State Senator Nickie J. Antonio
District 23

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Senate Health Committee
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Sponsor Testimony SB 137

Antonio:

Good morning Chair Huffman, Vice Chair Antani and members of the Senate Health Committee. Thank you for this opportunity to provide sponsor testimony on Senate Bill 137, which would modify the Pregnancy Associated Mortality Review Board. The Ohio Department of Health (ODH) established the Ohio Pregnancy-Associated Mortality Review (PAMR) to identify and review pregnancy-associated deaths with the goal of developing interventions to reduce maternal mortality, particularly for pregnancy-related deaths.

Every day, women die from preventable causes related to pregnancy and childbirth across the world. The Ohio Department of Health released a report stating that from 2012-2016, 57% of pregnancy deaths in Ohio could have been prevented.[1] We cannot address maternal mortality without recognizing that Black women are disproportionately impacted by maternal and infant mortality. The aforementioned study also reports that while Black women account for 17% of people giving birth in Ohio, they accounted for 34% of pregnancy-related deaths.[2] In order to reduce maternal deaths, we need to have a full picture of what factors contribute to the deaths. PAMRs help states get that full picture.

During the operating budget in the 133rd General Assembly (HB 166), an amendment was added that codified PAMR and required the board to produce biennial reports. This was the first step in strengthening the PAMR. This bill would continue to bolster the PAMR by requiring an annual report on maternal mortality and morbidity, specifying the professions and lay people who will sit on the board and requiring that the board meet a minimum of four times annually.

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[1] https://odh.ohio.gov/wps/wcm/connect/gov/f5f620c6-d444-4873-bbc8-bbc76bba1a71/A_Report_on_Pregnancy-Associated_Deaths_in_Ohio_2008-2016+website+version.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-f5f620c6-d444-4873-bbc8-bbc76bba1a71-n6O1KfN

[2] https://www.dispatch.com/news/20191115/over-4-year-period-57-of-pregnancy-deaths-in-ohio-could-have-been-prevented-report-says

Under the bill, in each report, the board also must:

- Identify the actual and potential causes of and factors contributing to pregnancy associated-deaths that occurred in the immediately preceding calendar year, including whether gaps in availability and quality of care, systemic care delivery issues, demographics, deficiencies in insurance coverage, and racial and other disparities played a role in such deaths.

- Make determinations regarding the preventability of pregnancy-associated deaths

- Address in its recommendations whether changes to both of the following would reduce pregnancy-associated deaths: services and programs that serve pregnant and postpartum women as well as the groups, professions, agencies and entities that serve them

- Assess its progress on implementing prior Board recommendations.

Kunze:

The bill requires that each annual report include data that is disaggregated by the insurance coverage, race and ethnicity, as well as other categories identified by the Director of Health, of the women who experienced pregnancy-associated death. To the extent possible, the data must be delineated to show differences between population subgroups within each category.

Each subsequent report must be submitted no later than December 1 each year beginning with the December that occurs in the calendar year immediately following the date on which the initial report was submitted. Each subsequent report must cover pregnancy-associated deaths that occurred in the immediately preceding calendar year. The bill specifies that the report is a public record that is not confidential.

PAMR is currently required to review pregnancy-associated deaths; however, cases of severe maternal morbidity (SMM) do not have the same review requirement. SMM is the unexpected outcomes of pregnancy, labor, or delivery that result in significant short-term or long-term consequences to a woman's health. While data is collected on SMM cases, PAMR does not review these cases. The bill requires the Director of Health, no later than 60 days after this bill's effective date, to adopt rules (1) specifying data on severe maternal morbidity that each hospital and freestanding birthing center in Ohio must report to the Director and (2) prescribing the manner in which such data must be reported. Hospitals and freestanding birthing centers must comply with the reporting requirement annually.

Using the data reported by hospitals and freestanding birthing centers as well as any other pertinent data, the bill requires the Department of Health to prepare an annual report evaluating trends and patterns on severe maternal morbidity in Ohio. Each report must include data that is disaggregated by the insurance coverage, race and ethnicity, as well as other categories identified by the Director of Health, of women affected by severe maternal morbidity. To the extent possible, the data must be

delineated to show differences between population subgroups within each category. Each report must be submitted with and in the same manner as the annual reports on pregnancy-associated deaths.

Thank you for the opportunity to testify on this legislation. We are happy to answer any questions the committee may have at this time.