U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

September 25, 2018

TO: Members, Subcommittee on Health

FROM: Committee Majority Staff

RE: Hearing entitled "Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S."

I. INTRODUCTION

The Subcommittee on Health will hold a hearing on Thursday, September 27, 2018, at 10:00 a.m. in 2123 Rayburn House Office Building. The hearing is entitled "Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S."

II. WITNESSES

The following panels of witnesses have been invited to testify.

PANEL ONE

- Jaime Herrera Beutler (R-WA), Member, U.S. House of Representatives.

PANEL TWO

- Charles S. Johnson, IV., Founder, 4Kira4Moms;
- Stacey D. Stewart, President, March of Dimes;
- Lynne Coslett-Charlton, M.D., Pennsylvania District Legislative Chair, The American College of Obstetricians and Gynecologists; and
- Joia Crear Perry, M.D., Founder and President, National Birth Equity Collaborative.

III. BACKGROUND

Each year, through the Pregnancy Mortality Surveillance System, the U.S. Centers for Disease Control and Prevention (CDC) request that all 50 states, along with New York City and the District of Columbia, voluntarily provide copies of death certificates for all women who died during pregnancy or within one year of pregnancy, along with copies of the matching birth or fetal death certificates, if those records are accessible. The information is then summarized and reviewed by medically-trained epidemiologists. The causes of death are then coded by a system

established in 1986 by the American College of Obstetricians and Gynecologists and the CDC and Prevention Maternal Mortality Study Group.

Although the pregnancy-related mortality ratio fell in the U.S. during the 20th century, more recently over the last two decades, the number of American women who die each year from a pregnancy-related cause has increased dramatically. Since the Pregnancy Mortality Surveillance System was implemented, the number of reported pregnancy-related deaths in the nation has steadily increased from 7.2 deaths per 100,000 live births in 1987 to a high of 17.8 deaths per 100,000 live births in 2009 and 2011.[1]

More recent data is even more alarming. A 2015 World Health Organization (WHO) report pointed out that the U.S. has a high maternal mortality rate and that half of the U.S. deaths were preventable.[2] In addition, a 2016 report in the *Journal of Obstetrics & Gynecology* found that from 2000 to 2014, the maternal mortality rate for 48 states and Washington, D.C. increased nearly 27 percent from close to 18.8 deaths per 100,000 live births in 2000 to 23.8 deaths per 100,000 live births in 2014.[3] Recent media reports have generated additional public awareness of the apparent increase in maternal mortality.

The reasons for the overall increase in pregnancy-related deaths are not fully understood. Better data collection, changes in the way causes of death are coded, and the addition of a pregnancy "checkbox" to the death certificate in many states have likely improved identification of pregnancy-related deaths over time. However, more analysis and data collections need to be done, as there are a multitude of factors at the patient, practitioner, and health system levels that can contribute to poor health outcomes in expectant or new mothers. Overall, better data surrounding maternal mortality should allow for a better understanding of its causes. This understanding can help educate health care providers and institutions so they can better optimize quality of care in order to prevent maternal deaths wherever possible.

IV. LEGISLATION

During this hearing, the Subcommittee will review a discussion draft of the following legislation:

- **H. R. ___, Preventing Maternal Deaths Act of 2018**, authored by Reps. Jaime Herrera Beutler (R-WA) and Diana DeGette (D-CO), enhances Federal efforts to support state maternal mortality review committees in order to improve data collection and reporting around maternal mortality, and to develop or support surveillance systems at the local, State, and national level in order to better understand the burden of maternal complications. These surveillance efforts include identifying groups of women with disproportionately high rates of maternal mortality and identifying the determinants of disparities in maternal care, health risks, and health outcomes.

[1] https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm
[2] http://apps.who.int/iris/bitstream/handle/10665/193994/WHO_RHR_15.23_eng.pdf;jsessionid=F916E3A0D2136E4CBDF800D8E585605D?sequence=1
[3] http://d279m997dpfwgl.cloudfront.net/wp/2016/08/MacDormanM.USMatMort.OBGYN_.2016.online.pdf

V. STAFF CONTACTS

If you have any questions regarding this hearing, please contact Kristen Shatynski or Josh Trent of the Committee staff at (202) 225-2927.