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HOUSE DEMOCRATIC POLICY COMMITTEE

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House of Representatives
COMMONWEALTH OF PENNSYLVANIA

HOUSE DEMOCRATIC POLICY COMMITTEE HEARING

Topic: Meaningful Solutions to Maternal Mortality –

Doula Care and Coverage

Saint Joseph's University – Philadelphia, PA

April 3, 2019

AGENDA

- 1:00 p.m. Welcome and Opening Remarks
- 1:10 p.m. Panel One – Defining Maternal Mortality:
- Dr. Loren Robinson, MD, MSHP, FAAP
Deputy Secretary for Health Promotion and Disease Prevention, Pennsylvania Department of Health
 - Marianne Fray
CEO, Maternity Care Coalition
 - Dr. David M. Jaspan, DO, OB-GYN
Chair of Obstetrics and Gynecology, Einstein Medical Center
- 1:40 p.m. Panel Two – Rates and Causes in Philadelphia and Across Pennsylvania:
- Dr. Jason Baxter, MD, MSCP, FACOG
Member, Pennsylvania Maternal Mortality Review Committee
 - Dr. Aasta Mehta, MD, MPP
Policy Consultant for Maternal Child and Family Health, Philadelphia Department of Health
 - Saleemah J. McNeil, M.S., MFT
Founder of Oshun Family Center
- 2:10 p.m. Panel Three – Best Practices and Solutions:
- Lexi White
Senior Policy Manager, New Voices for Reproductive Justice
 - Naima Black
Doula, Maternity Care Coalition Community Doula Program
 - Autumn Nelson, MSN, CNM
Member, Pennsylvania Association of Certified-Nurse Midwives
- 2:50 p.m. Closing Remarks



**Testimony for Public Hearing on Ensuring Healthy Births, Moms, and Babies
Wednesday, April 3, 2019**

Good morning, I am Dr. Loren Robinson. I am the Deputy Secretary for Health Promotion and Disease Prevention within the Pennsylvania Department of Health, and I am a physician trained in both Internal Medicine and Pediatrics. I would like to thank Representative Morgan Cephas for inviting me here today to speak about the importance of women's health, healthcare, and wellness for the moms and babies in our commonwealth.

There are many maternal risk factors that can lead to complications for both mother and infant during pregnancy. If mom is obese, smokes, uses of alcohol or drugs, has poor nutrition and suffers from depression, there are higher risks of complications. But mom's early life experiences and cumulative stress over the life course of her life play just as important of a role, if not more important. For black women, the social and built environments that reinforce discrimination and racism result in an increase in allostatic load, or the wear and tear on the body because of constant stress. This leads to declines in health over time at a different rate than those not subjected to discrimination and systematic racism. This 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 that 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, which are critical to reducing pregnancy-related complications and maternal and infant morbidity and mortality for all women. However, it is not enough to overcome the grave disparities in outcomes borne by black women. 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."¹

¹Metzler, M, Merrick, MT, Ford, DC et al. "Adverse childhood experiences and life opportunities: Shifting the narrative." Children and Youth Services Review. [Volume 72](#), January 2017, Pages 141-149.

At the department, we take the charge to improve overall maternal health outcomes in Pennsylvania very seriously and reducing the significant disparities in maternal health outcomes for those most at-risk, black women, is a priority.

While the general trend for all races in the state is increasing, in 2016, only 63 percent of black women had a birth with prenatal care beginning in the first trimester as compared to 78 percent of white women and 74 percent for the state. The Healthy People 2020 target is 78 percent for all women. Black women in Pennsylvania are also less likely to have received early and adequate prenatal care, only 65 percent as compared to 79 percent of white women and 75 percent for the state in 2016. The Healthy people 2020 target is 78 percent for all women.

In 2014, the most recent year of data available, black women in the state had a higher rate (43 per 100 deliveries in 2014) of maternal complications during hospitalized labor and delivery as compared to white women (31 per 100 deliveries). The Healthy People 2020 target is 28 per 100 deliveries.

Prenatal care is a widely recognized practice acclaimed to improve maternal and infant health outcomes. As a mode of prenatal care, the department currently provides the Centering Pregnancy Program, which is group prenatal care, in two locations with high proportions of low birth weight babies and racial disparities, Lancaster General and Albert Einstein Healthcare Network in North Philadelphia. 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. The curriculum discusses birth control and birth spacing throughout the pregnancy and postpartum periods. We are currently continuing to expand the Centering Pregnancy Program while also exploring the potential barriers black women face in obtaining care. Barriers in this case include addressing attitudes and biases of health care and among other service providers.

Although pre-natal care is important, it may not be enough or received too late to positively impact 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 between white and non-Hispanic black women.

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 the 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 use, 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 that the funded Maternal Child Health and Prenatal Program providers to 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 14 for 2006-2010 to 11 for 2012-2016, the average maternal mortality rate for black women over the same time period decreased from 29 (for 2006-2010) to 27 (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, at 27 compared to 9. The Healthy People 2020 target is 11 maternal deaths per 100,000 live births.

Other states that have adopted the maternal mortality review committees (MMRCs) 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. I am proud to say that in May 2018, Governor Wolf signed Act 24 into law, creating the Pennsylvania Maternal Mortality Review Committee. Pennsylvania is now equipped with a team of 30 members who are tasked with reviewing Pennsylvania's maternal deaths to better understand what is killing Pennsylvania's mothers at such a vulnerable and critical time. The recommendations produced by the Pennsylvania MMRC will be reviewed and implemented on several levels.

How will we implement the recommendations of Pennsylvania's Maternal Mortality Review Committee? Recently, a state Perinatal Quality Collaborative (PQC), which includes partners from across the state has been convened. Perinatal Quality Collaboratives (PQCs) are networks of teams working to improve the quality of care for mothers and babies across prenatal, labor/birth, newborn, and postpartum services. These teams are typically comprised of physicians, nurses, midwives, social workers, pharmacists, quality and safety leaders, administrators, and other licensed and unlicensed professionals. They identify processes that need to be improved and quickly adopt best practices to achieve collective aims. The Department of Health sees the PQC as the action arm of the MMRC. Their focus will be on reducing maternal mortality, improving care for pregnant and postpartum women with opioid use disorder and improving care for substance-exposed newborns. The Department of Health sees the PQC as the action arm of the MMRC. Their focus will be on reducing maternal mortality, improving care for pregnant and postpartum women with opioid use disorder and improving care for substance-exposed newborns. Additionally, local partners are conducting large scale implicit bias trainings to address bias, privilege, and systemic racism in organizations that provide maternal and child health services across the Commonwealth. The Philadelphia MMRC is already working to address maternal mortality in Pennsylvania's most populous county. Examples of ways to reduce maternal mortality including addressing the social determinants of health: ensuring access to health services, access to transportation, enabling supports so that pregnant women can receive pre-natal and post-natal care that is culturally respectful, expanding services covered by insurance and medical assistance, including mid-wife and doula care services in the pre-natal, delivery and post-natal periods to name just a few. Together with our local partners, we will reverse these terrible trends in the commonwealth.

Within the Department of Health, we are also closely following national developments in maternal mortality. There is currently a federal grant available from the Centers For Disease Control (CDC) to fund maternal mortality work, for which we will be applying, and I hope we can count on your support of our application.

I would like to thank you for your time 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.



Testimony of Marianne A. Fray, MBA, IOM, CAE
Chief Executive Officer, Maternity Care Coalition (MCC)
Before the Commonwealth of Pennsylvania House Democratic Policy
Committee Hearing on:
"Meaningful Solutions to Maternal Mortality – Doula Care and Coverage"
Saint Joseph's University – Philadelphia, PA
April 3, 2019

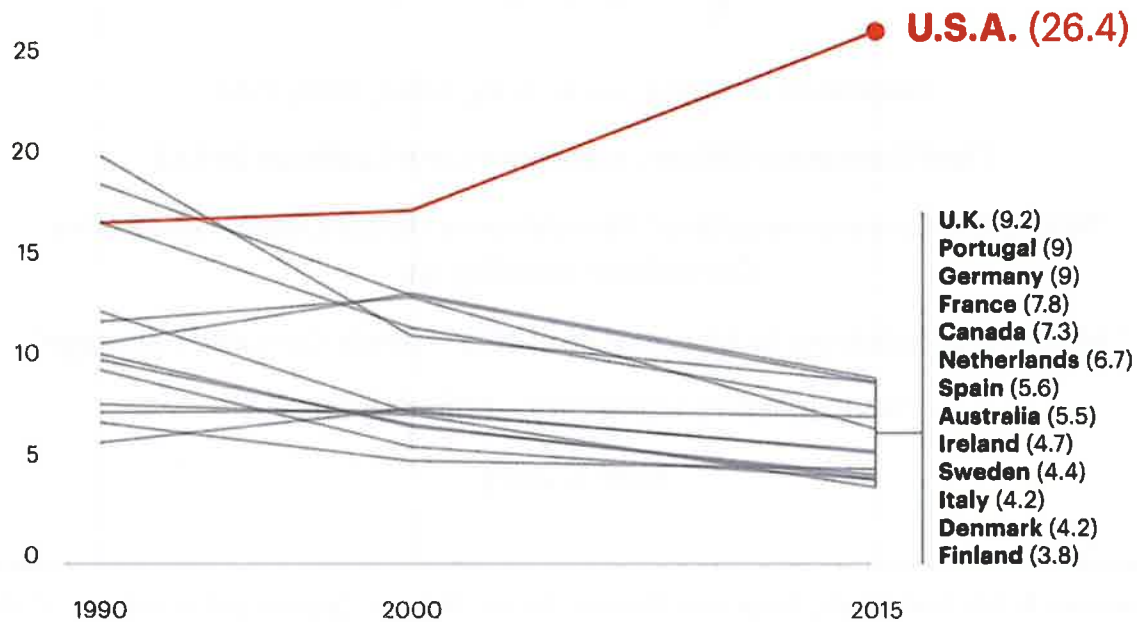
Chairman P. Michael Sturla, Host and Representative Morgan Cephas and members of the Democratic Policy Committee,

Good Afternoon and thank you to the Democratic Caucus and Representative Cephas for inviting me to testify on the Maternal Mortality epidemic. My name is Marianne Fray, and I am the Chief Executive Officer of Maternity Care Coalition. Since 1980 MCC has served over 125,000 families, confronting the abysmal rates of maternal mortality, infant deaths and inadequate early childhood education across Southeastern Pennsylvania. I am here today to share MCC's community informed voice on the topic of maternal mortality.

Despite lowering maternal mortality rates throughout most of the developed world, mortality rates across America are on the rise, and especially among African-American women.

Maternal Mortality Is Rising in the U.S. As It Declines Elsewhere

Deaths per 100,000 live births



Notes

"Global, regional, and national levels of maternal mortality, 1990–2015: a systematic analysis for the Global Burden of Disease Study 2015," *The Lancet*. Only data for 1990, 2000 and 2015 was made available in the journal.

Source: *The Lancet*

Credit: Rob Weychert/ProPublica

According to the American College of Obstetricians and Gynecologists (ACOG), "Racial disparities in maternal mortality are staggering -- black women are three to four times more likely to die from a pregnancy-related complication than non-Hispanic white women.ⁱ

Alarming, a black woman is **243 percent more likely to die from pregnancy- or childbirth-related causes** than a white woman.ⁱⁱ This is one of the largest disparities in women's healthⁱⁱ, and has captured the attention of maternal health experts throughout the US. The reasons for this higher maternal mortality in the U.S. is multifaceted. MCC has found that among our clients, largely low-income and women of color, the leading factors contributing to poor health outcomes are:

- institutional racism,
- chronic illnesses,
- effectively navigating the healthcare system, and
- lack of sufficient paid leave

Data shows that black women are more likely to die from preeclampsia or hemorrhage, despite being no more likely to develop these conditions during childbirth than white womenⁱⁱⁱ. Last year, Dr. Joia Crear-Perry, Founder of the National Birth Equity Collaborative, provided testimony to the U.S. House of Representatives Subcommittee on Health, in support of H.R. 1318: Preventing Maternal Mortality Act of 2017, and said that *"The legacy of hierarchy of human value based on the color of our skin continues to cause differences in health outcomes, including maternal mortality. Racism is the risk factor not black skin."*

Addressing racial disparities in health outcomes has consistently been a key component of MCC's work. For nearly 40 years, our direct service programs, research and advocacy focus on improving the health and well-being of pregnant women and parenting families with children 0-3 years old. We've been largely successful because our home-visiting staff reflect the communities we serve and there are high levels of trust.

Because of our deep staff expertise, we were invited to sit on both the Philadelphia and Pennsylvania Maternal Mortality Review (MMR) committees, serving as the voice of the community. MMR findings helped inform the design of MCC's innovative Safe Start program. Founded with support from the Merck for Mothers Initiative, the Safe Start program works in collaboration with health care providers and insurers to coordinate care and reduce maternal mortality in pregnant women with chronic health conditions like diabetes, hypertension, obesity, mental health diagnoses, substance use disorder and intimate partner violence.

Many of the women in our Safe Start Program have been in and out of various behavioral health and child welfare systems throughout their lives. As a result, their medical care has not been consistent or coordinated and they often come into their pregnancy sicker. We know that expecting moms, particularly high-risk moms, need to attend numerous medical appointments,

arrange transportation, find child care while often managing work schedules. This juggling act is extremely challenging and adds to their stress.

For example, one of our clients, Rena, came to MCC's Safe Start Program with a high BMI and hypertension. She was facing a seventh C-section at 28 years old. Her relationship with her healthcare provider had not been positive. She shared feelings of hurt, being judged, upset, frustrated and ready to walk away from prenatal care entirely. Her MCC Advocate, encouraged Rena to attend appointments and ask more questions. She accompanied Rena to her prenatal appointments and provided her with coaching on what questions to ask. Rena, trusting her Advocate, gradually became more comfortable and engaged in her own care. After Rena gave birth, she had serious complications related to her C-section wound healing. Her Advocate helped her get in-home nursing care through her insurance. Eventually Rena recovered and was able to connect with her baby. We know that without this support, the outcomes could have been very different.

We have also found that Doulas, in conjunction with their medical providers, can provide valuable added support for pregnant women. Doulas work collaboratively with moms to provide birthing education, develop birth plans, offer comfort measures and act as an advocate for mom during childbirth. Women who work with a doula are two times less likely to have birth

complications for themselves and their babiesⁱⁱⁱ. MCC uses doulas in some of our programs including Safe Start and our MOMobile at Riverside Correctional Facility program. We also train and match doulas through our community doula program. Later in this hearing you will hear more about the impact of Doulas from Naima Black, one of MCC's Doulas.

By improving access to doula services and having the service reimbursable by Medicaid, we can reach more women and help reduce maternal mortality and morbidity rates. MCC hopes to expand this service into more of our programs in the near future.

We commend the city of Philadelphia for being one of the first municipalities to convene a Maternal Mortality Review Team. We also encourage the city to convene and support a Perinatal Quality Collaborative empowered with the authority to implement the recommendations of the Maternal Mortality Review team.

We also recommend full support of the Alliance for Innovation on Maternal Health (AIM) Program. AIM is a national partnership of organizations organized to reduce severe maternal morbidity through the coordinated use of proven and **consistent maternity care practices**. The California Maternal Quality Care Collaborative (CMQCC), reduced their maternal mortality rates significantly by applying AIM's 'Maternal Safety Bundles' – evidence based quality improvement toolkits that address the leading causes of preventable death and complications for mothers and

infants^{iv}. Maternal Safety Bundles are a step in the right direction for supporting moms and providing quality care to *all* women.

Finally, the rise of maternal mortality in the United States is a complex problem and no singular recommendation will sufficiently address this issue. I have shared in this testimony how many MCC clients struggle with caring for themselves while also finding culturally sensitive maternal care. I believe that if we **collectively focus** on addressing the racial inequities in our healthcare and social institutions, we will reduce our rising maternal mortality rates. Thank you for this opportunity to speak with you today.

ⁱ Pregnancy Mortality Surveillance System. Centers for Disease Control and Prevention. Available at: <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html>

ⁱⁱ Nina Martin, P., & Montagne, R. (2017, December 08). Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why. Retrieved from <https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why>

ⁱⁱⁱ Tucker, M. J., Berg, C. J., Callaghan, W. M., & Hsia, J. (2007). The Black–White Disparity in Pregnancy-Related Mortality From 5 Conditions: Differences in Prevalence and Case-Fatality Rates. *American Journal of Public Health*, 97(2), 247-251. doi:10.2105/ajph.2005.072975

^{iv} Gruber, K. J., Cupito, S. H., & Dobson, C. F. (2013). Impact of doulas on healthy birth outcomes. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/>

^v What We Do. (n.d.). Retrieved from <https://www.cmccc.org/about-cmccc/what-we-do>

Philadelphia Department of Public Health
Aasta D. Mehta, MD, MPP
Women's Health Advisor—Division of Maternal, Child, and Family Health
Co-facilitator—Philadelphia Maternal Mortality Review Committee

Provided for House Democratic Policy Committee

April 3, 2019

Good afternoon, I am Dr. Aasta Mehta, the Women's Health Advisor for the Philadelphia Department of Public Health's Division of Maternal, Child and Family Health and a practicing OB/GYN here in Philadelphia. Thank you for the opportunity to provide written testimony for the House Democratic Policy Committee Hearing on Meaningful Solutions to Maternal Mortality.

The rate of pregnancy-related mortality in the United States has more than doubled in the past thirty years. The city of Philadelphia has seen an increase in maternal mortality that follows these national trends. In 2010, the Philadelphia Department of Public Health Medical Examiner's office and the greater Philadelphia maternal health community created the first county-level Maternal Mortality Review Team (MMRT) in the United States with the goal of pro-actively reducing maternal mortality.

The MMRT brought together the six labor-and-delivery hospitals in the city, along with city-based agencies and non-governmental organizations to develop a more accurate method of identifying and tracking the number of pregnancy-related deaths (which occur during or within one year of the end of the pregnancy, from any cause related or aggravated by the pregnancy or its management) and pregnancy-associated deaths (death which occurs during this time regardless of cause), and to conduct a multidisciplinary review of each case. The review process helped us identify the systematic shortfalls that women of childbearing age face and gaps in community resources. In turn, the review process helped focus limited resources to address these issues, in hopes of reducing pregnancy-associated deaths and improving the overall health and wellbeing of all women of childbearing ages.

Over the course of 35 meetings since 2010, the Philadelphia Maternal Mortality Review (MMR) team has gained knowledge and insight about maternal morbidity and mortality by reviewing over 160 pregnancy-associated deaths of Philadelphia residents. Based on aggregated surveillance data from deaths that occurred from 2010 to 2018, ~25% of these deaths were categorized as pregnancy-related – giving Philadelphia a pregnancy-related death rate of ~21 per 100,000 live births. Of the (estimated) 43 pregnancy-related deaths, ~40% were attributed to cardiomyopathies or other cardiovascular conditions, ~20% to embolisms, ~13% to infectious processes, and ~10% to hemorrhage. Black, non-Hispanic women account for ~41% of Philadelphian women of childbearing age and White, non-Hispanic women account for ~35%. However, Black, non-Hispanic women have accounted for ~74% of Philadelphia's pregnancy-related deaths from 2010-2018, while White, non-Hispanic women have accounted for ~15% of them.

If you exclude women belonging to two known faith-healing groups in Philadelphia who decline all medical care (with a combined population of about 3000 people), Black, non-Hispanic women have accounted for ~82% and White, non-Hispanic women accounted for ~5% of the pregnancy-related deaths of Philadelphia residents, making the racial disparity even more alarming.

The Philadelphia MMR dataset has thus-far revealed that ~45% of all reviewed deaths had a diagnosed mental health history, and ~60% had had a previous and/or current substance use disorder. Overdose-related deaths, which have risen dramatically in Philadelphia's general population (from roughly 400 in 2010 to over 1200 in 2017) has likewise risen rapidly among pregnant and postpartum women. Whereas ~25% of reviewed maternal deaths between 2010 and 2016 were due to accidental drug intoxications, that percentage increased to ~38% of reviewed maternal deaths between 2017 and 2018. Of course, deaths are just the tip of the iceberg, as for every death there are 5-7 times the number of near misses. Therefore, learning how to address

and engage pregnant women as well as mothers with young children who have an opioid or other substance use disorder is an important issue to tackle in Philadelphia so that significant headway can be made on reducing maternal mortality. Focus on this issue is paramount to improving overall maternal health care in Philadelphia.

Ongoing citywide initiatives to reduce maternal mortality in Philadelphia include:

- All Philadelphia delivery unit leaders meet monthly to share best practices to better reduce the risk of mortality and morbidity that result from pregnancy related causes of death such as hypertensive disease, infection, and embolism.
- The Philadelphia LARC coalition worked to change Medicaid reimbursement to increase access to post-delivery long-acting reversible contraception (LARC) for all Medicaid insured women.
- Postpartum units are working to more uniformly screen for perinatal depression and link the screening results to improved care for mothers who experience depression.
- PDPH and the Perinatal Centers of Excellence have developed a citywide educational program focused on effective screening, providing a brief intervention, and referral to treatment for opioid addicted pregnant women.
- The Philadelphia Department of Public Health with support from the William Penn Foundation is implementing a centralized intake system to improve home visiting services for pregnant women and infants.
- The Philadelphia Maternity Mortality team supported the establishment of a new state-wide Pennsylvania Maternity and Mortality Review team.

In sum, though progress has been made, more investment is needed to scale up and develop interventions to improve the way in which women are cared for during pregnancy and after they give birth. In order to meaningfully address maternal mortality in Philadelphia, these interventions should be focused on the following priority areas:

- Provide implicit bias training to MCH providers across the city
- Increase access to doula services
- Train family supports program staff on unmet legal needs that create barriers to health and social services
- Improve screening, treatment, and care coordination for women with substance use disorders
- Streamline citywide interagency communication and case management for pregnant and postpartum women.
- Integrate behavioral health services with prenatal care
- Improve HTN surveillance in the intrapartum and postpartum period

These interventions, if implemented citywide, have the opportunity to improved maternal health, the elimination of racial disparities and preventable maternal death, and ultimately, a reduction in maternal morbidity.

Thank you very much for the opportunity to address you today, I am happy to answer any questions you may have.

Good afternoon,

My name is Saleemah McNeil, I am one of the only Black Reproductive Psychotherapists serving Philadelphia and the surrounding counties. I come to you with experience on multiple levels. I am a retired birth / postpartum Doula, founder and CEO of Oshun Family Center, and a survivor of birth trauma. The title of mother, made me a statistic. In 2005 I gave birth to a healthy baby boy, pregnancy went well and no health concerns until 37wks and 3 days gestation. I went to my regularly scheduled prenatal appointment and was sent straight to the hospital due to high blood pressure. They never told me the number and placated me by saying "you will just get some testing and probably be sent home". When I arrived to the hospital my blood pressure was 202/153...stroke range, and the only cure was delivery of my baby. The culprit was preeclampsia. After a horrific c/section and 9 days in the hospital recovering, I went home. Weeks later, the postpartum mood fluctuations began to occur. I did not tell anyone. I lied at my postpartum appointment and said, "everything is fine," after crying while undressing for the exam. You may be wondering why I didn't ask for help. The answer is simple - I didn't feel safe. I did not trust that I could tell anyone, including a medical professional, that I felt emotionally depleted and still be viewed as a competent mother. In the black community, mental health challenges are seen as "white people's problems" and a sign of weakness. At organizations like mine, the Oshun Family Center, we work tirelessly to change that narrative because I see that my experience would have been different if I had a Doula present.

The department of human services reports that preeclampsia and eclampsia are the two leading causes of maternal death. This is 60% more common in the Black community.

Preeclampsia involves high blood pressure at or around 20wks gestation in women whose blood pressure was normal before pregnancy. Features of preeclampsia include blood pressure over 140/90 systolic and diastolic, water retention often in hands, legs and feet and protein in urine. This condition is serious enough to affect brain function and cause seizures or coma which is called eclampsia.

The MOMMA Act was introduced in Illinois to help combat these issues. It would require equitable access to prenatal care and cultural competency training for medical staff, enforce current national emergency obstetric protocols to ensure that best practices are being used, all while eliminating practices that don't benefit the mother. This legislation expands coverage for postpartum care under Medicaid for up to a year, and aims to support mothers in obtaining care for issues like postpartum depression after childbirth. This support should include birth and postpartum Doulas. Doulas are professionally trained and provide emotional, physical and educational support, comfort techniques during labor in addition to running light errands and meal preparation during the 4th trimester, postpartum phase. Historically, women have always given birth in a room full of supporters such as their mother, a granny midwife, cousins, sisters and friends. Men weren't allowed to be present during the laboring process. Therefore the benefits outweigh the risks of providing this service to help circumvent negative birth outcomes.

I am working to holistically change the narrative with Oshun Family Center. We have affiliate Doulas that have partnered with me to become trained in screening for perinatal mood disorders (PMADs) which include postpartum depression, anxiety, obsessive compulsive disorder (OCD) and psychosis. In addition to a

thorough intake process that asks questions regarding substance use/abuse, family history, and trauma. This will provide a better glimpse into the gestational parent's world and factors that may impact the outcome of the delivery. The opioid epidemic has gravely impacted families just as the crack epidemic devastated the black community in the 80's. The National Center for Biotechnology Information (NCBI) states that there is a correlation between the body's physiological response to trauma and substance abuse. As generations of families store trauma from historic events such as slavery, segregation, oppression, and mass incarceration, addiction is prevalent in the community.

The CDC reports that opioid use disorders have gone up more than 400% among pregnant women since 1999. Health outcomes include preterm birth, low birth weight, breathing issues, feeding problems, and maternal mortality. In 2013, the Journal of Perinatal Education reported that Doula-assisted mothers were four times less likely to have a low birth weight baby, two times less likely to experience a birth complication involving themselves or their baby, and significantly more likely to initiate breastfeeding. Are Doula's the cure? No. However, it is important to recognize that they are an essential member of the healing village that includes a culturally informed reproductive psychotherapist.

April 3rd, 2019

RE: PA House Democratic Policy Committee Hearing on Meaningful solutions to Addressing Maternal Mortality.

Thank you for the opportunity to provide testimony.

My name is Lexi White. I am a policy and advocacy professional, scholar, and activist. I serve as a Commissioner on the Philadelphia Commission for Women, and I am the Senior Policy Manager with New Voices for Reproductive Justice. We are a human rights and reproductive justice advocacy organization with a mission to build and advance a social change movement that is unapologetically dedicated to the full health and well-being of Black women, femmes, and girls in Pennsylvania and Ohio; We represent one of eight strategic partner advocacy organizations who are state-affiliates of In Our Own Voice: National Black Women's Reproductive Justice Agenda. Some of the information I will raise today is captured in the State of Black Women and Reproductive Justice Policy Report entitled *Our Bodies, Our Lives, Our Voices* and in other literature that leaders who are a part of this movement have generated.

In my role and work, it remains paramount to assert and highlight the blatant harm and hypocrisy of legislators who are making it their work to roll-back and restrict women's access to a full range of standard reproductive healthcare, yet who are silent and complacent in the very real risks and harm that Black women and women of color uniquely and disproportionately face, if and when we make the decision to embark on the journey of carrying a pregnancy to full term and then parenting.

My first call to action for state-lawmakers today on the solution side, is therefore, to affirm our basic human rights by codifying in state statute the essential health benefits of the Affordable Care Act, by advocating consistently and annually for increasing state assistance funding for all health care services, and by providing for equitable coverage and access to a full range of standard reproductive healthcare services including but not limited to: abortion and contraception, gender-affirming care, and especially and urgently maternity healthcare that is inclusive of full-spectrum Doula and Midwifery Care and services, expanded post-partum coverage up to a full year, and increased funding, access and coverage for mental healthcare services.

A Philadelphia-based Birth Justice advocate and practitioner in the community wrote to me yesterday to request that today, we explicitly mention the importance of expanding coverage and access to mental healthcare for pregnant women and mothers at all stages of pregnancy and also in the post-partum period. She noted that in her work and experience she has seen that mental health providers desperately need adequate perinatal mental health training and/or a certification process that reflects accountability to culturally competent delivery of care, especially when working in communities of color. She flagged that 45% of the women who died in Philadelphia (2010-2012) had a mental health diagnosis.

In the two states that have introduced Medicaid coverage for doula services, Minnesota and Oregon, the state legislatures served as catalysts for change, but not without hiccups. Lawmakers in PA who are envisioning expanding coverage for doula services through the state Medicaid program will need to continue to work intentionally and very closely with stakeholders and commit to learning from the shortcomings and implementation challenges in other states, as well as addressing the barriers of troublesome Medicaid re-imbursement rates.

NHeLP's doula publication, "Routes to Success for Medicaid Coverage of Doula Care," and most recently, a report entitled *Advancing Birth Justice: Community Based- Doula Models as a Standard of Care for Ending Racial Disparities* by Ancient Song Doula Services, Every Mother Counts, and Village Birth International are important resources. I will yield to my fellow panelists to discuss this in more detail and in doing so, offer their practitioner expertise.

Black mamas and babies in our communities are dying at rates we simply cannot ignore and in ways that we need to more comprehensively understand, name, and address. This work continues at the state-level by funding and supporting more data collection, including research that incorporates the embodied and environmental stressors that uniquely characterize Black women's experiences, as well as pushing state and local maternal mortality review teams to more comprehensively assess and capture all pregnancy-associated deaths.

Lawmakers should also take seriously the need to close the gender wage gap and support and expand paid maternal, paternal and family leave policies that support parents and caregivers.

We know that causes of adverse maternal health outcomes are nuanced and complex; they include everything from barriers to accessing high-quality, culturally-competent healthcare and other needed resources before, during and after pregnancy, personal health risk factors all within the context of the deeply connected social disparities like racism, poverty, and environmental toxins. Data has shown that the challenges Black women in particular face in accessing health care, which result in both maternal injury and mortality, transcend education level, a reality that points to other factors such as inadequate health care infrastructure and systems, high costs of healthcare, and lack of comprehensive insurance coverage as key barriers.

Not having enough Black healthcare providers, including OBGYN and nurse-midwives, make culturally competent care difficult to access. Funding and expanding access and coverage for community-based health programs, including community Doula programs and services, can help to combat this harm, and we need more funding for the programs highlighted here today that connect women in our communities to comprehensive pre-natal, post-partum care, birth support, birthing options, and mental healthcare.

I can say from navigating my own reproductive healthcare, that it has taken finding other women of color providers to obtain the kind of care and attention required to talk through my reproductive health care needs and options. This is an experience that is shared time and time again in conversations we are having with Black women in the community who are relying on peer-to-peer support where resources and information has been limited about which providers will be most affirming, attentive, reflective, and responsive to their own lived and embodied experiences and needs. We are across the board less likely to receive timely and consistent prenatal care, more likely to experience a pregnancy-related injury and/or complication resulting in death, and more likely to also be mistreated, mistrusted and punished instead of treated for substance use, a reality that discourages many of us from seeking care altogether.

The alarming statistics I could raise here today, however, could never capture the long-lasting personal and community effects of loss, trauma, fear and harm that results from a maternal health epidemic that has roots in institutional and environmental racism, and in state-sanctioned inequity on multiple fronts.

This is what we are hearing in the community. Where there is not enough data to capture the nuances of these experiences, the voices of women, families and communities most impacted must continue to be heard. I request that Pennsylvania lawmakers sincerely and intentionally listen to and trust Black Women in getting this right.

Our topic of discussion today is not merely a Philadelphia and Pennsylvania public health crisis; this is a national Human Rights crisis that is deemed as such by the international community. Recent reviews of the U.S. human rights record by independent bodies have highlighted the persistent racial disparities in health as a form of racial and gender discrimination. The United States has failed to meet its global commitment to decreasing maternal deaths by 75% by 2015, and meaningful action in the ways I've summarized needs to be taken at the state-level in order for us to get there. Thank you.

Commonwealth of Pennsylvania
House Democratic Caucus Committee Meeting
Testimony on Meaningful Solutions to Maternal Mortality –
Doula Care and Coverage
Naima Black, Doula, CLC
Coordinator - Community Doula & Breastfeeding Program
Maternity Care Coalition
St. Joseph's University-Philadelphia, PA
Wednesday, April 3, 2019

I am happy to be involved in this important conversation. I bring extensive personal and professional experience as a community doula, perinatal community health worker, Reproductive and Racial Justice activist. I also currently co-moderate a FB group on Expanding Doula Access, so I am immersed in these discussions on a daily basis.

Poor maternal health outcomes are an underreported human rights crisis in the United States. Our Maternal Mortality Rate (MMR) is the most striking and disturbing of these. The c- section rate which hovers just above 30% around the country is twice the rate recommended by the World Health Organization for any nation.

We have heard today the disturbing disparate maternal health outcomes for childbearing families of color. We also know that this is not because of the color of their skin, but a result of the long and persistent history and impact of the trauma of racism and implicit bias. Racism makes people sick. It is in my view, unquestionably the central root cause for the striking inequities in maternal health and beyond. And therefore all remedies must spring from a place of acknowledgement and commitment to undoing racism in every sector and across systems.

Medical schools and health care systems need to be examined using a racial equity lens and then design and implement a comprehensive training and education program on Implicit Racial Bias. Advancing the human right to safe and respectful maternity care requires a new paradigm with all hands on deck.

Expanding doula care and coverage is another important part of the solution. Doulas are birth companions trained to provide informational, emotional and other non-medical support to women before, during, and after childbirth. Their care is individualized. Extensive and reliable research has correlated doula care with higher breastfeeding initiation rates, fewer cesarean sections, fewer low-birth weight babies, lower risk for postpartum depression and improved satisfaction with the childbirth experience overall. Cost analyses have shown that doula support also reduces spending by avoiding unnecessary interventions that can result in expensive complications. Disappointingly it is mostly people who can afford to hire a private doula who benefit from this care.

Community Based Doula programs have emerged around the country in recent years to help fill this gap and to address the needs of communities of color and other communities on the margins who experience poor health outcomes. They go beyond the traditional doula model by providing extensive trainings to address the varied competencies needed to support families with complex social needs. Community doulas are recruited from the same neighborhoods where they will serve. Well trained and supported they have the ability to reduce the harmful effects of racism by providing culturally and linguistically connected, family-centered care.

The Community Doula Program we created at MCC is one of these innovative models. It has been a catalyst for an ongoing shift in the birth worker community and for birthing families in Philadelphia. We have trained more than 170 community doulas and breastfeeding peer counselors, predominantly people of color. And we have matched them with more than 1500 pregnant people who requested or were referred for doula or breastfeeding support. Women are hungry for options in childbirth. Women call me every day hoping for an experience that will honor and respect their autonomy in decision-making. They want to be participants in their labor and birthing journey without unnecessary interventions. And they want to tap into their strength and power. Community based doulas help women find their voice and their confidence and walk with them with respect. They help buffer some of the stress inducing situations that are so often present in our medical model of labor and delivery, including strong language of fear that can diminish one's sense of trust in themselves. Doulas affirm and stay throughout the birth so that even when things don't go the way a family has hoped, they are much more likely to have a

positive memory of the birth. Women are reclaiming their intuitive power and finding sisterhood, community and strength from this growing movement. Many of the people who had the support of one of our network doulas later became trained themselves. Many of our trained birth workers have formed their own groups and projects and some have gone on to nursing and midwifery school or found jobs in the maternal and infant health arena. Community based doula programs also promote economic and professional growth and self-sufficiency.

This is by no means meant to be a bashing of our doctors and nurses. We have incredible people working in this field. They too are often pressured by a system which has tipped the balance way too far into a medical model that does not trust women to birth their babies. I can't tell you how many times I have met providers who have never witnessed a completely natural birth.

Pennsylvania has an excellent opportunity to move forward with intention and integrity to create legislation that would have meaningful and far reaching impact. We should engage in a careful planning process. We can take lessons learned from Oregon and Minnesota, two states who have Medicaid reimbursement but who have faced challenges to successful implementation. There are two excellent recent reports which respond to New York's pilot program for Medicaid reimbursement for doulas. One is from the New York State Task Force on Maternal Mortality and Disparate Racial Outcomes. The second report, hot off the press, is *Advancing Birth Justice: Community Based Doula Models as a Standard of Care for Ending Racial Disparities* researched and written by Ancient Song Doula Services, Every Mother Counts, Village Birth International. Both of these resources offer critical analyses and highlight specific recommendations that are relevant here in Pennsylvania.

Key points to note are:

- Reimbursement rates must allow for doulas to earn a living wage
- Invest in community based models to ensure that doulas enrolled in the Medicaid reimbursement programs are trained and supported to serve in communities of color.
- Provide funding to train a diverse community of doulas and breastfeeding counselors from communities of color, immigrant communities and others facing poor access to care.

This is the time, a perfect moment to set forth evidence based, courageous practices and policies that promote racial healing and maternal and infant health. It is my hope that Rep. Cephas and other committed members will engage with a representative group of impacted people, including midwives and community based doulas. We know who and where they are and they are ready and willing to contribute to this conversation.

Thank you.

Good Afternoon, my name is Autumn Nelson. I am certified nurse- midwife at Lifecycle Woman Care, a board member of Philadelphia Midwife Collective and an ACNM and Philly Metro Midwives member and native Philadelphian.

We've heard how maternal mortality has increased in the United States while declining elsewhere in world and about health disparities. One of the many benefits of my work as a midwife is the ability to focus on and uphold evidenced based care, so I'm excited to talk about solutions and best practices, particularly doula care and midwifery care. Let's start with doulas.

The evidence on the positive impact of doulas and continuous support during labor is clear. The data from a 2013 Cochrane Review evaluating over 15,000 laboring people shows that utilizing doulas results in improved outcomes for women and infants. Included in these results are increased rates of spontaneous vaginal birth and shorter duration of labor. The presence of a doula decreases rates of instrumental vaginal births (use of vacuum/forceps). Laboring persons who have a doula present decrease their risk of a cesarean birth by 25%, simply by having the doula in the room (Bohren et al, 2017). Presence of a doula for labor support decreases that person's use of any anesthesia, regional analgesia, and low five minute APGAR scores. On top of these overwhelmingly positive results there has been no evidence of known harm as the result of having a doula present, something that can't be said of most medical interventions.

These results have been supported by the American College of Obstetrics and Gynecology, Association of Women's Health Obstetric and Neonatal Nurses, the World Health Organization, and many more highly regarded professional organizations (Bohren, 2017). If a birthing person has a doula present for the sole purpose of continuous labor support, both mothers and babies are significantly statistically more likely to have better outcomes than those without. Doulas are however currently an out of pocket cost, so most inaccessible to those without the financial means (Kozhimannil et al, 2014).

These improved health outcomes have correlating financial benefits for our health care system. If successful, Pennsylvania won't be the first state to increase access to doulas: we can benefit from the prior experience of states like Minnesota, New York and Oregon which have successfully implemented programs to cover doulas through insurance. At an average of \$1,000 savings in medical expenses per birth (Cooney, 2019), in 2017 that would have saved PA over \$137,000,000 plus the added benefit of improved maternal and infant health outcomes.

For me there is no question how clearly important it is to utilize and reimburse, at a fair wage, the work that doulas do. Again the United States has the highest maternal mortality rate of comparable countries and it is rising. Doulas are a critical band-aid for our broken system. Systemic change however demands integrating and enabling high quality (evidence based) midwifery care throughout Pennsylvania. We need the known evidenced-based resources and best practice midwifery models of care to become standard across the United States. If you want to discuss evidence based solutions, then we must discuss midwives. According to the World Health Organization midwifery with both family planning and interventions for maternal and newborn health could avert a total of 83% of all maternal deaths, stillbirths, and neonatal deaths (Homer, 2014).

Unlike doulas, Midwives are licensed health care providers regulated in PA by the Board of Medicine. While midwives attend as many as 80% of births in other countries, midwives attend only roughly 8% in the U.S. Midwives are educated in accredited programs, nationally certified, and can provide not only prenatal and birth care, but also relationship-based wellness care across the lifespan. Midwives work in all settings, in research, education, and clinical practice. The birth center setting highlights the midwifery model of care.

Midwifery-led birth center care is an innovative approach to reducing disparities and cost with proven results. The AABC Standards for Birth Centers, (originally created in 1985) are based on best maternity care evidence and revised periodically with input from professional stakeholder groups and consumers.

Comprehensive prenatal care is provided in a relaxed, respectful environment of informed, shared decision-making. Physiologic birth is promoted with enhanced education and support. Admission for labor is usually in the birth center, but hospital options are available if risk factors or choice preclude a birth center birth. Enhanced postpartum care includes lactation support, mental health screenings and close follow-up with home visits in the first days at home. Referrals to specialists, mental health services, or other resources are made as needed. Clients feel empowered and engaged in their pregnancy care. Birth center care leads to cost savings from better prepared parents and families, reduced risk of preterm birth, low birthweight, higher success with breastfeeding, and reduction of the overuse of cesarean births and other interventions when not medically indicated.

Midwife-led birth centers are a strong model for decreasing the high rate of cesarean birth in the U.S., while maintaining the highest safety standards. In the National Birth Center Study II fewer than 6% of the study participants had a cesarean birth, while for similar low-risk women receiving care in the hospital setting, the rate is estimated to be almost 24%. This performance is further supported by the Strong Start Initiative which showed that clients who received birth center prenatal care had cesareans at significantly lower rates than the matched comparison group.

With enhanced prenatal care in birth centers, the risk of preterm birth and low birth weight babies is significantly reduced. The Strong Start Initiative reported significant findings for birth center prenatal care results from risk matched comparison groups of Medicaid beneficiaries:^{2,3}

- 26% decrease in preterm birth risk
- \$2000 savings per mother-baby dyad over 1st year
- Reduction in low birth weight
- 40% Reduction in cesareans
- Increase in VBAC (24.2%-12.5%),
- Increase in weekend delivery rate
- Decrease in infant emergency department visits

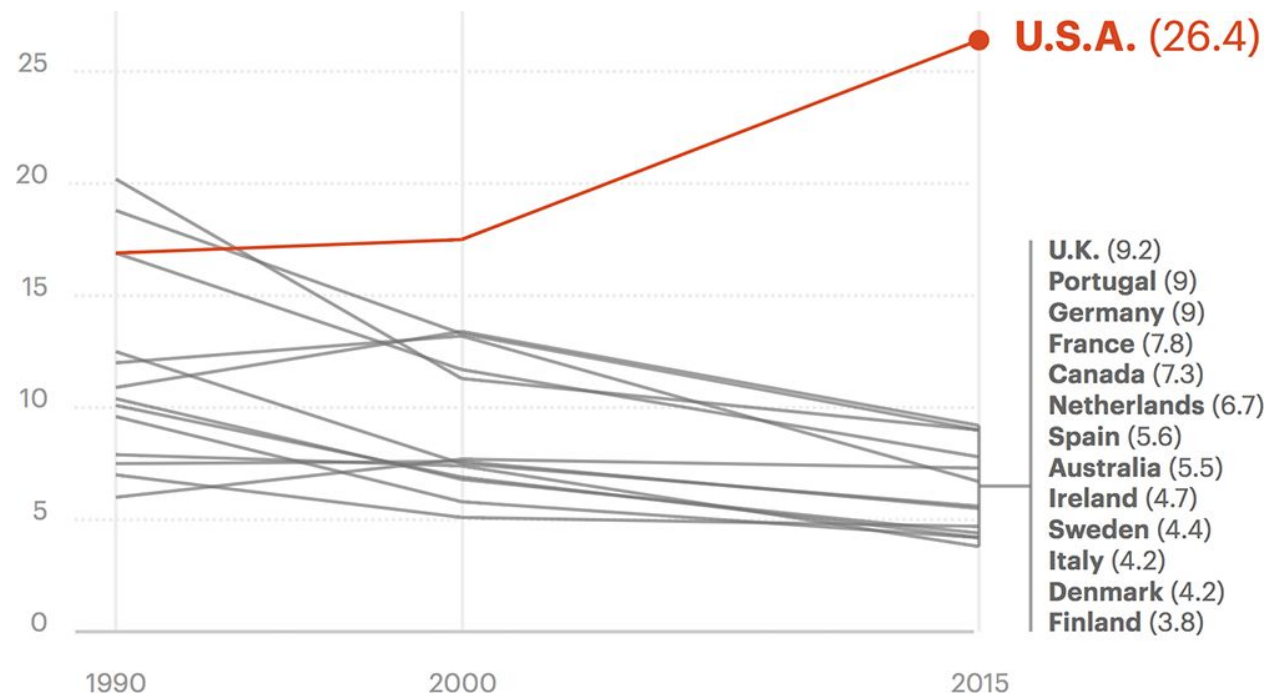
The birth center model demonstrates improved population health, patient experience, and value. Midwifery-led, birth center care results in better prepared, healthier mothers and parents who have a much lower risk of cesarean birth, and thus a lower risk of maternal mortality in current or future pregnancies. Further policy development is needed to quickly increase access to birth center model care, and to midwives nationwide.

In preparation for a system that does a better job of utilizing midwives we need to widen the pool. There is already a shortage of healthcare providers, including nurses. We must encourage RNs to pursue higher education, widen the pool of prospective midwives, remove obstacles and offer financial incentives especially for women of color to pursue midwifery as a career. The workforce should reflect the people.

What we need from policy makers is legislation to improve payment methods, examining both private and medicaid reimbursement for midwives, and regulations so that we can better promote access to midwives. In my professional opinion let's start on the systemic changes needed to increase and integrate access to midwifery care, and in the interim we should remove barriers of access to doulas so that women who are navigating our broken health system today can start accessing improved outcomes immediately. As a midwife, a woman of color, and a person I appreciate the attention that the maternal mortality crisis is receiving; I appreciate the podcasts, blogs, round tables, info sessions, and sumits. I am more excited to see those that are willing to take action, get involved and make big and small changes to get there. There's plenty of work to be done.

Thank you for having me.

Deaths per 100,000 live births



Notes

["Global, regional, and national levels of maternal mortality, 1990–2015: a systematic analysis for the Global Burden of Disease Study 2015," The Lancet.](#) Only data for 1990, 2000 and 2015 was made available in the journal.

Source: The Lancet

Credit: Rob Weychert/ProPublica

Definitions:

Doulas- a doula is a trained professional who provides physical, emotional, and educational support—but not medical care—to mothers before, during, and after childbirth.

Midwife- are traditionally care providers for mothers and infants. Midwives are trained professionals with expertise and skills in supporting women to maintain healthy pregnancies and have optimal births and recoveries during the postpartum period. Midwives provide women with individualized care uniquely suited to their physical, mental, emotional, spiritual and cultural needs. Midwifery is an empowering model of maternity care that is utilized in all of the countries of the world with the best maternal and infant outcomes (MANA)

Midwifery model of care- is based on the philosophy that birth is a natural part of life rather than a condition to be treated. The approach is holistic, wellness-based, and patient- and family-centered, using interventions only when medically necessary. Midwives provide extensive education and continuous, supportive care; for these reasons, midwifery care is generally more time-intensive than typical OB/GYN care (Goer, et al 2016)

References:

1. ACOG and the Society for Maternal-Fetal Medicine Safe Prevention of the Primary Cesarean Delivery; American Journal of Obstetrics and Gynecology, March 2014
2. Boehler, A., Mayhew, M.C., DHHS CMS Joint Informational Bulletin. 11.9.18. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib110918.pdf>
3. Bohren MA, Hofmeyr GJ, Sakala C, Fukuzawa RK, Cuthbert A. Continuous support for women during childbirth. Cochrane Database of Systematic Reviews 2017, Issue 7. Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub6.
4. Cooney, Victoria. Increased rates for doula services could improve access for women in need. Minnesota Legislature, March 2019. Available at: <https://www.house.leg.state.mn.us/SessionDaily/Story/13764>
5. Goer H, Romano AM. Optimal Care in Childbirth: The Case for a Physiologic Approach. Seattle, Washington: Classic Day Publishing; 2012. Available at: <http://www.optimalcareinchildbirth.com/>.
6. Homer, CS, Friberg, IK, Dias, MA et al. "The projected effect of scaling up midwifery". Lancet. 2014;384: 1146–1157
7. Kozhimannil et al., 2014). Potential Benefits of Increased Access to Doula Support During Childbirth. AJMC. Accessed at: <http://www.ajmc.com/journals/issue/2014/2014-vol20-n8/potential-benefits-of-increased-access-to-doula-support-during-childbirth/P-7> on 11/24/2015.
8. Sandall J, Soltani H, Gates S, Shennan A, Devane D. "Midwife-led continuity models versus other models of care for childbearing women". Cochrane Database of Systematic Reviews 2016, Issue 4
9. Stapleton SR, Osborne C, Illuzzi J. Outcomes of care in birth centers: Demonstration of a durable model. Journal of Midwifery and Women's Health. 2013. <https://onlinelibrary.wiley.com/doi/abs/10.1111/jmwh.12003.2>
10. Hill, I., et al. (2018). Strong Start for mothers and newborns evaluation: Year 5 project synthesis Volume 1: Cross-cutting findings. Center for Medicare and Medicaid Innovation. (pages75-78) <https://downloads.cms.gov/files/cmmi/strongstart-prenatal-finalevalrpt-v1.pdf>

Joint Informational Bulletin

DATE: November 9, 2018

FROM: Adam Boehler
Deputy Administrator and Director
Center for Medicare and Medicaid Innovation

Mary C. Mayhew
Deputy Administrator and Director
Center for Medicaid & CHIP Services

SUBJECT: Strong Start for Mothers and Newborns initiative (Strong Start)

This informational bulletin describes the improved outcomes and substantial savings associated with Birth Center care as reported in the final Strong Start for Mothers and Newborns (Strong Start) [evaluation](#). Strong Start was a Center for Medicare and Medicaid Innovation initiative for pregnant women enrolled in Medicaid or the Children's Health Insurance program (CHIP). The initiative intended to test psychosocial approaches to reducing preterm birth, improving overall pregnancy outcomes for mothers and infants, and reducing costs to Medicaid and CHIP during pregnancy and the year following birth.

From 2013-2017, model participants received care in one of three models: Maternity Care Homes, Group Prenatal Care, or Birth Centers, and found significantly improved outcomes among the Birth Center participants. Given these results, states may wish to consider studying the availability of Birth Center care in their states, and state Medicaid programs can use these evaluation results when considering how to improve care for pregnant women. Given the long-term repercussions of preterm births and the maternal morbidity and mortality risks associated with multiple cesareans, improved outcomes observed among Birth Center participants may offer health benefits and cost savings that are realized long past the infant's first year.

Background

Rates of preterm birth and low birth weight are high in the United States, especially among births to Medicaid beneficiaries. Research consistently shows that infants born preterm (before 37 completed weeks of gestation) have higher mortality risks and may endure a lifetime of developmental and health problems when compared to infants born at term. The Center for Medicare and Medicaid Innovation's Strong Start initiative tested three models of prenatal care to find successful ways to improve birth outcomes among Medicaid beneficiaries. Strong Start was designed to test which prenatal care models might improve maternal-infant health and reduce costs to Medicaid through pregnancy and the infant's first year.

Strong Start made 27 awards to organizations that operated more than 200 provider sites in 32 states, Washington, D.C., and Puerto Rico. From 2013-2017, the program provided enhanced prenatal care services to almost 46,000 women through three approaches:

- Maternity Care Homes, which offered standard clinical care enhanced with a consistent care coordinator and sometimes additional health education or other services;
- Group Care, which offered clinical care in a group setting, followed by extended health education and peer support; and
- Birth Centers, which offered the midwives' model of care, a time-intensive holistic approach, supplemented with peer counseling for additional education, referrals, and support.

Strong Start programs adjusted to meet needs of participants, who commonly faced issues such as unstable housing, unemployment, depression and anxiety, food insecurity, barriers to care (e.g. transportation), and a lack of social support.

Results showed particular promise in the Birth Center model. Birth Centers, which were all freestanding facilities that were members of the American Association of Birth Centers (AABC), employ certified nurse midwives and other state-licensed midwives who practice the midwifery model of care. These facilities follow standards for Birth Centers established by AABC (<https://www.birthcenters.org/page/Standards>). The midwifery model, a holistic and patient-centered model, is distinct from the medical model that is usually employed by both physicians and midwives in typical clinical settings. Best practices associated with the Birth Centers' midwifery model include prenatal care appointments that generally last at least 30 minutes, far longer than typical maternity care appointments, which usually last 15 minutes or less. These prenatal care appointments include extensive education on nutrition, exercise, childbirth preparation, breastfeeding, infant care and self-care. Most Birth Centers offer multiple postpartum visits, often including at least one home visit. During the Strong Start initiative, many Birth Centers offered classes on topics such as childbirth and breastfeeding free of charge to Medicaid patients. In addition, Strong Start Birth Centers employed peer counselors, who offered additional support and referrals prenatally and postpartum. Although the addition of peer counseling did not appear to impact outcomes, patients reported positive care experiences with the peer counselors, and many Birth Centers used their own funds to sustain them at the end of the Strong Start program.

The evaluation compared participants in Strong Start to other women enrolled in Medicaid, with similar demographic characteristics and medical risks (identified in birth certificates and Medicaid claims), and who lived in the same counties but received care in non-Strong Start practices. Regardless of where they gave birth (birth center or hospital) Birth Center participants had costs that were \$2,010 lower on average from birth through the first year for each mother-infant dyad. Birth Center participants had preterm birth rates that were 25% lower than those of comparators, along With better birth outcomes in other multiple areas, described in Table 1:

Table 1: Birth outcomes in Birth Center Participants and Comparison Group

Outcome	Birth Center Participants	Risk-matched Comparison Group	Statistically significant difference?
preterm birth rate	6.3%	8.5%	Yes ($p < .01$)
rate of low birth weight infants	5.9%	7.4%	Yes ($p < .05$)
average gestational age	39 weeks	38.6 weeks	Yes ($p < .01$)
average birth weight	3,342 grams	3,263 grams	Yes ($p < .01$)
Cesarean delivery rate	17.5%	29%	Yes ($p < .01$)
vaginal birth rate for women with a previous Cesarean	24.2%	12.5%	Yes ($p < .01$)
weekend delivery rate (indicates fewer scheduled inductions or Cesareans)	23.7%	19.8%	Yes ($p < .01$)
infant emergency department visits	0.86	0.99	Yes ($p < .01$)
post-birth hospitalizations among infants	0.07	0.08	Yes ($p < .05$)

All findings were robust to alternative specifications. Lower costs for Birth Center participants were likely driven by lower cesarean rates and shorter birth facility (birth center or hospital) stays, with added savings from reduced infant emergency department and hospital utilization in the year following birth.

A comparison of participants in the three models allowed controls for psychosocial risks (e.g. intimate partner violence, depression, food insecurity) in addition to medical risks and demographics. This comparison showed that relative to similar Maternity Care Home participants, Birth Center participants had lower rates of preterm birth, low birth weight infants, and cesarean sections. All findings were statistically significant at $p < .01$. Birth Centers also showed a higher VBAC rate ($p < .05$).

Interviews with Birth Center staff and providers and with Medicaid officials in 20 states indicated that, in many cases, Birth Centers face barriers to serving Medicaid beneficiaries. State Medicaid officials in many states reported paying lower rates to midwives than to physicians for the same services (reported rates ranged from 70-92%). Birth Center facility fees for uncomplicated vaginal birth were also reported to be less than those paid to hospitals in many

states, with reported rates from 15% to 70% lower. Many Birth Centers reported having difficulties in contracting with Managed Care Organizations (MCOs) providing Medicaid coverage because of inadequate reimbursement, state licensure requirements connected to inclusion in the contract, burdensome paperwork, or lack of interest on the part of the MCO.

Laws regulating the scope of practice for midwives and licensure of Birth Centers differ among states. Regulations, such as those requiring a hospital-affiliated physician to serve as a Birth Center's medical director or requiring that midwives practice under direct supervision of physicians, can make it difficult to establish and operate a Birth Center.

For states wishing to use these results to consider changes or enhancements to their prenatal care benefits and networks, a summary of federally mandated and optional coverage for midwifery and birth center care for Medicaid and CHIP programs is summarized below.

Medicaid and CHIP Coverage of Midwives

Nurse-midwife Services are a mandatory benefit described in regulations at 42 CFR 440.165. These are services furnished by a nurse midwife within the scope of practice authorized by state law or regulation and, in the case of inpatient or outpatient hospital services or clinic services, are furnished by or under the direction of a nurse-midwife to the extent permitted by the facility. These services are reimbursed without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other healthcare provider, unless such supervision is required by state law or regulations. Furthermore, to the extent nurse-midwives are authorized to practice independently under state law or regulation, Federal regulations at 42 CFR 441.21 require that the plan must provide that the nurse-midwife may enter into an independent provider agreement, without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider. In CHIP, nurse midwife services are an optional benefit that may be provided as child health assistance as a component of nursing care services as described in regulations at 42 CFR 457.402(o).

Licensed midwives are another type of practitioner that may be covered in the Medicaid program based upon regulations for Other Licensed Practitioner Services at 42 CFR 440.60. This optional benefit allows coverage of midwives who are not registered professional nurses, but are otherwise licensed by the state to furnish midwifery services. Additionally, there may be other Medicaid benefits a state may use to cover services should a practitioner possess other state established qualifications. There is also flexibility to provide coverage of licensed midwives in CHIP if they are recognized to practice under state law and meet the additional requirements at 42 CFR 457.402(x). Decisions regarding the inclusion of other licensed practitioners in the Medicaid benefit are left up to states, and CMS is not making any specific recommendations about the inclusion of a particular provider type in the State Plan.

Medicaid Coverage of Freestanding Birth Center Services

Section 2301 of the Affordable Care Act requires states that recognize freestanding birth centers in their state to provide coverage and separate payments under Medicaid for freestanding birth center facility services and services rendered by certain professionals providing services in a freestanding birth center, to the extent the state licenses or otherwise recognizes such providers under state law. This authority gives specific reference to birth attendant services, which is interpreted to mean any non-licensed practitioner (such as lactation consultants, doulas, etc.) recognized by the state to provide prenatal, labor, and delivery or postpartum care in a freestanding birth center. In general and specifically for freestanding birth centers, states have considerable discretion in setting provider payment rates that are reasonable, economic and efficient, and sufficient to encourage provider participation in the program. CMS issued a [State Health Official's letter \(SHO#16-006\)](#) on April 26, 2016 clarifying (in part) how freestanding birth centers are incorporated in managed care contracts. Unlike Medicaid, coverage of free standing birth centers under CHIP is not required, but states may provide coverage of services provided in these facilities to the extent the state licenses or otherwise recognizes such providers under state law.

Full results of the Strong Start evaluation, including a state-by-state assessment of outcomes, are available in the final evaluation report, which can be accessed at <https://innovation.cms.gov/initiatives/strong-start/>

Findings at a Glance

MODEL OVERVIEW

Strong Start funded 27 awardees from 2013 to 2017 to provide enhanced prenatal care to Medicaid and CHIP beneficiaries.

- Goal 1: Improve quality of care and reduce rates of preterm birth and low birthweight infants
- Goal 2: Reduce costs to Medicaid during pregnancy, birth, and the infant's first year

PARTICIPATION

There were three models of care distributed across the nation.

ENROLLEE CHARACTERISTICS

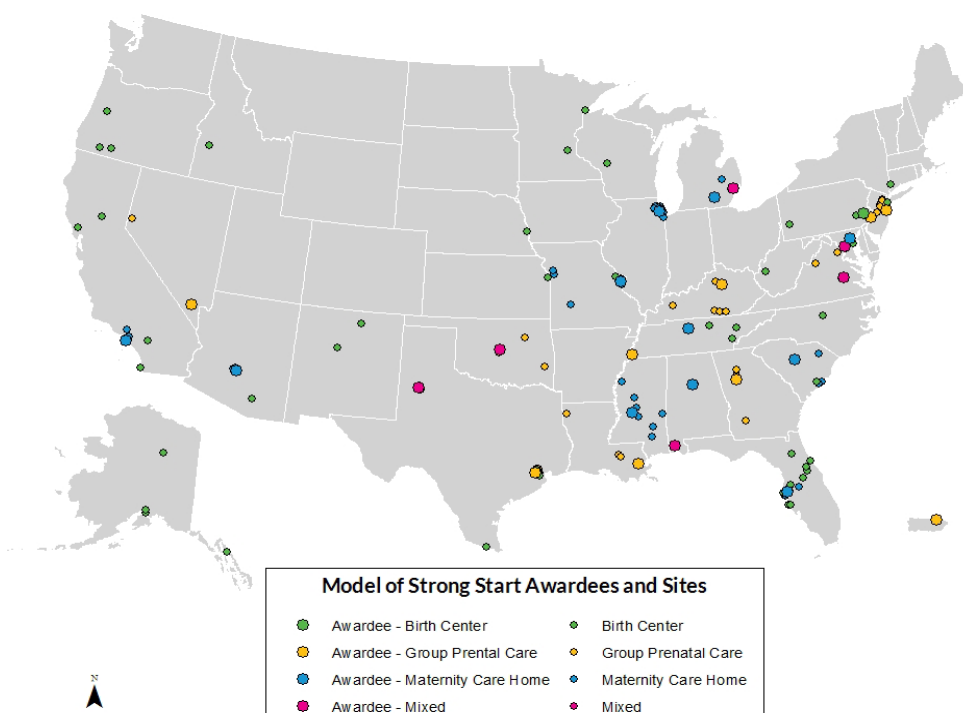
(varied by model and awardee)

42.1% of women exhibited symptoms of depression, anxiety, or both.

21.1% of women with a prior birth had a prior preterm birth.

A wide range of demographic groups were represented.

- 39.8% of women were black; 29.7% were Hispanic; 25.6% were white.
- 15.2% of women were teens (under age 20); 9.0% were 35 years or older.



Maternity Care Homes



Care coordination, sometimes with other enhanced services, in addition to clinical prenatal care

26,007 enrollees

112 sites

Group Prenatal Care



Prenatal care provided in a group, enhanced with health education and facilitated discussion

10,508 enrollees

60 sites

Birth Centers



Midwives' model of care enhanced with peer counseling for additional support and referrals

8,806 enrollees




47 sites

This document summarizes the evaluation report prepared by an independent contractor. To learn more about the Strong Start Model and to download the full evaluation report, visit: <https://innovation.cms.gov/initiatives/strong-start/>

Findings at a Glance

FINDINGS RELATIVE TO SIMILAR MEDICAID BENEFICIARIES

Strong Start participants in Birth Centers and Group Prenatal Care had better outcomes at lower cost relative to other Medicaid participants with similar characteristics.




	Maternity Care Homes 	Group Prenatal Care 	Birth Centers 
Costs	<ul style="list-style-type: none"> Higher costs through delivery period and following year. 	<ul style="list-style-type: none"> Costs \$427 lower per woman during 8 months before birth. 	<ul style="list-style-type: none"> Costs \$2,010 lower through birth and year following for each mother-infant pair.
Utilization	<ul style="list-style-type: none"> Fewer prenatal hospitalizations More infant emergency department visits and hospitalizations 	<ul style="list-style-type: none"> Fewer emergency department visits and hospitalizations for women and infants 	<ul style="list-style-type: none"> Fewer infant emergency department visits and hospitalizations
Quality	<ul style="list-style-type: none"> Higher rate of low birthweight More weekend deliveries[^] 	<ul style="list-style-type: none"> Lower very low birthweight rate More weekend deliveries[^] More VBACs⁺ 	<ul style="list-style-type: none"> Lower low birthweight rate Lower preterm birth rate More weekend deliveries[^] More VBACs⁺ Fewer C-sections

[^]weekend deliveries indicate fewer scheduled inductions and scheduled C-sections

⁺VBAC=vaginal birth after cesarean

FINDINGS AMONG CARE MODELS (Relative to Maternity Care Homes)

Birth Center participants have better outcomes relative to Maternity Care Home participants after controlling for demographic, medical, and social risks.

	Maternity Care Homes 	Group Prenatal Care 	Birth Centers 
Quality	This mode experienced: Preterm birth: 13% Low birthweight: 11% C-section: 31%	After controlling for risks, no significant differences in outcomes between Group Prenatal Care and Maternity Care Homes.	After controlling for risks, <ul style="list-style-type: none"> Lower rates of preterm birth Lower rates of low birthweight Lower rates of C-section Higher rates of VBAC

KEY TAKEAWAYS

Women who received prenatal care in Strong Start Birth Centers had better birth outcomes and lower costs relative to similar Medicaid beneficiaries not enrolled in Strong Start. In particular, rates of preterm birth, low birthweight, and cesarean section were lower among Birth Center participants, and costs were more than \$2,000 lower per mother-infant pair during birth and the following year.

These promising Birth Center results may be useful to state Medicaid programs seeking to improve the health outcomes of their covered populations.

Written Public Testimony from Family Practice and Counseling Network
April 2, 2019

RE: PA House Democratic Policy Committee Hearing on state-level solutions to address Maternal Mortality

The Family Practice and Counseling Network would like to extend gratitude to the Pennsylvania House Democratic Policy Committee for making this hearing public and inviting the public to participate in this process of addressing maternal mortality in the state.

We at Family Practice and Counseling Network, or FPCN, have been providing primary care including behavioral healthcare for 27 years to over 23,000 underserved Philadelphians through five federally qualified health centers. We are on the front lines of healthcare in the community and have observed the need and desire for better maternal care and outcomes, which has also been validated through research and health statistics. We are responding to this need and desire by piloting a birth center for underserved women and families – particularly African Americans – In order to improve maternal and infant healthcare and provide a scalable model that can be implemented throughout the state to address the high rates of maternal and infant mortality. This will be the only birth center in Philadelphia, a city which suffers very poor maternal and infant health outcomes.

Nationwide, the United States has the worst maternal mortality rate of developed countries, and it continues to rise¹. Black mothers and babies in the U.S. die at more than double the rate of their white counterparts². Philadelphia suffers disproportionately bad maternal and infant health outcomes including the highest infant mortality rate of major U.S. cities.³ The Philadelphia maternal mortality rate has been 53% higher than the national rate and 140% higher than the Healthy People 2020 goal. Black women make up about 45% of the city's annual birthing population but account for 75% of all pregnancy-related maternal deaths, traced to complications with coordination of care, access, systemic inequities in healthcare and social service resources available to prenatal and postpartum women, behavioral health problems, including mental illness, and history of drug abuse.⁴

Philadelphia must improve outcomes by providing more options and better care and could be a national example with innovative solutions. As previously stated, FPCN is addressing these needs by opening a brand new birth center in the Promise Zone of West Philadelphia, which – as the only birth center in the city – will serve medically underserved and economically disadvantaged families, providing options in childbirth and a healthy start for families starting in late 2019.

“Why a birth center?” you may ask. First, a birth center is a home-like setting where midwives provide family-centered care to healthy pregnant women. Birth centers improve population health, patient experience, and value by providing women with a safe and women and family-centered birth option. Midwife-led care will be the standard, which consistently results in better birth and health outcomes

¹ *Global, regional, and national levels of maternal mortality, 1990–2015*, The Lancet, 2016

² *Why America's Black Mothers and Babies Are in a Life-or-Death Crisis*, New York Times, 2018

³ *National Vital Statistics Report*, Centers for Disease Control and Prevention, 2010

⁴ *Maternal Mortality in Philadelphia*, City of Philadelphia, 2015

among diverse communities, including lower cesarean rates and higher breastfeeding initiation rates, thus improving birth and post-partum outcomes for mothers and babies.

The Centers for Medicare & Medicaid Services, or CMS, recently published results of their national initiative, Strong Start for Mothers and Newborns, which tested three evidence-based maternity care service approaches, including birth centers, that enhanced care delivery, and addressed the medical, behavioral and psychosocial factors that might be present during pregnancy and contribute to poor birth outcomes. The study found that women who received prenatal care in Birth Centers had better birth outcomes and lower costs relative to similar Medicaid beneficiaries not enrolled in this program. In particular, rates of preterm birth, low birthweight, and cesarean section – all direct causes of maternal and infant mortality and bad outcomes – were lower among Birth Center participants, and costs were more than \$2,000 lower per mother-infant pair during birth and the following year. We expect to see similar outcomes in our birth center, which is set to begin operations in late 2019.

Philadelphia is one of the largest cities in the US without a birth center. Wide interest from the community for additional women- and family-centered birth options, combined with poor infant and maternal health outcomes, show Philadelphia's need for a birth center. Highlights from community-based focus groups indicating the need for a birth center in the city include:

- “Women want a choice. The hospital is not what I wanted, and it’s scary to think you can’t choose.” - Isabelle, prenatal and postpartum patient at FPCN
- “Women are desperate for childbirth options in Philadelphia... Every day I hear from women who want to give birth at a birth center or have a home birth, but as Medicaid recipients their options are so limited.” - Naime Black, Maternity Care Coalition’s Breastfeeding & Doula Program Coordinator
- “I witnessed support and respect given to women during pregnancy and birth... I want more women who look like me to have access to this kind of care, too.” - Tahara Prescott-Palmer, West Philadelphia resident and Certified Nurse Midwife

To Whom it May Concern,

Thank you for the opportunity to comment on meaningful solutions to maternal mortality. We have had many conversations discussing the stark maternal mortality statistics in Pennsylvania, and in the United States, and now it's finally time to discuss what we will do beyond the formation of the statewide maternal mortality review commission.

I am Crystal Hawkins. I am a labor and delivery RN here in the Philadelphia area. I am also co-organizing the Black and Brown Maternal Health Fair in Philadelphia on June 8, 2019 in West Philadelphia. I am commenting on this subject because I am a black Philadelphia native, a mother, a birth worker, and an advocate of women's health.

In particular, I am concerned about the 19 deaths that were reported by the maternal mortality review board in 2015. In that review, 19 pregnancy related deaths were reported. Of those 19 birthing people, 14 were identified as black. We now have abundant evidence and data demonstrating that black women are dying at an alarming rate as compared to white women. In Philadelphia, over 90% of births occur in the hospital. However, not all of those people require high risk hospital care. With this knowledge, lawmakers should address the regulation of Certified Professional Midwives (CPMs) in Pennsylvania so that more birthing people have access to midwifery care that is community based and culturally relevant. We also need to invest in funding education for more black midwives in Pennsylvania, since we know that race concordance improves adherence to care plans, increases agency, and improves outcomes.

In the United States, it is normal for a birthing person to be discharged from the hospital 48-72 hours after delivery, and then not be evaluated again by a provider until six weeks postpartum. Six weeks is too long for birthing people to wait to see a provider. Lawmakers should address this by funding the training and providing a living wage with benefits to a collaborative team of providers, such as perinatal community health workers, birth and postpartum doulas, nurses, lactation consultants, certified lactation counselors, mental health workers with experience in the perinatal period, midwives, etc). The role of this team would be to closely follow the birthing person through their pregnancy and postpartum in their home to offer more frequent monitoring for signs and symptoms of negative outcomes (e.g., swelling, bleeding, infection, vital signs, mental health, support system, etc), as well as offer support for breast/chestfeeding and the adjustment to parenthood or the demands of a growing family.

Lawmakers should further address why black women are dying at a much higher rate than white women by investing in implicit bias trainings taught to nurses and healthcare providers by people of color. Nurses and providers have to address their inherent distrust of black people when they report symptoms and actively work to dismantle how those biases impact individual care, institutional policies and procedures, and structural and systemic barriers to health equity in our cities and throughout the commonwealth.

For the foregoing reasons, Pennsylvania lawmakers should consider regulating CPMs, scaling up the perinatal support workforce to meet postpartum needs, providing ongoing implicit bias training for nurses and providers, and funding the training of more black midwives and doulas.

Sincerely,
Crystal Hawkins, BSN, BA, RN

**Testimony before Representative Morgan Cephas and Policy Committee
on
Meaningful Solutions to Maternal Mortality**

**April 3, 2019
Saint Joseph's University
Philadelphia, PA**

Good afternoon, I would like to thank Representative Morgan Cephas and the committee for allowing me to testify on this very important issue.

My name is Brenda Shelton-Dunston. I am the Executive Director of the Philadelphia Black Women's Health Alliance.

Maternal mortality is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.² Maternal mortality is a significant public health issue. Although the United States spends more on healthcare than any other country in the world, more than two women die during childbirth every day, making maternal mortality in the United States the highest when compared to other industrialized nations.¹ Between 2000 and 2014, there was a 26% increase in the maternal mortality rate.³ African American women have the highest prevalence of maternal mortality in the United States. They are three to four times more likely to die from a pregnancy-related complication than non-Hispanic white women.³

Data Findings:

To date, much of the literature on maternal mortality focuses on understanding the medical causes behind death. However, there are no studies that explore how the social determinants of health impact maternal mortality among African American women. Therefore, there is a need to investigate how overt and covert racism, discrimination, trauma, and institutional oppression are affecting the daily experiences of black pregnant women, thus potentially increasing maternal mortality rates.

Health Disparity:

Racial disparities in maternal mortality are staggering. Black women face significantly higher mortality risk. Between 2011 – 2013, Black women

experienced 44 deaths per 100,000. White women experienced 13 per 100,000, and women of other races experienced 14 per 100,000.

Causes of Maternal Mortality:

The major complications that account for nearly 75% of all maternal deaths are:

- 1) Severe bleeding (mostly bleeding after childbirth) – 25%
- 2) Infections (usually after childbirth) – 15%
- 3) High blood pressure during pregnancy (pre-eclampsia and eclampsia) – 12%
- 4) Complications from delivery – 8%
- 5) Unsafe abortion – 13%

Additional Research and Interventions Needed:

How does the role of racism/discrimination impact maternal mortality rates for minority women?

How are risk factors such as poor nutrition, uncontrolled stress, obesity, and hypertension associated with adverse pregnancy outcomes among African American women?

Do any associations between adverse pregnancy outcomes and the risk factors of low socio-economic status and stress differ between black women and women of other ethnic groups, i.e. Caucasian, Korean, Native American?

Community-based education and awareness programs

Once again, I thank the committee for this opportunity to testify, and ask that the presented information be taken into consideration as you consider policy addressing this important public health issue.

References:

1. The American College of Obstetricians and Gynecologists. Women's Health Care Physicians. Retrieved from <https://www.acog.org/About-ACOG/ACOG-Departments/Government-Relations-and-Outreach/Federal-Legislative-Activities/Maternal-Mortality?IsMobileSet=false>

2. World Health Organization. Maternal mortality. Retrieved from <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality>
3. Centers for Disease Control and Prevention. Reproductive Health. Retrieved from <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-complications.html>

Fatima Jackson¹, MPH ©, Brenda Shelton-Dunston², MPH

¹LaSalle University, Philadelphia, PA, USA

²Black Women's Health Alliance, Philadelphia, PA, USA

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."

Martin Luther King

HRSA Maternal Mortality Summit

Promising Global Practices to Improve Maternal Health Outcomes

Maternal mortality remains a universally recognized public health priority, despite efforts and some success in addressing this issue. Maternal mortality is a key indicator of health and is associated with accessibility of maternal and other health care services in a country.

HRSA's Maternal Mortality Summit held in June 2018 discussed evidence-based approaches and identified innovative solutions to decreasing maternal mortality and severe maternal morbidity rates both in the U.S. and across the globe. The Summit invited international subject matter experts from Brazil, Canada, Finland, India, Rwanda, the United Kingdom, and the World Health Organization (WHO), as well as over 130 U.S. subject matter experts.



SUMMIT FINDINGS



ACCESS

Improve access to patient-centered, comprehensive care for women before, during, and after pregnancy



QUALITY

Improve quality of maternity services through efforts such as the utilization of safety protocols in all birthing facilities, such as Alliance for Innovation on Maternal Health (AIM) safety bundles



WORKFORCE

Provide continuity of care before, during and between pregnancies by increasing the types and distribution of health care providers



LIFE COURSE APPROACH

Provide continuous team-based support and use a life course model of care for women before, during and between pregnancies



DATA

Improve the quality and availability of national surveillance and survey data, research, and common terminology and definitions



REVIEW COMMITTEES

Improve quality and consistency of maternal mortality review committees through collaborations and technical assistance with U.S. states



PARTNERSHIPS

Engage in opportunities for productive collaborations with multiple Summit participants and others to decrease the rate of maternal mortality and severe maternal morbidity

GLOBAL MATERNAL MORTALITY STATISTICS



300,000+

Maternal Deaths
Per year*



216

Maternal Deaths
Per 100,000 live births



800+

Women Die Daily
Due to pregnancy** and
childbirth-related outcomes

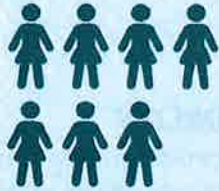
* http://apps.who.int/iris/bitstream/handle/10665/194254/9789241565141_eng.pdf

** [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(15\)00838-7/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)00838-7/fulltext)

U.S. MATERNAL MORTALITY STATISTICS¹

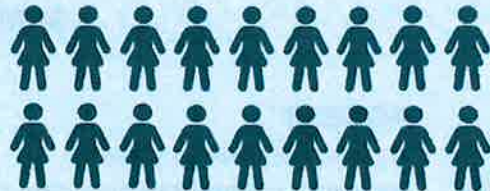
7.2

pregnancy
related
deaths in
1987*



18.0

pregnancy
related
deaths in
2014*



* Per 100,000 live births



ABOUT 700 WOMEN

in the U.S. die as a result of pregnancy or
delivery complications out of approximately
4 MILLION BIRTHS EACH YEAR



Maternal mortality rate in the U.S. is one
of the highest among developed countries



HRSA
Health Resources & Services Administration

¹Data are from the Centers for Disease Control and Prevention's (CDC) Pregnancy Mortality Surveillance System (PMSS) that includes death certificates for all women who died during pregnancy or within 1 year of pregnancy and matching birth or fetal death certificates. Pregnancy-related deaths are defined as the death of a woman while pregnant or within 1 year of the end of a pregnancy – regardless of the outcome, duration or site of the pregnancy – from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.