



STATEMENT

of the

American Medical Association

to the

**U.S. House of Representatives
Committee on Oversight and Reform**

**Re: Birthing While Black: Examining America's Black Maternal
Health Crisis**

May 6, 2021

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The American Medical Association (AMA) appreciates the opportunity to submit the following Statement for the Record to the U.S. House of Representatives Committee on Oversight and Reform as part of the hearing entitled, “Birthing While Black: Examining America’s Black Maternal Health Crisis.” The AMA commends the Committee for focusing on this critically important issue, which disproportionately affects Black women and Native American/Alaska Native women. The AMA also commends the many advocates who have paved the way for this issue to capture the attention of media, politicians, and the health care sector. As the largest professional association for physicians and the umbrella organization for state and national specialty medical societies, the AMA is committed to working with stakeholders to support efforts to reduce and prevent rising rates of maternal mortality and serious or near-fatal maternal morbidity, and specifically to address health inequities and social determinants of health (SDOH).

The Problem: Rising Maternal Mortality and Morbidity in the U.S.

Approximately 700 women in the U.S. die annually as a result of pregnancy or related complications. Those deaths occur over the course of pregnancy and into the postpartum period. Moreover, at least 50,000 women experience potentially life-threatening complications in childbirth each year. Maternal mortality (pregnancy-related death) is defined by the Centers for Disease Control and Prevention (CDC) as the death of a woman while pregnant or within one year of the end of a pregnancy—regardless of the outcome, duration, or site of the pregnancy—from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.¹ Severe maternal morbidity (SMM) includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman’s health. Using the most recent list of indicators, SMM has been steadily increasing in recent years and affected more than 50,000 women in the United States in 2014.² Experiencing severe maternal morbidity can have serious and life-long consequences for women and their families.

In a report by the CDC—which looked at pregnancy-related deaths from 2007 to 2016—there were significant disparities in the death rate for different racial, ethnic, and age groups. Alarming, the CDC

¹ <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm>

² <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html>

found that Black women were three to four times more likely (40.8 deaths for every 100,000 live births) than White women (13 deaths for every 100,000 live births) to die from a pregnancy-related cause; Native American and Alaska Native women were 2.5 times more likely (29.7 deaths for every 100,000 live births) to suffer a pregnancy-related death.³ The study also found that pregnancy-related deaths occurred over the course of the pregnancy, delivery, and postpartum period: more than 31 percent of deaths were during pregnancy; 36 percent occurred during delivery or in the week after birth; and 33 percent happened one week to one-year postpartum. Overall, heart disease and stroke were the leading cause of pregnancy-related deaths each year from 2011 to 2017, but the causes were different depending on when the deaths occurred. For example, obstetric emergencies such as hemorrhage (e.g., severe bleeding) and amniotic fluid embolisms caused most deaths at delivery; hemorrhage, high blood pressure, and infection were most common in the week after delivery; and cardiomyopathy (weakened heart muscle) caused most deaths one week to one year after delivery.⁴ Nearly 50 percent of all pregnancy-related deaths were caused by hemorrhage, cardiovascular and coronary conditions, cardiomyopathy, or infection. The leading underlying causes of death varied by race. Preeclampsia, eclampsia, and embolism were leading underlying causes of death among non-Hispanic Black women. Perhaps the most significant and troubling finding in the study is that the CDC estimates that 60 percent of all maternal deaths are preventable.^{5,6}

Health Equity and Social Determinants of Health

The AMA defines health equity as “optimal health for all” and recognizes the importance and urgency of advancing health equity and addressing SDOH to ensure that all people and communities reach their full health potential. SDOH are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems. Some examples of social determinants which can influence health equity in positive or negative ways include (this list is not exhaustive): education, housing, wealth, income, environment, food insecurity, and employment. We all experience conditions that socially determine our health. However, we do not all experience them equally. Some research has suggested that SDOH account for between 30-55 percent of health outcomes. The World Health Organization (WHO) defines health equity as the “absence of unfair and avoidable or remediable differences in health among social groups.”⁷ This definition clarifies that inequities and disparities do not have to exist, but that inequities are produced; they do not just happen; the people who are negatively impacted by experiencing the injustice are not to blame; and there is something that we can actually do to close the gap.

The SDOH are impacted by large and powerful systems that lead to discrimination, exploitation, marginalization, exclusion, and isolation. In this country, these historic and systemic realities are baked into structures, policies, and practices and produce, exacerbate, and perpetuate inequities among the SDOH, and therefore affect health itself. These large, powerful systems of racism and gender oppression—also known as the root cause inequities—are upstream to the social determinants of health. They have shaped the social conditions in which women and families live, and they work to produce inequities across society in complex ways, especially for those marginalized at the intersection of race and gender, i.e., Black, and Native American women.

³ <https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6835a3-H.pdf>

⁴ <https://www.cdc.gov/vitalsigns/maternal-deaths/index.html#:~:text=About%20700%20women%20die%20from,to%201%20year%20after%20delivery.>

⁵ <https://www.cdcfoundation.org/sites/default/files/files/ReportfromNineMMRCs.pdf>

⁶ <https://www.cdcfoundation.org/sites/default/files/upload/pdf/MMRIARepor.pdf>

⁷ https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

Birth inequities arise at the intersection of discrimination by race and gender for Black and Native American women. We know that in some places across the country, Black women with at least a college degree had higher severe maternal morbidity rates than women of other races/ethnicities who never graduated high school.⁸ Moreover, the State Pregnancy-Related Mortality Ratios (PRMR) for Black women with at least a college degree were five times as high as White women with a similar education.⁹ It is clear that racism and discrimination—at the provider, institutional, and societal levels—is an attributable etiology of the increased proportion of Black and Native American mothers experiencing higher birth-related mortality and morbidity, inclusive of inequitable access to and quality of care, institutional racism, mistrust for health care institutions, and delayed response to medical emergencies by both medical providers and patients, and a culture of disrespect that can lead to mistrust for health care institutions. Stories from Black women also tell us about a culture of disrespect as well as the reality of not being listened to or heard.

The AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole. The AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and as a barrier to appropriate medical care. The elimination of racial and ethnic disparities in health care is an issue of highest priority for the AMA.

At the provider and institutional levels, there is a growing body of evidence demonstrating that implicit and explicit biases exist that negatively impact the quality of health care equity and patient safety and drive these inequities. This was described originally in an Institute of Medicine (now the National Academy of Medicine) report, more than 15 years ago.¹⁰ The evidence shows that Black people are more likely to receive a poorer quality of care and less likely to receive the basic standard of care even when controlling for insurance status and income. This lower quality of care has been linked to higher death rates. The AMA supports the development and implementation of training regarding implicit bias, diversity, and inclusion in all medical schools and residency programs as well as increased research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

In addition, while more research is needed on the relationship between discrimination and the chronic stress of racism on maternal and infant health outcomes, there is evidence that experiences of discrimination and racism have a “weathering” effect on the body. Dr. Arline Geronimus, who coined the “weathering” hypothesis, explained that “Blacks experience early health deterioration as a consequence of the cumulative impact of repeated experience with social or economic adversity and political marginalization” over one’s life course. This physiologic pressure, also later described as allostatic load, can cause stress hormones, such as cortisol, and cause organ and cardiovascular, metabolic, and immune system damage over time. In addition, chronic stress, and trauma due to discrimination that occurs as early as in-utero and early childhood, also known as adverse childhood experiences, have been associated with poor health outcomes and early death as an adult.

⁸ <https://www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm>

⁹ <https://www.cdc.gov/reproductivehealth/maternal-mortality/disparities-pregnancy-related-deaths/infographic.html>

¹⁰ Institute of Medicine. 2003. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/10260>.

SDOH impact on maternal mortality and morbidity

Insurance and Access to quality reproductive health care

In 2018, almost half (43 percent) of all U.S. births were to women with public insurance. Further, Medicaid paid for a greater share of deliveries by Black (65.9 percent) and American Indian and Alaska Native women (67.3 percent).¹¹ Public insurance has large coverage gaps for the women who require it—in many states this coverage is not available prior to pregnancy, when women with medical conditions need it. Insurance also terminates in the months following pregnancy when the vast majority of maternal deaths occur. In order to assure optimal health care for the women at risk for medical or mental health conditions leading to maternal death, additional insurance coverage is required.

The AMA supports the extension of Medicaid coverage to 12 months postpartum. On April 12, Illinois became the first state to extend Medicaid eligibility to new mothers for 12 months after birth. Full Medicaid benefits will be available for women with incomes up to 208 percent of the federal poverty level (FPL) and the state will provide continuous eligibility during the entire postpartum period. Prior to the waiver approval, eligibility was limited to 60 days postpartum.¹² The American Rescue Plan Act of 2021 established a temporary, optional provision to assist states in expanding Medicaid and Children’s Health Insurance Program coverage opportunities to one-year postpartum in order to take swift action to combat maternal mortality and severe maternal morbidity further exacerbated by the COVID-19 pandemic.¹³

Reduced access to quality maternity care

Safe maternity care requires access to hospitals with quality obstetric units and access to appropriately trained medical teams led by obstetric physicians. Concurrent with the increased focus on maternal care delivery, hospitals with smaller maternity units have been closing. According to a policy brief by the University of Minnesota Rural Health Research Center, the percent of rural counties without obstetric services rose from 45 to 54 percent between 2004 and 2014. Moreover, only 30 percent of the rural noncore counties (areas with less than 10,000 residents) had continual access to obstetrics services.¹⁴ As a result, women in rural areas of the U.S. must travel greater distances for prenatal, obstetrical, and postpartum care. This trend of obstetric unit closures in the U.S. is true for both urban and rural maternity units. Further, data from the American Hospital Association (AHA) reveals that more than 10 million women of color live in rural communities in the United States.¹⁵ Additionally, research has indicated that rural counties with large populations of Black women have higher rates of obstetric unit closures.¹⁶

Depression/Mental Health/Substance Use Disorders

Depression in pregnancy is associated with poor maternal outcomes including maternal death. The CDC analyzed 2018 data from the Pregnancy Risk Assessment Monitoring System to describe postpartum depressive symptoms (PDS) among women with a recent live birth and to assess whether health care

¹¹ <https://www.macpac.gov/wp-content/uploads/2020/06/Chapter-5-Medicaid%E2%80%99s-Role-in-Maternal-Health.pdf>

¹² <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/il-continuity-care-admin-simplification-ca.pdf>

¹³ <https://www.kff.org/policy-watch/postpartum-coverage-extension-in-the-american-rescue-plan-act-of-2021/>

¹⁴ http://rhrc.umn.edu/wp-content/files_mf/1491501904UMRHRCOBlosuresPolicyBrief.pdf

¹⁵ <https://www.aha.org/system/files/media/file/2020/05/cms-rfi-on-maternal-health-in-rural-areas-letter-5-28-2020.pdf>

¹⁶ <https://www.ajmc.com/view/role-of-racial-and-geographical-bias-in-rural-maternity-care>

providers asked women about depression during prenatal and postpartum health care visits, by site and maternal and infant characteristics. The prevalence of PDS exceeded 20 percent among women who were aged ≤ 19 years, were American Indian/Alaska Native, smoked during or after pregnancy, experienced intimate partner violence before or during pregnancy, self-reported depression before or during pregnancy, or whose infant had died since birth.¹⁷

The AMA joined other health care organizations in voicing support for the “Dr. Lorna Breen Health Care Provider Protection Act” (S. 610/H.R. 1667).¹⁸ This bipartisan, bicameral legislation will help reduce and prevent mental and behavioral health conditions, suicide, and burnout, as well as increase access to evidence-based treatment for physicians, medical students, and other health care professionals, especially those who continue to be overwhelmed by the COVID-19 pandemic. The AMA believes that this legislation could certainly include pregnant, postpartum, and parenting physicians experiencing postpartum depression, or any other mental health stressor related to pregnancy.

Additionally, in 2015, the AMA convened more than 25 national, state, specialty, and other health care associations to develop industry-wide recommendations for physicians to help end the nation’s opioid epidemic. The Task Force continues its work to urge physicians to demonstrate leadership to help their patients as well as urges policymakers to take action and push back against health insurance companies and others who continue to erect and support barriers to evidence-based care for patients with pain and patients with a substance use disorder. **The AMA has continued its advocacy in support of pregnant, postpartum, and parenting women with a substance use disorder (SUD). This is a core recommendation of the AMA Opioid Task Force.**

The AMA is actively working with states to ensure that women who are pregnant are not punished as a result of seeking or receiving care for a SUD, including taking medications to treat opioid use disorder (MOUD). Some states have outdated reporting requirements under the Child Abuse Prevention and Treatment Act (CAPTA)/Comprehensive Addiction and Recovery Act (CARA) for women who are in treatment or under the supervision of a physician, who are inappropriately reported for investigation by a state child and family welfare agency—often resulting in trauma, massive stigmatization, and separation of the newborn from the mother, including when the child has neonatal abstinence syndrome (also called NAS). Similarly, the AMA recently held a webinar with Manatt Health to highlight the fact that women who are pregnant in a carceral setting are discontinued from MOUD either during pregnancy or immediately following return to jail or prison. The forced discontinuation leads to painful withdrawal, and arguably is a denial of a person’s constitutional right to health care while incarcerated. Given the disproportionate rates of incarceration for women of color, this is yet another area of structural racism that we believe must be confronted and ended.

What the AMA is doing to address SDOH and Maternal Mortality

A commitment to health equity means we must address the SDOH, and we must elevate and name the root causes of why health inequities exist and how they came to be—both in society and at the institutional level. The AMA demonstrates its commitment through addressing the social conditions that impact health, increasing health workforce diversity, advocating for equity in health care access, promoting equity in care, and ensuring equitable practices and processes in research and data collection. Although the AMA and physicians cannot control all factors that need to change to achieve health equity,

¹⁷ <https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6919a2-H.pdf>

¹⁸ <https://searchf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-3-25-Signed-On-Letter-re-Lorna-Breen-Act-Coalition-Support.pdf>

the AMA views its role to identify their importance and to urge and educate those who can have a direct role to act.

The AMA supports efforts designed to integrate training in SDOH and cultural competence across the undergraduate medical school curriculum to assure that medical students are prepared to provide patients with safe, high quality, and patient-centered care. In 2013, the AMA launched the “Accelerating Change in Medical Education” initiative. Today, the 37-member consortium, which represents almost one-fifth of allopathic and osteopathic medical schools, is delivering forward-thinking educational experiences to approximately 19,000 medical students—students who will provide care to a potential 33 million patients annually. One of the earliest innovations to come from the Consortium was the new and innovative curriculum on health systems science, which includes a chapter on SDOH. Nearly all of the 37 schools in the consortium are addressing SDOH with a focus on ensuring that students recognize the impact of SDOH outcomes and are working with inter-professional colleagues to address them.

In 2019, the AMA announced its Reimaging Residency Initiative, designed to transform residency training to best address the workforce needs of our current and future health care system. Many of the applications to the graduate medical education (GME) initiative have included health systems science training in their proposals.

All undergraduate medical education (UME) and GME partners in the consortium participated in a series in the fall of 2020 “Combatting Structural Racism in UME and GME” which addressed the pressing need to eradicate racial essentialism in medical education, to create more inclusive training environments and to strive for educational equity in our profession.

For practicing physicians, the AMA launched STEPSforward,TM an interactive practice transformation series offering innovative strategies that will allow physicians and their staff to thrive in the evolving health care environment by working smarter, not harder.¹⁹ **This series includes a continuing medical education module on “Addressing Social Determinants of Health: Beyond the Clinic Walls.” The interactive module helps physicians identify how to best understand the needs of their community, define a plan to begin addressing SDOH, and explains the tools available to screen patients and link them to resources.**

Additionally, the AMA, along with a coalition of national physician organizations and heart health experts, launched a campaign called Release the Pressure, with ESSENCE—the nation’s leading lifestyle magazine brand for Black women—aimed at partnering with Black women to improve their heart health and be part of a movement for healthy blood pressure.²⁰ The prevalence of high blood pressure among Black adults in the U.S. is among the highest in the world, with the prevalence of high blood pressure in Black women nearly 40 percent higher than White women in the U.S. Two of the leading causes of pregnancy-related deaths are heart conditions and stroke, which cause more than one in three deaths. Through Release the Pressure, the AMA is also working with GirlTrek and their one million members to support Black women’s health.²¹

On the legislative side, specifically related to addressing maternal mortality and morbidity, **the AMA supported legislation enacted into law in 2018, the “Preventing Maternal Deaths Act,”** that supports

¹⁹ <https://edhub.ama-assn.org/steps-forward>

²⁰ <https://releasethepressure.org/>

²¹ GirlTrek encourages women to use walking as a practical first step to inspire healthy living, families, and communities.

state maternal mortality review committees (MMRCs).²² MMRCs bring together local experts—ob-gyns, nurses, social workers, patient advocates, and other health care professionals—to review individual maternal deaths and recommend specific ways to prevent them in the future. Continued federal support for MMRCs is a critical first step in efforts to make pregnancy safer for women.

For the 117th Congress, the AMA is supporting the “Mothers and Offspring Mortality and Morbidity Awareness (MOMMA) Act” (S. 411).²³ The MOMMA Act uses a six-pronged approach to address and reduce maternal deaths by: establishing national obstetric emergency protocols through a federal expert committee, ensuring dissemination of best shared practices and coordination among maternal mortality review committees, standardizing data collection and reporting, improving access to culturally competent care throughout the care continuum, providing guidance and options for states to adopt and pay for doula support services, and expanding Medicaid coverage to new mothers’ entire postpartum period (one year).

The AMA has also voiced its support for the Connected Maternal Online Monitoring Act (“Connected MOM Act”) (S. 801), which would require the Centers for Medicare and Medicaid Services (CMS) to send a report to Congress that identifies barriers to coverage of remote physiologic devices (e.g., pulse oximeters, blood pressure cuffs, scales, blood glucose monitors) under state Medicaid programs to improve maternal and child health outcomes for pregnant and postpartum women.²⁴ This bipartisan legislation would also require CMS to update state resources, such as state Medicaid telehealth toolkits, to align with evidence-based recommendations to help decrease maternal mortality and morbidity.

In January 2021, in alignment with the AMA’s comments to CMS’ request for information regarding “Maternal and Infant Health Care in Rural Communities” and the 2021 Medicare Physician Fee Schedule proposed rule, the agency agreed to apply the increased relative values the agency adopted for standalone office visits to the office visit components of maternal global codes to recognize the importance of preventive prenatal and postpartum care for the health of women and infants.

The AMA has also joined a sign-on letter urging CMS to act as soon as possible to approve pending section 1115 demonstration projects aimed at extending the postpartum coverage period for individuals who were enrolled in Medicaid while pregnant to a full year after the end of pregnancy.²⁵

Additionally, the AMA has urged Congressional leaders to support at least \$750 million for the Title V Maternal and Child Health (MCH) Services Block Grant in the FY2022 Labor, Health and Human Services, Education & Related Agencies Appropriations bill.²⁶ Continued robust support of

²² H.R. 1318 (P.L. 115-344). <https://www.congress.gov/115/plaws/publ344/PLAW-115publ344.pdf>

²³ <https://searchf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-4-27-Letter-to-Durbin-and-Duckworth-re-MOMMA-Act-2021.pdf>

²⁴ <https://searchf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-4-7-Letter-to-Cassidy-and-Hassan-re-Connected-MOM-Support-v4.pdf>

²⁵ <https://searchf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-2-5-Signed-On-Letter-National-State-Local-Org.-To-Acting-HHS-Sec-Cochran-Acting-CMS-Admin-Richter-re-Postpartum-Coverage-Sec.-1115-Waivers.pdf>

²⁶ <https://www.aafp.org/dam/AAFP/documents/advocacy/prevention/women/LT-Congress-MCHBlockGrantAppropriations-032421.pdf>

the MCH Services Block Grant is important in furthering our national goal of improving the health of mothers and children.

The AMA has urged House Congressional leaders to support the highest possible funding level in FY2022 for programs at the Health Resources and Services Administration (HRSA), the CDC, and the National Institutes of Health (NIH) that seek to prevent maternal deaths, eliminate inequities in maternal health outcomes, and improve maternal health.²⁷

Most recently, the AMA signed onto a letter urging the House and Senate to direct \$20M to the CDC Hospitals Promoting Breastfeeding line item in the Fiscal Year (FY) 2022 Labor, Health and Human Services, and Related Agencies appropriations bill.^{28, 29}

To improve health equity, the AMA's strategic and focused approach includes a multi-pronged, multi-year investment, strategic partnerships, and advocacy. Our goals are to champion health equity and promote greater diversity within the medical workforce. To date, our most recent and greatest demonstration of a commitment to health equity is the creation of the Center for Health Equity (Center) at the AMA. The Center has been instrumental in initiating our new and explicit path to advance health equity.

As part of the AMA's broader effort to address these health inequities and eliminate obstacles to care, the AMA and Center are partnering with local stakeholders in Chicago to confront social determinants of health on the city's West Side. The AMA has made a \$2 million investment in a Chicago-based collaborative, West Side United,³⁰ that is working to promote health and well-being for a portion of the city where life expectancy is far below the national average.

The Center is a member of the COVID-19 Infant and Young Child Feeding Constellation Advisory Council organized by the United States Breastfeeding Coalition. The Constellation serves as a bi-directional learning forum and centralized advocacy hub for the First Food field, working through an equity lens to support and coordinate the response to the challenges posed by COVID-19 across the United States.³¹

Providers' and Health Care Systems' Role in Maternal Morbidity and Mortality

Providers, hospitals, and health care systems play a critical role in ensuring that all mothers and families have healthy and safe experiences around the time of birth. We applaud the growing number of places and people that are making significant investments to meaningfully engage health care systems and providers

²⁷ <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-4-15-Signed-On-National-Organizations-in-Support-of-Bipartisan-DeGette-Gallagher-Maternal-Health-DCL.pdf>

²⁸ <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-4-19-FY22-Hospital-Promoting-Breastfeeding-Sign-On-Letter-HOUSE.pdf>

²⁹ <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-4-19-FY22-Hospital-Promoting-Breastfeeding-Sign-On-Letter-SENATE.pdf>

³⁰ West Side United is a partnership of residents, health care providers, civic leaders, businesses, community groups and faith-based institutions. The organization is not only focused on improving the health of residents on Chicago's West Side, but also restoring economic vitality and educational opportunities in neighborhoods where historical disinvestment has contributed to profound health challenges for children and families.

<https://westsideunited.org/>

³¹ <http://www.usbreastfeeding.org/constellations>

to improve the quality and safety of care for women. This is being done by enhancing data tracking and analysis of maternal and pregnancy-related morbidity and mortality events in order to stop preventable complications; integrating structural competency, cultural sensitivity, and implicit bias training opportunities; and working with partners from different sectors and with patients to better inform system changes and improvements. Narratives from the lived experiences of Black women indicate there is a rupture of trust between Black women and the health care system that must also be addressed.

Medical education curriculum incorporates teaching and training on implicit and explicit biases, to provide tools and build skills to recognize and eliminate bias, and integrate structural competency education, which as described by Jonathan Metzel “is a framework for conceptualizing and addressing health-related social justice issues that emphasizes diagnostic recognition of economic and political conditions producing and racializing inequalities in health.”³²

Conclusion

The pursuit of health equity is a pathway towards excellence in our health care system, one that ensures the valuing of human experience and rights. It is one that recognizes that we must do more as institutions to protect individuals and families. The AMA thanks the Committee for this hearing and for the careful consideration of solutions to improve maternal health in this country. We look forward to working with the Committee and Congress to seek solutions that will ensure women, especially women of color, have success throughout their pregnancy experience.

³² <https://pubmed.ncbi.nlm.nih.gov/28225732/>