ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS

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May 30, 2019

The Honorable Richard Neal
Chair, Ways and Means Committee
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

The Honorable Kevin Brady
Ranking Member, Ways and Means Committee
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Neal and Ranking Member Brady:

The Association of State and Territorial Health Officials (ASTHO) is pleased to submit written comments for the House Committee on Ways and Means record for the May 16 hearing entitled, "Overcoming Racial Disparities and Social Determinants in the Maternal Mortality Crisis." ASTHO and its members are committed to protecting the health of mothers by urging action to address pregnancy-related complications and racial and ethnic disparities in maternal mortality through multidisciplinary efforts focusing on closing gaps in access to quality preconception and prenatal care, enhancing care for chronic conditions, identifying missed diagnoses, and expanding maternal education.

Rates of severe maternal morbidity (SMM), an unexpected outcome of labor and delivery that leads to short- or long-term health consequences, have been steadily increasing in the United States. SMM has increased by about 75% over the past decade and, in 2014, more than 50,000 women experienced complications that were near fatal. In addition, every year approximately 700 women die from pregnancy-related complications. Significant racial and ethnic disparities exist within this maternal mortality statistic: black women die at a rate that is 3.3 times greater than white women, and Native American or Alaskan Native women die at a rate 2.5 times greater than white women. Unfortunately, this statistic has remained unchanged over the last six decades. Most pregnancy-related deaths (about 3 in 5) are preventable, demonstrating the need to identify and implement strategies to address the multiple factors contributing to America's high maternal mortality rate.

ASTHO's 2019 President's Challenge is aligned with the National Association of County and City Health Officials (NACCHO) and the U.S. Surgeon General's focus on community health and economic prosperity. It calls on state, territorial, local, and tribal health officials to build healthier, more resilient communities by supporting investments in community-led, place-based approaches to improve the health of communities at highest risk of adverse health outcomes, including poor maternal and child health outcomes, due to poverty or other social, economic, and environmental determinants of health.

Governmental public health has an important role to play in working with communities and enhancing partnerships. Preventing maternal mortality and morbidity can only be accomplished if the social, economic, and healthcare issues that impact women's health are addressed at multiple levels using the strategies and approaches described below.

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Improving Access to Care

Supporting preconception health and reproductive life planning is an effective strategy to reduce maternal morbidity and mortality. Providing access to family planning services that include the full range of contraceptive options, along with counseling and preconception and interconception care, helps women prevent both unplanned and closely spaced pregnancies—both of which are associated with negative maternal outcomes. States have adopted measures to expand access to contraception and other reproductive health services. In 2015, the Oregon House passed OR HB 2879 authorizing pharmacists to prescribe self-administered birth control and provide same-day dispensing to women age 18 and older, and to women under 18 if they previously had a birth control prescription. Similarly, in 2015, Arkansas enacted AR HB 1524 requiring colleges and universities to create pregnancy prevention action plans.

State and territorial health officials are assessing maternal care programs and policies within their states to address the persistent racial disparities in maternal mortality. This includes implementing consistent maternity care and addressing implicit bias in the healthcare system. Recently, the Texas House passed TX HB744 (19R), a maternal mortality bill which would extend Medicaid coverage for women from 60 days to 12 months postpartum. Other states, including New Jersey and Illinois, are considering similar legislation that would extend Medicaid coverage to 12 months postpartum. Numerous health groups, including the American College of Obstetricians and Gynecologists (ACOG) and the Texas Maternal Mortality and Morbidity Task Force, recommend extending Medicaid benefits postpartum as a way to lower the state's high maternal mortality rate.

Expanding access to doula care is another emerging approach to improve perinatal and postnatal care to support healthy and safe pregnancies. Doulas are trained professionals that provide continuous physical, emotional, and informational support during and shortly after childbirth. Through this continuous support system, doulas positively impact both mothers and babies. For women at risk for adverse birth outcomes because of racial disparities, doula care can provide positive benefits and improve factors that mediate mortality, including decreasing cesarean births, operative vaginal births, use of analgesics, and duration of labor. Currently, two states, Minnesota and Oregon, allow reimbursement for doula services through the Medicaid program. Additionally, legislators have introduced bills to add doula services as a covered benefit for Medicaid; Massachusetts introduced H 1182, which would cover doula services in MassHealth, the state's Medicaid program.

Identifying Disparities in Maternal Mortality and Morbidity

To address maternal mortality, states can establish Maternal Mortality Review Committees (MMRCs) to implement surveillance efforts and recommend system and practice changes. MMRCs focus on promoting health and wellness during pregnancy, childbirth, and the postpartum period by collecting data to identify trends to improve health equity for mothers. The support of state legislation and the cooperation of healthcare systems and professionals makes retrieving protected health information possible to perform these reviews. Approximately 38 states have active maternal mortality review boards as recognized by the CDC to review the incidence and causes of pregnancy-related deaths.

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Authorization is in place in 33 states and the District of Columbia that codifies these committees in statute.
From 2001-2005, the North Carolina Maternal Mortality Review Committee (NC MMRC) conducted a five-year study of preventability to determine how many of the state's pregnancy-related deaths were preventable. NC MMRC developed a definition of preventability, and the pregnancy-related deaths determined by the committee to be preventable were further categorized by four domains that encompass several underlying factors and actions that could have potentially averted the death, including preconception care and counseling, patient actions, systemic factors, and quality of care. The efforts undertaken by NC MMRC have been associated with a reduction in disparities in pregnancy-related deaths over a 10-year period. Specifically, there was a substantial narrowing of the gap between the rate of pregnancy-related deaths among white and black women from 2002 to 2012. In 2002, the relative risk of pregnancy-related deaths for black women was 5.5 times higher than for white women. However, in 2012, the relative risk decreased to 1.8.

In 2013, Texas legislature convened a multidisciplinary Maternal Mortality and Morbidity Task Force to review cases of pregnancy-related deaths and severe maternal morbidity, identify trends and disparities, examine best practices, and make recommendations to reduce the incidence of pregnancy-related deaths and severe maternal morbidity. In 1997, the Massachusetts Maternal Mortality and Morbidity Review Committee was appointed by the commissioner of the Massachusetts Department of Public Health to review the deaths of all women who die while pregnant or within one year of pregnancy irrespective of cause, study the incidence of pregnancy complications, and make recommendations to improve maternal outcomes and prevent mortality. Massachusetts also recently introduced two bills to address maternal mortality: H 1971 to authorize the state's public health department to conduct infant mortality reviews and H 1949 to create a commission to reduce racial disparities in maternal health.

Implementing Patient Safety Change
The Alliance for Innovation on Maternal Health (AIM) helps translate findings and recommendations from MMRCs into action. AIM is a national data-driven maternal safety and quality improvement initiative that works to align national, state, and hospital level quality improvement efforts. AIM brings together state teams and health systems and supports them in implementing a set of open access patient safety bundles and tools. These safety bundles are best practices for maternity care that are designed to provide a standardized approach to addressing both clinical and non-clinical issues that can lead to pregnancy complications, such as managing severe hypertension during pregnancy, obstetric hemorrhage, and reducing peripartum racial and ethnic disparities. Over 27 states and 1,300 hospitals are implementing safety bundles to create a standardized approach to addressing both clinical and non-clinical issues that can lead to pregnancy complications, such as managing severe hypertension during pregnancy, obstetric hemorrhage, and reducing peripartum racial and ethnic disparities. Recently, AIM and the Council on Patient Safety in Women's Health Care released a new patient safety bundle on Obstetric Care for Women with Opioid Use Disorder. The Health Resources and Services Administration (HRSA), which funds and supports AIM, points to the promising results AIM has produced in states.

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In California, 99 hospitals participating in AIM demonstrated a 20% reduction in severe maternal hemorrhage over 12 months starting March 2015. This compares to a 1.2% reduction among non-participating hospitals in the same period. More recently, 66 California hospitals with high first-time cesarean rates participated in AIM and saw a 13.4% reduction in first-time cesareans.
In 2014, Oklahoma was the first state to join the AIM initiative to pilot the program. Currently, the Oklahoma Perinatal Quality Improvement Collaborative is leading the effort to reduce maternal mortality in the state and has seen a 20.5% decrease in severe maternal morbidity in 42 participating hospitals since April 2015. This represents a decrease of 19.3% in hemorrhages among women and a decrease of 12.4% among women with severe hypertension.

The Texas Department of State Health Services is leading the statewide Texas AIM initiative to help hospitals and clinics in Texas carry out consistent maternal care safety practices. TexasAIM is focused on implementing three maternal safety bundles addressing: (1) obstetric hemorrhage, (2) obstetric care for women with opioid use disorder, and (3) severe hypertension in pregnancy. As of December 2018, 206 (92%) of Texas' birthing hospitals are participating in TexasAIM.

Further, the Perinatal-Neonatal Quality Improvement Network of Massachusetts (PNQIN) teamed up with AIM to support implementation of maternal safety bundles in birthing facilities, clinics, and hospitals across the state. Reducing peripartum racial and ethnic disparities is among the maternal safety bundles PNQIN is focusing on as part of AIM.

Recommendations to Improve Maternal Mortality and Morbidity
ASTHO affirms that reducing preventable maternal morbidity and mortality is critical to promoting health across the lifespan and improving health outcomes for both mothers and infants. As noted above, addressing racial disparities in maternal mortality requires a multisector approach. Integrating targeted public health interventions with healthcare delivery to achieve accessible, affordable, culturally appropriate, and high-quality health services for women is the foundation of an effective and safe system of maternal care. These interventions must also connect with efforts to identify upstream root causes of morbidity, including social determinants of health, to effectively develop and implement prioritized strategies for primary, secondary, and tertiary prevention.

ASTHO strongly urges the House Committee on Ways and Means to support legislation that allows for states to take the following necessary steps to reduce and eventually eliminate maternal mortality and morbidity:

- Incorporate a Health in All Policies lens into upstream and mid-stream strategies within the design of maternal and neonatal health interventions. Invest in and sustain partnerships with community-based organizations, governments, and businesses to address social determinants of health including race, socioeconomic status, access to care, and other factors that influence maternal mortality and morbidity.
- Ensure access to the full range of contraceptive methods for women of reproductive age and promote preconception health, intrapartum care, healthcare, and reproductive life planning within existing family planning, educational, and public health settings. Providing access to

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family planning services that include the full range of contraceptive options, along with counseling a preconception and interconception care, helps women prevent both unplanned and closely spaced pregnancies—both of which are associated with negative maternal outcomes.

- Provide technical assistance and support to establish MMRCs in all 50 states to understand the causes and contributing factors to maternal mortality and morbidity and to identify opportunities for prevention.
- Develop flexible policies and funding mechanisms that allow states to use federal funding to support state perinatal quality collaboratives, maternal mortality review committees, and other maternal mortality and morbidity prevention efforts to identify, review, and make recommendations related to policymaking, clinical best practices, and public health interventions. Ensure coordination through cross-sector and governmental surveillance and prevention efforts to effectively understand the causes of maternal deaths, prioritize actions, and implement consistent maternity care practices.
- Develop policies to ensure an adequate obstetric and midwifery workforce and woman-centered midwifery care.
- Ensure that the Title V Maternal and Child Health Block Grant performance measures related to maternal health are aligned with effective maternal mortality and morbidity prevention practices.
- Coordinate with and leverage key public health programs and available funding sources including, but not limited to, the Title V Maternal and Child Health Services Block Grant, Title X, Maternal, Infant, and Early Childhood Home Visiting (MIECHV), National Breast and Cervical Cancer Early Detection Program, Medicaid, public and private insurance provisions, and other public health programs, such as the Children's Health Insurance Program (CHIP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to support efforts in preventing maternal mortality and severe maternal morbidity.
- Promote public education campaigns related to maternal and newborn outcomes in different birth settings, including hospitals, birthing centers, and at home.
- Encourage the effective integration of perinatal quality collaboratives and maternal mortality review initiatives with state public health department initiatives to identify the primary drivers of state and local patterns of maternal morbidity and mortality so prevention efforts can be prioritized. The following actions can help promote this integration:
    - Encourage states to increase linked vital records files that are readily available for supporting maternal morbidity and mortality information.
    - Identify best practices in abstraction, review, and recommendation processes that could serve as a model for state perinatal quality collaboratives and maternal mortality review teams.
    - Gather, track, and provide resources to support states in complete ascertainment of pregnancy-related deaths.
    - Support the documentation, dissemination, and implementation of effective action plans developed by integrated perinatal quality collaboratives and maternal mortality review initiatives to address preventable maternal mortality and morbidity.

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ASTHO commends your efforts to reinvigorate discussions on how to act on the social determinants of health and eliminate the health inequities seen across our nation.

We look forward to working with you, both specifically on this topic and on addressing the maternal mortality crisis generally. Please contact Carolyn McCoy, ASTHO's senior director for government affairs, (cmccoy@astho.org) for additional information.

Sincerely,

Michael Fraser, PhD, MS, CAE, FCPP
Chief Executive Officer
ASTHO