Written Testimony

Of

The American College of Obstetricians and Gynecologists

Submitted by:

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Before the

House Ways and Means Committee

Regarding the Hearing

Overcoming Racial Disparities and Social Determinants in the Maternal Mortality Crisis

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Chairman Neal, Ranking Member Brady, and distinguished members of the Ways & Means Committee, thank you for inviting me to speak with you today on behalf of the American College of Obstetricians and Gynecologists (ACOG) at this hearing entitled "Overcoming Racial Disparities and Social Determinants in the Maternal Mortality Crisis. ACOG, with a membership of more than 58,000, is the leading physician organization dedicated to advancing women's health. Key to that mission is our core value that all women should have access to affordable, high-quality, safe health care.

As a practicing ob-gyn specializing in high-risk obstetrics, I have dedicated my career to improving the lives of my patients. Ensuring a healthy outcome for moms and babies is my life's work.

In addition to serving as Immediate Past President and Interim CEO of ACOG, I am the Chief Medical Officer for Obstetrics and Gynecology with Texas Children's Health Plan and Chair of the Texas Maternal Mortality and Morbidity Task Force.

As a physician in training, I worked alongside experts trying to save the life of a young, new mother. We couldn't. I remember seeing the loss on her husband's face as he was taking their newborn daughter home. Alone. It broke my heart and fueled my decision to devote my life to eliminating preventable maternal mortality.

Background

As you know, and the title of this hearing reinforces, the United States has a maternal mortality crisis. More than 700 women die each year in the United States from pregnancy-related or pregnancy-associated complications.[i] We have a higher maternal mortality rate than any other developed country.

At a time when 157 of 183 countries in the world report decreases in maternal mortality, ours is rising.[ii] Black women are disproportionately affected and are three to four times more likely to die than white women.[iii] And Native American/Alaska Native women are two to three times more likely to experience a pregnancy-related mortality.[iv] For every maternal death in the United States, there are 100 women who experience severe maternal morbidity, or a "near miss." This is all unacceptable, and the time for action is now. ACOG is committed to our goal of eliminating preventable maternal deaths, and we are eager to continue our strong partnership with this Committee and other valuable partners to achieve this important goal.

We know, and the Centers for Disease Control and Prevention (CDC) has confirmed, that over 60 percent of maternal deaths are preventable.[v] Common causes include hemorrhage, cardiovascular and coronary conditions, cardiomyopathy, and infection. Overdose and suicide, driven primarily by the opioid epidemic, are also emerging as leading causes of maternal mortality in a growing number of states.[vi] If we have a clear understanding of why these deaths are occurring, and what we can do to prevent them in the future, we can save women's lives.

We applaud you and your colleagues in the US Congress for taking an important first step last year in passing the Preventing Maternal Deaths Act, P.L. 115-344, to encourage states to create and expand maternal mortality review committees (MMRCs). MMRCs are multidisciplinary groups of local experts in maternal and public health, as well as patient and community advocates, that closely examine individual maternal deaths and identify locally-relevant ways to prevent future deaths, saving mothers' lives. While traditional public health surveillance using vital statistics can tell us about trends and disparities, MMRCs are best positioned to comprehensively assess and characterize maternal deaths, to understand the causes and contributing factors and identify opportunities for prevention.

Accelerating Evidence-Based Patient Safety Changes

Once those opportunities for prevention are identified by MMRCs, states can best target resources toward needed interventions. The Alliance for Innovation on Maternal Health, or the AIM program, is helping translate MMRC findings and recommendations into action. The AIM program is a national data-driven maternal safety and quality improvement initiative based on proven implementation approaches to improve maternal safety and outcomes. Launched in 2015, the AIM program is funded through a cooperative agreement with the Maternal and Child Health Bureau at the Health Resources and Services Administration and ACOG.

The goal of AIM is to eliminate preventable maternal mortality and severe morbidity in every US birthing facility by promoting safe maternal care for every US birth, regardless of zip code. AIM, a voluntary program, engages multidisciplinary partners at the national, state, and hospital levels. To participate in the AIM program, states must have an MMRC. Also key to the successful implementation of the AIM program are state perinatal quality collaboratives, largely considered the implementation arm of MMRCs.

AIM promotes safe maternal care through development and implementation of evidence-based maternal safety best practices that have been shown to improve outcomes and quality of care. They don’t provide a single protocol, but instead offer a standard framework for each facility to develop protocols specific to its resources and patients. Examples include obstetric hemorrhage, severe hypertension in pregnancy, obstetric care for women with opioid use disorder, and reduction of racial/ethnic disparities.

Implementation of a particular program is not enough to achieve meaningful, sustained change in outcomes. AIM promotes a culture of safety and teamwork, encouraging multidisciplinary drills for ob-gyns, anesthesiologists, nurse-midwives, nurses, and laboratory staff, to ensure readiness of the team for complications that may be rare, but are life-threatening.

Early evidence shows that AIM is indeed shifting hospital systems and culture. Initial AIM states, including Illinois, Florida, and Michigan, represented on this Committee, observed a severe maternal morbidity reduction of 7% to 21% between 2015-2018. One AIM state had a 21.3% reduction in patients who suffered from severe complications from hemorrhage. In Illinois, timely treatment of severe hypertension rose from 41% to 85%, with no observed significant differences in hospital results based on race, ethnicity, and Medicaid patient mix. These are very promising success stories.

AIM is now in 27 states, applied to about 75% of the total US birthing population. Our goal is all 50 states, a critical way we as a Nation can help ensure high quality maternity care for every woman, regardless of her race, income, or location.

At the same time, we must address the rural access gap, exacerbated by the rapid rate of rural hospital closures and the shuttering of OB units, and its impact on adverse maternal health outcomes. ACOG is working closely with the American Academy of Family Physicians and the National Rural Health Association to ensure access to high quality maternity care for every woman, regardless of if you live in a rural, urban, or suburban community. As the Committee considers potential actions to address maternal mortality, we urge you to keep this access concern front of mind and ensure that no actions unintentionally exacerbate rural access gaps.

Addressing Racial Disparities

While there is an AIM bundle specific to reducing perinatal racial and ethnic disparities, we know that is just a start, providing the guidance for collection of data, utilization of a disparities dashboard in all birthing facilities and clinics, and examination of bias. We intend to incorporate mechanisms to address disparities in all AIM bundles.

To help achieve that in a meaningful way, ACOG is working with our partners at the National Birth Equity Collaborative and the California Maternal Quality Care Collaborative to eliminate preventable maternal mortality by raising up the voices and experiences of Black women through Mother's Voices Driving Birth Equity, a project funded by the Robert Wood Johnson Foundation. This work is being led by Black scholars to better understand Black women's birth experiences in different geographic regions.

Through this project, we'll be able to incorporate patient voices and lived experiences in our patient safety work. If we hope to change how care is delivered, we must ensure that the methods hospitals and clinicians use to address implicit bias and racism align with Black women's needs, values, and preferences. Black women's feedback must be a driver for quality improvement measures.

ACOG also supports the ACTTion for Safe Maternity Care Initiative, a program currently in development with the goal of empowering and equipping Black mothers to obtain respectful, person-centered care. The Initiative – led by a group of 18 African-American nurses, ob-gyns, doulas, certified nurse-midwives, educators, social workers, community leaders, and activists – will develop and disseminate an

interactive curriculum offering knowledge and skills that pregnant and birthing persons can employ to obtain their desired birth experiences and outcomes.

We recognize that we – and all care providers – have work to do and are committed to addressing implicit bias and increasing the provision of culturally competent care to our patients.

What's Happening in Texas

The work being done in my home state of Texas speaks to the importance of an active and well-supported MMRC. One of the many hats I wear is Chair of the Texas Maternal Mortality and Morbidity Task Force. News reports of the maternal mortality rate in Texas – which was initially reported as markedly higher than any other state – helped bring this issue to the national spotlight. Those news reports primarily relied on vital statistics data, which has many limitations and resulted in both over and under reporting. The Texas MMRC process of detailed review helped us ensure we had an accurate accounting of maternal mortality in Texas, which was lower than originally reported.[vii] It also helped ensure that we understood the causes behind each death, enabling us to make informed recommendations to improve maternal health outcomes in our state.

In the latest report of the Texas MMRC, which was released in September 2018, we found that the leading causes of pregnancy-related death were cardiovascular and coronary conditions, obstetric hemorrhage, infection/sepsis, and cardiomyopathy. We also found that Black women bear the greatest risk for maternal death, and that risk exists regardless of income, marital status, or other health factors. In addition, the majority of maternal deaths were to women enrolled in Medicaid at the time of delivery, and most maternal deaths occurred more than 60 days postpartum.[viii]

The findings of our review informed a number of key recommendations, including the need for enhanced screening and appropriate referral for maternal risk conditions; promotion of a culture of safety through implementation of best practices in birthing facilities, such as those developed by the AIM program; and increased efforts to eliminate health disparities.[ix] The perinatal quality collaborative in our state, the Texas Collaborative for Healthy Mothers and Babies, is our key partner as we work to bring these recommendations to patients' bedsides.

In addition to my work with the Texas MMRC, I was co-chair of the Harris County Community Plan to improve maternal health, convened by the Houston Endowment to identify the most important forces behind Harris County's high rate of maternal morbidity and offer recommendations to improve maternal health.[x] This public-private partnership, which is now in the implementation phase, is a successful model that I encourage other cities to consider.

What Can Congress Do: Enact a MOMNIBUS

Thank you for your support in enacting the Preventing Maternal Deaths Act, a critical step in our efforts to eliminate preventable maternal mortality. We urge this Committee and the Congress to build on its commitment to healthy moms and babies, and take important next steps.

As Congress considers actions to take in the 116th Congress, ACOG urges you to prioritize four key initiatives to accelerate evidence-based patient safety changes:

1. **Support and expand the AIM program**. Our goal of reaching all 50 states can become a reality with authorization of the program and additional federal support.

2. **Support state-based perinatal quality collaboratives**. Collaboratives bring together local experts to accelerate adoption of best practices, including recommendations of MMRCs and AIM safety protocols. Additional federal investment would help ensure collaboratives have the resources they need to continue to spearhead state-level quality improvement work.
3. **Support efforts to end racial and ethnic disparities in maternal outcomes**. While ACOG's work continues, we support proposals to establish implicit bias and cultural competency training programs for medical students, residents, and practicing health care professionals.
4. **Extend Medicaid coverage to 12-months postpartum**. Medicaid is the largest single payer of maternity care in the US, covering 42.6% of births.[xi][1] Yet that coverage ends roughly 60-days postpartum. As MMRCs have increasingly revealed, many deaths related to pregnancy occur after this time. In fact, the CDC estimates that 33% of maternal deaths occur one week to 12 months after delivery. Notably, the CDC, in its recent *Vital Signs* report, included extending Medicaid coverage as a strategy to prevent pregnancy-related deaths.[xii]

We're extremely pleased that so many Congressional leaders have recognized and are committed to this important issue. Key bills introduced in the 116th Congress include HR 1897, the MOMMA's Act, sponsored by Representative Robin Kelly (D-IL) and HR 1551, the Quality Care for Moms and Babies Act, sponsored by Representatives Eliot Engel (D-NY) and Steve Stivers (R-OH). Packaged together as a "MOMNIBUS," these provisions would have a meaningful impact on women and families and improve maternal health outcomes.

[1] The percent of births financed by Medicaid is higher in certain states. For instance, based on the latest available data, Medicaid financed 58% of births in Alabama (2010) and 54% of births in Georgia (2014). Source: Vernon K. Smith, Kathleen Gifford, Eileen Ellis, and Barbara Edwards, Health Management Associates; and Robin Rudowitz, Elizabeth Hinton, Larisa Antonisse and Allison Valentine, Kaiser Commission on Medicaid and the Uninsured. Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017, The Henry J. Kaiser Family Foundation, October 2016.

Thank you for the opportunity to share our work with you today. We are making significant and meaningful progress on the path to better maternal outcomes for all moms, and look forward to working together with you to achieve our goal of eliminating preventable maternal mortality.

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

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

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

[iv] Petersen EE, Davis NL, Goodman D, et al. Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017. MMWR Morb Mortal Wkly Rep 2019;68:423–429. DOI: http://dx.doi.org/10.15585/mmwr.mm6818e1

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

[vi] Ibid.

[vii] Baeva S, Saxton DL, Ruggiero K, Kormondy ML, Hollier LM, et al. Identifying Maternal Deaths in Texas Using an Enhanced Method, 2012. Obstet Gynecol. 2018 May;131(5):762-769.

[viii] Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report, September 2018. Retrieved from https://www.dshs.texas.gov/mch/pdf/MMMTFJointReport2018.pdf.

[ix] Ibid.

[x] Improving Maternal Health in Harris County: A Community Plan. April 2018. https://36su8y45dw4h332koa18cw3v-wpengine.netdna-ssl.com/wp-content/uploads/HE-Community-Plan-to-Improve-Maternal-Health-4-20-18-update.pdf

[xi] Martin JA, Hamilton BE, Osterman MJK, Driscoll AK, and Drake P. Births: Final Data for 2016. National vital statistics reports; vol 67 no 1. Hyattsville, MD: National Center for Health Statistics. 2018. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_01.pdf.

[xii] Petersen EE, Davis NL, Goodman D, et al. Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017. MMWR Morb Mortal Wkly Rep 2019;68:423–429. DOI: http://dx.doi.org/10.15585/mmwr.mm6818e1