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**Ohio House District 26**

**House Bill 434 Sponsor Testimony (as prepared)**

Chairman Lipps, Vice-Chair Manning, Ranking Member Boyd, and members of the House Health Committee, thank you for the opportunity to provide sponsor testimony on House Bill 434, which will provide modifications to the Pregnancy-Associated Mortality Review board.

In 2017, approximately 810 women died from preventable causes related to pregnancy and childbirth every day.[[1]](#footnote-1) In the U.S. every year, 700 to 900 new and expectant mothers die, with an additional 500,000 experiencing life-threatening postpartum complications. The majority of the deaths are from preventable causes.[[2]](#footnote-2) Black women in the United States are three to four times more likely to die from childbirth or pregnancy-related causes than white women.[[3]](#footnote-3)

The United States has the highest maternal mortality rate in the industrialized world and the only industrialized country with increasing rates. One of the key recommendations by the CDC to decrease this trend is for states to create a robust review process of maternal deaths. Every state, with the exception of three, have established or are in the process of establishing their own version of a maternal mortality review board.[[4]](#footnote-4) The purpose of these boards are to gather information that will help researchers and doctors understand how to prevent women from dying of preventable causes. California was able to cut its maternal mortality rate by 55 percent, from 16.9 deaths to 7.3 deaths per 100,000 live births from 2006 to 2013. The state was able to do this by establishing a review committee and targeting toolkits for hospitals to use.[[5]](#footnote-5)

Because the women are dying at increasing rates, and the disparities between White women and Black women continue to grow, the U.S. Congress passed the “Preventing Maternal Deaths Act” (The Act) in 2018. This bipartisan legislation is meant to support states in their work to save and sustain the health of mothers during pregnancy, childbirth, and the postpartum period. The legislation also aims to eliminate disparities in maternal health outcomes for pregnancy-related and pregnancy-associated deaths and identify solutions to improve health care quality and health outcomes for mothers. The “Preventing Maternal Deaths Act” allocates $58 million each fiscal year to provide states with the funds to establish and maintain the work of their maternal mortality review committees. Ohio was awarded 2 grants from “The Act” in September 2019 to address maternal mortality. I will expand on this later in my testimony.

In 2010, Ohio’s Department of Health established the Pregnancy-Associated Mortality Review (PAMR), to review maternal deaths in the state. In this General Assembly, during HB166, the State operating budget, I was able to get an amendment in the budget which codified PAMR and required the board to produce biennial reports. While this was a step in the right direction, there’s so much more that needs to be done to combat maternal mortality and strengthen the PAMR Board. Clarifying the language is a start to strengthening PAMR to better combat maternal mortality.

Prior to being codified, PAMR had not released a report since 2014. PAMR released its most recent report in November 2019. During the time that reports were not released, mothers continued to die.

According to the most recent PAMR report, a pregnancy-related death is the death of a woman while pregnant or within one year of the end of pregnancy, regardless of duration and site of pregnancy, from any cause related to or aggravated by her pregnancy or its management (e.g., from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy).[[6]](#footnote-6)

Ohio’s maternal death rate was 14.7 per 100,000 live births between 2008 and 2016. The report found that during this time, there were 610 pregnancy-associated deaths in Ohio. Of those, 186 women died due to pregnancy-related reasons. Black women died at a rate more than two and a half times that of white women, accounting for 34 percent of pregnancy-related deaths while only making up 17 percent of women giving birth in Ohio.[[7]](#footnote-7) Over half of all pregnancy-related deaths (57 percent) between 2012 and 2016 were preventable.[[8]](#footnote-8)

As a state, not only are we behind on releasing data, the most recent report only provides data through 2016. Once again, while we have these delays, women are dying from preventable issues.

House Bill 434 will strengthen 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 meets a minimum of four times each calendar year.

The individuals who sit on the PAMR board will be from diverse racial and ethnic backgrounds, including individuals who have been affected by severe maternal morbidity and experts with diverse backgrounds. The board will also consists of a lay midwife, two women who have experienced a delivery hospitalization with severe maternal morbidity, and representatives for women and mothers who are considered medically underserved. The importance of the diverse board members is to ensure that cases are being examined from a variety of perspectives in order to fully understand the issues and find solutions to the problem.

It is extremely important that the board have a patient’s view in order to grasp an understanding of what patients are experiencing and the treatment they are receiving. The lived experience of a delivery hospitalization can provide another perspective of what patients experienced leading up to their hospitalization and during treatment. This information allows best practices to be replicated and things that contributed to traumatic experiences to be eliminated.

The board’s responsibilities, include but are not limited to:

* Identify and make recommendations to improve gaps in care and systemic care delivery issues, including from racial disparities;
* Recommend and develop plans for implementing service and program changes, as well as changes to the groups, professions, agencies, and entities that serve pregnant and postpartum women and families;
* Develop and disseminate evidence-informed interventions to reduce the mortality of pregnant and postpartum women;
* **Preventability -** Makes determinations how such deaths may be prevented, including changes that should be made to policies and laws;
* **Tracking Progress -** Assesses the board's progress on implementing prior board recommendations.

Currently, women are going into a healthcare system that does not treat everyone fairly or equitably. This legislation will also identify adverse outcomes that result from differences in the quality of care that may be experienced by women of various geographic areas, races, ethnicities, and socioeconomic circumstances that may contribute to pregnancy-associated deaths.

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. SMM cases occur 100 times more frequently than a maternal death.[[9]](#footnote-9)

A 2017 factsheet released by ODH shows that in 2013, Ohio’s SMM rate was 143 per 10,000 hospital deliveries. Ohio must address these incidents as they greatly and adversely affect women’s health and wellbeing.[[10]](#footnote-10) Understanding what went wrong in an SMM case and what was done to save the mother has the ability to prevent future SMM incidents as well as incidents of maternal mortality.

House Bill 434 will require the Department of Health to prepare an annual report that evaluates trends and patterns on severe maternal morbidity. This report will 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 shall be delineated to show differences between population subgroups within each category.

ODH was recently awarded two federal grants to address maternal mortality within the state. $2,000,000 each year for the next five years, for a total of $10,000,000, comes from, the Health Resources & Services Administration’s (HRSA) State Maternal Health Innovation Program.[[11]](#footnote-11) Among the requirements for receiving this funding states must:

1) Establish a state-focused Maternal Health Task Force to create and implement a strategic plan that incorporates activities outlined in the state’s most recent State Title V Needs Assessment;

2) Improve the collection, analysis, and application of state-level data on maternal mortality and SMM; and,

3) Promote and execute innovation in maternal health service delivery, such as improving access to maternal care services, identifying and addressing workforce needs, and/or supporting postpartum and interconception care services, among others.[[12]](#footnote-12)

ODH was also one of 24 awardees, awarded $2,250,000 over 5 years from the CDC for the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program.[[13]](#footnote-13) The funding from this program is meant to support agencies and organizations that coordinate and manage Maternal Mortality Review Committees to identify, review, and characterize maternal deaths; and identify prevention opportunities. This funding will also:

* Assist ODH in determining what interventions at patient, provider, facility, system and community levels will have the most impact; and,
* Implement initiatives in the right places for families and communities who need them most.

Currently, the data within the PAMR report is very broad, race is broken down by Hispanic, Non-Hispanic Black, Non-Hispanic White, and Non-Hispanic, Other Races. It is important that the data be disaggregated because we know, there are some health conditions that certain races may be more likely to experience. Disaggregation of data in health is important because it has the ability to improve how we create, understand, and handle race and ethnicity, migration status, and disability when pursuing treatment, health improvements and overall health equity.[[14]](#footnote-14)

Race is not the only data that will be disaggregated by PAMR. Social determinants of health play a significant role in data and health outcomes. Disaggregating the data will allow the board to drill down on non-medical factors that impact health and contribute to maternal mortality and morbidity such as economic factors, insurance coverage, education, etc. The more the PAMR board is able to know about the individuals who experience maternal mortality and morbidity, they can make their recommendations for improvement more accurate.

Finally, House Bill 434 will designate the month of May as Maternal Mortality Awareness Month. We have heard of cases like Serena Williams, who had to demand that doctors address her known medical history of pulmonary embolisms. Many have heard of the unfortunate case of Kira Johnson, who lost her life after doctors waited too long to address the blood that was seen in her catheter after giving birth to her second child. Or, in my own personal situation, most of you have heard my story of experiencing a traumatic pregnancy with my twin girls. Bringing awareness to this issue of maternal mortality gives a voice to those who were not able to be saved while also helping people understand the importance of the need for solutions.

There are several pieces of legislation introduced during the GA that focus on mothers carrying their pregnancies to term. We need healthy moms and healthy babies. Establishing these guidelines for the PAMR board will allow our state to learn from near misses in the cases of SMM and from those mothers whose lives were lost due to their pregnancy complications. Where these deaths are preventable, it is our responsibility to do everything we can to ensure that families come first in Ohio and mothers can live their lives without the fear of dying during or after childbirth.

Thank you again for the opportunity to speak on behalf of this legislation, and at this time I will be happy to answer any questions you may have.

1. “Maternal Mortality.” World Health Organization. World Health Organization. Accessed February 12, 2020. https://www.who.int/news-room/fact-sheets/detail/maternal-mortality. [↑](#footnote-ref-1)
2. “America Is Failing Its Black Mothers.” Harvard Public Health Magazine, December 21, 2018. https://www.hsph.harvard.edu/magazine/magazine\_article/america-is-failing-its-black-mothers/. [↑](#footnote-ref-2)
3. “Pregnancy-Related Deaths.” Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, February 26, 2019. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm. [↑](#footnote-ref-3)
4. “State Maternal Mortality Review Committees, PQCs, and AIM.” ACOG.org. American College of Obstetricians and Gynecologist , September 2019. https://www.acog.org/-/media/Departments/Government-Relations-and-Outreach/MMRC\_AIM-State-Fact-Sheet-Aug-2019.pdf?dmc=1&ts=20200212T1624014431. [↑](#footnote-ref-4)
5. “CA-PAMR (Maternal Mortality Review).” CA-PAMR (Maternal Mortality Review) | California Maternal Quality Care Collaborative. Accessed February 12, 2020. https://www.cmqcc.org/research/ca-pamr-maternal-mortality-review. [↑](#footnote-ref-5)
6. “A Report on Pregnancy-Associated Deaths in Ohio 2008-2016.” Ohio Department of Health, November 2019. https://odh.ohio.gov/wps/wcm/connect/gov/f5f620c6-d444-4873-bbc8-bbc76bba1a71/A Report on Pregnancy-Associated Deaths in Ohio 20018-16 finalx.pdf?MOD=AJPERES&CONVERT\_TO=url&CACHEID=ROOTWORKSPACE.Z18\_M1HGGIK0N0JO00QO9DDDDM3000-f5f620c6-d444-4873-bbc8-bbc76bba1a71-mVLW5zb. [↑](#footnote-ref-6)
7. *Id.* [↑](#footnote-ref-7)
8. *Id.* [↑](#footnote-ref-8)
9. *Id.* [↑](#footnote-ref-9)
10. “Severe Maternal Morbidity.” Ohio Department of Health, 2017. https://odh.ohio.gov/wps/wcm/connect/gov/db0ab299-4e0d-411e-a107-2db1f555106a/SMM-Factsheet.pdf?MOD=AJPERES&CONVERT\_TO=url&CACHEID=ROOTWORKSPACE.Z18\_M1HGGIK0N0JO00QO9DDDDM3000-db0ab299-4e0d-411e-a107-2db1f555106a-mMBwu6k. [↑](#footnote-ref-10)
11. Pregnancy Associated Mortality Review (PAMR) Activities. Accessed February 12, 2020. https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/pregnancy-associated-mortality-review/resources/PAMR-Initiatives. [↑](#footnote-ref-11)
12. “State Maternal Health Innovation Program.” Health Resources & Services Administration, February 12, 2020. https://www.hrsa.gov/grants/find-funding/hrsa-19-107. [↑](#footnote-ref-12)
13. Pregnancy Associated Mortality Review (PAMR) Activities. Accessed February 12, 2020. https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/pregnancy-associated-mortality-review/resources/PAMR-Initiatives. [↑](#footnote-ref-13)
14. “Counting a Diverse Nation: Disaggregating Data on Race and Ethnicity to Advance a Culture of Health.” PolicyLink. Accessed February 12, 2020. https://www.policylink.org/sites/default/files/Counting\_a\_Diverse\_Nation\_08\_15\_18.pdf. [↑](#footnote-ref-14)