UT Southwestern Medical Center

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May 3, 2021

To Ranking Member Comer and distinguished members of the House Committee on Oversight and Reform:

I am trained as an Obstetrician-Gynecologist as well as having sub-specialty fellowship training in Maternal-Fetal Medicine. Currently, I am a Dedman Family Scholar in Clinical Care at the University of Texas Southwestern Medical Center and serve as the Chief of Obstetrics at Parkland Hospital in Dallas, Texas. Parkland Hospital—a maternal level IV (highest) of care birthing facility—is one of the largest single, public maternity services in the United States with approximately 12,000 women delivered annually. This delivery volume represents, in total, more births than occurred in ten separate states in the country last year. Because of this breadth of experience, I appeared before the United States Congressional Subcommittee on Health on September 10, 2019, at the hearing entitled, "*Improving Maternal Health: Legislation to Advance Prevention Efforts and Access to Care*" and provided testimony on the issues of maternal health in our country. At the request of Ranking Member Comer's office, I have been asked to provide information and comment specifically outlining: (1) use of non-physician providers, and (2) the role of virtual healthcare.

I would first like to applaud the members for scheduling this hearing, "*Birthing While Black: Examining America's Black Maternal Health Crisis*" to address healthcare disparity. Indeed, disparity in maternal healthcare outcomes is recognized as a marker for healthcare inequity. Recently, there has been a heightened awareness of maternal morbidity and mortality due to the reported rising rates of maternal deaths in the United States.[1,2] Unfortunately, these rates are even worse among women of color, with pregnancy-related mortality more than three-fold higher for Black women.[1-4] Importantly, reports from state-directed maternal mortality review committees identify that some of these maternal deaths are potentially preventable, and many of the pregnancy-related deaths are occurring after delivery.[3,4]

There is a growing body of literature that validates the public health impact of racial bias, implicit and explicit, on the lives and health of people of color.[5] Moreover, evidence suggests that factors such as stereotyping and implicit bias on the part of the healthcare provider may contribute to racial and ethnic disparities in health.[6,7] Addressing such implicit bias is one of the priorities in advancing maternal care in the United States. At a national level, for example, the American College of Obstetricians and Gynecologists is taking a leadership role in addressing this issue.[6,7] At both Parkland Hospital and UT Southwestern Medical Center, we have recognized these disparities and have developed programs to address such bias. These include organizational commitments to bias training and cultural competency to advance health equity. For example, at Parkland Hospital, there is a Diversity, Inclusion, and Health Equity Department that uses a

blueprint from the National Culture and Linguistically Appropriate Services to foster an inclusive workplace and advance health equity. There is also a no-cost instructor-led series offered monthly to employees to educate and coach on culturally-sensitive practices and to review the impact of unconscious bias and stereotypes. For our non-English speaking (Latina) mothers, a robust Language Services department provides access to translation services in an effort to ensure effective communication and shared decision-making.

To address the specific requests for information:

1. Use of non-physician clinicians to expand access to care:

The use of non-physician clinicians in providing both continuity and coordination of care is vital as the availability of physicians for maternal care is limited. In fact, there are significant workforce shortages within obstetrics and gynecology due to an aging workforce. Furthermore, the average number of work hours are declining and increasing numbers of obstetricians and gynecologists are retiring from obstetrics altogether.[8] More than 15,000 of the nearly 40,000 actively practicing obstetricians and gynecologists will likely retire in the next 10 years.[8] Importantly, the number of obstetricians and gynecologists retiring will soon equal the number of resident graduates, and the demand for obstetricians and gynecologists in 2020 in Texas is projected to be among the highest in any state.[8] Nationally, there is expected to be a shortage between 3,000-9,000 obstetrician-gynecologist physicians by 2030.[8] With projections of relatively fewer general internists and family physicians, more women will be in need of health care. Thus, the strain on the obstetric workforce will likely heighten. This is sobering when considering that approximately half (49%) of the 3107 United States counties currently lack an obstetrician-gynecologist physician.[9]

One solution to this serious healthcare shortage is the incorporation of non-physician providers to promote collaborative models with certified nurse midwives, nurse practitioners, and physician assistants to establish “teams” led by obstetrician-gynecologist physicians. Both at Parkland Hospital and UT Southwestern, this model is effectively deployed. At Parkland Hospital, advanced practice providers—both certified nurse midwives and nurse practitioners—are a resource used to extend care across Dallas County. Among the 10 women’s health care clinics and central high-risk clinic, there are more than 100 advanced practice providers delivering prenatal and postpartum care. The certified nurse midwife program established by Dr. Kenneth Leveno has been in place for more than 30 years. Today, more than 30 certified nurse midwives with more than 500 combined years of experience are integrated with our physician teams. In 2017, we published a manuscript as one of the three “Editor’s Choice” articles discussed for the July 2017 edition of Obstetrics & Gynecology—the official journal for the American College of Obstetricians and Gynecologists (ACOG).[10] This was a four-year prospective study of nearly 4,000 women evaluated in our triage unit and discharged to home after standardized assessment by our advanced practice providers under the supervision of physicians. We found that women discharged with false labor at term after a standardized assessment were not at increased risk for adverse perinatal outcomes or cesarean delivery. The results of this manuscript have far-reaching implications to providers and patients by providing evidence-based information regarding the safety of clinical decision-making. In the fight against the effects of the coronavirus, our advance practice provider teams were deployed as “frontline” staff to serve in the assessment and screening for COVID-19 disease. Additionally, the advance practice providers utilized telemedicine services to provide clinical care through virtual visits to limit the on-site clinic volume across the women’s healthcare platform.

2. Use of virtual visits and telemedicine services:

The COVID-19 crisis emphasized the importance of access to care and challenged our medical community. One important area of healthcare that rapidly evolved during the COVID-19 crisis was the use of virtual care. Indeed, the use of telemedicine services both at Parkland Hospital and UT Southwestern was emphasized during the COVID-19 pandemic to provide access to care during this crisis. The use of such services can be challenging in medically underserved areas with 'digital deserts' limiting availability of medical specialties. To address this barrier, we deployed audio-only virtual prenatal visits at Parkland Hospital and measured the impact of this new service on both the patient perspective of care and healthcare outcomes. We have found that deploying audio-only virtual prenatal visits within Dallas County increased access to care, satisfied patients, and did not result in an increase in adverse perinatal outcomes in more than 6,000 pregnant women delivered during the COVID-19 pandemic in 2020. Both the patient-perspective and acceptance as well as healthcare outcomes have been published in peer-reviewed journals to offer evidence-based guidance on future use of such services.[11,12] From our experience, audio-only virtual options are not only acceptable, but for the disadvantaged they are preferable, as a supplement to in-person visits and should be considered as a viable virtual option in the future beyond the COVID-19 pandemic.

In closing, thank you for this opportunity to share our experiences from Parkland Hospital and UT Southwestern and our efforts to promote non-physician providers and audio-only virtual care to expand access to women with healthcare disparities. To advance the national effort in improving both maternal mortality and morbidity, especially among women of color, it is critical that accurate, relevant clinical data are reported and are used to guide decisions for healthcare policy. Ultimately, these efforts can lead to safer deliveries of mothers and their infants for the future generations of our country. I have included peer-reviewed publications from our program for evidenced-based practices addressing these issues, and I look forward to the opportunity to expand this discussion in the future as we have recently deployed a targeted program titled, "*extending Maternal Care after Pregnancy (eMCAP),*" to women living in at-risk areas in our community. This program serves as a demonstration project of providing community-based resources, nurse home visitation, audio- and provider-based care for 12-months after delivery in our most vulnerable areas of Dallas County where a substantial number of women of color reside.

Sincerely,

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