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RPTR WARREN

EDTR SECKMAN

IMPROVING MATERNAL HEALTH: LEGISLATION TO ADVANCE PREVENTION EFFORTS AND ACCESS TO CARE

TUESDAY, SEPTEMBER 10, 2019

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:00 a.m., in Room 2123, Rayburn House Office Building, Hon. Anna G. Eshoo [chairman of the subcommittee] presiding.

Present: Representatives Eshoo, Engel, Butterfield, Matsui, Castor, Sarbanes, Lujan, Schrader, Kennedy, Cardenas, Welch, Ruiz, Dingell, Kuster, Kelly, Barragan, Blunt Rochester, Rush, Pallone (ex officio), Burgess, Upton, Shimkus, Guthrie, Griffith, Bilirakis, Long, Bucshon, Brooks, Mullin, Hudson, Carter, Gianforte, and Walden (ex officio).

Also Present: Representatives Schakowsky and Soto.

Staff Present: Jacquelyn Bolen, Counsel; Jeff Carroll, Staff Director; Waverly

Gordon, Deputy Chief Counsel; Tiffany Guarascio, Deputy Staff Director; Stephen Holland, Health Counsel; Zach Kahan, Outreach and Member Service Coordinator; Josh Krantz, Policy Analyst; Una Lee, Chief Health Counsel; Aisling McDonough, Policy Coordinator; Meghan Mullon, Staff Assistant; Joe Orlando, Staff Assistant; Kaitlyn Peel, Digital Director; Tim Robinson, Chief Counsel; Kimberlee Trzeciak, Chief Health Advisor; Rick Van Buren, Health Counsel; Margaret Tucker Fogarty, Minority Legislative Clerk/Press Assistant; Caleb Graff, Minority Professional Staff Member, Health; Peter Kielty, Minority General Counsel; James Paluskiewicz, Minority Chief Counsel, Health; Brannon Rains, Minority Legislative Clerk; Zack Roday, Minority Communications Director; and Kristen Shatynski, Minority Professional Staff Member, Health.

Ms. Eshoo. The Subcommittee on Health will come to order.

Welcome back, everyone. I hope you had a productive August and that you have got some rest with your families, and we will roll up our sleeves and get back to work.

The chair now recognizes herself for 5 minutes for an opening statement.

And the witnesses, please come to the table. And thank you each one for being here.

The United States is the most dangerous place in the developed world to deliver a baby. That is a quote and the conclusion after major investigation by USA Today last year. Each year, about 700 American women die, and 50,000 women are severely injured due to complications related to childbirth. If you are a Black woman in the United States, it is even more dangerous to give birth.

Black and American Indian and Alaska Native women are three to four times more likely to die from pregnancy-related causes. This is absolutely unacceptable. And what is more, it is preventable. The CDC estimates that more than 60 percent -- more than 60 percent -- of these deaths could be prevented.

Our witnesses will instruct us today that there is a clear way to save mothers' lives. We need to make sure that women have high-quality care and coverage before, during, and after their pregnancy. And the four bills we are considering today do just that.

Congresswoman Kelly's MOMMA's Act uses standardized data to inform healthcare professionals about the best practices and protocols to manage a mother's care in an emergency, such as when a mother hemorrhages after birth. This data-driven approach was spearheaded in my district at Stanford, California's Maternal Quality Care

Collaborative, which has reduced severe health problems from pregnancy-related hemorrhages by 21 percent to date and has contributed to reducing the maternal mortality rate in California by a whopping 55 percent.

Representative Engel's Quality Care for Moms and Babies Act also works to improve maternal care through data by using care surveys, quality measures, and Perinatal Quality Collaboratives.

Both Congresswoman Kelly's legislation and Congresswoman Pressley's Healthy MOMMIES Act recognizes that to truly make progress, women must be able to get medical care when they need it.

Women are more likely to die of a pregnancy-related condition in the weeks following birth than during pregnancy or delivery, but many American mothers lack health insurance during that critical postpartum period. Every year, hundreds of thousands of mothers are kicked off Medicaid only 2 months after giving birth. The MOMMA'S Act and the Healthy MOMMIES Act extend Medicaid for a full year postpartum. These bills make sure the Medicaid safety net is there for women at one of the most vulnerable times in their lives, and this extension makes sense. That is why State legislatures in California, New Jersey, Texas, South Carolina, and Illinois are seriously considering measures to extend Medicaid for 1 year for eligible new mothers.

Finally, the Maternal CARE Act introduced by Congresswoman Alma Adams addresses the insidious way racism kills Black mothers. The bill funds implicit bias training programs for health professionals. As Nina Martin describes in her investigative series "Lost Mothers," African American mothers repeatedly report being devalued and disrespected by medical providers who did not take their medical concerns seriously.

I will conclude as I began. The United States is the most dangerous place in the developed world to deliver a baby. Shame on us. I believe a high maternal death rate is a reflection of how much a society values women. As the first chairwoman of this subcommittee, I think it is time we reverse this by making a healthcare system that better cares for women.

I now would like to yield the remainder of my time to Representative Engel, the author of H.R. 1551, the Quality Care for Moms and Babies Act. Oh, he is not here. All right.

Well, I will -- the chair will now recognize Dr. Burgess, the ranking member of our subcommittee, for 5 minutes for his opening statement.

[The prepared statement of Ms. Eshoo follows:]

******** COMMITTEE INSERT ********

Mr. Burgess. Thank you, Chairwoman Eshoo. Thanks for the recognition.

And I certainly appreciate that our Health Subcommittee is revisiting the issue of maternal mortality. Certainly we addressed this last year when we held the hearing on Jaime Herrera Beutler's H.R. 1318, the Preventing Maternal Deaths Act, which was signed into law last December. And whether the people realize it or not -- I don't know how many people do realize it -- unusual for the House of Representatives to pass a standalone bill dealing with maternal mortality, but it did indeed happen in the last Congress.

And now we are here today to see if we can build on that success, build on that progress, utilize the data that is going to become available because getting H.R. 1318 across the finish line.

By authorizing grants and allowing States to establish Maternal Mortality Review Committees, such as the one that Texas established back in 2013, States will be able to clearly identify the causes of maternal mortality and use that data to inform solutions. Given the robust bipartisan discussions that occurred last year, we do want to continue those robust bipartisan discussions. Unfortunately, today the bills that we have before us are all on the majority side. Our staffs have spent some time in preparation for this hearing. So it is unfortunate that that could not have been a little more expansive. Dr. Bucshon on this committee and Representative Andre Carson, a member of the majority, introduced a bipartisan bill, H.R. 4215, the Excellence in Maternal Health Act, along with a number of Energy and Commerce members, and I believe that a version of this language could become law and be signed by the President, and we should discuss the merits of such a policy at this hearing.

I think it is worthwhile to have a productive dialogue about the ideas put forth in all of the bills before us today, but there certainly are some questions about how implementation would occur and whether the bills would actually make a difference.

I in my former life did practice obstetrics and gynecology. Now as a Member of Congress, I want you know that addressing maternal mortality is one of my top priorities. And that is why I advocated, along with Representative Herrera Beutler last year, for the passage of H.R. 1318. Over the course of this year, I have been carefully looking at the right next step to build on the success we had last year. I have engaged with the Congressional Budget Office on several policy options related to Medicaid coverage of pregnancy, and I am committed to finding a way to address this issue, but we do need to be tactful and inclusive in this approach.

As we move through the discussion of these bills, I have some questions that I would like our witnesses to have in mind.

First, what is the Centers for Disease Control and Prevention already doing to aid States, process data through Maternal Mortality Review Committees? And do these bills we have before us today, are they additive or are they simply duplicative of existing efforts?

~~More than --~~S~~ s~~econdly, more than 40 percent of the births in the United States are covered by Medicaid. What tools do States need to address the unique needs of their own Medicaid populations?

Thirdly, some States are already submitting 1115 waivers to expand Medicaid coverage for 1 year postpartum without any intervening Federal legislation. How would these existing State efforts be impacted by a Federal law, and is there any danger of

hampering State innovation?

Fourthly, how can we support hospitals' existing efforts to coordinate care and maintain access to physicians throughout the delivery?

Fifth, are any States employing innovative maternity care models in Medicaid that would be worthy of exploring at a demonstration at a Federal level?

And then, finally, what are the main barriers to women receiving pre- and postnatal care? And what are the best practices that can be deployed to address maternal mortality and severe morbidity, the so-called near misses that occur when someone actually survives but has a very untoward event?

Now, I do want to spend a moment and give a special thanks and a special Texas Welcome to Dr. David Nelson, the chief of obstetrics at Parkland Hospital.

Chairwoman, you said, quoting from USA Today, that the United States is the most dangerous place in the world to have a baby. I would submit that Parkland Hospital is probably the safest place in the world to have a baby. It is because of the tremendous leadership, the clinical staff, and the dedicated staff of UT Southwestern and the residents and house officers and the nurses who all provide care to the medically indigent in Dallas County, Texas.

So, as a former Parkland resident, I am looking forward to hearing about the practices that your team employs to ensure safe delivery for both mothers and babies in Dallas, down in Texas.

And I yield back my time.

[The prepared statement of Mr. Burgess follows:]

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******** COMMITTEE INSERT ********

Ms. Eshoo. The chair thanks the ranking member for his comments. Let me just add something to them. The committee is hearing four bills today, and together they contain all of the provisions in the Senate health bill and Representative Bucshon's bill, but they also go beyond those provisions to include extending Medicaid coverage for postpartum women. So I wanted to add that to the conversation.

The chair is now pleased to recognize the chairman of the full committee, Mr. Pallone, for his 5 minutes for his opening statement.

The Chairman. Thank you, Madam Chair.

Today, we are examining the often tragic reality of the maternal health system in our Nation and a number of policies that could dramatically improve health outcomes for new mothers and their children. Every year, about 700 women die here in the United States from a pregnancy-related condition, and thousands more face severe maternal morbidity. That is simply disgraceful. And when you compare these outcomes to other countries around the world, the United States is near the bottom. We are also the only industrialized country in the world with a rising maternal death rate.

In a nation as wealthy as ours, these statistics are simply shocking and inexcusable, but I am hopeful that we can begin to turn the tide to improve maternal health. The Centers for Disease Control and Prevention estimates that 60 percent of maternal deaths in the U.S. are preventable, and the legislation we are discussing today is a strong step forward.

Now, a number of the bills that we have today will strengthen prevention efforts that already exist, including policies that follow up on the Preventing Maternal Deaths Act, which was enacted last year. This new law improved data collection and helped to

expand Maternal Mortality Review Committees to all 50 States. The legislation also authorizes and strengthens the Alliance for Innovation on Maternal Health and Safety, or the ~~A TM program -- or~~ AIM program. This program helps physicians and health systems implement evidence-based practices that have been shown to improve patient outcomes when performed in a healthcare setting but have not yet been implemented nationwide.

Maternal mortality and morbidity are problems that affect women throughout our country, but especially in African American and Native American communities where women are three times as likely to die due to pregnancy-related conditions as White women. The bills also offer a number of proposals to reduce health disparities along racial, ethnic, and cultural lines.

We are also going to be looking at ways to improve health coverage for new mothers. According to the CDC, one-third of all pregnancy-related deaths occur between 1 week and 1 year postpartum. And while Medicaid and the Children's Health Insurance Program cover more than half of all births in the U.S., coverage for some new mothers ends just 60 days after delivery. That is why I am glad we will be reviewing additional proposals to extend that coverage to 1 year after delivery, extending access to regular physician checkups and other health services ~~who~~ that help women and their healthcare providers detect and treat health issues, such as high blood pressure and heart disease, two of the most common causes of pregnancy-related deaths. It is my sincere hope to work with our Republican colleagues to enact a bipartisan proposal to extend this vital health coverage for new mothers.

Our witnesses today offer views from diverse backgrounds, and I am confident that their experiences and expertise will help us all learn more about the problems we are

facing and the solutions that will make a real difference. I thank them all for being here.

And I also want to recognize the leadership of so many bipartisan members of the House who testified on this important topic at our recent Member Day hearing, including several members of the Congressional Caucus on Maternity Care and the Black Maternal Health Caucus.

So, I have a couple of minutes left. I would like to yield that to the woman from Chicago, Ms. Kelly, the author of the H.R. 1897, the MOMMA's Act.

[The prepared statement of The Chairman follows:]

******** COMMITTEE INSERT ********

Ms. Kelly. Thank you, Mr. Chair.

Chairman Pallone, Chairwoman Eshoo, and Ranking Member Burgess, thank you for allowing me to make this brief opening statement.

Like you, I am shocked by our Nation's growing maternal mortality crisis. While losing 700 to 900 new moms each year is devastating, this crisis, like too many others, takes a disproportionate toll on communities of color. Nationwide Black mothers die three to four times the rate of White mothers. In my home State of Illinois, that disparity climbs to six times. In the State of Washington, American Indian moms die eight times the rate of their White counterparts.

It is clear that race is playing a role in these deaths. That is why my proposal, the MOMMA's Act, which I will discuss in depth later, includes provisions to ensure cultural competency training to ensure all moms and families are listened to during their childbirth journey.

However, this provision will only take us so far. It is imperative that we continue investing in diversifying the provider pipeline. The racial disparities underlying the shocking maternal mortality statistics make an already tragic situation more tragic. However, these challenges are not insurmountable. Today's hearing and the commitment from this subcommittee give me great hope for a future where all mamas get the chance to be mamas. I thank the chairwoman for the time and appreciate your efforts in addressing the crisis.

I yield back.

[The prepared statement of Ms. Kelly follows:]

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******** COMMITTEE INSERT ********

Ms. Eshoo. We thank the gentlewoman for her work on her important legislation.

I now would like to recognize the ranking member of the full committee, my friend, Mr. Walden, for his 5 minutes for an opening statement.

Mr. Walden. Thank you, Madam Chair. And thanks for having this very important hearing.

I appreciate all the witnesses who are here to share your stories and to comment on the legislation before us.

This critical issue of maternity morbidity and mortality, it is an issue that is quite literally a matter of life and death and for all women across the country. It is a difficult topic. It is one that is close to my heart.

Despite massive innovation in healthcare and advancements in technology, recent reports have indicated that the number of women dying due to pregnancy complications has increased in recent years. The effects of such a tragedy on any family are impossible to comprehend.

This hearing builds off the important work of our committee in the last Congress under the leadership of Dr. Burgess and the Health Subcommittee. Last year, as you have heard, the President signed into law H.R. 1318, the Preventing Maternal Deaths Act. This important law, led by Representative Jaime Herrera Beutler of Washington State and Diana DeGette of Colorado, seeks to improve data collection reporting around maternal mortality and develop systems at the local, State, and national levels in order to better understand the burden of maternal complications.

These efforts include identifying the reasons for disparity in maternal care, health

risks that contribute to maternal mortality, and clinical practices that would improve health outcomes for moms and babies.

We have continued to lead the way this Congress as well and on a bipartisan basis, I would add, sending letters earlier this year to six Health and Human Service agencies where we asked for the latest information on what they are doing to combat maternal mortality. I hope we finish the briefings requested in those letters very soon.

Unfortunately, I do have to say I am dismayed at the way that this legislative hearing today came together. For an issue that is absolutely bipartisan, I am just disappointed the majority would not allow consideration of Dr. Bucshon's bill, H.R. 4215, the Excellence in Maternal Health Act. It is a bipartisan bill. It is led by Dr. Bucshon. It serves as the House companion to the maternal mortality provisions in Senator Alexander and Senator Murray's bipartisan Senate legislation, Lowering Health Care Costs Act.

So I strongly support the bipartisan language in this bill as it demonstrates our commitment to further addressing maternal mortality, just as we did in a bipartisan way last Congress. The bill authorizes grants to identify, develop, and disseminate maternal health quality best practices, supports training at health profession schools to reduce and prevent discrimination and implicit biases, enhances Federal efforts to establish or support Perinatal Quality Collaboratives, and authorizes grants for establishing and/or operating innovative evidence-informed programs that deliver integrated services to pregnant and postpartum women.

The language in this bill passed the United States Senate Committee on Health, Education, Labor and Pensions as part of Senator Alexander and Senator Murray's

bipartisan package, and so I truly don't understand why we wouldn't have had that on the docket today for consideration as well. I just hope we will. I hope there will be another hearing where we can hear from Dr. Bucshon on his legislation.

Some of today's bills would expand Medicaid and CHIP coverage for pregnant and postpartum women from 60 days to 1 year. This is a significant policy change and one, of course, we need to carefully consider before we advance such a policy through the committee. Importantly, several States have already undertaken such initiatives. And we should gain a greater understanding about the state experiences, as that will be critical as we move forward.

Given the huge impact some of these bills will have on HHS, I would also note that HHS is not here before us today to discuss what they are already doing to address maternal mortality -- we would benefit from hearing from them -- nor to provide their thoughts on the incomplete list of bills before us today.

Given this absence, I call on the majority to schedule a second legislative hearing before moving to a markup. And I strongly urge the majority to include H.R. 4215 in such a hearing. It is a good-faith bipartisan bill with Senate support that deserves consideration in the House.

Despite my concerns about this process, I have no concerns about our distinguished witnesses today and our panel of experts. I want to thank you all again for being here today to talk about the bills before us, to share your stories and your expertise. I know we will learn much about the landscape of maternal mortality and care and what more we can do to improve the health outcomes in expectant and new mothers across the country. That is a goal we all share. So thank you for being here.

Madam Chair, with that, I yield back.

[The prepared statement of Mr. Walden follows:]

******** COMMITTEE INSERT ********

Ms. Eshoo. The gentleman yields back.

It is always a pleasure to be joined by former Members of Congress, and this morning former Congressman Phil Gingrey is with us. So welcome and thank you for being here.

I want to remind members that, pursuant to committee rules, all members' written opening statements will be made part of the record.

I now would like to introduce the witnesses for today's hearing, beginning with Ms. Wanda Irving, the mother of Shalon Irving. Thank you very much for being here. Your very moving piece in ProPublica, anyone that has read that, I think you are really not the same person after you read it. So thank you very much for being here today.

Dr. Patrice Harris is president of the Board of Trustees of the American Medical Association. Thank you to you for being here.

Dr. Elizabeth Howell, director of the Blavatnik Family Women's Health Research Institute at the Icahn School of Medicine at Mount Sinai, welcome to you and thank you.

Dr. David Nelson, assistant professor of obstetrics and gynecology at the University of Texas Southwestern Medical Center, thank you to you for being here.

And, Ms. Usha Ranji, the associate director of women's health policy at the Kaiser Family Foundation, our thanks to you.

We are very grateful because this is, as the ranking member of the full committee said, this is a very important hearing. And we look forward to your testimony. So, at this time, the chair will recognize each witness for 5 minutes to provide their opening statements. If you are not familiar with the light system, green obviously is go. When you see the that the light has turned yellow, you will have one minutes remaining. And

guess what? When it turns red, your time is up.

So I will begin by recognizing the very distinguish Ms. Wanda Irving for your 5 minutes of testimony.

You need to turn the mic on. That is it. And get close to it. We don't want to miss a word. We have some very energetic people outside of our hearing room. So get the microphone even closer so we don't miss a word. Thank you.

STATEMENTS OF WANDA IRVING, MOTHER OF DR. SHALON IRVING; PATRICE HARRIS, M.D., PRESIDENT, BOARD OF TRUSTEES AMERICAN MEDICAL ASSOCIATION; ELIZABETH HOWELL, M.D., M.P.P., DIRECTOR, BLAVATNIK FAMILY WOMEN'S HEALTH RESEARCH INSTITUTE, ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI; DAVID NELSON, M.D. ASSISTANT PROFESSOR OF OBSTETRICS AND GYNECOLOGY, DIVISION OF MATERNAL-FETAL MEDICINE UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL CENTER; AND USHA RANJI, ASSOCIATE DIRECTOR, WOMEN'S HEALTH POLICY, KAISER FAMILY FOUNDATION.

STATEMENT OF WANDA IRVING

Ms. Irving. Good morning, Chairwoman Eshoo, Ranking Member Burgess, distinguished members of the committee. Thank you for the opportunity to address you.

New data released from the CDC demonstrates that pregnancy-related deaths for Black women with at least a college degree are five times higher than that of a White woman with similar education. Shalon MauRene Irving had a dual titled Ph.D. in sociology and gerontology and a master of science, both summa cum laude, from Purdue University and earned before the age of 25. By 26, she was a college professor at Hofstra University but decided, after watching her older brother who suffered numerous indignities during treatment for multiple sclerosis, that she wanted to work on the front lines fighting for health equity. She earned a master of public health from Johns

Hopkins, also summa cum laude, and became certified as a health education specialist while being a weekend caregiver for her brother who was then in a wheelchair.

She started her public health career as a Kellogg Fellow, working with pregnant women at Healthy Start in Baltimore. From there, she was hired as a consultant to the CDC, working on former First Lady Michelle Obama's Let's Move! Initiative. She went on to be accepted into the globally renowned Epidemic Intelligence Service and was quickly promoted to lieutenant commander.

As a well-respected epidemiologist at the CDC, she made major contributions to several scientific books written by colleagues and wrote various articles published in scientific and medical journals. She was dedicated and committed to racial equality and health equity. On her Twitter profile, Shalon said: I see inequity wherever it exists, call it by name, and work hard to eliminate it. I vow to create a better Earth.

She believed in action over words and launched a consulting firm specializing in inclusivity training. This is the picture of Shalon Irving, the professional, but she was so much more than that. She was my only daughter, born between two brothers that she idolized. Shalon was every mother's prayer and the one few of us are lucky enough to receive.

And unexpected pregnancy at 36 only added to the fullness of her life. She was so excited to become a mother. On January 3rd, Shalon underwent a planned c-section and gave birth to a beautiful baby girl she named Soleil Meena Daniele. Shalon thought Soleil was her greatest accomplishment. The 3 weeks that followed Soleil's birth should have been filled with joy and happiness, but it wasn't.

Instead, Shalon's general state of health steadily declined, while her blood

pressure rose. She experienced leg swelling, decreased urine output, weight gains, and headaches. But despite repeated visits to her healthcare providers during this period, her complaints were not adequately addressed.

Shalon suffered cardiac arrest at home on the night of January 24th, 2017, 21 days after the birth of her daughter and just a few hours after her last trip to her health provider. My beautiful, vibrant, brilliant daughter was officially declared brain dead on Thursday, January 26th. Believe me, there is nothing more heart-wrenching than seeing your child connected to life support. On January 28th, life support was removed. After reading her medical directive, the handwritten last line shattered my heart: Mommy, I will fight hard, but if there is no hope, please let me go.

Shalon fought hard. She did what she was supposed to do. It was the medical profession that let her down. She was a 36-year-old woman of color who went to a healthcare workers again and again in distress and was not properly treated. Imagine the many gerontology breakthroughs, epidemiology victories, and social advances that Shalon could have generated if only her medical providers had listened to her and addressed her cries for help.

Shalon's daughter, Soleil, is transitioning into a little girl. She is 31 months old now with a smile every bit as brilliant as her mother's. Soleil is fearless and determined like her mother. She constantly amazes me with her rapidly expanding vocabulary, her capacity for learning French, her athleticism as a gymnast, and her love for art and ballet. But there are no words in the English language to adequately portray the pain I feel when Soleil looks up at me and asks, "Where's my mommy, Nona? Why can't I see her?" or cries, "I want my mommy," while clutching a picture of Shalon.

The loss of my daughter has earned me the right to demand the transformation of the healthcare system. I ask you -- no, I implore you -- to take three points from my words today. Not every maternal mortality is because of lack of insurance nor access to care, poverty, or lack of education. The dialogue needs to be reframed so it widens the lens to include the insured, those with access, and the educated.

Most pregnancy-related deaths can be prevented. According the latest CDC Morbidity and Mortality Weekly Report, further identification and evaluation of factors contributing to racial and ethnic disparities are crucial to inform and implement prevention strategies that will effectively reduce disparities in pregnancy-related mortality.

Quality of care plays a pivotal role in pregnancy-related deaths and associated racial disparities. It is imperative that more aggressive strategies to break down racial bias and prejudice be deployed now. Sending medical folks to cultural sensitivity or implicit bias training is not going to fix the problem without a redesign of medical school curricula. Postpartum care must be redefined and optimized as well. Healthcare professionals must be accountable.

The reduction of preventable maternal death among Black women is a national disgrace and has become an urgent national priority. To paraphrase a line from Abraham Lincoln, it is the cause for which my daughter gave her last measure of devotion.

Thank you.

[The prepared statement of Ms. Irving follows:]

******** INSERT 1-1 ********

Mr. Long. Madam Chair, Madam Chair, I don't know if I need to ask to for a point of personal privilege or what, but I am going to say something.

I am a member of the Black Maternal Health Caucus, and I care deeply about this issue, and I think it is repugnant that we have to sit here and listen to whatever in the world is going on out there in the hall. These women deserve better. These women that passed away during and after childbirth. This is a very serious hearing, and that -- whatever they are celebrating or complaining about out there in the hall, the Capitol Hill Police need to put a stop to it. If you could ask them to do it, I appreciate it.

I yield back.

Ms. Eshoo. I thank the gentleman.

Thank you, Ms. Irwin, for your -- this is the first step to the promise that you are asking us to keep. Thank you for being here today.

Dr. Patrice Harris, you are recognized for your 5 minutes.

STATEMENT OF PATRICE HARRIS, M.D.

Dr. Harris. Good morning, Chairwoman Eshoo, Ranking Member Burgess, and committee members.

The American Medical Association commends you for holding today's legislative hearing. My name is Dr. Patrice Harris, and I am President of the AMA. I am a practicing child and adolescent psychiatrist from Atlanta, and I am adjunct faculty at the Emory University School of Medicine and the Morehouse School of Medicine. I thank you for the opportunity to testify.

The data on maternal mortality in the U.S. are deeply alarming. The U.S. is only one of three countries in the world where the rate of maternal deaths is rising. Moreover, there is a large disparity in maternal deaths. As you have heard, a recent CDC report found that Black women are three to four times and Native American/Alaska Native women are two and a half times more likely to die from pregnancy-related causes as White women. And Black and Hispanic women are disproportionately affected by severe maternal morbidity defined as life-threatening complications during or after childbirth. Most alarmingly, 60 percent of pregnancy related deaths are preventable. This is simply unacceptable when we know these inequities and disparities are avoidable. Inequities and disparities do not have to exist, and we must collectively increase our efforts to close the gap.

What is causing these deaths? And why is the rate so much higher, particularly for Black and Native American women? Among the factors that play a role are as

follows: Millions of women still lack insurance or have inadequate coverage prior to, during, and after pregnancy. There is increased closures of maternity units both in rural and urban communities and, thereby, reduced access to quality maternal care. There is a lack of appropriately trained interprofessional teams in best practices, and that also impacts quality of care. There are structural determinants of health, which include public policies, laws, and racism. And those impact the social determinants of health, which include education, employment, housing, and transportation. Discrimination, racism, implicit biases exacerbates stress, which negatively affects the body and can result in hypertension, heart disease, and gestational diabetes during pregnancy.

The evidence tells us that clinician and institutional biases can lead to missed warning signs, can and do lead, I must say, to missed warning signs and delayed diagnoses. Women of color are not being heard.

So how do we move forward? Regarding specific solutions, the AMA believes that ongoing surveillance and activities to promote appropriate screening, referral, and treatment are needed. I want to thank the House Energy and Commerce Committee for advancing H.R. 1318. We continue to support the expansion of State Maternal Mortality Review Committees and appreciate continued funding to support prevention efforts.

We also support the MOMMA's Act to improve data collection, spread that information from that data on effective interventions, and expand access to healthcare and social services for postpartum women. And to ensure optimal health for women at risk for medical or mental health conditions leading to maternal death, additional insurance coverage is required. And the AMA believes that Medicaid coverage should be extended to cover women 1 year postpartum.

And, finally, let me highlight what the AMA is doing in this space internally in our own house. The medical community absolutely has a role to play here. The AMA recently hired Dr. Aletha Maybank as the AMA's first chief health equity officer, and she is initiating our new and explicit path to advanced health equity through the AMA Center for Health Equity and, although our Center for Health Equity is just getting up and running, there is great potential to partner with Congress to expand implicit bias training and other structural competency trainings in medical schools, residencies, and throughout the physician's career.

So it will take all of us working in partnership, and the AMA is committed to doing so, to build and continue on a path forward to more holistically and effectively improve maternal health and advance health equity.

Thank you.

[The prepared statement of Dr. Harris follows:]

******** INSERT 1-2 ********

Ms. Eshoo. Thank you, Dr. Harris.

We now will call on Dr. Elizabeth Howell, Director of the Blavatnik Family Women's Health Research Institute at Mount Sinai. You have 5 minutes for your testimony. Welcome and thank you.

STATEMENT OF ELIZABETH HOWELL, M.D., M.P.P.

Dr. Howell. Chairwoman Eshoo, Ranking Member Burgess, Representative Engel of New York, and members of the Subcommittee on Health, thank you for inviting me to testify.

My name is Elizabeth Howell, and I am an obstetrician/gynecologist and a researcher. I serve as a professor in the Departments of Population Health Science and Policy and Obstetrics, Gynecology, and Reproductive Science, I also direct the Blavatnik Women's Family Health Research Institute at the Icahn School of Medicine at Mount Sinai.

So we are here today because the United States is in a maternal healthcare crisis. You have heard that every year in our country around 700 women die from pregnancy-related causes. Our maternal mortality rate is higher than all other high-income countries. And our numbers, as you have heard, are far worse for women of color. While leading causes of maternal death include heart conditions, high blood pressure, infections, blood clots, rates of maternal death from overdose and suicide are rapidly climbing. And opioid-related deaths have doubled over the last decade.

But a maternal death is just the tip of the iceberg. For every death, over a

hundred women experience a life-threatening complication related to pregnancy and childbirth. Severe maternal morbidity impacts over 50,000 women every year in our Nation. Every hour, six new moms will have a tragic event like a stroke, a blood clot, or kidney failure. As you heard, the good news is that over half of these tragic events, actually 60 percent, are preventable if we improve the quality of care women receive before, during, and after pregnancy.

Quality of care includes women, no matter who they are and where they live, having access to doctors and nurses who are well-trained, prepared, and equipped with the right tools. It also means having systems in place that make it easy for women to receive evidence-based care. That means hospitals equipped with adequate resources, policies, and practices, staffing, and more. If we raised quality of care for pregnant women, we could lower the rates of these tragic events.

And quality of care differs for women of color. You have heard that Black women are three to four times and American Indian women are three times more likely to experience a pregnancy-related death than are White women. In New York City, Black women are 8 to 12 times more likely to experience a maternal death than are White women.

Although many want to think that income differences drive these disparities, it goes beyond class. A Black woman with a college education is nearly twice as likely to die as a White woman with less than a high school education, and she is nearly three times more likely to experience a severe maternal morbidity.

There is a growing recognition that social determinants of health, like racism and segregated housing, contribute to these disparities, and the powerful story you heard

from Ms. Irving about her daughter highlights an additional underlying cause: quality of care, lack of standards, and postpartum care. Her daughter was seen multiple times by clinicians after her delivery, but she still died.

Reasons for Black/White differences highlight the need to adequately resource programs that enhance quality of care. Research by our team and others has shown that, for a variety of reasons, Black women tend to deliver in a specific set of hospitals. And those hospitals have higher rates of severe maternal morbidity for both Black and White moms, regardless of patient risk factors. This is true overall in the United States, where about three quarters of all Black women deliver in these hospitals but less than one-fifth of White women do.

In New York City, a woman's risk of having a life-threatening complication during her delivery in one hospital can be six times higher than in another hospital. Black and Latina mothers are more likely to deliver in hospitals with worse outcomes. In fact, differences in delivery hospital explain nearly one half of the Black/White disparity in severe maternal morbidity in New York City.

But it does not have to be this way. We can come up with simple and effective ways to measure and improve quality of care for childbearing women, whether they are Black Or White, rich or poor, rural or urban. I am pleased today to provide testimony in strong support of a number of elements discussed in the bills.

First, development of maternal health quality measures that are patient-centered and address disparities; authorization of the Alliance for Innovation in Maternal Health, the AIM program, which is a national partnership that works to reduce maternal mortality and morbidity by implementing standardized standardized care practices across hospitals

and health systems; extension of Medicaid for 12 months postpartum to ensure access to needed care; development and expansion of State perinatal care quality collaboratives to improve quality of care for moms and infants; support for healthcare professional training to address implicit bias. I would expand this to include training on patient-centered communication, shared decisionmaking, and actions to address both implicit and explicit bias. And, last, I would echo efforts that are already started but we need more to build a better infrastructure to support data collection and measurement.

I would like to end my testimony by saying that we have to value pregnant women from every community. We can and must do better. I thank you for this opportunity to provide testimony, and I look forward to your questions.

[The prepared statement of Dr. Howell follows:]

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Ms. Eshoo. Thank you, Dr. Howell.

Members may notice that I am allowing witnesses to go past their 5 minutes, but I think every word that they have to be instructive to us is really essential.

Dr. David Nelson, it is your turn to testify. You have 5 minutes, and thank you again for being here.

STATEMENT OF DAVID NELSON, M.D.

Dr. Nelson. Chairwoman Eshoo, Chairman Pallone, Ranking Member Walden, Ranking Member Burgess, and members of the Energy and Commerce Subcommittee on Health, thank you for inviting me today. I am an obstetrician and gynecologist with fellowship training in maternal-fetal medicine. I am the chief of obstetrics at Parkland Hospital in Dallas, Texas. Parkland is one of the largest single public maternity services in the country. Last year, we delivered 12,671 women. This is more deliveries than 10 States in our country.

As the medical director of this service, I would like to share my appreciation of this committee for their efforts and celebrate the Preventing Maternal Deaths Act that encourages State programs to establish Maternal Mortality Review Committees. However, as you know, our work is not done. A single preventable pregnancy-related death is one too many. Mr. Johnson's testimony last year to this committee and Shalon's mother's testimony today emphasized this issue.

So what are the next meaningful steps? To answer this question, I offer two themes: one, access to prenatal care, and, two, use of relevant quality data. The

significance of access to care depends on how the issue of maternal mortality is framed. The findings of the Texas Maternal Mortality Review Committee from last year were that the majority of the pregnancy-related deaths could be prevented. Similar to other reports, there was a significant racial disparity. Women of color were significantly more likely to die when compared to non-Hispanic White woman, and the majority of these deaths under review were Medicaid-funded at delivery.

So how can we address pregnancy-related deaths that are potentially preventable among women of color and receiving Medicaid funding? I offer our experiences from Parkland Hospital as one strategy. Parkland is unique. It represents a public hospital serving almost exclusively medically indigent women. Of the more than 12,000 women delivered last year, 90 percent were Medicaid funded. At Parkland, there has been a concerted effort to improve access to prenatal care. And today there are 10 clinics located throughout Dallas County. These clinics are in the neighborhoods where our patients live and are often co-located with pediatric services to enhance patient use.

Of the more than 12,000 women delivered in 2018, 97 percent accessed prenatal care. These clinics also serve as the medical home for our patients with important followup for services like blood pressure surveillance and depression screening after delivery. The system has administrative and medical oversight that is seamless. The same protocols are used by nurse practitioners at all 10 sites, and this guarantees consistent care that is standardized for referrals of high-risk women to a centrally located clinic.

Not all complications, though, can be identified before delivery. At the hospital a multidisciplinary team of nurses and providers work together according to standardized

protocols. Individualized care is stratified based upon medical acuity and risk for complications. For example, we have standardized management strategies for response to obstetric emergencies like hypertension and hemorrhage. This emphasizes a culture of safety with continuous quality improvement. Recently, we have implemented an urgent request to the bedside function with our nursing partners to electronically track and monitor a timeliness to a patient's bedside for immediate care.

These efforts dovetail Parkland's participation in the newly formed regionalization program known as Maternal Levels of Care, as well as the Alliance for Innovation in Maternal Health. These initiatives share similar principles with California Maternal Quality Care Collaborative. Putting this together, access to prenatal care is considered one component of a comprehensive public healthcare system. It is community-based and extends to the inpatient care setting for a standardized approach.

An example of how access to prenatal care translates to improved outcomes, the maternal mortality rate during pregnancy and that delivery for the 3 percent of women that did not access prenatal care is more than 25-fold higher than those that had prenatal care access at our hospital.

Moving to the second theme, how do we measure quality? An obvious method is to track rates of maternal mortality. This unfortunately is easier said than done, and our hope is the recent passing of the 2018 legislation is a key step forward in this effort.

Another method of assessing quality is measuring rates severe maternal morbidity, or SMM, rates. These are unexpected outcomes that result in significant consequences to a woman's health like hysterectomy or transfusion. These rates are almost universally derived from hospital billing codes simply because no other data

sources are available. We must consider the potential unintended consequences of tracking such metrics, especially transfusion, because this can become a perverse surrogate of quality. If a provider hesitates or, worse, withholds a transfusion of blood, then a patient may have a risk of mortality. It is critical we use relevant data to guide our policies.

Thank you again for this opportunity to share our experiences from Parkland and our efforts to establish access to care. Also thank you for your understanding of the importance of the relevant quality data. Ultimately these efforts can lead to safer deliveries of mothers and their infants for the future generations of our country.

Thank you.

[The prepared statement of Dr. Nelson follows:]

******** INSERT 1-4 ********

Ms. Eshoo. I thank you, Doctor.

Usha Ranji, you are recognized for your 5 minutes of testimony. You can proceed and thank you.

STATEMENT OF USHA RANJI

Ms. Ranji. Good morning, Chairwoman Eshoo, Ranking Member Burgess, and members of the committee. I am Usha Ranji, Associate Director of Women's Health Policy at The Kaiser Family Foundation, a nonprofit, nonpartisan organization that provides health policy analysis.

Thank you for inviting me to testify about the role of Medicaid coverage for pregnant and postpartum women. I will highlight three main areas: research on the importance of health coverage for babies and mothers, the role of State policy decisions on access to care during and after pregnancy, and some of the current efforts to close gaps in postpartum coverage.

Medicaid is the primary source of health coverage for low-income women and the major financier of maternity care. In the mid-1980s in response to rising rates of infant mortality, Congress and State saw an opportunity to use Medicaid to improve birth outcomes by expanding the program to more low-income pregnant women and children. Today, the program finances more than 4 in 10 births nationally and more than half in many States.

Research shows that women with Medicaid coverage consistently fare better than uninsured women on several measures of access, including greater use of timely prenatal

care. More recent research suggests that Medicaid expansion is associated with a narrowing in racial and ethnic disparities in infant outcomes. Our work at KFF finds that low-income women with Medicaid use care at rates that are comparable to their privately insured counterparts, and there is broad agreement that access to care before and after a pregnancy is essential for prevention, early detection, and treatment of some of the conditions that raise a woman's risk for pregnancy complications.

Medicaid plays a critical role in promoting access to that care. Maternity care is one of the benefits that all States must cover under Medicaid. Eligibility for Medicaid is based on decisions that States make within Federal guidelines. Federal law requires that all States cover pregnant women with incomes up to 138 percent of the Federal poverty level, which is just under $30,000 a year for a family of three, but most States cover pregnant women with higher incomes, recognizing the importance of coverage during the perinatal period.

Yet after a woman gives birth, there is no requirement to continue Medicaid coverage beyond 60 days postpartum. Historically many women would become uninsured in the months following pregnancy as a result. But policymakers have opportunities to improve coverage for postpartum women and their families. States across the country have made different decisions about whether to expand Medicaid under the ACA.

In the 14 States that have not changed their Medicaid program eligibility levels, postpartum women cannot stay on the program unless they re-qualify as parents. However, in these States eligibility for parents is much stricter than for pregnant women. For example, in some States, a new mother would lose Medicaid coverage 2 months after

giving birth if she and her partner have income above $4,000 a year.

Federal subsidies are available to help --

Ms. Eshoo. Can you say that one more time?

Ms. Ranji. Sure. When we look at the eligibility criteria for parents, it is much lower than it is for pregnancy under Medicaid, and it is State-determined, and in all States, it is actually lower for pregnancy, and in some States, it is as low as $4,000 a year for a family of three.

Ms. Eshoo. Wow.

Ms. Ranji. Federal subsidies are available to help some lower income mothers purchase private marketplace insurance. But when a mother's income falls between her State's Medicaid level for parents and the poverty line, she does not qualify for either Medicaid or private insurance subsidies.

Today, a handful of States are exploring options to improve Medicaid coverage for women after pregnancy. All States can set and raise the income eligibility levels for parents, and that is without adopting the Medicaid expansion.

Earlier this year, Illinois approved extension of postpartum coverage under Medicaid to 1 year. Policymakers in Missouri and California have also proposed extending coverage for mothers in need of substance abuse treatment and mental healthcare respectively. These are a few examples of efforts to enhance care and coverage for low-income moms.

Madam Chair, members of the committee, the research is clear. Having health coverage before, during, and after pregnancy promotes access to care. And lack of coverage is associated with poor health outcomes. Furthermore, our understanding of

the health needs of women shows that the postpartum period has evolved beyond one visit, yet in more than a dozen States, Medicaid coverage ends 2 months after childbirth, even though for a mom, her need for care does not end then.

In short, there is strong empirical evidence to support what families across the country already know and experience on a daily basis, that a mother's ability to care for her own health and well-being is integral to her ability to do the same for her children.

Thank you.

[The prepared statement of Mr. Ranji follows:]

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Ms. Eshoo. Thank you, Ms. Ranji.

Those are some startling numbers that it sounds like you have a child and then the system becomes punitive.

The witnesses have now concluded their opening statements. We are going to move to member questions. Members each have 5 minutes to ask a questions of our witnesses, and I will start by recognizing myself for 5 minutes.

There are many layers to this, but I want to go back to where we began with Ms. Irwin and many of the things that she said in her testimony to us. She said that we need to hold healthcare professionals accountable for improving the quality of care and ensuring equity.

Her daughter has had, I think, more education as one person than most members sitting on this dais. So she was not low income. She was not uneducated. And it seems to me that racial bias is alive and well in this area of giving birth and what happens postpartum.

Let me ask Dr. Harris: What is the AMA doing about this? I mean, it seems to me that you can track the hospitals where women of color frequent those hospitals than others. I think the statistics are really very clear. This is not a foggy picture. We heard Dr. Nelson talk about their very purposeful training.

So what is the AMA doing before you came to the witness table? Have you targeted the hospitals? Is it red light and siren to do something that addresses this? Maybe you can just briefly explain to us what the AMA is doing, and if you are not, what you plan to do, to be fair.

Dr. Harris. Thank you, Chairwoman.

From the AMA's standpoint, we would see our audience as impacting the physician community. Certainly, I heard from Dr. Howell, though, that there is value in hospitals developing standards. And it would be the recommendation that those standards include some metrics for evaluation.

Ms. Eshoo. That hasn't before begun yet, in terms of AMA partnering with hospitals and doctors?

Dr. Harris. No, we have not worked with hospitals to develop any specific metrics. But we are starting internally, as I mentioned earlier. We have just hired Dr. Aletha Maybank. She is our first --

Ms. Eshoo. That is a first step. It's a first step.

Dr. Harris. -- chief health equity officer.

And that is building on the work that we already have been working on from our Commission to End Disparities.

Ms. Eshoo. Thank you.

Obviously, the causes of pregnancy-related deaths differ. The doctors on the panel, what I want you to instruct us about, because we know heart disease and stroke cause most of the deaths overall. Obstetrics emergencies, severe bleeding, amniotic fluid, embolism cause the most deaths at delivery, but severe bleeding, high blood pressure, and infections are the leading causes in the week after delivery and weakened heart muscle is the leading cause of deaths 1 week to 1 year postpartum.

This is in our memorandum from the committee staff.

How best do you recommend to us to pursue each one of these categories? And for the life of me, I don't understand why the doctors that are trained in this -- I mean,

this is a specialty, as our ranking member is -- that these deaths are a result of these areas, and, as you said, Dr. Howell, they are preventable. Where have we gone wrong? Have they forgotten what they learned? Is their training not up to snuff?

Can you be instructive to us on that, Dr. Howell?

Dr. Howell. Sure. Sure. So, you bring up a really important point, which is what we are pushing for through ACOG and the Alliance for Innovation on Maternal Health. We need standardized care practices based on evidence-based medicine --

Ms. Eshoo. And that is not the case now?

Dr. Howell. Well, we do. So AIM has started a few years ago. And it is growing in numbers. It now reaches 27 states, and these are partnerships with hospitals and health systems, departments of health, caregivers to try to work together to improve quality and safety. And we don't just target the most preventable causes like hypertension, you know, blood clots, et cetera. We also target additional things.

We have come up with an AIM bundle on how we might address reducing disparities in hospitals and health systems with some key steps that we recommend. We also have, as part of this effort -- it is very much a data-driven effort -- so we have quality -- we have measures and metrics that we are trying to use to utilize and examine how hospitals are doing, which we think is a very important part. So we can't only implement, but we have to evaluate to make sure what we are doing is the most meaningful way.

So that is one big effort that has been going on for about I believe AIM started in about 2015, and it is very much a partnership.

Ms. Eshoo. Well, thank you very much.

My time is up, but I also think the American Hospital Association has to lean in on this as well because the statistics can be traced right back to where women of color, what hospitals they go to, and the number of deaths there or the tremendous complications that follow. But my time is up.

So the chair will now recognize the distinguished Dr. Burgess, the ranking member of our subcommittee, for his 5 minutes of questions.

RPTR PANGBURN

EDTR SECKMAN

[10:59 a.m.]

Mr. Burgess. Thank you.

Dr. Nelson, you look like you wanted to say something. Can I give you a moment to respond to previous discussion?

Dr. Nelson. I agree with Dr. Howell that part of the issue is our view. We have not had the full view that we need to see. There is the issues surrounding pregnancy, delivery, and the now subsequently postpartum. One of the issues we need to recognize is the process measures that need to be in place, meaning our response that is consistent to emergencies like hypertension and hemorrhage; things like a massive transfusion protocol where we directly get blood to the patient's bedside that needs help; Processes like simulation to train our team members in a safe environment. And then we need performance measures that are meaningful to track data and identify quality and sincere efforts to improve that space. That, I think, is a major step forward for us collectively that we are trying to see.

Mr. Burgess. And since you are talking about it -- and, once again, I want to thank you. You were very kind to show me around the new unit at Parkland Hospital. They have just moved in to new facilities, and so it is different from what it was back in the 1970s when I was there, but I was impressed that there are some of the things that I learned in the 1970s that are still appropriate today, but you have also made things different in a number of ways. And one of the ways that really impressed me was the availability of, I guess, an emergency bleeding cart that would be just footsteps

away -- and you had several of them strategically positioned throughout the labor and delivery units so that the response time could be significantly reduced. Dr. Howell in her written testimony talks about coming into a scene where somebody is exsanguinating an hour after delivery. We had a hearing last year, Mr. Johnson, whose wife had a bleeding complication after cesarean section, can you speak to that and how the urgency with which the situation is responded to has helped you in managing this crisis?

Dr. Nelson. Yes, sir. And Dr. Howell is absolutely right. Time is of the essence in these emergencies. Our labor and delivery suite is over the size of a football field. There are 44 labor and delivery rooms, and in partnership with the Maternal Levels of Care Program for Texas and in alignment with the AIM program, we have four hemorrhage carts on our unit. These are carts that contain specific resources, specific instrumentation, and needs that a nursing team or physician team might need to immediately respond to a hemorrhage event. We debrief after every time we utilize a massive transfusion protocol, meaning every time we activate a massive resource allocation to a patient, we debrief with the team to understand if there is opportunities to learn from the nurses or physicians. We use multidisciplinary simulation where we train in an environment with nursing -- nurse midwives, anesthesiologists, and team members. We formalized a checklist that is consistent with the AIM platform. We have the hemorrhage cart that we mentioned. We also perform daily huddles for every scheduled surgery that we have performed, and because our service deals with a fair number of women with what is called placenta accreta spectrum disorder, or morbidity -- placentas, we actually have a dedicated team of maternal-fetal medicine faculty and public surgeons for those cases.

Mr. Burgess. For people who don't know that can be one of the scariest situations you can encounter. So let me ask you this, and one of your predecessors, Dr. Norman Gant, who was the chairman of OB/GYN when I was a resident back in the 1970s, I forget what he was haranguing us about one day, but he was famous for doing that, and he was giving us the business about how he was worried that his residents were giving care without caring, and he wanted us to be sure to delve into the interpersonal part of the relationship with the patient and being able -- being certain we listened to the patient and heard the patient. Some of that strikes me as -- when Mr. Johnson was here last year and gave his testimony about the problems his wife had after a cesarean section and when we listened to Ms. Irving talk about her daughter's problems, I mean, there were some significant things that happened, and I don't want to say there were care lapses, but I am sorry. A diastolic blood pressure of 118 millimeters of mercury, that is not an appointment to clinic tomorrow; I mean, that is something that needs -- something needs to be acted upon. So are we empowering people to make the decisions that need to be made when they encountered these points?

And either Dr. Howell or Dr. Nelson, since you are the clinical specialists.

Dr. Nelson. I absolutely agree accountability is critical, and tracking that accountability is one issue. The urgent requested bedside function we actually have in place to track time from the blood pressure to when a response was seen. To add on to the comments from Dr. Howell and some of our other panelists, there is absolutely an issue of racial disparity in our services. At Parkland alone, we have a diversity inclusion officer. We have an instructor-led course once a month on this issue, and every new hire has to go through that because of our environment served. That is a commitment

that we have at our organization.

Mr. Burgess. And I would just stress that. Because of the environment served, you are basically what would be described as an inner city hospital and you deal primarily with the indigent population of Dallas County, Texas?

Dr. Nelson. Yes, sir.

Mr. Burgess. Thank you for being here today. Thanks all of you for your testimony. It has all been very enlightening.

I will yield back.

Ms. Eshoo. The gentleman yields back.

I now would -- let's see. Where is -- a pleasure to recognize the gentlewoman from California, Ms. Matsui, for her 5 minutes of questioning of the witnesses.

Ms. Matsui. Thank you very much, Chairwoman Eshoo and Ranking Member Burgess, for holding this very important hearing. Like our witnesses here today, I am deeply concerned about the rates of maternal death and severe maternal morbidity in this country that is supposed to be one of the most developed countries in the world. And a special thank you to Ms. Irving for sharing your family's loss. I am so sorry.

Keeping our mothers and babies safe and healthy is vital. As a cosponsor of last year's Preventing Maternal Deaths Act, I am pleased that we are building on this effort to address outstanding racial and ethnic disparities that exacerbate poor maternal health. Extending Medicaid coverage for maternal health services across continuum of care is a critical next step, and strengthening the quality measures and training programs will help protect our mothers and babies when care is delivered. I thank the committee for prioritizing the hearing on this issue. Several of you pointed out in your testimony the

uncomfortable truth that a significant portion of severe maternal disease and death is preventable. It is clear how critical Medicaid coverage is to ensure access to care and avoid preventable maternal health complications.

Dr. Howell, you touched upon how quality of care pertains to both clinician practice and system policies. In your holistic view, what is the link between coverage and quality of care?

Dr. Howell. So coverage is essential, and I think we heard from Ms. Ranji about how important coverage is, you know, preconception, antenatal, during delivery, and postpartum, and the growing awareness that a third of these deaths are happening in the postpartum way out period. We are talking about cardiomyopathies. We are talking about suicides. We are talking about women dying from things that we could do something about, but we have not been given adequate access to care. So it is instrumental, and it is a key link.

Ms. Matsui. Okay. In Sacramento, we have been looking at -- through a Black Child Legacy Campaign since 2015 on this whole area of maternal death, prenatal, postpartum activity, and we have come across quite a lot of activities that have really increased our chances here in Sacramento County, and we are really pleased to see that most of the country is sort of looking at how we are doing it too.

In Sacramento, we also have cultural brokers at one of our FQACs, the WellSpace Health, that helped to engage and support pregnant women by integrating medical care, parental education, and community resources for housing and transportation into a prenatal program for families. It has to be all-inclusive, as you know. This comprehensive model has led to rates of premature and low birthrate that are

significantly below the national average.

Dr. Harris, it sounds like the AMA is doing some interesting work around social determinants. Can you elaborate on how you envision health plans integrating social and environmental health data -- environmental data to better address a mother's unique needs, and how will this lead to healthier babies?

Dr. Harris. Absolutely, and thank you. And the structural and social determinants of health are critical as we understand how to address this issue and actually other healthcare crises. We have to look at transportation. Is there access to get to prenatal visits? We have to look at other social supports to make sure that our pregnant moms get to their prenatal visits. For moms who are pregnant and diagnosed with depression, we have to make sure that they have access to psychiatric care and care for therapy, and so addressing housing and education and employment are all critical as we address actually this issue, but really all health issues.

Ms. Matsui. Sure. Both you and Ms. Ranji made it clear that mental healthcare throughout the pregnancy is paramount to improving the health of mothers and their babies. Would you both expand on the transmaternal mortality with regards to mental health? What is the link between depression and pregnancy and maternal outcomes? You want to take this one, Ms. Ranji?

Ms. Ranji. Thank you. I will let Dr. Harris and my colleagues comment on the clinical aspects, but I will say what we have heard from all the other witnesses is that maternal mental health is a very serious issue. It is a contributor to the maternal mortality and morbidity rates that we have been seeing, and that that is -- what we know is that is an issue that does not resolve in perhaps 2 months' time. That that is an

ongoing chronic condition that could require various levels of care depending on a woman's individual situation. And so access to care and services is likely needed for an extended period of time.

Ms. Matsui. Okay. I wanted to follow up. Dr. Nelson, what mental healthcare services are offered to women through your clinic's healthcare home model, and why is mental healthcare both before and after birth so vital?

Dr. Nelson. I appreciate you asking that. Mental health is critically important. In Texas, in our maternal mortality reviews from 2012 to 2015, there were 33 suicides and 85 percent were postpartum. In 2013, I published a paper screening 17,000 women with postpartum depression. We identified rates consistent with other populations served. Only 22 percent made it to a psychiatrist that were identified to screen positive. From that our service identified an opportunity. We now have mental health counselors placed strategically in all 10 clinics similar to the home you described. Recently, we have actually exercised telehealth and telemedicine with virtual visits. Last year, 1,100 phone calls were made by those mental health counselors to the patients at their home and at their work for those that can't access the clinic directly.

Ms. Matsui. Oh, that is wonderful. Thank you very much, and I know I have run out of time.

I yield back.

Ms. Eshoo. The gentlewoman yields back.

Pleasure to recognize the ranking member of the full committee, Mr. Walden, for his 5 minutes of questions.

Mr. Walden. Thank you, Madam Chairwoman.

And, again, thanks to all our witnesses for your testimony.

Dr. Howell, as I mentioned in my testimony, we have more to do on maternal mortality and morbidity, but we took a good first step, I think, in the last Congress with H.R. 1318, the Preventing Maternal Deaths Act, which, as you know, became law. That bill reauthorized key CDC programs to improve data collection reporting around maternal mortality. That will help support State review committees like the ones set up in my home State of Oregon to study these issues.

Dr. Howell, you are set up in New York, as I understand it, but your organization does national research. How has the work of the State review committees informed Alliance for Innovation on Maternal Health maternal safety and quality improvement initiatives?

Dr. Howell. So the maternal mortality reviews around the country are key and essential to the program for AIM because they teach us about each death and where are the preventable moments, what are the things we really need to work on to prevent a death. And then that information is brought to the perinatal collaboratives using some of the tools that AIM has brought together, and that is the way we can implement. We learn from the deaths. We take data and information. And then we act on it. And I think that is why these partnerships with the CDC/AIM are so important, but we need all States to have Maternal Mortality Review Committees. We need them all to review their deaths. We need them to submit them to the CDC so that they can have a central system for monitoring. And so we still need to continue to improve our data acquisition and management.

Mr. Walden. But it is fair to say where it does exist it is working? You are

seeing the information flow which allows then a positive response?

Dr. Howell. So I think it is mixed in the sense that, yes, there are places that it is really working and you are seeing a lot of movement and you see a lot of positive energy around this. Sometimes the resources are not fully there yet, and so some places are not able to actually do as well as others.

Mr. Walden. Okay. Good. Dr. Harris, it is important to look at every factor related to maternal mortality and morbidity, but one piece I am worried about is the mental health, as has been discussed here already. And in your testimony, you mentioned that depression in pregnancy is associated with poor maternal outcomes including maternal death. We have tried to take the lead in this committee on reforming America's mental health laws, but we all know there is more work to be done, especially from others with postpartum depression. And I must say as a footnote, I was deeply disappointed in my own State, the Governor and the legislature actually cut mental health support funding in my State and why I cannot imagine, but I in townhalls and other meetings I had this August, I learned the legislature just did that, and it is stunning. You say it occurs in nearly 15 percent of births. That is staggering, especially considering some of the dire outcomes we now know about. Are the State Maternal Mortality Review Committees capturing these outcomes, and are there ways that we can do better?

Dr. Harris. Actually, I will have to defer to my colleagues who are obstetricians to maybe talk more about whether or not that data is captured, but I will say, if it is not captured that is certainly an opportunity gap. We have, as you notice, I think, from the last 30 years or so had a mental health system, no infrastructure, severely underfunded,

and we certainly need to catch up, if we can, overall but particularly in this issue. You heard Dr. Howell talk about suicide. I think for many years there was a misperception that depression was normal after the birth of the baby, that it was the baby blues. And so it is critical that we end -- there are some emotional swings that do occur, but those are not what we are all talking about with the diagnosis of a major depression, and we have to make sure that the major depression is treated if it is identified within the first visit.

Depression is a chronic disease, and it will need treatment as sometimes for a lifetime, but certainly it is not just a take a pill and your depression will be cured. So this is a huge issue, and we certainly have a long way to go. Funding for mental health overall and certainly as regards to postpartum moms.

I will say one more thing, and there is some great research -- I don't have time, but I think we provided this to the committee staff from the Center on the Developing Child at Harvard University. It talks about the importance -- of course, we all know the importance of brain development in the first 2 to 3 years, but moms who are depressed are perhaps not interacting with their children in a way, and it may impact even the architecture of their brain development. And, of course, later there are all sorts of negative impacts from that. So many nuances to the importance of mental healthcare for pregnant moms.

Mr. Walden. That is a really important point that could easily be overlooked is that in relationship. Thank you.

Thank you all for your testimony, and we will keep you in our hearts. Thank you.

Ms. Eshoo. The gentleman yields back. Thank you.

I now have the pleasure of recognizing the gentleman from Massachusetts, Mr. Kennedy, for his 5 minutes of questions.

Mr. Kennedy. Thank you, Madam Chair. Thank you for calling this important hearing. Thank you to all of the witnesses for being here for the work you do every day and for lifting up the voices that need to be heard. It is easy to study the stats to hear some of these stories, to learn about the inequities and implicit bias, to look into the eyes of a spouse, a parent, child and to talk to a survivor and become, candidly, a bit dejected, to begin to question why we can't in this Nation protect mothers like the rest of the world can, to ask why nearly a thousand American women die from pregnancy and childbirth every year, and why do another 65,000 nearly die or bear those scars for a lifetime?

The tragic truth is that we already know the answer to these questions: a long and pernicious history of racism calcified in our institutions, including our healthcare sector; economic inequality that leaves entire communities relying on unfunded, unprepared hospitals already stretched too thin; and the politically motivated decision by many States to reject Medicaid expansion that leaves thousands of women uninsured less than 2 months after giving birth.

So, to begin with, Ms. Irving, words will never suffice, and there is nothing we can say or do that will make up for the preventable loss of your daughter. Please know that we will carry her story with all of us. In your testimony, you told us about implicit bias training and that it isn't enough, and you are absolutely right. What systematic reforms would you like to see in our healthcare system beyond that mandatory training?

Ms. Irving. I would really like to see some type of a program/policy standardized -- what would you call them -- I guess, standardized policies that are tied to

either accreditation or funding. That is, I think, the only way you are going to get people to move off the dime. The implicit bias training is great, but you need to have some kind of evaluation on whether or not that is making a difference in the lives of patients, mothers who are coming there. And if it is not, if it is going -- if it is causing harm, then they need to be held responsible, whether it is funding cuts, whether it is accreditation that is withheld, or however you want to put it, but there has to be an incentive for folks to do the right thing.

Mr. Kennedy. Thank you.

Ms. Ranji, nearly half American counties do not have a single practicing OB/GYN, and there are stark divides across access to care within cities like Washington or Boston. Would adding doula services as a covered benefit under Medicaid, as, by the way, a bill introduced by my colleague, Ayanna Pressley, the Healthy MOMMIES Act, would do, with increased access to care and reduced rates of preventable maternal deaths or complications?

Ms. Ranji. Thank you for the question. Currently, you raise the issue of doula services. Currently, doula services is covered under in, as far as I know, two States, Oregon as well as Minnesota under Medicaid. It is a benefit that is not available to many women covered by Medicaid across the country. It is an area that has been of interest in many States. New York is also piloting a program, and several other States have considered recently adding doula services. Doula services are an important -- could be an important source of support for pregnant and postpartum women. Doula services expanded beyond just labor and delivery. I am not familiar with the research necessarily tying it to rates of maternal mortality or morbidity or the

effect of that, but there is a lot of research, particularly the Listening to Mothers Survey that has looked at women's perceptions around doula care and have found it very useful. And perhaps some of my clinician colleagues here could speak to working with doulas.

Mr. Kennedy. Thank you, and just very briefly here, question for each witness if I can. Can any of you tell me how many postpartum women die annually from suicides or accidental overdoses?

Dr. Nelson. I can speak to the Texas maternal mortality review. From 2012 to 2015, overdose was the number one cause, and from 2012 to 2015 in Texas, there were 33 suicides.

Mr. Kennedy. No national figures, though?

Dr. Nelson. I do not have that, no.

Mr. Kennedy. Nobody? And to be clear, we do not have any idea how many women die in this country after giving birth from suicides or accidental overdoses because it has

never been studied, and it is not reported. So we can't address something we don't know to be a crisis if we don't even know how big a crisis that it is, yet I think we can all acknowledge that it certainly is one, Doctor, given the statistics that you indicate. But we also can't wait for years for these studies to take place before we act, and that is why we need to have perinatal mental health providers in these conversations and why we need to have guaranteed Medicaid coverage for a full year after birth.

Grateful to all of you for being here today. Thank you for your attention to a critical health crisis in our country.

I yield back.

Ms. Eshoo. The gentleman yields back and thank him for his questions.

I gave birth to two children in 1969 and 1971, which means they are both older than I am now, but when I complained to my doctor postpartum after each birth how depressed I felt, I was told that is just the way it is. So I just place that on the table for everyone to think about, and now I would like to recognize the gentleman from Michigan, Mr. Upton, who served as the chairman of our full committee and with special leadership qualities.

Mr. Upton. Thank you, Madam Chair. I know that we all appreciate today's hearing. I want to do what we can, particularly on a bipartisan basis to resolve this. Every one of our districts is different. All of our States are different. My district has a central city of Kalamazoo, hundred-some thousand people and some rural counties as well. In the past, we have had some counties without hospital to help so people literally had to go out of their county that they reside in if they were going to deliver at a hospital, and, obviously, that happens. Michigan has got pretty rural area, particularly in the UP, and we had pretty high death rate, maternal, in Kalamazoo back in the 1990s. And we worked very closely with HHS and got some special money to grant to really target Kalamazoo to see what we could do to alleviate some of those terrible statistics that are there, which go right along with what you have been saying. Women of color, Hispanics, Medicaid births at our hospitals generally are over 50 percent and have been for some time, whether it be either in an urban setting or maybe a rural hospital as well. And I am -- Dr. Nelson, I have heard of Parkland Hospital. I don't know how many hospitals are in Dallas, and it seems like you have done a remarkable job trying to really reach out with the satellites and others. I guess the question is a little bit of a followup to

Chairwoman Eshoo to Dr. Harris. So, when you see these statistics that are out of sorts, bad, things that none of us would accept, what efforts -- what collaborative efforts -- and I guess, Dr. Howell, I ask you to be part of this since you are with Mount Sinai, so thinking about the hospital situation -- what efforts are you taking on yourself to say, what can we work with? How do we work with the AMA and others to try and duplicate a success that we have seen -- I would call it a success -- of what we have seen at Parkland? Maybe if the three of you could chat a little bit about that. I have got one last question for Ms. Ranji at the end as well, but if you could just expand on that a little bit. Because we see these statistics, what are you going to do? What is happening? Where is the leadership to try and get it done?

Dr. Howell. So, in New York, we have had a lot of work around this for the last 4 to 5 years when we recognized that we were doing so poorly as a State and the significant racial and ethnic disparities that existed. So, at the State level, we have had a collaborative across all the States trying to implement some of the AIM bundles, three of those bundles in hospitals across the State. And in New York City, the Department of Health had a lot of efforts trying to work on quality improvement, implicit bias training to do so. At my own institution, we have done a lot of similar things that Dr. Nelson has mentioned in terms of trying to standardize care, building a culture of safety and equity. We have had implicit bias trainings and required it of our obstetrician, gynecologist. We have had all sorts of different things. But one other point I would just like to quickly raise is, a lot of the research that I have done has really been looking at New York City hospitals, and part of the story here is some hospitals don't have the resources, have the know-how to be able to implement these bundles and do these things. It takes

resources. You need protected time because you need a partnership between physicians and nurses, a physician and nurse leader to champion these efforts. And so, while it is in part healthcare professionals in the way that they treat patients, another big part of this story is the place matters and where you deliver matters. And the resources, the staffing, some of the basic bread and butter of high-quality efficient hospitals is just not there, and that is something else we need to be thinking about.

Mr. Upton. So, just to comment. So all of us here support community health centers, all of us, everyone on this committee. It has been a great bipartisan effort for many, many years. And I know I have been to all of my community health centers. I am going to be meeting with some of my folks from Michigan this afternoon. I am going to follow up with questions based on this hearing. I know that they are very active, and I applaud what they are doing, and we are going to push them hard. And I would just -- my remaining time, Dr. Harris, if you can help, particularly in your leadership role now, I think that would be terrific. My last question, Dr. Ranji, so one of the things that has come up, some States have that 1115 waiver to extend the time beyond 60 days that a woman might be able to be able to get some care under Medicaid. Some States have it; some States don't. A couple of the bills that we are talking about today, in fact, have that coverage, which I think is good. I think it is very good.

What is the impact on the States because, again, Medicaid is run by the States, so they have to make the application. So what is the reaction of the States going to be if, in fact, we do this thing that I think most of us could support?

Ms. Ranji. Well, Federal legislation would allow uniformity for --

Mr. Upton. So they wouldn't have to apply for the waiver? They would

automatically -- if they want do it, they do it.

Ms. Ranji. Right. Allow availability of coverage across the country.

Mr. Upton. So my time is expired, but let me just say, so how many States you think right away would -- how many States have it now, and how many States would say, "Sign us up"?

Ms. Ranji. I can't tell you how many States would say, "Sign us up." I should say Illinois earlier this year did approve that policy and is, in fact, seeking a Federal waiver to secure Federal financing, but again, if it was written into Federal legislation that would allow -- that would be uniform across the country.

Mr. Upton. Thank you, and all my time is expired.

I yield back.

Ms. Eshoo. I thank the gentleman, and he yields back. It is now a pleasure to recognize the author of the MOMMA's Act, Congresswoman Robin Kelly for her 5 minutes of questioning.

Ms. Kelly. Thank you, Madam Chair. Again, good morning, and thank you all for being here to share your expertise, your insights, your experiences surrounding this critical issue of maternal health.

Ms. Irving, thank you so very much. It can't be easy, but I just want to thank you over and over again.

And Dr. Harris, thanks for all of your support. We could not have written the bill without the expertise and support of the AMA, ACOG. We really appreciate everybody.

In recent years, as you have heard today, the number of American moms dying from pregnancy and childbirth has climbed drastically while globally the rate has declined.

New American moms are twice as likely to die today than in 1985, and it is very scary to me. My husband and I have four children between us, three girls, only one has had a baby yet, and it is interesting or scary to think that it was safer for me to have a baby than my next two daughters, who I think are going to give me grandchildren.

After almost 35 years -- never know -- the situation should be getting better, not worse. As with nearly all health disparities, women of color, especially Black and Native American moms, as we have heard, bear the burden of this crisis and continue to die at much higher rates. In some places that disparity grows even larger such as my State of Illinois. One of these mothers was Kira Johnson, the daughter-in-law of TV's Judge Glenda Hatchett. Kira raced cars, flew planes, spoke five languages. She died soon after giving birth to her second son Langston.

While each death is tragic, the reality of the situation foretells more tragedy. According to ACOG's research more than half of all maternal deaths are preventable. In Illinois, it said 75 percent of them are. It is clear that we can and must do more to protect mothers' lives. Conditions like hemorrhaging and preeclampsia can and should be prevented. We must understand the need to listen to women and their health concerns. Just last month, I held a field inquiry in Chicago on maternal mortality. Over and over again I heard the same problem: Women are not being listened to, especially women of color. The hard truth is that no law can legislate away racism. No laws can change the hearts and minds of people who operate on, deliver care to, or just look at people of color from the lens of unconscious bias. But our laws can change how care is delivered within our hospitals by equipping our providers with standardized emergency obstetrical protocols. Our laws can support providers across their training continuum

with tools that help them become more reflexive about how their own biases play out in the care they provide to women of color. Our laws can extend care to mothers who are Medicaid beneficiaries throughout the entire postpartum period. Our laws can support full collection of consistent data about who dies on the way to motherhood and why.

Knowing this, I introduce the MOMMA Act, which builds on recent successes and data standardization and protocol development to prevent deaths and also establishes a National Maternity Mortality Review Committee, expands Medicaid coverage for new moms to a full year, and seeks to address the racial disparities in maternal mortality.

As chairwoman of the Congressional Black Caucus Health Braintrust and co-chair of the Congressional Caucus on Black Women and Girls, a prime importance to me is equitable healthcare access and delivery and the healthcare systems impact on those who, before the ACA, historically experienced barriers to care, whether due to cost, geographic isolation, insurance coverage, and especially due to forms of exclusion, such as race and the residuals of racism. The time has come for action. We have already lost too many mothers to this crisis, and there are too many kids growing up without mothers because of preventable maternal deaths, and I think that is something this committee needs to look at: How long do we postpone? How long do we keep talking about this as mothers continue to die? It is incumbent upon us to honor their lives with action, action that will prevent another mother from needlessly dying or another family from being torn apart. We see the inequity. We are calling it out, and we are here to eliminate it.

I would also like to enter into the record a statement from Stacey Stewart, president and CEO of March of Dimes, and from Advocate Aurora Health. Thank you,

again.

[The information follows:]

******** COMMITTEE INSERT ********

Ms. Kelly. And I yield back.

Ms. Eshoo. The gentlewoman yields back.

It is a pleasure to recognize the gentleman from Illinois, Mr. Shimkus. I didn't like the news that went out with your name attached to it, but we have, let's see, 16 months left to work with you, so take it away. You are recognized for 5 minutes.

Mr. Shimkus. Thank you, Madam Chairman. I appreciate that. I like the news. My wife likes the news. So I have been on the ballot since 1988 for every 2 years. So it is time to not be on the ballot. So thank you for those kind words, and we will get the chance to work together more.

Ms. Irving, we grieve with your loss. Thank you for being here.

I am encouraged that this committee is continuing its efforts to understand and address underlying causes of our Nation's maternal mortality challenges. As we have mentioned a couple times today, the President signed H.R. 1318, which is Preventing Maternal Deaths by our colleagues Herrera Beutler and Diana DeGette from the full committee. This legislation enhanced Federal efforts to support State Maternal Mortality Review Committees to improve data collection. I am going to talk about why that is important. I am glad my colleague, Congresswoman Kelly, is here from Illinois because these are most recent stats based upon having starting to gather more and better information.

In fact, in October last year, October 2018, Illinois Department of Public Health released its first maternal morbidity and mortality report, which found that, during 2014 and 2016, there were 231 pregnancy-associated deaths with the pregnancy-associated mortality ratio being highest for women living in rural counties and in the city of Chicago,

60 to 56 respectively. You know, obviously, we mourn every death, and one is too high, but that is just the stats that now we can now dig into and figure out what is going on.

Understanding that this issue affects a broad and diverse population, it is important to make sure any Federal legislation considers the unique needs of States and the localities as opposed to a one-size-fits-all solution. For example, Illinois has a waiver to cover mothers up to 200 percent of the Federal poverty limit. And the ACA exchange coverage begins at 100 percent of the Federal poverty limit, and this is due -- Ms. Ranji, are you concerned that additional Federal legislation affecting patients at these income levels could complicate State efforts or, worse, end up punishing States for having made such investments by simply bolstering States and dedicating their resources elsewhere?

Ms. Ranji. Thank you. You know, the Federal legislation or a Federal, as I said before, would add a uniformity to the policy and make it --

Mr. Shimkus. Yeah, that is exactly why I am asking the question because if the State of Illinois is better than the Federal legislation, then you are penalizing Illinois for what it is trying to do internally to address these concerns.

Ms. Ranji. Well, States would still retain the option and flexibility that they have now --

Mr. Shimkus. We have to make sure that that is available in the legislation. We can't assume that that is going to be the way the legislation comes out. We have to -- that is part of the package.

Ms. Ranji. Certainly that would have to be part of the terms if that was --

Mr. Shimkus. Right, and that is our concern.

Ms. Ranji. I would just add that, you know, I think what we have talked about

today is that coverage is one part of this whole conversation, and that is one area that States have been making efforts in, as has been discussed. You know, States as well as providers and you alluded to differences in provider availability in different regions. Provider States all have a role in this.

Mr. Shimkus. And States follow the money, just like anybody else, and so the FMAP does drive decisions by States, and I think we have to understand that and make sure that these kind of contradictory sometimes competing messages are direct into the way in which we want them to perform.

Mr. Shimkus. Let me go to Dr. Howell real quick. In your testimony, you mentioned specific elements of legislation to combat maternal mortality specifically those elements pertaining to data collection and support for implicit bias training for health professionals.

As a member of the Communications and Technology Subcommittee, we discuss the potential benefits of using Big Data and machine learning, algorithms and such, but also note that the data we often rely upon to inform decisions is inherently biased. You know, that old garbage in/garbage out debate that we have all the time. I am curious if you or others on the panel could expand on or off for examples of effective ways to limit the negative impact this bias has on patient care.

Dr. Howell. I think you bring up a really good point about data quality, and I want to echo that if you just use vital statistics alone to figure out the maternal deaths, you are going to miss a lot of the mental health and the -- you know, the late deaths because it was not a reliable system. The pregnancy check box, which was introduced in 2003, was introduced differently across all the different States, and so, again, you are not

dealing with apples to apples comparisons.

That is why Maternal Mortality Review Committees are so essential because we are really collecting data from multiple sources on each death. So we really understand what is the underlying cause, what were the contributing factors. And then now we have the CDC trying to have the MMWR program, which is surveillance, 33 States are part of it, to actually collect this information from the MMRCs so that there is now a national understanding of what is going on. We need to get that all the way up to 50 States, but that is the way to have better quality data around maternal deaths.

Mr. Shimkus. Thank you, Chairman.

Ms. Eshoo. I thank the gentleman. Excellent questions and highly instructively answers.

I now would like to recognize Dr. Ruiz from California for his 5 minutes of questioning.

Mr. Ruiz. Thank you. While it is stating the obvious, I would be remiss not to stay that is abhorrent that the United States of America is one of only three countries where maternal mortality is on the rise, along with Afghanistan and Sudan, and it is unacceptable that 60 percent of pregnancy related deaths are actually preventable. Even worse is the fact that the CDC found that Black women were three to four times more likely to die from a pregnancy related cause than White women. This is one of the reasons that I have been working on legislation to address health disparities in women's health equity. The Women's Health Equity Act will create a centralized independent interagency council in the executive branch to facilitate coordination between Federal agencies on women health issues.

The problem is that you have different agencies working in silos, and they are not communicating being efficient in what they are doing, and they are not opening up the resources as well as they could be with efficiency between all the different governmental agencies addressing this issue. This will enhance coordination and communication between the agencies when addressing women's health issues and health disparities.

The interagency council would focus on collecting and analyzing programs currently in place and give recommendations on how to better coordinate their efforts. The council would also be responsible for monitoring, evaluating, and providing recommendations to address women's health equity and health disparities. It would also streamline programs and activities within Federal agencies that are working towards the same goals.

Dr. Harris, do you agree that the lack of coordination on the Federal level is hampering efforts to truly address health disparities?

Dr. Harris. Well, what I would say is you bring up a great point about the importance of getting out of our silos, and interagency coordinating councils are a proven method to do that in other disease and public health crises. And so I would say that any opportunity where folks get out of their silos and work together and agencies coordinate their efforts better is a step in the right direction. I would say, from the AMA's standpoint, we would hope that there would be physician input into any of that agency coordination.

Mr. Ruiz. Well, just to let you know, AMA has been very active in contributing their input into this legislation. Dr. Howell, what are your thoughts on that?

Dr. Howell. I agree with what Dr. Harris said, that, you know, us working

together, collaborating, and sort of figuring out the next steps, having the voices of many parties, including physicians in this discussion is really important.

Mr. Ruiz. Excellent. So, you know, I grew up in a farm worker community where residents were largely poor, with English as a second language. And as a kid growing up and later as a doctor who practiced medicine there, I saw firsthand how critical cultural competence is to delivering effective high-quality care, and it is not just understanding terms from a different culture; it is a cultural sensitivity where you can understand the practice of truly trying to understand a person's background in order to provide the best therapy and increase compliance and increase success of those recommendations. The Giving Voice to Mother Study released this summer surveyed women in the United States in an effort to learn more about mistreatment during birth and found that 17.3 percent of women experience one or more types of mistreatment, including, but not limited to, privacy violations, being shouted at, or scolded by healthcare providers or having treatment withheld.

Women of color were more likely to report an experience of mistreatment with 33 percent of indigenous women, 25 percent of Hispanic women, 22 percent of Black women reporting an experience of, at least, one form of mistreatment. We have heard on our panel today about at least one terrible example of what can happen when a patient doesn't receive the care she is saying that she needs. These experiences further perpetuate mistrust in healthcare systems and influence women's desires to access care.

Dr. Harris, in your experience, how can we imbed improving the experience of care in efforts to improve the quality of care?

Dr. Harris. Another important topic and thanks to the committee members for

raising this. There is this whole universe of how we understand and work with others, so you mentioned two terms: cultural competency, cultural sensitivity. I even use the term cultural humility. So we have to appreciate all of these issues in the context. Several of the committee members have mentioned implicit bias, unconscious bias, another part of that universe.

What we know is all of us have unconscious and implicit biases and how should we -- but unfortunately there is no gold standard at this point and one of the things that AMA wants to do is look at not necessarily developing a gold standard, but what might be the components of a great program to get it all.

Mr. Ruiz. I would love to work with you on that. Just in closing, Chairwoman, we can't look at mortality -- maternal mortality disparities if we don't look at the overall health disparities in our system because a pregnant woman doesn't exist only when she is pregnant, right? So you have to look at her health and her experience with her health because that is one of the leading factors of health outcome is her health prior to being pregnant. And just recently, for example, as an example of how we have these inherent biases, September 6th, JAMA Open Network published an article that showed that, out of over 800,000 women and men under Medicare, they found that Black and Hispanic women were diverted from EMS, from the emergency department designated for them, took a longer trip to send them to the safety net hospital elsewhere --

Ms. Eshoo. Thank you, Doctor, your time has expired.

Mr. Ruiz. -- which, you know, has dire consequences.

Ms. Eshoo. The gentleman yields back.

I would like to recognize Mr. Guthrie of Kentucky for his 5 minutes of questioning.

Mr. Guthrie. Thank you, Madam Chair. I appreciate it very much.

And thanks, Ms. Irving, for telling your story. We had a hearing on this for some bills that we did pass and signed into law. There was a husband in your seat, and he was talking about his wife, and he made the same arguments that you made. He said his wife -- I think it was either a business consultant or private equity. His wife I think was a Ph.D., athlete, UCLA, if I remember, delivered at UCLA Hospital, and then had complications and went back. I don't know how many days it was. It was several days, and she was just dismissed with "you are exaggerating" or whatever.

And so what we are saying here -- I know we are implicit bias, cultural bias, and we are using those terms, and they are absolutely accurate. But what we are saying is -- you said it wasn't lack of education, it wasn't lack of insurance, it wasn't lack of access. I think Dr. Howell said that, if you control for education, insured, African American women or women of color are treated different than less educated and within coverage for whites, so what we are saying is, African American women or women of color are showing up in front of healthcare professionals and healthcare professionals are treating them differently. We need to do -- if it is commission, if it is the agencies, if it is cross-referencing that we can do in Washington, we need to do that to make sure that this is taken care of.

Dr. Harris, you are the only one here representing healthcare profession. What is going on? Is the AMA trying to address this internally? I know we are here in Washington trying to address it, but we know there is a problem. We know it is lack of -- there is bias, and what do you think it is, and what is AMA trying to do to address that?

Dr. Harris. I think we are trying to find the answers to those questions, and as I mentioned earlier with our new work and, by the way, this is building upon work for many years that the AMA, our commission to end health disparities -- again, I just talked to Dr. Aletha Maybank this morning, and we talked about the possibilities. Now we are just getting our center up and running, but this is one of the areas where we want to focus on, we want to understand why, and then what are the solutions that physicians can implement.

Of course, as you know, I am a psychiatrist by training, so I am trained to listen maybe in a different way, but, as I said in my testimony, for whatever reason, many of them are racism, discrimination, implicit/unconscious biases, women are not being heard, particularly African American women are not being heard. So the fact that we are talking about that is the first step, and I know at the AMA that we are going to move forward and try to find solutions and spread that to the medical community. Of course, our partners at ACOG are here, and we will work closely with them.

Mr. Guthrie. I want to correct the record. I think she was UCLA athlete. She was -- Cedars-Sinai was the hospital. So I want to make sure I have that corrected, the previous witness, it was her -- so Parkland, though, you have 90 percent Medicaid, and you have this extensive program, and so I think what Dr. Howell said, in New York City, you have hospitals -- and I understand that. It is absolutely a fact; you have hospitals that have better outcomes, and hospitals, others. And you are saying it is more women of color go to their -- they are kind of divided up in where they go to get their service. But what I don't understand -- getting back to the healthcare professionals, why aren't they just showing up -- are they showing up at your hospital, Dr. Nelson, saying: What

are you doing? How can we replicate it and move forward?

It looks like we are here doing a mandate from Congress, and if Congress needs to mandate it, we need to mandate it. But it seems like within the healthcare profession, they would be flooding to what you are doing, or in New York, some of the hospitals go into the hospitals having better outcomes, and just, what are you doing different? Because when we did the bill last year, we found that, in high-risk pregnancy, some hospitals didn't even have high-risk kits available when they were doing high-risk deliveries, just the basic stuff. And it is hard for us to fix when they are not even doing the basic stuff from Washington.

So, Dr. Nelson or Dr. Howell, whoever wants to talk about that, it is disturbing that the healthcare profession is not addressing this better than they are? Not saying you are not.

Dr. Nelson. Well, I think to speak first, you are absolutely correct and that the first issue that Dr. Harris mentioned is we have to recognize we have a problem, and collectively we have to agree that we have a problem and this includes issues within high-resource settings and low-resource settings. And one of the steps forward that I am proud of is the regionalization of care that we have provided in Texas, and that is not to say we are closing hospitals in rural communities. We support that. It is really to identify women with prenatal care that have a high-risk condition, identify their needs, and get them to a facility that has resources --

Mr. Guthrie. I understand what you are doing, but are other hospitals flocking to you from other cities and trying to understand what you are doing and replicate it?

Dr. Nelson. That model is one of the opportunities and it dovetails AIM, and it

dovetails the California initiative. These are standardized practices that we can all collectively agree to in the medical community to say --

Mr. Guthrie. Because you being 90 percent Medicaid, you are not at the top of the chain in terms of financing?

Dr. Nelson. But the principles --

Mr. Guthrie. It can be replicated.

Dr. Nelson. The principles of care are the same, and that is emergent response to emergent conditions, and time is key.

Mr. Guthrie. Right. Thank you.

My time has expired, and I yield back.

Ms. Eshoo. I thank the gentleman, and he yields back.

Pleasure to recognize the gentleman from North Carolina, Mr. Butterfield, for his 5 minutes of questioning.

Mr. Butterfield. Thank you very much, Madam Chair.

Thank you to all of the witnesses for your testimony today.

Let me begin with you, Ms. Ranji. Thank you for coming today and thank you for your words.

As you pointed out in your testimony, research shows that health coverage before, during, and after pregnancy is important to support healthy pregnancies and positive outcomes. Medicaid, that favorite word that we all talk about, Medicaid, I wish it was available in every State in the Union with respect to its expansion, but Medicaid is a vital program for many families in my district and all of our districts. I am glad the committee is looking at bills that would extend Medicaid eligibility for pregnant women

to 1-year postpartum. A maternal-fetal medicine specialist at Duke University in my district shared with my staff recently that extending Medicaid coverage to 1-year postpartum postpartum would be life altering and potentially lifesaving for her patients, many of whom have not had regular care until finding out that they were pregnant. Extending Medicaid coverage for new moms is a vital step to ensure these women can continue to be cornerstones of our families.

Ms. Ranji, simply put, healthy moms lead to healthy babies. Is that an overstatement?

Ms. Ranji. There are certainly a lot of research that connects the health of moms with the health of their children and as well as coverage that access to coverage for moms also connects to access to coverage for children.

Mr. Butterfield. Could you describe for me the long-term positive benefits that 1-year postpartum Medicaid coverage would have on moms and their children?

Ms. Ranji. Well, like I said, in several States now, women do lose coverage after 2 months and so extending to 1 year would provide access -- seamless access so that women could continue to see the same providers and follow up on many of the issues that -- clinical issues that my colleagues have talked about today. Cardiac-related health, maternal mental health, and again, coverage provides access to a provider and being able to continue and follow up on all of those issues that, again, that we know don't resolve within 2 months usually.

Mr. Butterfield. Thank you. Many of the witnesses, Madam Chair, today have commented on the disgraceful and disturbing fact that African American women are three to four times more likely to die from a pregnancy-related cause than their

counterparts. Black women are also more likely to have complicating conditions, like uterine fibroids and hypertension, among others, which can cause severe maternal morbidity and have potentially life-threatening and lifelong consequences.

There have been countless stories of women dying or becoming ill because their symptoms were ignored or treatments were not offered. What should we do -- and let's try you, Dr. Howell, on this if we can. I just looked at your bio. It looks like you are well suited to handle this. What should we do to educate providers about conditions like these that disproportionately impact women of color and how to identify and treat them?

Dr. Howell. So, again, a very important point about risk status for women when they enter our healthcare system, antenatally as well as on labor and delivery. So risk stratification is an important part, and it is something that we use also in our AIM bundles to understand who is most at risk and to make sure those people are getting what they need and when they need it. So I think in addition to just pure clinical care and thinking about the best way to optimize care for individual patients, we also need to think about some of these other issues around communication strategies, decisionmaking, shared decisionmaking, listening to patients to better understand their story, and recognizing and teaching healthcare providers that there is a bias not to listen to women in general, which we have heard in our own focus groups across race and ethnicity, but it is more pronounced for women of color. So I think those are some of the steps that we need to take.

Mr. Butterfield. Thank you. Thank you very much.

Madam Chair, since Dr. Ruiz went over 1 minute, I will go under 1 minute, and

maybe we can cancel each other out. Thank you.

I yield back.

Ms. Eshoo. I always knew you were a good man, always.

Mr. Butterfield. Yes. He is my friend.

Ms. Eshoo. Yeah. Well, you are both my friends.

The gentleman yields back, and now it is a pleasure to recognize the gentleman from Virginia, Mr. Griffith, for his 5 minutes of questioning.

Mr. Griffith. Thank you very much, Madam Chair.

And clearly somebody said it earlier, we have to identify that we have a problem, and clearly that has been identified, and we heard the testimony last year of Mr. Johnson. We heard your testimony today, Ms. Irving, and those losses where the mothers were just -- they just weren't paid attention to. And that clearly is a concern.

But I was struck, Dr. Howell, by one paragraph in your testimony, and I am going to repeat that paragraph because I think it is helpful, and then I am going to ask you a question. Quoting your testimony: Research by our team and others has shown that for a variety of reasons, Black women tend to deliver in a specific set of hospitals, and those hospitals have worse outcomes for both Black and White moms regardless of patient risk factors. This is true in the United States overall where three quarters of all Black women deliver in a specific set of hospitals while less than one-fifth of outcomes in those hospitals by -- while less than one-fifth of White women deliver in those same hospitals. Both Black and White women have worse outcomes in those hospitals. In New York City, a woman's risk of having a life-threatening complication in one hospital can be six or seven times higher than in another hospital. Black and Latino mothers are

more likely to deliver in hospitals with worse outcomes. In fact, differences in delivery hospital explain nearly one-half of the Black/White disparity and one-third of the Latina/White disparity in severe maternal morbidity.

So here is my question, with their choosing a specific set of hospitals, how do we fix those hospitals, and should we have some way of getting the information out if we can't fix those hospitals that these hospitals are far more dangerous? Doesn't solve all the problems, but your testimony indicates that one-half of the disparity is because of specific hospitals. Nothing else that we are doing here at the Federal level or the State level, but the specific hospitals they are choosing? How do we fix them?

Dr. Howell. So I think what is interesting about the work we have done in New York City is that it is not the traditional hospital characteristics, so it is not percent Medicaid. The median percent Medicaid in New York City hospitals is like 80 percent, so we are talking about a highly -- 60 percent of our deliveries are covered by Medicaid. So it is not volume. It is much more -- we don't really understand why there is such a variation, other than having to go in and talk to hospitals, and that is what our research team is doing. So we are going into hospitals who have low rates and hospitals that have high rates to try to understand what the differences are. And what we are finding is that it is things like staffing. It is things like culture -- the culture of the institution and the way that they treat adverse events. It is things like communication and the emphasis. It is quality and safety on labor and deliveries and the use of evidence-based practices, but it is also whether there is any focus on equity and diversity and how they think about it.

So more work needs to be done to understand these variations, especially in large

urban centers where you have high volume, but that is one key important piece because, in certain hospitals, regardless of what you look like, your risk is higher to have one of these severe complications, and that is an important part of the story we are talking about today.

RPTR WARREN

EDTR SECKMAN

[12:02 p.m.]

Mr. Griffith. And so, while we look at these bills -- and I think this was the same point that Mr. Guthrie was making just a minute or two ago, and he and I hadn't talked about what we were going to discuss, but he started hitting some of that same testimony.

While we are working on this legislation, that is an area we need to focus on. And right now, while there is some studies in these bills, I don't think the bills are really focused on that area and maybe we need to give some more money to the NIH to focus in on that so that we can figure out what the problem is. Maybe they need to be doing what Dr. Nelson is doing in Texas, but maybe that doesn't work in New York City because what works in Texas might not work in New York City, but we still need to figure out, if that is half of the problem, then it ought to be addressed in some of our bills as more than just a casual line in a study.

Would you not agree, Dr. Howell?

Dr. Howell. I think that it is one important part of something that needs to be addressed. So, yes, I do agree that it is one more element that we need to look at and a very important one in New York City.

Mr. Griffith. And, Dr. Nelson, you would be more than happy to talk with anybody who wants to figure what you are doing right. Is that correct?

Dr. Nelson. Yes, sir.

Mr. Griffith. And you would be willing to work with these hospitals that in the testimony are just listed as -- and I am not asking for names today -- a specific set.

Dr. Howell, real quick. I just have a few seconds left. Should we identify for the public those specific set of hospitals where your risk is higher?

Dr. Howell. So I think that, Dr. Nelson, I think we both agree that measurement is a key. Quality measures that are important and that women can use to help choose hospitals I think is an important measure, but we have to be very careful about the development of appropriate risk-adjusted quality measures so we do not penalize the hospitals that take care of the sickest and the hardest cases, and I think that is a really important part of doing really well-done, quality measure development in maternal health that focuses on both the patients -- patient-centered, thinking about experience -- as well as on disparities.

Mr. Griffith. Thank you.

I am out of time. If the chair lady would like to give you time, Dr. Nelson, she can. But I am out.

I have to yield back.

Ms. Eshoo. Well, the gentleman yields back, but I think that his question to you is really very, very important. All of the collection of the data is essential so that you have something that is foundational, but we already know where women of color deliver and die. So there has to be -- I think there needs to be a red light and siren team that gets into these hospitals, and I also think that we should consider the accreditation of that hospital based on the morbidity rates.

So I don't know if that is what the -- where the gentleman was going, but it certainly is my sentiment.

Mr. Burgess. Would Dr. Nelson respond to that?

Ms. Eshoo. Certainly.

Dr. Nelson. So one of the comments of sharing, in all seriousness, sharing our experiences and what we do as practices is actually part of the outreach and one of the things that we actually stress as part of the regionalization of care. We actually have an outreach team going to lower level facilities to talk about emergent response to hypertension and labor management. So that actually is one of the existing programs we currently are using right now.

Ms. Eshoo. I mean, I don't know if El Camino Hospital in Mountain View, California, knows what you are doing. And I am not saying that they have a problem. It is marvelous what you are doing, but this needs to be under a national umbrella, and I don't think anyone is arguing with that.

It is a pleasure to recognize the gentlewoman from California, Ms. Barragan, for her 5 minutes of questioning.

Ms. Barragan. Thank you, Madam Chairwoman.

And thank you all for being here today, for sharing your stories. The statistics are quite tragic, completely unacceptable in a country like ours.

I first learned about the issue of racial health disparities when I was in the White House. I was an intern, and The New England Journal of Medicine came out with a study. It showed that they had sent an African American woman, a White Woman, a Latina woman to similar doctors, same doctors, complaining of the same symptoms, and they were all treated differently, and that is when I first learned of it.

And I think one of the points made by my colleague Dr. Ruiz is critically important. It is certainly overall health and making sure we are all getting access to equal care but

that we are being listened to.

And, Ms. Irving, I want to thank you for coming and sharing your story of your daughter, and the testimony that you provided is something that we all needed to hear. And that is why I am glad we are having this hearing today to kind of look at these bills and see what can be done.

It sounds to me there is not one fix. It sounds like there is going to be a series of things that need to be done to be fixed, to fix this issue and to the make this wrong right.

And so I thank you all for coming.

Dr. Howell, two of the bills that we are being presented with and are looking at are H.R. 1898, the MOMMA's bill that my colleague Ms. Kelly has, and H.R. 2902, which is a bill that my colleague Alma Adams has. Have you had a chance to look at those bills? I would like to know if you believe those bills might help eliminate some of the implicit bias among the medical professionals.

Dr. Howell. So I did get a chance to look at those bills. I don't have my notes. Could you just repeat the names of the two you wanted me to talk about real quickly?

Ms. Barragan. Sure. The MOMMA's Act.

Dr. Howell. Yeah.

Ms. Barragan. And the other one is the Maternal Care Access and Reducing Emergencies Act.

Dr. Howell. Got it. So, yes, I did have chance to look at all of the bills which, again, I think there are elements that are key for this issue.

The MOMMA'S Act, authorizing the AIM program, which I told you is the key to having standardized care practices implemented in hospitals and health systems across

the United States currently reaching 27 States, so potential to reach more than 50 percent of all U.S. births, very important. We need to authorize that.

Second, Perinatal Quality Collaboratives, Maternal and Infant Health Quality Collaboratives are so important as a tool to improve quality of care. And these are partnerships with hospitals and health systems and Department of Health.

As you have heard from my colleague, very important to extend Medicaid for 12 months postpartum. You know, there are so many cases of women who have gestational diabetes. They go on to have a risk. They are seven times more likely to have type 2 diabetes, but if we don't capture them in that postpartum period, they could go on and be much sicker the next time they get pregnant, as well as cardiovascular complications that are so important.

Then, finally, the Regional Centers of Excellence to address implicit bias and culturally competent care, which we have had a discussion about, which I think is a really important piece, again, I would expand it to think about patient-centered communication, shared communication. It is not just bias. That is the problem. But we are not doing a good enough listening to our patients, communicating with our patients, and understanding their perspectives. So having centers of excellence that really focus more broadly with a focus on explicit and implicit bias I think are important.

And I think that the Maternal CARE Act has very similar themes it to. The Maternal CARE Act, though, does talk a fair amount about care coordination and its importance to target social determinants of health which I think is an important piece. It calls for a medical home demonstration project, which I think is of interest.

My one thought I would just share is that CMMI Innovation project looked at

group prenatal care versus birth centers, which is predominantly midwifery care, versus maternity home care for prenatal services to see if we could lower adverse birth outcomes, lower costs, and improve satisfaction. And the other two models performed better than the maternity home model.

So that is evidence that I think we have to include in these discussions. There is no question that care coordination in general seems to really do a good job targeting disparities, and it may need to be a piece, but we need more evidence to make sure because this early evidence is not telling us it may be the best step forward.

Ms. Barragan. Thank you, Dr. Howell.

I also want to mention I think another component is making sure that we get more people of color into the medical profession that are there to listen, that are there to understand. I am proud to have Charles Drew University Medical School in my district which is a Historically Black Graduate Institute that is a district that is 88 percent Latino/African American, that is bringing more and more people into the fold, into these professions and certainly, if I had more time, would ask about your opinion, but I wanted to certainly say that I think this is another angle we can certainly improve in as well.

Thank you very much, and I yield back.

Ms. Eshoo. The gentlewoman yields back.

It is pleasure to recognize the gentleman from Florida, Mr. Bilirakis, for his 5 minutes of questions.

Mr. Bilirakis. Thank you, Madam Chair. I appreciate it so much.

And thank you to the witnesses here who are testifying. Very informative.

Dr. Howell, we can't solve what we don't understand. That is why, last Congress,

this committee passed bipartisan legislation, the Preventing Maternal Deaths Act, which provides funding through the CDC for States and other entities to develop Maternal Mortality Review Committees so we can start collecting -- collectively understanding and reducing our rate of maternal mortality.

CDC recently announced its funding the first round. It is funding the first round of grants to support 25 States, their efforts to combat maternal mortality through the creation of Maternal Mortality Review Committees. As States prepare their implementation efforts, what should this committee be paying the most attention to?

Dr. Howell. Well, I think it is wonderful that the CDC is now sponsoring 25 Perinatal Quality Collaboratives. I think the data is at a key point.

I also want to say one thing though. You are absolutely right. What we don't understand, we can't really address; but there are models of success. We have heard a lot about Parkland today. If we look at California Collaborative and what they have done, by using Maternal Mortality Review Committees, gathering the information around deaths, then using that information to drive quality improvement. And they have done a number of the bundles, the same bundles we are talking about for AIM. They started -- hemorrhage, hypertension, venous thromboembolic disease -- and they have actually lowered deaths in hospitals that adopted these bundles by, like, 21 percent for the hemorrhage-related deaths and their mortality rate, while the rest of the United States has been going up, theirs has been going down. So we have evidence that, when we tie data to quality and improvement, we can really make a difference.

The important lesson about California, though, is, an additionally important lesson, is that their disparities, however, did not decrease. So they lowered mortality

for White women and they lowered it for Black women, but that gap is still there. And now they are trying to target a lot of the things that the rest of us are trying to target around health equity, combining quality improvement, what the data tells us with cultural humility, and sort of trying to understand communities, getting them involved to help tackle this problem, which is something that the AIM bundle also tries to do. The ACOG partners with community organizations to get their input about how best we implement these bundles not only in hospitals and health systems, but we get communities on board as well.

Mr. Bilirakis. Thank you.

Are there concerns within the research community regarding the integrity of the data being collected in States, and, if so, what are those concerns, and how might they be addressed? Are there any concerns with regard to the integrity of the data?

Dr. Howell. Well, there are certainly concerns with the use of what I had mentioned about if you only base maternal mortality rates on vital statistics data only that you are only getting a slice of the picture, and it is not a great way of monitoring our trends across the Nation. The CDC now uses vital stats. It combines it with State discharge abstract data, which gives a better estimate, but still the best estimates are the data from the Maternal Mortality Review Committees that actually get multiple sources of data to figure out how this death occurred, what were the contributing causes, and then feeding that back up to the CDC through their MMWR program is probably the best way for us to get data on this that we can use for improvement.

Mr. Bilirakis. Very good.

Thank you. Last week, the CDC released a report titled "Racial and Ethnic

Disparity in Pregnancy-Related Deaths." In the report, CDC suggested that steps still need to be taken in order to better integrate care delivery between hospital and pre- and postcare services for mothers and their newborns, as well as better management of high-risk patients.

How might this committee consider addressing these specific challenges highlighted by the report. And can you highlight any States or entities that can be looked at as models, again, best practices in these areas?

Dr. Nelson. So I think that I would echo. Much of what Dr. Howell just mentioned I think is reflective in that effort. California has been a model for a lot of the programs, but the same principles are true within the AIM domain. Parkland Hospital publishes "Williams Obstetrics" as a textbook. It is the most popular textbook worldwide. We have 17 authors on our faculty, including myself, and these principles are the same. The important part of this is disseminating that level of scholarship and information to the community centers, to the communities at large, and the providers in those communities.

Mr. Bilirakis. Well, thank you very much.

And I yield back, Madam Chair. Thank you.

Ms. Eshoo. The gentleman yields back.

It is a pleasure to recognize the gentlewoman from Florida, Congresswoman Castor, for her 5 minutes of questioning.

Ms. Castor. Well, thank you.

And, Chairwoman Eshoo, I want to thank you very much for organizing this hearing here today on the maternal health crisis in America.

It is good to see so much engagement by the committee this morning, right, our first committee meeting back after the district work period.

First off, I want to say I am really proud to be a cosponsor of Representative Kelly's MOMMA's Act. And I am so glad that she joined the committee this year. She is a champion on this issue, and her voice is vital to this discussion, and it is needed. It is just horrendous what is happening with disparities when it comes to maternal health in the United States of America.

And I want to thank the witnesses for being here and for providing your expertise. Already I have seen members making long lists of how we can improve the bills that are before us today.

Ms. Irving, I thank you very much for sharing the story of your daughter. You are very brave to do so, and I know she would be very proud to know that you are carrying on her work.

I am also grateful to the advocates across America who engage every single day, whether it is the March of Dimes or it is the American College of Obstetricians and Gynecologists or Every Mother Counts, the folks in the trenches, making sure that, whether they might be Healthy Start, making sure that women and families have every opportunity to have healthy children.

In the Tampa Bay area, I am very fortunate. We have a terrific Healthy Start REACHUP initiative led by Lo Berry. They are one of the national leaders. But what they tell me is, while they have years of experience and they are making progress, they are not able to reach everyone. We are still not able, after so many years, to ensure that women of childbearing age get the services, get the support that they need. I

mean, in America, it is so disjointed, Medicaid and maybe private health insurance and maybe you are uninsured and you are trying to find a community health center but that community health center doesn't provide care. It is still not enough.

And I was really taken by the comments of Dr. Ruiz and Representative Butterfield, who highlighted this really is a continuum of care that is in crisis, and add on top of it the disparities, the racism that continues, the social stigma probably in many different groups. We have got to do so much more. So I will look forward to as we get into the markups on these bills how we can really tackle this continuum of care.

I am also fortunate, back in Tampa, we are home to the University of South Florida. Dr. Judette Lewis is the chair of the College of Medicine's Obstetrics and Gynecology Department. She shared, again, the sobering statistics. In Florida, Black women are nearly three times more likely to die from pregnancy-related causes than White women. She said that, yes, the Maternal Mortality Review Committees and the Perinatal Quality Collaboratives are helping, but so much needs to be done.

I want to start my questions with Ms. Irving. You have listened. These folks are very smart. Members of Congress have had some insightful questions. What would your daughter want to highlight after listening to everyone here today? What would your daughter say, "Boy, that is absolutely right"? What would she have wanted to highlight to this?

Ms. Irving. I wish I knew. My daughter was a brilliant person. I think the most, what she might say or start off saying is this is not a new phenomenon. This has been going on for decades. Why can't we get it right? There are things that can be done but are not being done. I think she would probably say that behind every one of

these statistics, there is a woman who is loved, who is missed. And look at the domino effect. Look at the families. Look at the children that are suffering because we can't get it right.

She would want us to look at making sure that there are the standard care policies and procedures in place, and there is some accountability behind it so that we can make sure that folks are being listened to.

I listened to all of your talk and things about people come in, and it is the hospitals, and there are certain hospitals where you can't go or where you won't get the same amount of care. That wasn't the case for Shalon. The case was that she wasn't heard. She came in. She presented with the symptoms. It wasn't that she was making it up. She came in with swollen legs. She wasn't voiding. She was gaining weight. She gained 7 pounds in one week, and she was there three times that week. Her blood pressure was off the chart. She was not only not listened to; she wasn't -- her symptoms were not addressed. She was there. She was in a very, very good hospital. She had great doctors in that hospital. She had gold-plated insurance. She was not an ignorant woman. She knew what was wrong, and she kept saying it: I don't feel well. This is not -- this is not me. There is something going on here.

But she was dismissed with the: Oh, it is fine. You just had a baby. Give it time. Don't worry about it.

I think my daughter was just so tired at that point. She didn't stand up and say: Look. I am going to the emergency room, or I am going to call another doctor, or I am going to another hospital or whatever until somebody listens to me.

With a newborn baby with colic, with respiratory distress, she just was tired.

And she needed someone to advocate for her. She needed someone to realize that they had to take care of her at that time, and so I think she would just be off the chart right now because that is not happening.

Ms. Castor. Well, let that be a lesson for all of us as we move these bills. Thank you.

Ms. Eshoo. The gentlewoman yields back.

I now would like to recognize the gentleman from Missouri, Mr. Long, for his 5 minutes of questioning.

Mr. Long. Thank you, Madam Chairwoman.

In this final round of jeopardy today, we only have one category left. And that is "Who said it." So in the category of "Who said it" for $1,000: After delivering another perfect baby, I was sitting next to Kira by her bedside in the recovery room. That is when I first noticed blood in her catheter. I notified staff immediately. A series of tests were ordered, along with a CT scan to be performed stat. I understood "stat" to mean the CT scan would be performed immediately.

Hours passed, and Kira's systems escalated throughout the rest of the afternoon into the evening. We were told by the medical staff at Cedars-Sinai Kira was not a priority, and we waited for the CT scan to be done. We waited for the hospital to act so she could have her recovery. Kira kept telling me, "Charles, I am so cold. Charles, I don't feel right." She repeated these same words to me for several hours. After more than 10 hours of waiting and watching my wife's condition deteriorate, after 10 hours of watching Kira suffer in excruciating pain needlessly and begging and pleading them to help her, the medical staff at Cedars-Sinai finally took action.

As they prepared Kira for surgery, I was holding her hand as we walked down the hall to the operating room. Kira looked at me and said, "Baby, I am scared." I told her without doubt everything would be fine. The doctor told me I would see her in 15 minutes. Kira was wheeled into surgery, and it was discovered that she had massive internal bleeding caused by a horrible medical negligence that occurred during her routine c-section. She had approximately three liters of blood in her abdomen. Kira died at 12:22 a.m., April 17th, 2016. Langston was 11 years old.

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

Of course, those were the words of Charles Johnson, IV, who I believe was of means. Kira was of means. It wasn't someone that didn't have good prenatal care. It wasn't someone that had -- didn't have a -- it was a preplanned c-section.

We are talking here today, and I hear a lot of people talking about access to prenatal care which, of course, is vitally important, but cases like this, cases is like Ms. Irving's, all I want to do is come down there and hug your neck. I can tell you that.

But I am the only Missouri member that is on Energy and Commerce. So, consequently, I am the only to Missouri member is that on the Healthcare Subcommittee. So I feel an obligation to travel the State for healthcare issues. I visited just during this break a week ago -- it may have been a week ago today; I am not sure of the timing -- but Kansas City Children's Mercy hospital. Went through the neonatal. Went -- you know, and I do that quite often. I go to St. Louis Children's up there.

Our oldest daughter is a pediatrician, and I know when she does her rounds at the hospital, that, you know, all that she wants to do and you think all any doctor would want to do is love these babies and make sure they get a good start and love the mothers and so whatever we can do on this committee.

I mentioned earlier in my little outburst when we had the outburst in the hall, which I apologize to you all that that went on for any length of time during your testimony, I am a member of the Black Maternal Health Caucus. And I deeply care about this issue. The timing didn't work out to bring up H.R. 4215 today, the Excellence in Maternal Health Act. Nobody's fault, just the timing didn't work out.

But I am an original cosponsor of that, and I just want to thank you all for being here today and your heartfelt testimony. I have said a lot of words today, but there is no words to say, to express what an unbelievable issue this is and the things that happen, but if your testimony here today, Charles' testimony back in September of 2018, I believe it was, we have had a lot of important, lot of big hearings, a lot of memorable hearings in Energy and Commerce. Mark Zuckerberg from Facebook is an example of; Dorsey, Jack Dorsey of Twitter, you know, the rooms were packed, a lot, you know, but no hearing ever moved me like Charles Johnson's testimony that day, and your testimony here today is right along there with it.

So God bless you and thank you for being here and thank all of you for being here, and if there is anything that me, my staff, the committee can do, please keep us apprised, any suggestions, ideas. We will be honored and glad to work with you.

I yield back.

Ms. Eshoo. The gentleman yields back.

It is now a pleasure to recognize the gentlewoman from Delaware, Ms. Blunt Rochester, for her 5 minutes of questions.

Ms. Blunt Rochester. Thank you, Madam Chairwoman.

And thank you so much to the witnesses for your testimony. I especially want to acknowledge Representative Kelly for her leadership in this important issue.

I held a townhall meeting last -- in the past month over the recess, and a midwife stood up and shared her perspective on the role that she plays. And one of the things that she focused on was the social determinants of health, particularly in maternal mortality. And she said that she was caring for a soon-to-be mother, many of which are told go out and get some exercise, but they don't feel safe walking around their neighborhoods, or who are being told to eat nutritious diets, but don't live within blocks of a grocery store selling fresh fruits and vegetables.

And as we transition our health system, you know, I think it is critical that we think about the social determinants of health and all those things that surround it.

And so my first question is to Dr. Harris. Can you talk about the social determinants of health and how we can address this challenge of maternal mortality by dealing with the social determinants of health?

Dr. Harris. Thank you.

And I can. I can say that the AMA is very committed to addressing these issues because, if you look at that circle of care and you look at the fact that maybe health outcomes are impacted, and we know they are impacted some by physicians and hospitals, but we see a huge impact on -- related to the social determinants of health: transportation, housing, whether or not you have a job. You mentioned whether or not

you live in a food desert, and I know now and my colleagues can talk about whether or not you live in maternity care desert.

So those are all pieces that we plan to focus on as we build out the work of our Center for Health Equity, but I will say we have current policies that raise the importance of social determinants of health. So, wherever we go, I mention that and, in my own work, that it is not enough for us to say to exercise. Physicians should say that, but we have to make sure there are equitable opportunities for exercise, to access healthy nutritious foods. So that work will be included in the work of our Center for Health Equity.

Ms. Blunt Rochester. Thank you.

This questions is for the panel, and it is one that has plagued me for a long time.

And, Ms. Irving, first of all, thank you so much for sharing your testimony and for sharing your daughter's story. And it is at the heart of my question. I don't understand why. I can talk about the social determinants of health and understand that there is a disconnect sometimes between access to healthcare or the kind of healthcare, but your daughter, you know, smart, understood health.

I watched a Jon Stewart piece last night about maternal mortality, which is interesting, and he said that -- they showed a clip of a father, an African American man, who said his wife died because he was afraid to be perceived as the angry Black man if he spoke up for her.

So I am curious. Can you explain to me for those African American women that are experiencing this and it is not an issue of access to healthcare, education, a doctor, can the panel, can someone help me understand? What is it? What is going on?

Ms. Irving. I will start off and then turn it over, but I had the same issue, and I suffer now from regret that I wasn't that angry Black woman, and I think my daughter kept me from doing that because she would say: Mom, just calm down. Just let them handle it. It is going to be okay.

But it wasn't okay, and I wish now that I had stood up and said: Look, you are going to do something right now.

But I think it might have had the negative effect because then I would have pushed them away, and it might -- well, it would have -- I can't see how it would have turned out any worse than it did, but that is what a lot of Black women or Black men face when you are coming in because you are looked at as a threat. Then, if you start getting loud, the next thing you know, you could be put out of the hospital because you are not communicating in a way that is acceptable.

Ms. Blunt Rochester. Doctor.

Dr. Harris. So that is an important part. I would say that is the other end of folks examining their own implicit biases. I have not had a child, but I have often been the only African American woman in a room, and I think people of color, particularly African American women, because there are issues around discrimination based on gender and race, end up self-editing sometimes and being extra careful so that we are not the angry Black woman or the angry Black man.

And I think as we have this conversation, we have to talk about that more. It only comes, I think, with some practice and some experience and, frankly, some privilege that you feel more comfortable raising issues. And that should not be the case.

Ms. Blunt Rochester. You are right.

Dr. Harris. And so I will say that was part of our discussion, will be part of our discussion at the AMA. But it really needs to be part of this society's discussion to look at, I think, the biases and the racism and discrimination in all contexts.

Ms. Blunt Rochester. I know I am out of time, and it is just something that has plagued me. I know people like Serena Williams, Beyonce have gone through this, and it is not even -- it is beyond privilege.

Thank so you much for having this hearing, and I will send questions in writing. Thank you.

Ms. Eshoo. The woman -- the gentlewoman yields back, and you ask a very heavy question but a necessary one.

It is a pleasure to recognize the gentlewoman from Indiana, Ms. Brooks, for her 5 minutes of questioning.

Mrs. Brooks. Thank you so much, Madam Chairwoman.

And I also want to thank the ranking member because this is something that we have been focused on for a couple of Congresses, and we must do more. We rarely in this body, I think, have an opportunity like we have now to educate those medical providers of the future.

And one thing that you mentioned, Ms. Irving -- and I want to thank you so much for sharing your horrible, very, very sad story, but the power of your testimony, the power of your written testimony, which I read this morning and was quite moved this morning, even before you spoke, you mentioned something that I don't think that we have talked about enough, although Dr. Burgess mentioned it. In his medical training, he had a doctor who talked about care, about caring, and you mentioned med schools.

And I think the hearing we had last Congress and the hearing we are having this Congress from all of the incredible professionals here that are studying it, that are working on it, that are trying to improve -- Indiana has the third highest rate of maternal mortality. Now, yes, we just instituted that review committee. Luckily our new or fairly new head of State Department of Health is an OB/GYN and this is a top priority, Dr. Kristina Box, top priority now for our State, but we have got to start earlier. The review committees are after the fact. We have got to study the data. We have to collect the data to understand the problem.

But what would you all like to see our med schools do, our nursing programs do, our -- we haven't really talked. That is one aspect we haven't really talked about.

Maybe starting with you, Ms. Irving.

Ms. Irving. I think the training that we have talked about before as far as the implicit bias training, et cetera, is good to start early. They must recognize that every patient should be treated as an individual. Even though we have standards of care, you look at the patient as a whole. And I haven't been to medical school. So I don't know what the training is, but you have to have that "it could be my mother, it could be my wife, it could be my daughter" and look at each patient through those lenses and work on it from that point.

Mrs. Brooks. Thank you.

Dr. Harris, how do we take what Ms. Irving is hoping and praying that folks like you all implement?

Dr. Harris. I think that is critical, and the AMA 5 years ago looked at the issue of training the next generation of physicians, and we awarded 11 $1 million grants and have

since then developed a consortium of other medical schools that can share best practices, and I will say a couple of those medical schools are specifically focused from our grant, although they were already working in these areas, on two issues that have been raised.

One is the social determinants of health. So we have medical students now getting trained and understanding and appreciating the importance of social determinants of health. And we have a couple of other medical schools that are talking about health disparities, making sure that the future workforce is a diverse workforce so that the faces of our physicians match the faces of our patients and then, of course, from those learnings we are spreading that out to the consortium of medical schools, and then hopefully that will be spread out to the entire medical school community.

So we are committed and do agree that we need to raise these issues early in training of physicians.

Mrs. Brooks. Dr. Nelson, I want to commend Parkland.

And thank you, Dr. Harris.

Has the med school community reached out, and are they studying your model in Parkland, and how do we do a better job getting -- because it is not just doctors. It is nurses. I am sure there were many nurses that didn't listen to your daughter's needs, not just doctors, doctors, nurses, others. How about the medical -- the medical training? I don't just mean med schools.

Dr. Nelson. Correct. That is what I was going to build upon. So I am a faculty at the University of Texas Southwestern Medical Center. And we are one of the largest obstetrics and gynecology programs in the country. We have 72 residents in our current existing program. And part of our responsibility is to talk about and begin the training

that you heard here. It also extends to the training that we have within our nurse midwives, our advanced practice providers with nurse practitioners, and nursing students who are responsible for training the next generation.

And this is the part that becomes really difficult, is translating the importance and advocacy that we are hearing that we need to share in fighting for our patients and hearing their voice is something that is our responsibility to carry forward.

Mrs. Brooks. Thank you all. My time is up, but I certainly hope that our med schools take the opportunity to actually listen to your testimony, to read it and to listen to it. I think it would be incredibly instructive.

With that, I yield back.

Ms. Eshoo. The gentlewoman yields back.

I now would like to recognize the gentleman from Maryland, Mr. Sarbanes, for his 5 minutes of questioning.

Mr. Sarbanes. Thank you, Madam Chair.

I want to thank our witnesses for your testimony today. Extremely compelling and in certain instances certainly heart-wrenching. So thank you for being here.

Ms. Ranji, I wanted to talk a little bit more about the situation that women can find themselves in when they have to make a switch to different coverage because of the expiration of Medicaid coverage, and we have heard from many of you and it is well-documented that the Medicaid, current Medicaid pregnancy coverage only covers women for 60 days after they give birth, and then, at that point, what happens can range from losing coverage completely, potentially being able to enroll through a marketplace plan on one of the exchanges, et cetera.

Obviously, getting some coverage after that 60 days is better than having no coverage. But I think it is important to recognize that forcing women to change plans during what is a very, very critical time can also generate negative consequences. So I would just like to ask you a few questions about that phenomenon, which is referred to in shorthand as churning.

If a woman gains Medicaid coverage as a result of her pregnancy, what are the coverage options after that coverage ends 60 days postpartum? What is the range of things that could happen there?

Ms. Ranji. Right. Well, it really depends where you live. And this is what, when it comes to postpartum coverage, there is a lot more variation across the States for low-income women. So, like you said, some women are able to continue on Medicaid. Some may be able to get subsidies to purchase private insurance. Some may be uninsured. But the phenomenon that you refer to, churning, certainly has an impact.

We know that disruptions in conversation are relatively frequent for low-income women around the time of delivery, and we know that churning can negatively affect access to care. It can really result in delays in care, having to switch providers, identifying a new provider network. And down the road that can lead to delays in things like preventive services like cancer screenings, et cetera.

So churning is relatively common among this population when you have to switch plans.

Mr. Sarbanes. I mean, in fact, that is exactly the moment in time when someone's condition might change in a way where, if there was a continuous perspective because the coverage was lasting for a longer duration, that change would be captured in

terms of the care plan for that particular individual. But because there is a transition happening to a different coverage, potentially involving different providers, involving a different set of benefits as to what is covered and what is not covered, the system will miss the opportunity to identify the kind of care that should be delivered. Then you can end up having drastic consequences from that. Is that correct?

Ms. Ranji. Well, and being able to stay with the same coverage plan can allow you to stay with the same provider and provide that continuity of care from a relationship that a woman may have formed with during the prenatal period. With the provider being able to continue with that provider or with that group of providers, could streamline her access to follow up on conditions and obtain preventive services.

Mr. Sarbanes. I would also imagine that it's going to be easier to deploy strategies for more sensitivity to the patient population, and we have heard testimony about the importance of that today. If the coverage situation is not one that is in flux, it is just better if you have got a longer period of time in which to deploy these strategies to get out in front of some of the biases, discriminatory practices, and other things that we have heard testimony about today.

So, clearly, there are strong arguments in favor of extending the Medicaid coverage period substantially. And that is at the heart of a number of the proposals that we are hearing about today.

Thank you all for your testimony. I appreciate it, and I yield back.

Ms. Eshoo. The gentleman yields back.

It is a pleasure to recognize the gentleman from Montana, Mr. Gianforte.

Mr. Gianforte. Thank you, Madam Chair.

Ms. Irving, I just want to say I am sorry for the loss of your daughter. And I want to thank you for being here to tell your story. Unfortunately, Montana has a higher maternal death rate than the national average, and our State faces unique challenges in this space.

Dr. Howell, in your testimony, you state that maternal deaths from substance use disorders and mental health are climbing. Unfortunately, methamphetamine use is an epidemic in Montana. How does drug addiction impact maternal deaths, and what changes can we make to help mothers who are facing a drug addiction?

Dr. Howell. So, just as substance-use disorders are growing across our country and we are having an opiate crisis, that also affects maternal deaths, as well as from other areas. And, although this is not my area of expertise, I will just share that I think that the risk factors and some of the issues are lack of treatment centers for opiate abuse and also lack of access to opiate replacement therapies.

Mr. Gianforte. So our specific problem is methamphetamine.

Dr. Howell. So that is not my area of expertise, but I think some of the general things that we know about substance-use disorder can be applied in the maternal healthcare setting and that we don't recognize that there are other options, and there are treatment alternatives and that there is not enough being done. I would defer also to my colleague, if he has more to add.

Mr. Gianforte. Dr. Nelson.

Dr. Nelson. So, we have a robust perinatal intervention programs that covers opioids as well as methamphetamine use. This requires intense multidisciplinary care. It involves case management, addiction medicine, obstetricians, and pediatricians. And

it has implications related to the care of the mother during the pregnancy. It can also have implications to the baby at delivery as well.

Mr. Gianforte. Okay. Thank you.

Today is World Suicide Prevention Day, and, unfortunately, Montana leads the Nation in suicide, number one. We understand the impact that a lack of access to mental health services has on our communities. To ensure that people have access to these services, they need in the face of this crisis I recently introduced a bipartisan bill to designate 988 as the National Suicide Prevention Hotline. This is an essential resource for anyone facing mental health crisis. I look forward to working with my colleagues to get this bill through committee, and I hope it will become -- it will be available to help mothers that we are discussing today.

Dr. Howell, again, if we could, can you describe what is being done especially in rural areas to address the increase in maternal deaths for mental health complications such as postpartum depression?

Dr. Howell. So I am not an expert on rural healthcare, coming from New York City. But I can comment that I think a lot of the things that you were hearing about, depression is a major issue for pregnant women and postpartum women. You have heard rates of around 15 percent, and so it is a major issue, not only for breastfeeding, maternal-infant bonding, but everything can you think about for both the mother, the child, and the family and so we have to do a better job around mental health.

Now, in rural areas, just like there are major access issues in cities around mental health, as you have heard, but there is also additional barriers and so the use of telemedicine, the use of new techniques around cognitive behavioral therapy on, you

know, internet platforms, sort of thinking outside of the box is the way that we have to move forward to sort of broaden our ability to reach patients from everywhere around the country.

Mr. Gianforte. And that is really essential, particularly in our rural communities. We are not going to have a specialist in every discipline, in every community. Telehealth is one way to do it. So I appreciate your comments there.

Dr. Harris, Montana has seven federally recognized American Indian Tribal Governments. You mention in your testimony that CDC recently released a report that American Indian women are two to three times more likely to die from pregnancy-related causes than White women.

Can you talk a little bit about the key drivers of this disparity in our Native American population?

Dr. Harris. So I would imagine that it is about access, it is about bias, all the issues that we have discussed today. We want to make sure that we appreciate all of the issues faced by those who are not of the same community. Again, that is why we stress the importance of a more diverse physician workforce, making sure that those in rural areas have access to healthcare. You mentioned telemedicine. Making sure that everyone, again, has affordable, meaningful coverage.

So I think all of those drivers are the same or similar. They won't be absolutely the same for Native American women as African American women, and I appreciate your point on methamphetamine being an issue in your State, and I think that is why certainly we need to do all that we can to address opioids, but I think there is an opportunity here to make sure we have an infrastructure for substance abuse disorders in general and not

just regarding opioids.

Mr. Gianforte. Yeah, thank you, Doctor.

And just, in closing, Madam Chair, if I could, I want to echo the comments of Ranking Member Walden in his call for additional hearings, and I would just suggest that, if we do that additional hearing, that we might include the Native American voice at the table because the Tribal communities are not represented here today and possibly his, Indian Health Services, as well as we continue to look at these issues.

With that, I yield back.

Ms. Eshoo. I think that is an excellent suggestion from the gentleman. And we have two Members of Congress, women Members of Congress, for first time in the history of the Congress that are Native Americans. So, thank you.

Now I would like to recognize the gentleman from California, Mr. Cardenas, for his 5 minutes of questioning.

Mr. Cardenas. Thank you so much, Madam Chairwoman.

And also I would like to thank Ranking Member Burgess for having this important hearing on this very important and heartbreaking issue.

I want to also thank all of the panelists for providing your expertise, especially Ms. Irving. You are someone who should have never had to learn so much about this issue and to endure what you have had to endure. So thank you for coming in and enlightening us.

Ms. Irving, I would like to thank you for sharing with us today what you have been going through, and I know it is not about you. It is about making sure that we do better for the families and the women of today and tomorrow. So thank you for enlightening

us. As a parent and a grandparent, I can only imagine the pain that you have gone through, and I certainly agree with those who have been calling you very brave, but I would also like to point out that I truly do believe that you are an embodiment of what it is to have faith. And by being here today, you are putting that faith into action.

And I believe that it is incumbent upon us on this side of the room to act responsibly and to do whatever we can to make sure that we pay heed to your advice and the wisdom of all of you so that we can actually take action swiftly and accurately so that less pain is endured by families going forward.

I do have a question for you. Could you please describe for us what high-quality, fair, and respectful postpartum care for your daughter could or should have been, should she still be with us?

Ms. Irving. I think for the first time what should have happened is she should have been able to see her doctor within a week after giving birth. Just like the baby went in 2 or 3 days after birth, there should be a mandatory 1 week, let's come in, let's check you out, let's see how you are doing. She should have been able to call up a doctor or go in and see the doctor right there.

Instead, what she had was she saw a nurse practitioner a couple of times, and that nurse practitioner left and said she came back to see the doctor, but the doctor never showed up at all. So I would think the doctors would follow their patients and make sure that they see the patient and make sure that their symptoms or concerns are addressed right then and there.

Mr. Cardenas. Thank you. What you just described is proper standards of care in the moment, case-by-case, not just theoretically. So thank you so much.

Dr. Howell, we have heard about some of the systematic barriers to care that Black women face. And we know that Hispanic women face many of the same obstacles, as do Native Americans, et cetera. Yet reporting on the rates of maternal mortality for Hispanic women has been inconsistent and it is difficult to find clarity on what it is telling us.

Can you speak to this issue and what the potential consequences to this lack of data might be?

Dr. Howell. Yes. So a perfect example is the national statistics do not suggest that Latina women have an elevated rate. Our pregnancy mortality review done in New York City revealed, when I said that they were 8 to 12 times higher for Black women, for Latina women, it was 3 times higher. And it shows you that when you get more granular data and when you invest in maternal mortality reviews that actually collect data from multiple sources, you can get better data on race and ethnicity. You can get the causes. That allows to us actually see a true story.

Without the data, you don't know. And that is what happens, when you have a vital statistics system that doesn't collect the stuff in a good way. That is why I think it was underreported.

Mr. Cardenas. Thank you.

One of the things I would like to personally comment on that I want to thank all the women who are here in this committee room and also the men, but the women vastly outnumber the men who are guests and experts apprising this important committee on this very, very critical issue.

And I personally want to add to that, that I believe that when this side of the room

looks more like that side of the room, I think that, especially when it comes to issues facing women and families, we are going see much quicker, much more accurate results out of what happens in the decisionmaking of this elected body.

I am not casting aspersions on us men or what have you, but what I am saying is, when there are women in the room, you enlighten us in a way that I -- and you think of things and approach in a way that I just can't, and I just want to thank you for doing that at every opportunity and certainly today.

Thank you very much. I yield back.

Ms. Eshoo. I thank the gentleman for most especially for those comments, as well as the others.

It is a pleasure to recognize the gentleman from Georgia, Mr. Carter, for his 5 minutes of questions.

Mr. Carter. Thank you, Madam Chair.

And I want to thank each and every one of you for being here today. This is an extremely important subject.

And especially I want to thank you, Ms. Irving, for being here. Yours is quite a compelling story, and we just cannot say enough about your courage and your work, and we thank you very much for that.

Ladies and gentlemen, I am from the State of Georgia. This is obviously -- maternal mortality is a national problem. There is no question about that, but in the State of Georgia, it is a serious problem. In fact, we have the unenviable, unenviable position of being the number one State in the Nation in maternal mortality, and for what reason we can't figure out. But that is what really is driving us to try to do

something about this, and I have been doing it. I have been doing it in my district. I have held many roundtable discussions with different groups about why is this and how can we address this situation and how can we make things better because we all want to make it better. Regardless of which side of the aisle you are on, you want to make it better.

This is not a Republican, this is not a Democrat issue. It does not discriminate against anyone, and we have to work toward a solution, and I have to tell you that I am really proud the last session that Representative Jamie Herrera Beutler, her bill, Preventing Maternal Deaths Act, passed. And that is good. It was signed into law. We need more bills like that, and I am really proud of that.

I will have to tell you I am a little bit disappointed that we don't have some Republican bills that we are talking about here. In fact, we don't have even much Republican input in these bills. And I hope that that is going to change for a couple of reasons.

First of all, we have been out in our district for the past 5 weeks, and I have been proudly proclaiming that not only do I serve on the oldest and the most diverse as far as subject matter is concerned committee in Congress but also the most bipartisan committee, and I consider it to be the most bipartisan committee. So I am a little disappointed -- I have to express that to the chairperson -- we don't have more Republican bills.

Having said that, I do have to tell you I do have a bill I am working on with Representative Katherine Clark of Massachusetts that has to do with Medicaid. It is a Medicaid demonstration project that tests how we might be able to enhance access to

care by better utilizing birth centers. All throughout our testimony today, what we have heard about is access to healthcare. That is extremely important in the solution to this problem. We all understand that. And birth centers, I think, are not being utilized to the point that they could be, and I hope that it is something, and I thank Ms. Clark for working with me on this, and it is something that I want to work with her on.

Ms. Ranji, I will ask you first. Again, one of the things that we have heard during this testimony has been access to healthcare. And I would just ask you, is there a better place or a place for a better use of birth centers, that we could possibly use them in a potential solution or a partial solution to this national health problem?

Ms. Ranji. Well, thank you for the question.

Just as Medicaid policies vary between States, it is a similar situation with birth centers, and so while I -- birth centers themselves are not my area of expertise. I know the availability and the certification and the licensing procedures and practices vary between the States. I could certainly see that there would be room for growth of presence in birth centers and coverage under Medicaid, but, again, the availability and access, those vary a lot between localities, and the financing policies would then have to be worked out with it on the State level.

Mr. Carter. One thing I will inform you about is that I represent South Georgia. You know, there are two Georgias. There is Atlanta and everywhere else, and I am in everywhere else. So birthing centers are extremely important for us and particularly in the rural areas. So that is why I look at that, and I am excited this bipartisan bill that Representative Clark and I are working on.

Dr. Nelson, I want to ask you. Currently I am the only pharmacist serving in

Congress. So I have a very, an interest in opioid epidemic and a very strong interest in how it is impacting maternal health.

And I just wanted to ask you, could you very quickly help us to understand, when you have a mother who is going through an opioid addiction, how they are handled and treated during the pregnancy?

Dr. Nelson. So the problem of opioids is also a major crisis for this country. In 2017 alone in Parkland, we delivered 69 women with opioid disorder. In 2018, I personally toured Dr. Giroir and Dr. Adams, the Assistant Secretary of Health and the U.S. Surgeon General, through Parkland Hospital to see our program. Our program is comprehensive, and the challenges are both related to the maternal care, the risks to mom, but also the neonatal opioid withdrawal syndrome risk to the baby. And that is a chronic life-changing opportunity for us to have resources provided for a pregnant mother and her unborn child.

Mr. Carter. Real quickly, just how do you get over the stigma -- or not stigma, but the obstacle of a mother who is addicted that doesn't want that to be known, so she doesn't reach out for care? I know that has got be a problem and something we have got to address as well.

Dr. Nelson. I agree that stigma is important. Our service as physicians is to be a healthcare home for those patients and to provide them access, and that is a complex issue related to interfacing the legality of some of those circumstances. But our first and foremost effort should be providing access to care to those women and getting them resources to potentially even get better.

Mr. Carter. Great. Thank you all for being here. This is a most important

subject, especially for the State of Georgia and for our country.

Thank you, and I yield back.

Ms. Eshoo. The gentleman yields back.

It is a pleasure to recognize Mr. Engel from New York, who is the author of the Quality Care for Moms and Babies Act.

Thank you for your solid work, Mr. Engel. And you are recognized for 5 minutes of questioning.

Mr. Engel. Thank you. Thank you, Madam Chair.

And thank you for holding this very, very important hearing.

And thank you to all the panelists. Thank you so much. We appreciate everything that you have done.

Ms. Irving, I want to single you out because what you are doing today takes an enormous amount of courage, and so God bless you and know that we support you, and what you are doing today will save the lives of countless other people tomorrow. So thank you for having the courage.

I want to thank the chairwoman and the chairman, Pallone, for holding today's subcommittee hearing on the Nation's maternal mortality crisis and which includes my bipartisan, as the chairman said, bicameral legislation, the Quality Care for Moms and Babies Act. The bill would bring together diverse stakeholders to develop care quality benchmarks for women and children, as well as to also find existing and new Quality Collaboratives.

Quality Collaboratives are on the front lines of the efforts to end this crisis. The New York State Quality Collaborative has developed resources to address the leading

causes of maternal deaths in New York, which include hypertension and hemorrhaging. These resources were distributed to over 126 birthing hospitals in New York.

So I urge Members on both sides of the aisle to support this commonsense bipartisan legislation. I would also like to ask for unanimous consent to submit a letter of support from many, organizations including March of Dimes, the American College of Obstetricians and Gynecologists, in support of Quality Care For Moms and Babies Act.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Engel. Dr. Howell, it is always good to see more New Yorkers in Washington. I get lonely over here. So please come back, and thank you for the great work that you do and that Mount Sinai does as well. Mount Sinai, of course, is very well-known in New York and very well-respected.

So I want to personally thank you, Dr. Howell, for your service on the New York State Task Force of Maternal Mortality, and it is my understanding that the task force issued a report this past March in which it recommended expanding the New York State Perinatal Quality Collaborative and as you know, as you mentioned, which I appreciate you mentioning it, I am sponsoring the Quality Care for Moms and Babies Act with my friend, Congressman Steve Stivers. It is a bipartisan bill. Our legislation authorizes funding for existing and new Perinatal Quality Collaboratives.

Let me ask, you Dr. Howell. Can you again share -- I think it is worth repeating -- why developing and sustaining Perinatal Quality Collaboratives is an important tool for addressing racial and ethnic disparities in maternal health outcomes?

Dr. Howell. It is a very important tool for us to use across the United States, as well as in New York, because it allows us to build -- have partnerships with physicians and nurses, with departments of health, hospitals, and health systems to target specific processes based on the evidence that we can target together to improve, and we have done it in a number of different situations, not only in terms of the bundles that you have heard about but in terms of trying to lower our cesarean section rates, in terms of our elected delivery rates. We have done it on the NICU side.

So it is these groups that can take the shared learning and utilize that to help make improvements in hospitals and your bill supports that, and I think it is a really

wonderful and important part of this story that we need to advocate for.

Mr. Engel. Well, thank you, and I have high hopes that we will pass the bill and pass it on the floor and hopefully get it passed in the other body and have the President sign it into law. So thank you for everything you are doing.

Dr. Harris, let me ask you. In your written testimony, you note that the quality of maternal care can vary greatly by provider and facility. Given that public health programs cover most births in the U.S. with Medicaid alone covering 43 percent of them, I believe obviously these programs are uniquely situated to improve maternal health.

To that end, the Quality Care for Moms and Babies Act would direct the development of a core set of maternal and infant health performance measures for Medicaid and CHIP that promote best practices.

So let me ask you, Dr. Harris, how would the creation of this measure core set affect the quality of care and reduce maternal morbidity and mortality, especially for women of color?

Dr. Harris. Mr. Engel, Congressman Engel, if you don't mind, I would like to let Dr. Howell talk about the specifics of that, of the core metrics, and how they would help. But from sort of the 30,000-foot view, it is very important to have the data. Data then informs. And that is, again, why the AMA is very supportive of these review committees. You have heard a lot today, but there is no sort of one-size-fits-all solution, and patients are unique.

And as Dr. Howell mentioned earlier, California has done a great job of reducing mortality but not African American women. So we still need to look at the data and why overall mortality decreased but not African American women.

So I think the opportunity there is to get that data, get the data specifically for African American women. And then, once we get that data, it is important to have funding to implement what we find in the data. So I would say that from a 100,000-foot view and let Dr. Howell talk about specific measures that should be included to improve those disparities.

Mr. Engel. Well, thank you.

If the chairwoman will indulge, we will have Dr. Howell.

Dr. Howell. So, I think it is incredibly important that we develop quality measures in maternal healthcare that are both patient-centered and address disparities. We have done showing that hospital performance on primary low-risk cesarean or hospital performance on elective delivery is not correlated with hospital performance on severe maternal morbidity.

So the current group of quality measures don't really provide information to mothers about the different facilities in terms of safety, and they weren't correlated either with neonatal morbidity at term. We need better quality measures that can serve and we can give to the public so that they can better understand what is going on.

So your bill that advocates for quality measure development I think is really instrumental and a very important piece. And having quality measures also target disparities and address disparities is another piece because previous data shows that the quality measures in obstetrics are not really doing that either.

Mr. Engel. Thank you.

Thank you, Madam Chair, for your indulgence. And thank you for all the great work you are doing.

Ms. Eshoo. Thank you for your work, Mr. Engel, and this sounds like a resounding -- we recognize endorsements, don't we, when they occur? I think I just heard one.

I now would like to recognize the gentleman from Illinois, Mr. Rush, who is -- I am really pleased to be joining him in his congressional district in a handful of weeks where he is conducting a field hearing on this very issue.

And you are now recognized for 5 minutes for your questions.

Mr. Rush. I want to thank you, Madam Chair, and I certainly want to applaud you for holding this critically important hearing.

Ms. Irving, I feel you. I understand some of what you are going through. I am reminded just this very day that, some 10 years ago, this very same committee, subcommittee, had a hearing on postpartum depression. I had introduced a bill entitled, Melanie Blocker-Stokes Postpartum Depression Act of 2007; and her mother, Melanie Blocker-Stokes' mother, Ms. Carol Blocker, sat at this very same table that you are sitting at 17 years ago.

Melanie was one of my constituents who had been seeing a series of doctors postpartum, and none of them diagnosed the depression that she was going through. And she ultimately, on a bright Saturday morning, spring Saturday morning, went up to a hotel in Chicago, on near the north side of Chicago, and leaped to her death from the 10th floor and the cause of it was postpartum depression.

So here you are a mother in a line of mothers who are coming to this Congress asking and pleading and bringing your pain to this -- to our presence, to this table, asking us to help, and I want you to know that some of us are determined to provide the help

that you are seeking and other mothers are seeking.

My bill was -- the language of my bill was included in the ACA Act, in the ObamaCare, and I was very pleased with that, but we have such a long, long way to go. So I applaud you, and I commiserate with you, and I just -- you know, your pain is a pain that generations will remember and will bear until we are able to solve this problem of maternal mortality.

I want to move to questioning, if I have got a few moments here. And I want to ask Dr. Ranji. Dr. Ranji, I am curious about doulas and the effect on the healthcare system of doulas, and can you explain to us why you think that doulas can improve health outcomes, and also can you address what are some of the cultural and economic variants to presenting a nationwide system that would include doulas?

Ms. Ranji. Well, the research shows that women and moms have expressed, in many surveys, have expressed interest in having doulas care, more support during the prenatal, labor, and delivery, and postpartum periods. There is, you know, some sense, we talked earlier, the panel was talking about the ability to be able to, sometimes for patients being able to challenge providers or ask for what they need, and there is some research showing that women have said that maybe if they had more support, for example, with assistance of a doula, that that might be part of expanding her ability to be able to recognize and sort of understand what her options are.

Currently, under Medicaid, only two States, as far as I know, Oregon and Minnesota, include coverage for doulas, but there are some other States that have certainly been considering it, and New York is one that has a pilot program going in certain parts of the State where they are also considering, at least are doing for some

women expansion of coverage for doulas.

Mr. Rush. So do you know of any -- what are some of the barriers that you see that we may face in terms of implementing or creating a doula care system?

Ms. Ranji. Right. Well, some of the barriers include sort of administrative and procedural barriers. Right now, you know, Medicaid reimburses licensed medical practitioners and the sort of doula training standards and doula certification and licensing is still an area that is in work. It is not an area that I have focused on, but there is a lot of published research out there that I certainly will also be able to share with you, if that is of interest.

Mr. Rush. I want to thank you, Madam Chair.

I yield back.

Ms. Eshoo. I thank the gentleman for his work on this issue, and I look forward to the hearing in your district.

Now I would like to recognize Ms. Schakowsky of Illinois, who is a member of our full committee and is waiving onto the Health Subcommittee today where she served for many years.

So you are recognized for your 5 minutes of questions.

Ms. Schakowsky. Thank you so much, Madam Chair, for allowing me to waive onto today's hearing. And it is such an important one.

I want to thank all the witnesses. And I want to give a special thank you to my friend and colleague from Illinois, Robin Kelly, who has been such a champion of this issue for our State.

Illinois has been one of the most extreme pregnancy-related death disparities in

the Nation. According to data from our Department of Public Health, Black women are six times more likely to die of pregnancy-related conditions as White women. It is just totally unacceptable.

And I want to say a really special thank you to Ms. Irving, and I am so grateful that you have shared your daughter, Shalon's, story with us today, and I just want to add when I read the article that was given to us that this is the third child and the last child that you have also buried. So I am so sorry for that.

I fully believe the words of your testimony, that this disparity, quote, has to do with the appallingly way Black women are or aren't attended to or listened to, unquote. I am complete -- I am fully supportive of extending Medicaid coverage for the postpartum care up to -- from 60 days to 1 year, as the bill that we are considering today proposes, and though that will make a transformative change, that is certainly not enough.

Ms. Irving, I wanted to ask you a question. Here you have such an educated daughter in the healthcare field. She is a doctor herself. What did the physicians tell her as she continued to suffer after the birth of her daughter that somehow indicated that they must not have been hearing her?

Ms. Irving. Every time she went to the doctor's office -- and there were probably at least five times, three times I know of, in 1 week. Each time it was a dismissive "you just had a baby, give it time, you will feel better."

Ms. Schakowsky. Did they do any of tests that would have indicated what the problems were?

Ms. Irving. On the last day that she went, which was the 24th, 5 hours before she collapsed, she went in, and they gave her a test for preeclampsia, but since she didn't

have any blurriness of vision, they said: Well, we can rule that out.

And they gave her a test for blood clotting. She said: I have had blood clots. I know what they feel like. This is not a blood clot.

And, of course, it wasn't a blood clot. But her blood pressure was still off the roof. I think if I am correct it was 174 over 119, and she was sent home, and 5 hours later she collapsed.

Ms. Schakowsky. You also said in your testimony that essentially that no one is really immune, regardless of education, et cetera.

Ms. Irving. No.

Ms. Schakowsky. And that the issue of racial disparities is certainly a huge problem.

I wanted to ask Dr. Howell a question. I am interested in the idea of holding hospitals accountable for maternal care, maternity care through a value-based care model. Do you believe that bundled payments for an entire episode of maternal care could give health systems more incentives and greater control to improve the pregnancy-related outcomes from beginning to end with regard to racial disparities in particular?

Dr. Howell. I think we need more work on alternative payment models to think about maternity care and incentivize clinicians and hospitals correctly. I do worry about under intended consequences, specifically that certain hospitals will be penalized if we don't do this right in terms of the fact that they have the highest risk patients and we are not recognizing that. So I think there is a lot of work to be done in this space. I don't have the perfect solution yet because I want to make sure that we think about those

unintended consequences as we move forward.

Ms. Schakowsky. So do you think bundled payments may be one thing that at least should be explored so that, from prenatal care through the full year, maybe issues like postpartum depression be considered in a bundle of pavements?

Dr. Howell. I think they should be explored. I think that the measures that they would be accountable for would need to be partnered with new quality measures that are really well-developed, and so that we have the right things. Some of those measures would also be targeting disparities. So, if you measure the success based on those quality metrics that look at patient centeredness and disparities, it might be a promising avenue, but, again, always remembering that we can't penalize those hospitals that take care of the sickest patients. So we have to make sure that we are accounting for that in our models.

Ms. Schakowsky. We also want to make sure that diversity in the workforce is there so that everyone is represented at every level of care. Thank you so much.

And, again, Ms. Irving, thank you so much very much.

I yield back.

Ms. Eshoo. The gentlewoman yields back.

I want to, on behalf every member of the subcommittee, I want to thank each witness.

Ms. Irving, there really aren't words. You are a source of inspiration to us to move ahead in your daughter's name, in your name, in your granddaughter's name, and I think that if -- I think as she is watching and listening from heaven, she is -- you can hear the bravos from there. Thank you. Thank you.

You really have, you have touched all of us, and we are not going to rest until we have solid legislation that addresses this and that this statistic in the United States of America piercing the conscience of our country, and I think it is a combination of things, women being undervalued, women not being listened to. In the history of humankind, no man has given birth to a child, and so I remember the doctor saying to me, "Well, they are the blues, but they will go away." So we have a lot of work to do. Thank you.

Thank you to you, Dr. Harris, Dr. Howell, Dr. Nelson, Ms. Ranji. This has been an outstanding hearing.

Mr. Rush. Madam Chair, if I just could for 10 seconds.

Ms. Eshoo. Sure.

Mr. Rush. Ms. Irving, I was just looking at some notes. Melanie was also in the healthcare area. She was a pharmaceutical sales manager. So she was very aware of health issues with doctors. Her husband was a physician, and she had a daughter, only child, and her name was Summer. So, your granddaughter's name is Soleil. So there are so many similarities here.

I wanted to note that for the record.

Thank you, Madam Chair.

Ms. Eshoo. Okay. I would like to remind members that, pursuant to committee rules, they have 10 business days to submit additional questions for the record to be answered by the witnesses.

And I know that you will all cooperate, give straightforward, succinct answers. Okay?

And I ask each witness to do so promptly to any questions that you may receive.

I now want to ask unanimous consent to enter into the record the following: a statement from the March of Dimes; a statement from the American College of Obstetricians and Gynecologists; a statement from the American Hospital Association; a statement from America's Health Insurance Plans; a report the Center for American Progress on racial disparities and maternal mortality; a coalition letter from the American College of Nurse-Midwives, et al; statement from the Premier Healthcare Alliance; a statement from Gauss Surgical; a report from Premier Incorporated, on maternal health trends; a report from ProPublica and NPR on maternal mortality.

So I ask for unanimous consent.

Mr. Guthrie. No objection.

Ms. Eshoo. So ordered.

[The information follows:]

******** COMMITTEE INSERT ********

Ms. Eshoo. And this will conclude our hearing today. The subcommittee is adjourned.

[The information follows:]

******** INSERT 3-1 ********

This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.

[Whereupon, at 1:25 p.m., the subcommittee was adjourned.]