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TO THE UNITED STATES HOUSE OF REPRESENTATIVES

COMMITTEE ON OVERSIGHT AND REFORM

"*BIRTHING WHILE BLACK: EXAMINING AMERICA'S BLACK MATERNAL HEALTH CRISIS*"

MAY 6, 2021

Madam Chairwoman Maloney, Ranking Member Comer and Members of the Committee on Oversight and Reform, thank you for inviting me to testify and give my perspective on America's Black maternal health crisis. I am truly honored.

My name is Dr. Veronica Gillispie-Bell. I am an obstetrician-gynecologist who has practiced in New Orleans, Louisiana at Ochsner Health System for the past 13 years, and I am a Fellow of the American College of Obstetricians and Gynecologists. Additionally, I serve as the Medical Director of both the Louisiana Perinatal Quality Collaborative (LaPQC) and the Pregnancy Associated Mortality Review (PAMR). As a practicing OBGYN and as a Black mother, the Black maternal health crisis is heart breaking. Many of my Black patients look me in my eyes and with fear in their heart and ask me if they are going to die if I am not there when they deliver their baby. Our Black birthing persons are afraid, and they have every right to be. We, as clinicians, as a community, as a nation are failing them.

The rate of maternal mortality in the United States is higher than that of any other peer country. We spend about 17% of our Gross Domestic Product on healthcare, yet, we have the

worst outcomes. Furthermore, the rate of maternal mortality has consistently increased in the United States over the last 30 years. Each year, about 700 American families lose a mother, a sister, a wife to a maternal death. What is more alarming than our rate of maternal mortality is the disparity of deaths among Black birthing persons. Nationally, Black women are four times more likely than white women to suffer a pregnancy-related death.

The reasons for the increasing rate of maternal mortality are many. However, the reasons for the inequities of maternal deaths among Black birthing persons are few. As discussed in my commentary, *The Contrast of Color: Why the Black Community Continues to Suffer Health Disparities,* the root of health disparities among Black individuals is implicit bias and structural racism. **Race is a social construct, not a biological condition.** Historical characterization of biological differences that are simply false have misshapen the unconscious bias of practicing providers. False narratives such as, "Black individuals do not feel pain in the same way as other races" have informed care that is biased and inequitable. While our biases are unconscious, the effect on how we deliver care is very real. Black individuals are less likely to have their pain treated; less likely to be offered the influenza vaccine; and less likely to be offered cancer screening. When you adjust for socioeconomic status, the maternal morbidity rate for Black individuals is still higher than that of their white counterparts. In fact, a Black woman with a college degree is twice as likely to experience a severe maternal morbidity compared to a white woman with less than a high school diploma. This is due to the differences in the care they receive. Everyone deserves unbiased, quality care.

Historical systems perpetuated through racial residential segregation, economic suppression and heath care inequality have negatively impacted the social determinants of health for people of color and normalized the poorer health outcomes for Black Americans. Minority

neighborhoods are found to have higher rates of tobacco ads increasing the likelihood of tobacco use. Higher rates of crimes in minority neighborhoods and an increased chronic stress have all been found to be contributors to negative maternal outcomes such as preterm birth. Lack of access to employment opportunities and economic stability negatively affects health outcomes. The rate of uninsured in the nonelderly population is the highest among Black and Latinx individuals.

While the statistics about maternal mortality and the disparity of deaths among Black women are shameful, there are solutions to the Black maternal health crisis:

1. **Support state perinatal quality collaboratives as arms for continuous quality improvement.** In August 2018, the Louisiana Perinatal Quality Collaborative launched the *Reducing Maternal Morbidity Initiative* with the goal of reducing Severe Maternal Morbidity by 20% among those persons who experience a hemorrhage or severe hypertension as well as decrease the Black-white disparity gap in Severe Maternal Morbidity outcomes by May 2020. By the end of our initiative, the Severe Maternal Morbidity among hemorrhage was reduced by 35% among all birthing persons and by 49% for Black birthing persons. The Severe Maternal Morbidity among those experiencing severe hypertension was reduced by 12%. The percentage of patients receiving a risk assessment for hemorrhage upon admission to Labor and Delivery increased by 78% and those who received quantification of blood loss during delivery increased by 172%. The percentage of patients receiving timely treatment of hypertension increased by 210%. Though we talk a lot about maternal mortality, it is just the tip of the iceberg. If we reduce Severe Maternal Morbidity, we will reduce maternal mortality.

The success of our initiative was founded in our use of quality improvement science to implement the Alliance for Innovation on Maternal Health (AIM) Patient Safety Bundles.[1] It takes 17 years for translational research to be implemented into practice at the bedside without improvement science. With improvement science, it takes only 3 years. Evidence-based medicine, such as the AIM Patient Safety Bundles, tell us the "what" we need to do as healthcare providers. Improvement science tell us the "how" to implement these changes into clinical practice. Consistent, standardized practices ensure equitable care. To tackle the Black-white disparity gap, we do not need the same care. We need the same quality of care.

State Perinatal Quality Collaboratives are the improvement arm that can implement the AIM Patient Safety Bundles. Many states have Perinatal Quality Collaboratives (PQC), but only 12 states have funding from the Centers for Disease Control and Prevention (CDC). PQCs need sustainable funding to secure the resources of time and people to create lasting improvement.

2. **Support state maternal mortality review committees.** State maternal mortality review committees are key to review, establish trends and determine causes of maternal mortality. The Louisiana Pregnancy-Associated Mortality Review works to quantify the drivers of maternal mortality, complications of pregnancy and to understand disparities in outcomes. This is accomplished through a multi-disciplinary review committee that studies all maternal deaths, regardless of cause. The rich

[1] The Alliance for Innovation on Maternal Health (AIM) Program, a cooperative agreement between the Health Resources and Services Administration and the American College of Obstetricians and Gynecologists, is a national data-driven maternal safety and quality improvement initiative to improve overall maternal health outcomes in birthing facilities across the nation and reduce preventable maternal mortality and severe maternal morbidity.

information gathered from this review process fosters the development of recommendations that are used to support state legislation; guide state quality improvement initiatives, such as those led by the LaPQC; and provide health systems with key processes needed to improve coordination of care.

Thanks in part to the enactment and continued implementation of the *Preventing Maternal Deaths Act* (Public Law 115-344), nearly every state either has or is in the process of establishing a maternal mortality review committee. However, these committees need additional assistance, in the form of financial support and technical assistance, to aid adoption of best practices, ensure sustainability of their operations, and enable consistency in data collection, analysis, and reporting across states. Currently only 25 states have funding from the CDC to support their maternal mortality review committees. As with state perinatal quality collaboratives, funding is needed to secure the resources of time and people to support these committees that are able to locally identify drivers of maternal mortality.

3. **Support extending Medicaid postpartum coverage to 1-year.** In many states, Medicaid coverage expires at 60-days postpartum. As recommended by the American College of Obstetricians and Gynecologists, we must redefine the postpartum period to up to 1-year after birth. In the United States, about 30% of maternal deaths occur between one week and up to 1-year postpartum. Based on our Louisiana Pregnancy-Associated Mortality Review 2017 Report, 20% of our pregnancy-related deaths occurred from 43 days to 1-year after pregnancy and more than 60% of pregnancy-associated but not related deaths occurred from 43 days to 1-year after pregnancy. 43 days up to 1-year after pregnancy defines a crucial time for optimization of medical

conditions and provides an opportunity for family planning, key steps in reducing pregnancy-related deaths. Having insurance coverage to facilitate access to the healthcare system can reduce all causes of maternal mortality. Through the American Rescue Plan Act, Congress took an important step to incentivize states to extend postpartum Medicaid coverage to 12 months after the end of pregnancy. While some states will take up this option, many will not. More must be done to ensure all Medicaid-eligible individuals have coverage through the critical postpartum period. Especially for those states that have not expanded Medicaid under the Affordable Care Act, extension of Medicaid coverage to 1-year postpartum would ensure access to care.

4. **Support systems that ensure pregnant women receive the appropriate level of care based on the complexity and acuity of their medical issues.** Individuals with high-risk conditions who are cared for at facilities designed to serve low-acuity patients are more likely to experience complications, including death. As such, the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine have published Levels of Maternal Care guidelines to establish a classification system that standardizes the maternity facility capabilities and personnel to facilitate patients receiving risk-appropriate maternal care. However, this classification system has not been adopted in all states. Currently, in Louisiana, I am leading a workgroup to update our maternal levels of care to be more consistent with these national recommendations. All states should adopt these guidelines, but states will need resources to meet the requirements, especially hospitals in smaller, more rural communities.

5. **Support infrastructure to ensure telehealth is available for all.** The benefits of telehealth with remote home monitoring devices are well noted in the obstetric population. At Ochsner, building on our experience with the Ochsner Digital Hypertension Program, an obstetrical digital medicine program was launched in 2017. Connected Maternity Online Monitoring (MOM) is a remote monitoring program that allows pregnant individuals to stay connected to their healthcare team by digitally submitting weekly blood pressure readings and weights to the electronic health record via their smartphone. Enrollees are provided a blood pressure cuff and a scale that connect to their smartphone via Bluetooth technology. Connected MOM was a critical aspect in our ability to provide safe access to prenatal care during the pandemic. In addition to the convenience provided to patients, preliminary data demonstrates improved outcomes for some populations. In a retrospective cohort study, we demonstrated individuals with a hypertensive disorder of pregnancy enrolled in Connected MOM were twice as likely to have a blood pressure check within 7-days of discharge from the hospital compared to traditional care. Connected MOM is supported by private foundation funding. Federal support for this work would enable its expansion to additional facilities and additional states.

   Telehealth has the potential to address some social determinants of health that are barriers to accessing care. However, if infrastructure to support telehealth is not addressed, telehealth has the potential to exacerbate disparities. According to the 2018 Broadband Deployment Report, over 30% of rural areas did not meet the Federal Communications Commission minimum benchmark for high-speed broadband internet. The rate of smartphone ownership and home broadband access is

lower in low-income individuals. These are all important considerations as telehealth is expanding. We do not want the use of telehealth to further increase our gap in health disparities. Broader efforts to support broadband infrastructure are needed

6. **Create and support programs to increase diversity within the physician workforce.** Studies have demonstrated when the physician is the same race as the patient, higher levels of trust and satisfaction in the health care professional are reported. Black, Latinx, and Indigenous physicians are more likely to practice in underserved areas and are more likely to accept patients covered by Medicaid. However, Black physicians account for only about 5% of the entire physician workforce, and Latinx physicians only account for 5.8%. National programs that invest in showing elementary-age minority children a pathway to a profession in medicine are needed. We need increased support of programs such as the Summer Health Professions Education Program and the National Workforce Diversity Pipeline Program, both designed to support the development of minorities with a desire to pursue careers in health care.

I would like to thank you for the opportunity to share my perspective on the causes and solutions for the Black maternal health crisis. Through ensuring equitable, quality care where our Black mothers are centered in the care, we can see a change. Our Black mothers deserve better and we can be better.

References

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1. Laurie Zephyrin, M.D., and Eugene Declercq, Ph.D., "Measuring Maternal Mortality," *To the Point* (blog), Commonwealth Fund, Feb. 6, 2020. https://doi.org/10.26099/c14w-nq52. Last accessed on May 2, 2021.
2. Pregnancy Mortality Surveillance System. Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm. Last accessed on May 2, 2021.
3. Peterson EE, Davis NL, Goodman D, Cox S, Syverson C, Seed K, Shapiro-Mendoz C, Callaghan W, Barfield W. (2019) Racial/Ethnic Disparities in Pregnancy-Related Deaths – United States, 2007-2016. MMR Morb Mortal Wkly Rep; 68:762765. DOI: http://dx.doi.org/10.15585/mmwr.mm6835a3
4. Gillispie-Bell V. (2021). The Contrast of Color: Why the Black Community Continues to Suffer Health Disparities. *Obstetrics and gynecology*, *137*(2), 220–224. https://doi.org/10.1097/AOG.0000000000004226
5. Leonard, S. A., Main, E. K., Scott, K. A., Profit, J., & Carmichael, S. L. (2019). Racial and ethnic disparities in severe maternal morbidity prevalence and trends. *Annals of epidemiology, 33, 30–36. https://doi.org/10.1016/j.annepidem.2019.02.007*
6. Morris, Z. S., Wooding, S., & Grant, J. (2011). The answer is 17 years, what is the question: understanding time lags in translational research. *Journal of the Royal Society of Medicine, 104(12), 510–520. https://doi.org/10.1258/jrsm.2011.110180*
7. Benno J, Trichilo R, Gillispie-Bell V, Lake C. (2020) Louisiana Pregnancy-Associated Mortality Review 2017 Report. https://ldh.la.gov/assets/oph/Center-PHCH/Center-PH/maternal/2017_PAMR_Report_FINAL.pdf
8. ACOG Committee Opinion No. 736: Optimizing Postpartum Care. (2018). *Obstetrics and gynecology*, *131*(5), e140–e150. https://doi.org/10.1097/AOG.0000000000002633
9. Wallace, M., Dyer, L., Felker-Kantor, E., Benno, J., Vilda, D., Harville, E., & Theall, K. (2021). Maternity Care Deserts and Pregnancy-Associated Mortality in Louisiana. *Women's health issues : official publication of the Jacobs Institute of Women's Health*, *31*(2), 122–129. https://doi.org/10.1016/j.whi.2020.09.004
10. Butler Tobah, Y. S., LeBlanc, A., Branda, M. E., Inselman, J. W., Morris, M. A., Ridgeway, J. L., Finnie, D. M., Theiler, R., Torbenson, V. E., Brodrick, E. M., Meylor de Mooij, M., Gostout, B., & Famuyide, A. (2019). Randomized comparison of a reduced-visit prenatal care model enhanced with remote monitoring. *American journal of obstetrics and gynecology*, *221*(6), 638.e1–638.e8. https://doi.org/10.1016/j.ajog.2019.06.034
11. Rural Health Information Hub. Barriers to Telehealth in Rural Areas. https://www.ruralhealthinfo.org/toolkits/telehealth/1/barriers. Last accessed on May 2, 2021.
12. Badawy SM, Radovic A. Digital Approaches to Remote Pediatric Health Care Delivery During the COVID-19 Pandemic: Existing Evidence and a Call for Further Research. *JMIR Pediatr Parent*. 2020;3(1):e20049. Published 2020 Jun 25. doi:10.2196/20049

13. Clapp, M. A., James, K. E., & Kaimal, A. J. (2018). The effect of hospital acuity on severe maternal morbidity in high-risk patients. *American journal of obstetrics and gynecology*, 219(1), 111.e1–111.e7. https://doi.org/10.1016/j.ajog.2018.04.015
14. Levels of Maternal Care: Obstetric Care Consensus No, 9 Summary. (2019). *Obstetrics and gynecology*, *134*(2), 428–434. https://doi.org/10.1097/AOG.0000000000003384