinical issues contributing to these tragic deaths.

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

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