



**Testimony for Public Hearing on Overcoming Racial Disparities and Social Determinants
in the Maternal Mortality Crisis
Thursday, May 16, 2019**

Good morning, I am Dr. Loren Robinson, the Deputy Secretary for Health Promotion and Disease Prevention within the Pennsylvania Department of Health. I am a physician trained in both Internal Medicine and Pediatrics. I would like to thank Chairman Richard Neal and Ranking Member Kevin Brady for the invitation to address issues surrounding the importance of women's health, healthcare, and wellness for mothers during perhaps one of the most vulnerable periods of their lives.

There are many maternal risk factors that can lead to complications for both mother and infant during pregnancy. Unfortunately, for black women, the social and built environments that reinforce discrimination and institutional racism result in an increase in the wear and tear on the body due to constant stress. This leads to declining health over time at a different rate than those not subjected to discrimination and institutional racism. This process is known as weathering.

The path to optimum health for all Americans leads to and through women. Maternal and infant health outcomes are critical measures by which the health of states and nations are measured and compared. The conditions for a healthy pregnancy and improved birth outcomes begin long before a woman becomes pregnant. While improving health begins with access to care, there are a range of biological, social, environmental, and physical factors that have been linked to maternal health outcomes.

In Pennsylvania, we have aligned programming to federal outcome measures to increase access to quality prenatal to postpartum care, all of which are critical to reducing pregnancy-related complications and maternal morbidity and mortality. While many people know of Philadelphia and Pittsburgh, our state is also made up of a rich collection of small and mid-size cities, such as Erie, and vast rural areas, that contribute much to our nation's agricultural market. The narrative of maternal mortality has different faces across the commonwealth, and women in our rural areas are also bearing the brunt of healthcare disparities. The opioid epidemic has caused significant impact in both maternal and infant morbidity and mortality, especially in our rural areas and smaller cities. In many cases, however, these communities have started to rally and organize to implement practices that are saving lives, such as linking home visiting services to our Centers of Excellence, which provide treatment and counseling for opioid addiction. However, these efforts have not yet been enough to overcome the grave disparities in outcomes borne by minority women, especially black women. The complex interplay of individual, relationship, community and societal factors necessitates addressing issues across the range of factors to optimize the health of black women and the health of their children as "the choices a person makes are shaped

by the choices a person has, which are themselves shaped by structural policies and processes.”¹ At the Department, we take the charge to improve overall maternal health outcomes seriously, and reducing the significant disparities in maternal health outcomes for those most at-risk, black women, is a priority. The Department of Health has implemented several programs and has collaborated with the Department of Human Services as well as local partners to work toward this goal.

Prenatal care is a widely recognized practice acclaimed to improve maternal and infant health outcomes. While the general trend for accessing adequate prenatal care is increasing for all races in Pennsylvania, Black women are less likely to have received early and adequate prenatal care, only 65 percent as compared to 79 percent of white women. The Healthy People 2020 target is 78 percent for all women. As a mode of prenatal care, the department currently provides the Centering Pregnancy Program, which is group prenatal care, in two locations (one urban and one rural) with high proportions of low birth weight babies and racial disparities. The provision of prenatal care through this model has been shown to reduce the number of low birth weight babies, reduce the number of preterm births and increase the number of prenatal visits and breastfeeding rates in those that participate.

Although prenatal care is important, it may be received too late or not be enough to positively impact pregnancy outcomes. Preconception and health care can provide opportunities to promote the health of women before they become pregnant. Preconception care is particularly important to reducing disparities in maternal and infant health between white and non-Hispanic black women. State governments have incredible convening power, even while there are restrictions on how, when, and for whom our federal dollars can be spent. By bringing together community organizations, payers/insurance companies, large academic healthcare systems, and smaller community-based hospitals, state governments can be the bridge for idea exchange. The imperative that comes from such an exchange is the creation of interdisciplinary policy and programs that reach communities who have typically not benefitted from federal funding and programming.

The department promotes this connection and collaboration through several approaches:

- 1) The Department implements the IMPLICIT Inter-conception Care program which uses scheduled pediatric well-child visits to check on the health of mothers. Each visit screens mothers for four behavioral risk/protective factors: smoking status; depression; birth control and multivitamin with folic acid intake.
- 2) Working closely with the Department of Human Services, the inclusion of long-acting reversible contraception (LARC) as part of state Medicaid fee schedules, the Department of Health has conducted an initial needs assessment to understand current provider training needs regarding LARC. We will use this data to develop resource tools and provide technical assistance to increase LARC usage in clinics across the state, in both urban and rural areas.

¹Metzler, M, Merrick, MT, Ford, DC et al. “Adverse childhood experiences and life opportunities: Shifting the narrative.” Children and Youth Services Review. Volume 72, January 2017, Pages 141-149.

- 3) Since 2007, the Department has administered the Centers for Disease Control and Prevention's Pregnancy Risk Assessment and Monitoring System (PRAMS). PRAMS is a random representative sample survey of new mothers designed to identify risk behaviors associated with poor birth outcomes as well as the populations most likely to be affected by these behaviors. PRAMS data is used to target programming accordingly. Over the next several years the department will be integrating more questions onto the survey to capture maternal adverse childhood experiences, the influences of the social determinants of health, and experiences of discrimination and racism in service provision.
- 4) The Pennsylvania Department of Human Services administers both the Social Services Block Grant and the Maternal, Infant, and Early Childhood Home Visiting (MIECV) Program. Currently, over 6000 individuals, representing 3200 households, are served through the MIECV program, with a total of 40,090 home visits being conducted in 2017. While these programs provide services for many Pennsylvanians, the Department of Health fills the gaps to provides supports and home visiting for families that may not qualify for these abovementioned programs.

While national gains have been made in reducing maternal morbidity and mortality rates, the U.S. rates are still higher than most other industrialized nations, despite major advances in medical care. Additionally, racial disparities persist with the risk of pregnancy-related deaths for black women at rates three times higher than that of white women in Pennsylvania. While state maternal mortality rates have been decreasing slightly over time, from 2012-2016, the average maternal mortality rate (maternal deaths per 100,000 live births) for black women was 27.2 while the rate for white women for the same time period was 8.7. The Healthy People 2020 target is 11 maternal deaths per 100,000 live births. While Pennsylvania has a significant and growing Hispanic/Latino population, we do not yet have data on the maternal mortality rates for this population.

The implementation of maternal mortality review committees (MMRCs) has promoted progress in reversing the trend of maternal mortality, especially preventable maternal deaths. I am proud to say that in May 2018, Governor Tom Wolf signed Act 24 into law, creating the Pennsylvania Maternal Mortality Review Committee. The language of Act 24 was modeled off of the important work and legislation passed in Chairman Neal's home state of Massachusetts, where the Maternal Mortality Review Committee has been in place for over 20 years. Pennsylvania is now equipped with a team of 30 members who are tasked with reviewing Pennsylvania's maternal deaths to better understand what is killing Pennsylvania's mothers at such a vulnerable and critical time. Our MMRC membership includes physicians (obstetricians, high risk maternal fetal medicine experts, Emergency Medicine doctors and pathologist), but we also have included the voices and experiences of nurse practitioners, doulas, statisticians, women of color, representation from both the urban and rural parts of the state, 2 coroners, and 2 psychiatrists who specialize in the treatment not only of pregnant women and women with partum depression, but also have experience treating the disease of addiction. The recommendations produced by the Pennsylvania MMRC will be reviewed and shared with our state legislative partners and community members/advocates, and will be prioritized and implemented on several levels. While our state legislation did not include funding for the work of the MMRC, we were able to

leverage funding in our Title V maternal and child health block grant to fund the initial work of the committee.

How will we implement the recommendations of Pennsylvania's Maternal Mortality Review Committee? Recently, a state Perinatal Quality Collaborative (PQC), which includes partners from across the state, has been convened. Another promising practice with success stories out of states such as North Carolina and Massachusetts, the Perinatal Quality Collaboratives (PQCs) are networks of teams working to improve the quality of care for mothers and babies across prenatal, labor/birth, newborn, and partum services. These interdisciplinary teams identify processes that need to be improved and quickly adopt best practices to achieve collective aims. The Department of Health sees the PQC as the action arm of the MMRC. Its focus will be on reducing maternal mortality, improving care for pregnant and postpartum women with opioid use disorder and improving care for substance-exposed newborns. Additionally, local partners are conducting large scale implicit bias trainings to address bias, privilege, and systemic/institutional racism in organizations that provide maternal and child health services across the Commonwealth.

Examples of ways to reduce maternal mortality include addressing the social determinants of health: ensuring access to health services, access to transportation, enabling supports so that pregnant women can receive prenatal and postpartum care that is culturally respectful, expanding services covered by insurance and medical assistance, including midwifery and doula care services in the prenatal, delivery and postpartum periods to name just a few. Within the Department of Health, we are also closely following national developments in maternal mortality. There is currently a federal grant available from the Centers for Disease Control and Prevention (CDC) to fund maternal mortality work, made possible by the Preventing Maternal Deaths Act of 2018, for which we will be applying. As we look forward, the MOMMA Act, introduced in 2018 by Congresswoman Robin Kelly, would further strengthen states' abilities to address the social determinants of health and reduce maternal mortality. By empowering local organizations with resources, while leveraging the convening power of state governments, some of the specific ways the MOMMA Act addresses maternal mortality are: first, expanding Medicaid access to cover a partum period of one full year (as opposed to the current 2 months of coverage), second, ensuring the sharing and implementation of best practices between practitioners and hospital systems (i.e. expanding the creation of perinatal quality collaboratives), third, establishing and enforcing national emergency obstetric protocols across all delivery hospitals, and finally, improving access to culturally-competent care by addressing institutional racism through the training of hospitals AND community maternal health providers on the needs of *all* American mothers.

We continue to follow and be thankful for the dedicated time and energy of this committee and our elected officials here in Washington.

I would like to thank you for your time this morning and I look forward to working together to improve the health of mothers in our great nation. I welcome any questions you may have at this time.