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HOUSE DEMOCRATIC POLICY COMMITTEE

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House of Representatives
COMMONWEALTH OF PENNSYLVANIA
HARRISBURG

HOUSE DEMOCRATIC POLICY COMMITTEE HEARING
Topic: Ensuring Healthy Births, Healthy Moms, and Healthy Babies
William Jeanes Library and Karabots Center for Learning
Lafayette Hill, PA
May 29, 2018

AGENDA

- 2:00 p.m. Welcome and Opening Remarks
- 2:10 p.m. Panelists:
- Dr. David Kelly
Medical Director in the Office of Medical Assistance Programs
Pennsylvania Department of Human Services
 - Dr. Loren Robinson
Deputy Secretary of Health Promotion and Disease Prevention
Pennsylvania Department of Health
 - Dr. Sindhu Srinivas
Director of Obstetrical Services
Associate Professor of Obstetrics and Gynecology
Hospital of the University of Pennsylvania
- 3:30 p.m. Closing Remarks



**Testimony for Public Hearing on Ensuring Healthy Births, Moms, and Babies
Tuesday, May 29, 2018**

Good afternoon, I am Dr. Loren Robinson. I am formally trained as a physician, in both internal medicine and pediatrics, and I am also the Deputy Secretary for Health Promotion and Disease Prevention within the Pennsylvania Department of Health. I would like to thank Representative Mary Jo Daley for inviting me here today to speak about the importance of women's healthcare for the moms and babies in our Commonwealth.

Imagine a walk on the beach. Protective factors like education, high income, and social support, enable you to walk on solid, dry sand. Risk factors, like a traumatic event, unsafe neighborhood, social isolation, and single parenting force you to walk on wetter sand. Single acts of discrimination are waves hitting you, soaking the sand, and requiring more effort to move forward. Systematic racism and discrimination become the waves breaking over you, where even more effort is required to move forward and there is no way to fully leave the water. Two women may walk the same distance but the effort needed by a woman of color can be much greater because of the effects of walking in the wet sand and waves creating so much more wear on the body over time and across generations. These are conditions that even a high income and education do not fix. Even at high income and education levels, Black women still have worse maternal outcomes than white women of the same income and education levels.

There are many maternal risk factors (or health factors) that can lead to complications for both mother and infant during pregnancy such as obesity, smoking, use of alcohol or drugs, and depression. Disparities in birth outcomes and complications can also be the result of the trauma of early life experiences and cumulative stress over the life course. For black women, social and built environments that reinforce discrimination and racism result in an increase in allostatic load (or stress) that leads to declines in health over time at a different rate than those not subjected to discrimination and systematic racism. This process is known as weathering.

The path to optimum health for all Pennsylvanians leads to and through women. Maternal and infant health outcomes are critical measures by which the health of states and nations are measured and compared. With their reproductive years spanning, on average, ages 15-44 years old, the ability to birth children puts women in a unique position whereby the combination of risk and protective factors influencing their health have long term health consequences across their lifespan, and across the lifespans of their children and families. The conditions for a healthy pregnancy and improved birth outcomes begin long before a woman becomes pregnant. While improving health

begins with access to care, there are a range of biological, social, environmental, and physical factors that have been linked to maternal health outcomes.

The Department has aligned programming to federal outcome measures to address increasing access to quality preconception, prenatal, postpartum and inter-conception care. These are critical to reducing pregnancy-related complications, and ultimately reducing maternal and infant morbidity and mortality for all women. It is not enough, however, to overcome the grave disparities in outcomes experienced by women of color. The complex interplay of individual, relationship, community and societal factors necessitates addressing issues across the range of factors to optimize the health of black women and the health of their children as “the choices a person makes are shaped by the choices a person has, which are themselves shaped by structural policies and processes.”

At the Department of Health, we take very seriously the charge to improve overall maternal health outcomes in Pennsylvania and reducing the significant disparities in maternal health outcomes for those most at-risk: women of color.

While the general trend for the state and all races is increasing, in 2016, only 63 percent of black women had a birth with prenatal care beginning in the first trimester as compared to 77.5 percent of white women and 73.8 percent for the state. The Healthy People 2020 target is 77.9 percent for all women. Black women in Pennsylvania are also less likely to have received early and adequate prenatal care, only 65.1 percent as compared to 78.5 percent of white women and 75.2 percent for the state in 2016. The Healthy people 2020 target is 77.6 percent for all women. In 2014, the most recent year of data available, black women in our state had a higher rate (43.0 per 100 deliveries) of maternal complications during hospitalized labor and delivery as compared to white women (31.0 per 100 deliveries). The Healthy People 2020 target is 28.0 per 100 deliveries.

Prenatal care is a widely recognized practice that improves maternal and infant health outcomes. As a mode of prenatal care, the department currently provides the Centering Pregnancy Program, a group prenatal care program, in two locations with high proportions of low birth weight babies, as well as racial disparities. The provision of prenatal care through this model has been shown to reduce the number of low birth weight babies, reduce the number of preterm births and increase the number of prenatal visits and breastfeeding rates in those that participate. We are currently continuing to expand the Centering Pregnancy Program, while also exploring the potential barriers minority and low income women face in obtaining care, including addressing attitudes and biases of health care and other service providers.

While prenatal care is important, it may not be enough or may be received too late to positively impact a pregnancy outcomes. Preconception and inter-conception health and health care can provide opportunities to promote the health of women before they become pregnant, as many factors influence pregnancy-related health outcomes. This

is especially important as half of all U.S. pregnancies are unplanned. Preconception care is particularly important to reducing disparities in maternal and infant health.

The department promotes preconception and inter-conception health through several approaches:

The county and municipal health departments implement the One Key Question® initiative, developed by the Oregon Foundation for Reproductive Health across their maternal and child health programming. One Key Question® is a pregnancy intention screening tool used to decrease unintended pregnancies and improve the health of wanted pregnancies by allowing providers to proactively address some of the root causes of poor birth outcomes and educate and develop a reproductive health plan with women to achieve optimal health before a potential pregnancy.

The Institute of Health and Recovery's Integrated Screening Tool (5P's) is now used by Pennsylvania county and municipal health departments to screen all women receiving services for behavioral health issues. The 5P's screening tool is a non-threatening and quick conversational tool that assesses risk for alcohol, substance abuse, violence, and depression based on 5 Ps: Parents, Peers, Partner, Pregnancy, and Past. Service providers make referrals or recommendations based on responses. The department is requiring the funded Maternal Child Health and Prenatal Program providers incorporate smoking screening and cessation referrals, particularly to the PA Free Quitline, into their programs.

The department implements the IMPLICIT Inter-conception Care program which uses a family's scheduled well-child visits to check on the health of mothers. Each visit screens mothers for four behavioral risk factors: smoking status, depression, birth control and folic acid. Women are counseled and referred for services as necessary.

With the inclusion of long-acting reversible contraception (LARC) as part of state Medicaid fee schedules, the department has conducted an initial provider needs assessment to understand current provider training needs regarding LARC. We will use this data to develop resource tools and provide technical assistance to increase LARC routinization and uptake in clinics across the state.

Since 2007, the department has administered the Centers for Disease Control and Prevention's Pregnancy Risk Assessment and Monitoring System (PRAMS) in Pennsylvania. The PRAMS program is a random representative sample survey of new mothers designed to identify factors and risk behaviors associated with poor birth outcomes as well as the populations most likely to be affected by these behaviors. PRAMS data is used to target programming accordingly. Over the next several years the department will be integrating more questions onto the survey to capture maternal adverse childhood experiences, the influences of the social determinants of health, and experiences of discrimination and racism in service provision.

Future inter-conception care programming will begin to integrate ways to address chronic stress and weathering and increase social supports in addition to promoting healthy behaviors at the individual and community levels.

While national gains have been made in reducing maternal morbidity and mortality rates, the U.S. rates are still higher than most other industrialized nations, despite major advances in medical care. Additionally, racial disparities persist with the risk of pregnancy-related deaths for black women at rates two to three times higher than that of white women in Pennsylvania. While state maternal mortality rates have been decreasing slightly over time from a four-year average maternal mortality rate (maternal deaths per 100,000 live births) of 13.5 for 2006-2010 to 11.4 for 2012-2016, the average maternal mortality rate for black women over the same time period decreased from 29.2 (for 2006-2010) to 27.2 (for 2012-2016); when comparing whites to blacks, the mortality rate for black women is over three times the rate for white women for the same time period. The Healthy People 2020 target is 11.4 maternal deaths per 100,000 live births.

On May 9, Governor Wolf took a major step in putting Pennsylvania on a course to reducing maternal mortality. By signing House Bill 1869 into law, Governor Wolf sent a message to all Pennsylvanians that the lives of Pennsylvania mother matter. Act 24 of 2018 will create the Pennsylvania Maternal Mortality Review Committee under the auspices of the Department of Health. Other states that have adopted maternal mortality review committees have shown progress in reversing the trend of maternal mortality. They have concentrated their efforts on preventable maternal deaths including developing evidence-based toolkits, implementing quality improvement initiatives, and connecting women to resources; especially those with mental health issues and experiencing intimate partner violence. Pennsylvania, now equipped with legislation establishing maternal mortality review committee, aims to follow and reverse the terrible trend in the commonwealth.

As the department is tasked with the formation of the committee, our Bureau of Family Health, who administers all of the programs I previously described, will play a key role in the dissemination of key committee findings and the development of funding of prevention activities through the Title V Maternal and Child Health Services Block Grant. Work will be focused on improving data collection around maternal morbidity and mortality.

On behalf of the moms in our state and our nation who did not live to see this moment, I would like to thank you all for listening today. In the name of public health, this is a proud time to be a Pennsylvanian. I would like to thank you for your time today and I look forward to working together to improve the health of moms and babies in Pennsylvania. I welcome any questions you may have at this time.

Written Testimony

Public hearing on ensuring healthy births, moms and babies

May 29, 2018

Submitted by:

Sindhu Srinivas, MD, MSCE

Associate Professor

Director of Obstetrical Services

Vice Chair for Quality And Safety

University of Pennsylvania, Department of OBGYN

Vice Chair Health Policy and Advocacy Committee, Society for Maternal Fetal Medicine

Good afternoon. Thank you for inviting me to participate in this very important and timely briefing. My name is Dr. Sindhu Srinivas. I am a maternal-fetal medicine physician at the Hospital of the University of Pennsylvania. There, I am a practicing obstetrician and maternal fetal medicine specialist, the Director of Obstetrical Services and Vice Chair for Quality and Safety. Today I am here in that capacity, and as Vice Chair for the Health Policy and Advocacy Committee of the Society for Maternal-Fetal Medicine (SMFM) and importantly as a high risk Obstetrician.

Maternal Fetal medicine specialists treat high-risk pregnant women – women who have underlying medical conditions and are pregnant, or when an issue is identified with the fetus. MFMs are obstetricians who have an additional three years of training. We are on the front lines of the most complicated pregnancy cases, and we are concerned with this country's rising maternal morbidity and mortality rates.

Despite my years of formal training and 13 years of providing direct care for women both with complicated and uncomplicated pregnancies, the truth is, there is still much we do not know about why so many women are dying in childbirth. What we do know is that maternal mortality is just the tip of the iceberg and as many as half are potentially preventable. For each maternal death, there are numerous other women who suffer complications, what we refer to as severe maternal morbidities. We are working to understand more and do more to prevent these tragic outcomes.

What we also know is that we can do better. Despite advances in obstetrical care, the United States still trails the developed world in its maternal mortality rate. While the rate of maternal mortality has fallen in most developed nations, it is rising here. In a 2015 study, the United States had the highest maternal mortality rate at 26.4 deaths for every 100,000 live births, followed by the United Kingdom at 9.2 deaths for every 100,000 live births. That translates into 2 to 3 women dying each day in the United States at a time that should be one of the happiest in their lives and the lives of their families.

We know that when obstetrical care is standardized – in other words, when all women receive certain interventions when they are in severe circumstances – outcomes can improve. The state of California has demonstrated remarkable improvements in pregnancy outcomes by reviewing the death records of pregnancy and postpartum women and standardizing care based on what they learned. The United Kingdom has long had what is known as the Confidential Inquiry into Maternal Deaths. As a result of that program, standardized interventions were developed and implemented that have had a dramatic impact on reducing maternal deaths from conditions like venous thromboembolism.

Philadelphia has a maternal mortality review that I have had the privilege of participating in for the last several years. A recent report published from that review reported 55 deaths over a 3 year period, 31 of which were considered to be due to natural causes. Based on the review of these tragic deaths and deliberations of our very thoughtful multidisciplinary group, we had several recommendations. One of those recommendations was to establish a state based Maternal Mortality review committee. I am thrilled to see our state moving forward in establishing this much needed review.

But the review while a big step, is only the first step. Once you have established a review committee, developing a systematic process for the review and strategies for improvement is critical.

To assist with this, in September 2016, the Society for Maternal Fetal Medicine and the American College of Obstetricians and Gynecologists published an Obstetric Care Consensus outlining a process for identifying maternal cases that should be reviewed. We need better, more standardized data surrounding maternal mortality so that we can accurately attribute its causes and prevent it wherever possible. There are some new tools available to share knowledge – for example the Association of Maternal and Child Health Programs has a fantastic web portal on performing maternal mortality reviews so that states that have maternal mortality review committees can share information about best practices with states that are interested in setting up review committees. The National Network of Perinatal Quality Collaboratives sponsored by the Centers for Disease Control and Prevention and the March of Dimes was recently launched to provide support to state Perinatal Quality Collaboratives so that they can improve maternal and infant health outcomes. But to accomplish this they need more information about the problem that they are attacking.

But data is only the first step. Once you have data it will be important to translate that data into actionable recommendations that can be implemented on a state level. This last piece is critical if we truly want to move the needle on reducing maternal morbidity and mortality in Pennsylvania and ensuring healthy births, moms and babies.

From our Maternal mortality review work in Philadelphia, some of the most striking gaps seem to be related to systems of information sharing, access to long acting reversible contraception – which recently has improved in our state, and access and collaboration between medical prenatal providers and mental health providers, among others.

Additionally, a focus on care coordination and the importance of considering social determinants of health in all of our solutions can't be stated enough. I have been lucky to be a part of a collaborative program between the University of Pennsylvania, Maternity Care coalition, Keystone First and Community Behavioral Health whose mission is to improve health outcomes for pregnant women with chronic health conditions, ensuring women receive the care they need before, during and after childbirth. In this program, at risk moms are partnered with advocates who also function as birth doulas. We have enrolled over 200 women in this program and are seeing significant increases in their engagement in prenatal care and breast feeding rates, among other outcomes. Programs like this one exemplify care coordination between providers, payers, mental health providers and a community organization. Policies that help with supporting these types programs will be an important potential future direction to ensure healthy births, moms and babies.

Finally, I need to mention the importance of innovation in developing patient centered approaches to care as critical in our quest to ensure healthy births moms and babies. As an example, we have recently developed, tested and deployed a program called Heart Safe Motherhood at the Hospital of the University of Pennsylvania. The Heart Safe Motherhood

experience takes a scary diagnosis of hypertension in pregnancy—a leading cause of maternal morbidity and mortality—for a new mom and turns it into a process of engagement and empowerment in self-management and self-monitoring. We provide women with a blood pressure cuff, enroll them into a bidirectional text based platform that allows us to monitor women safely at home by providing information that we can act on when needed. It also leads to tremendous satisfaction from patients and improved health care engagement. Through this program we have been able to initiate blood pressure medications on mom at home and prevent significant morbidity that previously led them to being readmitted to the hospital.

The mission to ensure healthy births moms and babies is one that I know all of us share and are passionate about.

No woman goes into pregnancy fearing a significant complication or death. Having a child should be a joyous time – but far too often complications arise and these impact not just the woman—but also her baby and her entire family. We can do more, and we must do more. With a state based review process, better data, actionable recommendations and a focus on policies that are informed by findings from state based review process and evidence, we can and will make a big difference. Thank you again for providing me the opportunity to speak and for shining a light on this important issue.