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BETTER DATA AND BETTER OUTCOMES: REDUCING MATERNAL MORTALITY IN THE U.S.

THURSDAY, SEPTEMBER 27, 2018

House of Representatives

Subcommittee on Health

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 10:00 a.m., in Room 2123 Rayburn House Office Building, Hon. Michael Burgess [chairman of the subcommittee] presiding.

Members present: Representatives Burgess, Guthrie, Barton, Shimkus, Latta, Lance, Griffith, Bilirakis, Long, Bucshon, Brooks, Mullin, Hudson, Carter, Walden(ex officio), Green, Engel, Schakowsky, Castor, Schrader, Kennedy, Cardenas, DeGette, and Pallone (ex officio).

Staff present: Mike Bloomquist, Staff Director; Samantha Bopp, Staff Assistant; Daniel Butler, Staff Assistant; Adam

Fromm, Director of Outreach and Coalitions; Zach Hunter, Director of Communications; Ed Kim, Policy Coordinator, Health; Ryan Long, Deputy Staff Director; Drew McDowell, Executive Assistant; Brannon Rains, Staff Assistant; Austin Stonebraker, Press Assistant; Josh Trent, Deputy Chief Health Counsel, Health; Hamlin Wade, Special Advisor, External Affairs; Jacquelyn Bolen, Minority Professional Staff; Jeff Carroll, Minority Staff Director; Evan Gilbert, Minority Press Assistant; Waverly Gordon, Minority Health Counsel; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Tim Robinson, Minority Chief Counsel; and Samantha Satchell, Minority Policy Analyst.

Mr. Burgess. And the Subcommittee on Health will now come to order. I recognize myself 5 minutes for purpose of an opening statement. And I want to thank everyone for joining us this morning to discuss a topic that is important to each and every one of us. This is a subject matter that has been brought to the forefront by members of this subcommittee, members of Congress generally, actions of state legislators, and the media.

Having spent 3 decades myself practicing OB/GYN, I believe it should be a national goal to eliminate all preventable maternal mortality. Even a single maternal death is too many. All too often we have read about the stories of seemingly healthy pregnant women who are thrilled to be having a child and then to everyone's surprise suffers severe complications, death, or near death during a pregnancy, birth, or postpartum. The death of a new or expecting mother is a tragic event that devastates everyone involved, and if there are preventable scenarios we need to do what we can to stop that.

The alarming trend in our country's rate of maternal mortality first came to my attention in September 2016 reading a copy of the American College of Obstetricians and Gynecologists, The Green Journal. The original research found that the maternal mortality rate had increased in 48 states and Washington, D.C. from 2000 to 2014, while the international trend was moving in the opposite direction. Since reading that article, I have spoken to providers, hospital administrators, state task forces,

and public health experts. The more I looked into this troubling issue, the more I realized that we have got much more we need to understand.

This subcommittee had an informational briefing last year on this topic to inform members and to start the road toward this hearing. This is an issue that we cannot solve without accurate data. There were efforts in our nation to address maternal and infant mortality in the first half of the 20th century and the data showed that these efforts were indeed successful.

But according to the Centers for Disease Control and Prevention the United States' maternal mortality rate, 7.2 deaths per 100,000 in 1999 and increased to 18 deaths per 100,000 live births in 2014. The Centers for Disease Control began conducting national surveillance of pregnancy related deaths in 1986 due to a lack of data on causes of maternal death.

In 2003, the Centers for Disease Control National Center for Health Statistics revised standards for certain death certificates and added a pregnancy checkbox. While this checkbox has led to increased data collection on maternal deaths, it does not provide enough insight as to why or how these deaths occurred. Representative Jaime Herrera Beutler joining us this morning, the discussion draft that she has put forward will address the complex issue of maternal mortality by enabling states to form maternal mortality review committees to evaluate, improve, and standardize their maternal death rate.

This is a critical step in the right direction as physicians, public health officials, and Congress are unable to reach conclusions based upon current data as to what the causes for maternal mortality increases are. Once we establish what these are, there will be an opportunity to use the data to implement the best practices toward a solution. Texas is a good example of a state that has enacted legislation to create and sustain a Maternal Mortality and Morbidity Task Force. Texas has put time and effort in funding and to reviewing maternal deaths in order to find the trends in the increases and the causes of death. The Task Force's September 2018 report, which I have here and later on we will ask unanimous consent to be made part of the record, stated that the leading causes of pregnancy-related death in 2012 included cardiovascular, obstetric hemorrhage, infection sepsis, and cardiomyopathy.

This report is just a snapshot of the national picture as causes do vary from state to state. Additionally, this May, various researchers involved in the review of Texas' maternal deaths published a paper, again in The Green Journal, detailing that unintentional user error and other issues led to inaccurate reporting of maternal mortality. The researchers concluded that relying solely on obstetric codes for identifying maternal deaths appears to be insufficient and can lead to inaccurate ratios.

The moral of this story is we must ensure accurate data to accurately pinpoint the clinical issues contributing to these

tragic deaths. I would like to submit a statement for the record from Dr. Gary Hankins and, without objection, so ordered, the chairman of the Department of OB/GYN at the University of Texas Medical Branch in Galveston.

[The information follows:]

**********COMMITTEE INSERT 1**********

Mr. Burgess. And Dr. Hankins was one of those doctors who briefed us during the briefing last year. Dr. Hankins has subspecialty training in maternal fetal medicine and served as vice chair for the Texas Morbidity and Mortality Review Committee.

At one time we were scheduled to be joined by Dr. Lisa Hollier, also of Texas, who is also part of that committee. I think we had to postpone last week because of a hurricane and she could not accommodate the reschedule. But Dr. Hollier has also been integral in working on this at the state level.

So I certainly look forward to hearing from our panel of witnesses today as how we can address this vital and devastating issue. Mr. Burgess. The chair recognizes the ranking member of the subcommittee, Mr. Green, 5 minutes for your opening statement, please.

Mr. Green. Thank you, Mr. Chairman, for calling today's hearing on maternal mortality in the United States, and I would also like to thank our colleague who is in our distinguished panelists for joining us this morning.

I would like to take just a moment, Mr. Chairman. My deputy chief of staff, LD/LA, Sergio Espinosa, this will be his last committee hearing and he has been working with me on health care in our office for many years -- 8 years, it has been 8 or 9. This is his last hearing. And those of you who someday decide you are not going to run for reelection, you will know that you will be losing staff members in the last 2 or 3 months. But I

just want to thank Sergio for his work in the office on many issues, but particularly in the last number of months on health care.

So -- and I will continue with my statement.

[Applause.]

Mr. Green. The Centers for Disease Control and Prevention reports that more than 700 women in the United States die each year due to complications related to pregnancy and childbirth, and more than 50,000 women experience a life-threatening complication. Maternal mortality in our country has more than doubled between 1987 and 2014, from 7.2 to 18 maternal deaths per 100,000 live births. In comparison, a recent World Health Organization study found that maternal mortality is on the decline in 157 of the 183 countries.

These numbers are troubling as we are because even more acute when you look at the existing racial, socioeconomic, and geographic disparities, for example, African American women are nearly three times as likely to die of complications relating to pregnancy and childbirth compared to white women. In America in the 21st century, no woman should ever die of complications related to pregnancy and childbirth.

Congress has a duty to act and reverse this terrible trend. I would like to thank my colleagues both Congresswoman Diane DeGette and Congresswoman Jaime Herrera Beutler for offering their discussion draft, The Preventing Maternal Deaths Act that will help protect pregnant and postpartum mothers. This

legislation will provide grants to states and tribes to help establish and support already existing maternal mortality review committees, MMRCs, to identify and review pregnancy-related and pregnancy-associated deaths.

MMRCs which are currently operating in over 30 states have been helping strengthen public health surveillance by linking vital data to the multidisciplinary healthcare professionals practicing in women's health. I support the bipartisan legislation and hope our committee will recommend it in consideration before the full House before the end of the year.

My Preventing Maternal Deaths Act is an important first step. Our committee can and must do more to protect our nation's mothers. Despite the gains made under the Affordable Care Act, nearly one in seven women of childbearing age remain uninsured. The biggest barrier to women of childbearing age receiving healthcare coverage is continuing refusal of 19 states, including my home state of Texas, to expand Medicaid. Continuing of a comprehensive health insurance is critical for expecting and postpartum mothers to receive the post and postnatal care they need for themselves and their babies.

Medical research shows chronic conditions such as hypertension, diabetes, heart disease, and obesity which are becoming more common for expecting mothers can increase their risk for complications during pregnancy. Ensuring continuing of coverage preceding pregnancy will help women of childbearing

age best manage these chronic conditions before they become a problem.

Last year I introduced Incentivizing Medicaid Expansion Act, H.R. 2688, in order to incentivize states to provide critical Medicaid coverage for uninsured Americans and avoid the kinds of tragedy that has led to the rising rate of mortality in my home state. My legislation would guarantee that the federal government covers a hundred percent of expansion costs for the first 3 years for states that have not yet expanded, and no less than 90 percent afterwards. I ask the committee to give this legislation the serious consideration that it deserves and help reverse the public health crisis that maternal mortality and severe maternal morbidity have become too many for our communities and our country.

And in my last 39 seconds, UTMB in Galveston has been the catchment for most of the births in East Texas and South Texas and for decades, and I appreciate that university and that medical school for doing that for our families. In the Houston area we have a hospital district, but Medicaid would at least help get them reimbursed. But UTMB is the catchment for problem pregnancies in South Texas and East Texas.

Thank you, Mr. Chairman. I yield back. Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from Oregon, the chairman of the full committee, Mr. Walden, 5 minutes for your opening statement,

please.

The Chairman. Well, thank you, Chairman Burgess.

Doctor, we are glad that you are chairing this subcommittee and this subcommittee hearing especially given your many decades of real-world experiences in OB/GYN. So we are glad to have you at the helm for this hearing especially. It is a difficult topic and it is one that is close to many of us.

Far too many mothers die because of complications during pregnancy, and the effects of such a tragedy on any family is impossible to fully understand. What is both surprising and devastating is that despite massive innovation and advances in health care and technology we have experienced recent reports that have indicated that the number of women dying due to pregnancy complications is actually increasing. It is actually going up.

According to the Centers for Disease Control and Prevention, maternal mortality rates in America have more than doubled since 1987, and I think we are all asking how can that be? Well, this is not a statistic any of us wants to hear. There are questions as to whether the increases due to data collection are broader questions about healthcare delivery. The bill before us today will help us answer these really important questions and hopefully ensure that expectant newborn mothers receive even better care.

I want to thank Congresswoman Herrera Beutler, my neighbor to the north in Washington State, for bringing this issue to our attention. She has been a real leader on this effort for many,

many months, if not years. And especially given what you have been through in your own situation, we are proud of you and of your children and so we are glad to have you before the committee.

I also want to thank my colleague and friend from Colorado, Diana DeGette, for her partnership on the draft legislation that is before us today. She has been a real leader on 21st Century Cures and other public health issues that are so important. And I want to extend a sincere thank you to the members of our second panel. Mr. Johnson, it is good to see you again. We appreciate you coming back here. I am sorry for what you have been through, but I appreciate your willingness to come share with us. Your testimony makes a difference in public policy.

The draft bill we are examining today is the Preventing Maternal Deaths Act of 2018. The bill would enhance our federal efforts to support maternal mortality review committees in each of our states. And earlier this year, the Oregon legislature passed a bill to establish such a committee in my home state which brings a wide range of medical providers together with community organizations and with public health experts to study maternal mortality and figure out its underlying causes. That information and lessons learned will then be shared with law enforcement and healthcare providers across Oregon. Congress should support and it should build off of these efforts and others across the country so many of these deaths could be prevented if best practices for maternal health care were followed and more widely understood.

So that is what this hearing is all about. We appreciate you being here and we look forward to the testimony from our other panelists and of course from our colleague. I will tell you in advance we actually have two subcommittees going on simultaneously, and as chairman of the overall committee I have to bounce back and forth between them. But thank you for being here and we look forward to moving forward to find solutions.

And with that, Mr. Chairman, I yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from New Jersey, Mr. Pallone, the ranking member of the full committee, 5 minutes for an opening statement, please.

Mr. Pallone. Thank you, Mr. Chairman. Hundreds of women die each year from pregnancy-related or pregnancy-associated complications in the United States, and more than 60 percent of these deaths are preventable. Shamefully, the maternal mortality rate in the U.S. has increased while most of the rest of the developed world has actually fallen. And this is not just alarming, it is unconscionable. We have a responsibility to understand why this is happening and what we should be doing to combat this crisis.

Mr. Green and I wrote a letter to Chairman Burgess and Chairman Walden on this issue in May and I am pleased we are finally holding a hearing today. Today we will discuss a draft of the Preventing Maternal Deaths Act which mirrors a version that passed

out of the Senate Health Committee. This is a good bill. It is critical that we have the necessary data to understand the underlying causes of maternal deaths and identify strategies that can help us combat it.

This bill encourages states to implement maternal mortality review committees to study this data and make recommendations on ways to combat maternal death. Review committees that are diverse and interdisciplinary can identify trends, patterns, and disparities that contribute to preventable maternal deaths. And with this information, healthcare providers can monitor the effectiveness of their policy and practice changes.

Now my home state of New Jersey was the second state in the nation to institute a maternal mortality review committee which has worked extensively to review New Jersey's maternal death cases to better understand their root causes and prevent deaths in the future. However, New Jersey's maternal mortality rate remains much too high and much more work still needs to be done.

Extensive public reporting has vividly described the risks American woman face in childbirth and the postpartum period and has also highlighted the vast disparities in outcome. While women of all backgrounds are at risk for pregnancy-related complications, it is critical we also examine why maternal death rates are disproportionately higher for women of color, low-income women, and women living in rural areas. And we must understand why, and work together to address these disparities.

However, we must also consider other ways we can combat maternal mortality, including by expanding health insurance coverage and ensuring all women have access to the reproductive health services they need. Unfortunately, efforts by the Trump administration to sabotage the Affordable Care Act, curtail the Medicaid program, and limit family planning services have only served to harm women and their families. Reducing maternal deaths in the United States must be a public health priority. I look forward to working with my colleagues to advance this bill and to begin addressing this crisis in a meaningful way.

And I would like to now yield the 2 minutes to my colleague, the Democratic sponsor of H.R. 1318, Ms. DeGette. Ms. DeGette. Thank you very much for yielding.

Mr. Chairman, thank you so much for having this hearing. And I know my co-sponsor, Congresswoman Herrera Beutler, and I very much hope that we can mark this bill up and pass it during the lame duck session. In my opinion, it has been far too delayed given what we are seeing in this country. Maternal mortality rose in the United States between 2000 and 2014 by 26 percent. This is really shocking to people who I talk to about this because other developed nations in the world have slashed their maternal mortality rates in half. And here is what is even worse, maternal mortality disproportionately affects women of color. Pregnancy-related death is nearly four times higher among African American women. And there are multiple factors that

contribute to these maternal mortality rates -- the high incidence of preeclampsia, obstetric hemorrhaging, and mental health conditions.

Now to combat this trend, 33 states have established maternal mortality review committees. These panels bring together local healthcare professionals who collectively review individual maternal deaths and then target individual policy solutions towards them. The panels have been very effective. In California, for example, which established one in 2006, they have reduced their maternal mortality by more than 55 percent. And that is why what this bill does is it provides federal support for state-based maternal mortality review committees including for states, critically, that have not yet established these panels. It also promotes efforts to standardize data collection practices for maternal mortality which will help public health experts, researchers, and policymakers develop evidence-based solutions to address this crisis.

The bill has 171 co-sponsors and a number of organizations, some are which here in the audience today. The March of Dimes, the American College of Obstetrics and Gynecologists, and others all support it and so I really hope we can quickly advance the bill. I hope we can pass it by the end of the year and send it to the President's desk. Thank you and I yield back.

Mr. Burgess. The chair thanks the gentlelady. The gentlelady yields back and this concludes with member opening

statements. The chair would remind all members that pursuant to committee rules, members' opening statements will be made part of the record.

We do want to thank our witness on the first panel for being here today and taking time to testify before the subcommittee.

I do want, as a housekeeping note, after Representative Herrera Beutler testifies we will move immediately to the second panel. We will not break in between the panels of witnesses. And again as is the custom, when we have a Member at the witness table there will not be questions from the dais to the Member, so we will go right into the second panel after Representative Herrera Beutler testifies.

So our first witness is Representative Herrera Beutler from the state of Washington who is principal author of this legislation. We appreciate you being here today and you are recognized 5 minutes for your opening statement, please.

STATEMENT OF HON. JAIME HERRERA BEUTLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Ms. Herrera Beutler. Thank you, Mr. Chairman, for having this hearing and for your work in this field. This isn't an issue of the moment for you, but this is what you have dedicated your life to and we are very grateful.

Thank you, Ranking Member Green, for your support of this critical issue, and members of the subcommittee today for participating in this effort to reduce maternal mortality in the United States and for giving me this opportunity to speak in strong support of this discussion draft of the Preventing Maternal Mortality Deaths Act that is before us. So you either are a mom or you have a mom, so this issue impacts you. The very title of this bill speaks to why I have introduced this bipartisan legislation with my co-sponsor Ms. DeGette from Colorado. We have to take vital steps towards moving this bill in Congress and I believe we are going to save lives and prevent more families from suffering the profound loss of a cherished family member.

The testimonies today will shed light on a truly disturbing trend in our nation. More mothers die from pregnancy-related or pregnancy-associated deaths here in the U.S. than in any developed country in the world. Although the assumption is often that a nation with some of the most advanced obstetric and emergency care would also demonstrate low maternal mortality

rates, tragically, an estimated 700-900 maternal deaths occur in the U.S. every year.

And not only does the U.S. rank 47th for maternal mortality globally, we have actually seen an increase in maternal deaths in recent years. This makes us one of only eight nations in the world with rising maternal mortality rates. It is unacceptable. In fact, Iran has a better maternal mortality rate than we do here in the United States. In New Jersey where Mr. Pallone is from, and he knows this, if you are a woman of color, a black woman, you are 79 -- out of 100,000 deaths, 79 are likely to pass away from a pregnancy-associated or pregnancy-related death. You are three or four times more likely as a woman of color to experience this tragedy in our country. It is unacceptable. For families, single fathers, grandparents, and children who have all lost a mother, perhaps the most heart-wrenching of all of this is that according to the CDC 60 percent of these maternal deaths could have been prevented.

As a mother, as a citizen, and a lawmaker, I believe we can and we must do better. It is time for this to become a national priority, which is why I am proud to speak in support of the Preventing Maternal Deaths Act. This legislation would enable states to establish and strengthen maternal mortality review committees. MMRCs bring together local experts in maternal, infant, and public health to review each and every instance of a pregnancy-related or pregnancy-associated death. We are going

to investigate every single one because these moms are worth it. This is going to give us the information to understand why it is happening and what we need to do to fix it. This is how we are going to save future mothers' lives.

As members of the committee are aware, we know many of the conditions that contribute to high maternal mortality rate such as preeclampsia, gestational diabetes, obstetric hemorrhage, as well as emerging challenges such as suicide and substance use disorder. However, the truth is that the available data is woefully inadequate, which greatly hinders our ability to understand why mothers are dying. The Preventing Maternal Deaths Act seeks to address this data deficiency by empowering states to participate in national information sharing through the CDC, allowing for increased collaboration and the development of best practices.

Now before closing, I want to note that the legislation before us was crafted from key policy recommendations made by multiple organizations supporting this bill including the Association of Maternal & Child Health Programs, the American College of Obstetricians and Gynecologists, the March of Dimes, Preeclampsia Foundation, the Society for Maternal-Fetal Medicine -- thank you to all of you tireless warriors in this fight.

Finally, and most importantly, I would like to extend my deepest gratitude to the families, fathers -- one of whom you are going to hear from today, sitting behind me. Charles Johnson

is going to tell you the story of the preventable death of his hero and hopefully this will be a tribute to ending those tragedies. He wants no one else to go through what he has gone through.

And to every advocate who has spoken out, shared their stories, and called for change, these courageous individuals are the champions of this movement and this bill. With wide bipartisan support and well over a 160 co-sponsors in the House, I remain committed to passing the Preventing Maternal Deaths Act into law and I look forward to working with this committee, you, Mr. Chairman, and my colleagues in Congress to accomplish this imperative goal.

With that I thank you and I yield back.

[The prepared statement of Ms. Herrera Beutler follows:]

**********INSERT 2**********

Mr. Burgess. We thank you, Representative Herrera Beutler, for, number one, putting forward the discussion draft and working on it so hard over this past year in bringing all of the different people together that had to finally come together to get this hearing a reality today. And I know it took a lot of work on your part and we really appreciate your dedication. So thank for being with us this morning and we will move immediately to our second panel.

And while the transition is occurring, I will just use this time to thank all of our witnesses for being here today and taking time to testify before the subcommittee. Each witness will be given the opportunity to deliver an opening statement followed by questions from members.

Mr. Green. Mr. Chairman?

Mr. Burgess. For what purpose does the gentleman from Texas seek recognition?

Mr. Green. I would like to submit the following letters, ask unanimous consent to submit the following letters for the record. From the Moms Rising, Alexis Joy Foundation, and the Society for Maternal Fetal Medicine into the record.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT 3**********

Mr. Burgess. Do we have copies of those?

Mr. Green. Yes.

Mr. Burgess. So today we are going to hear from Mr. Charles Johnson, founder of 4Kira4Moms; Ms. Stacey Stewart, president of the March of Dimes; Dr. Lynne Coslett-Charlton, Pennsylvania District Legislative Chair, The American College of Obstetricians and Gynecologists; and Dr. Joia Crear Perry, president of the National Birth Equity Collaborative. We appreciate each of you being here today.

And Mr. Johnson, you are now recognized 5 minutes for an opening statement. Please turn your microphone on. Pull it close. This is the premier technology committee in the United States House of Representatives and we have fairly rudimentary amplification devices.

So Mr. Johnson, you are recognized.

STATEMENTS OF CHARLES S. JOHNSON, IV, FOUNDER, 4KIRA4MOMS; STACEY D. STEWART, PRESIDENT, MARCH OF DIMES; LYNNE COSLETT-CHARLTON, M.D., PENNSYLVANIA DISTRICT LEGISLATIVE CHAIR, THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS; AND, JOIA CREAR PERRY, M.D., FOUNDER AND PRESIDENT, NATIONAL BIRTH EQUITY COLLABORATIVE

STATEMENT OF CHARLES JOHNSON

Mr. Johnson. I think I will manage. Thank you so much. So, first and foremost, to members of this committee, thank you. It is an honor to be here speaking on behalf of the tens of thousands of families that have been affected by this maternal mortality crisis and hundreds of thousands of women who have been affected by near misses.

So let me just begin by telling you about the woman that absolutely changed my life. My wife, Kira Dixon Johnson, was the closest thing that I had ever met to a superhero. She made me far better than I ever thought I could be and she was far better than I ever deserved. We are talking about a woman that ran marathons; that raced cars; that spoke five languages fluently.

So we were blessed to welcome our first son, Charles, on September 18th of 2014. We always wanted back-to-back boys, Chairman Burgess, and we were blessed to find out we were going to welcome our second son, Langston, in April of 2016. We walked into Cedars-Sinai Medical Center on April 12th of 2016 with a

woman that just wasn't in good health, she was in exceptional health. This picture that you see on the screen is literally taken 10 days before Kira went in for the procedure.

We went in for what was supposed to be a routine scheduled C-section on what was supposed to be the happiest day of our lives and we walked right into what was a nightmare. Shortly after the procedure took place around 2 o'clock, shortly afterwards we went back to recovery. As I am sitting there reflecting in all this glow and pride of being a new father for the second time, Kira is resting, my new baby is resting, and as I look at her bedside I begin to see the catheter begin to turn red with blood.

I brought it to the attention of the staff, the nurses at Cedars-Sinai. They came in. They said we are going to do a couple of things. We are going to order a set of tests and we are going to order a CT scan to be performed stat. I was concerned, but I said you know what, my wife is healthy and we are at what is supposed to be one of the best hospitals in the world. I am concerned but we have got a plan, okay. Blood work comes back, it is showing that it is abnormal and she is hemorrhaging and they ordered a CT scan that was supposed to be performed stat. Keep in mind this is around 4 o'clock. 5 o'clock comes, no CT scan. Her blood level was continuing to drop. By this time she is beginning to shiver uncontrollably. 6 o'clock and no CT scan. She is beginning to become pale, she is in extreme pain. 7 o'clock, 8 o'clock comes, no CT scan. I am begging,

I am pleading the staff to do something.

And around 9 o'clock as I continue to plea for my wife's life, the staff at Cedars-Sinai Medical Center tells me, sir, your wife just isn't a priority right now. 8 o'clock comes, 9 o'clock, 10 o'clock. They said, well, we need to do a blood transfusion. I am saying, well, where is the CT scan? It wasn't until after midnight that they finally took my wife back to surgery, after I begged and pleaded for them to take action for more than 10 hours. When they took Kira back to surgery they opened her up and there were three and a half liters of blood in her abdomen and she coded immediately. Now I am here to tell you this. I am not here to tell you what I think. I am here to tell you what I know. There are people on this panel that are far more intelligent than I will ever be that are going to talk to you about the statistics and how horrifying they are. What I am here to tell you is this. That there is no statistic that can quantify what it is like to tell an 18-month-old that his mother is never coming home. There is no matrices that can quantify what it is like to explain to a son that will never know his mother just how amazing she was.

My wife deserved better. Women all over this country deserve better. I am so grateful to my shero, Congresswoman Jaime Herrera Beutler. Thank you so much, Congresswoman DeGette. And for those of you all who have supported this bill, I honest to goodness would love to come up there and just give you a big hug,

but I have been explained that that is not protocol.

And let me say this for those that choose to stand in opposition of this bill, you don't owe me an explanation. You owe an explanation to my boys. You owe Tara Hansen's son an explanation. You owe Mustafa Shabazz and his son an explanation. We have an opportunity to do something, here and now, to send a loud, definitive message to this country that women and babies matter.

Lastly, Kira and I always talked about raising men that would change the world. It is time for us to stop telling our children that they can change the world and show them how it is done. Thank you for your time.

[The prepared statement of Mr. Johnson follows:]

**********INSERT 4**********

Mr. Burgess. Mr. Johnson, we do sincerely appreciate your testimony and as a committee I will say we are terribly sorry for your loss, but grateful for your courage to be here today and present your testimony to us. Thank you, Mr. Johnson.

Ms. Stewart, you are recognized for 5 minutes.

STATEMENT OF STACEY STEWART

Ms. Stewart. Thank you, Mr. Chairman.

Mr. Burgess. I know, he is tough to follow.

Ms. Stewart. Very hard to follow that so -- and I am known by my family to be one of the biggest crybabies, but it is for good reason.

So thank you for inviting me to testify at this very important hearing today. I am Stacey Stewart. I am president of the March of Dimes. March of Dimes is leading the fight for the health of all moms and babies. And I would like everyone in this room to take a look at this blanket. Just about everyone that has had a child will never forget the very moment when a doctor placed a precious baby boy or baby girl into our arms wrapped into one of these blankets. More than 700 times a year, beautiful babies are wrapped into these blankets, in one just like this one, but unfortunately there is no mother to hold a child that is wrapped in that blanket. So that is not just a statistic. There are 700 mothers that die every single year and almost and over 50,000 who experience dangerous complications that could have killed them, making the U.S. the most dangerous place in the developed world to give birth.

And we think and we know that you agree that this situation is completely unacceptable. Our nation is in the midst of a crisis of maternal and child health. Across this nation,

virtually every measure of the health of pregnant women, new mothers, and infants is going in the wrong direction. The number of babies born premature is rising in this country. In many communities, infant mortality, rates of infant mortality exceed those in developing nations. Nations such as Slovenia and French Polynesia have better infant mortality rates than here in the United States.

Women are tragically dying, women like Kira, from pregnancy-related causes and are suffering from severe health consequences like infertility. While other countries have reduced their infant mortality rates, the number of women who die from pregnancy-related causes in the U.S. has doubled in the last 25 years. And as we have heard this morning already, black women are three to four times more likely to die from pregnancy-related causes than white women, which is a truly shocking and appalling disparity.

Maternal mortality is also significantly higher in rural areas where obstetrical providers may not be available and delivery in rural hospitals is associated with higher rates of postpartum hemorrhage. March of Dimes will release a report in the coming weeks that will show that maternity care deserts exist in this country and in these deserts pregnant women face serious challenges in receiving appropriate care.

The state of maternal health in the United States is dire, but there are things we can do and we must do. Many factors are

contributing to the maternal health crisis in this nation and our work to address it is important and it must be equally multifaceted. The bill before the subcommittee today is a critical step towards preventing death or serious health outcomes for pregnant women and new mothers.

The discussion draft of H.R. 1318, the Preventing Maternal Deaths Act, would provide grants to states and tribes to help establish or improve maternal mortality review committees or MMRCs. MMRCs are interdisciplinary groups of local experts that come together in maternal, infant, and public health to investigate the cases of maternal death, identify those systemwide factors that contributed to these deaths, and then develop recommendations that would help prevent future cases.

MMRCs are unique in that they identify solutions. Not just collect the data, but then identify solutions that are targeted to the needs of pregnant women and mothers in specific states, cities, and communities. The discussion draft of H.R. 1318 would also establish a demonstration project to determine how best to address disparities in maternal health outcomes.

Mr. Chairman and members of the subcommittee, while this bill is extremely important, maternal mortality is not a single problem with a single solution. The causes of maternal mortality and severe maternal morbidity are diverse. They include physical health, mental health, social determinants, and much more. They can be traced back to the issues in our healthcare system including

the quality of care as we just heard so passionately from Charles, systems problems, and of course the issue of implicit bias that exist in our healthcare system. They stem from factors in our homes, our workplaces, and our communities.

Mr. Chairman and members of the subcommittee, thank you for recognizing the urgency and the magnitude of this public health crisis. Our nation's mothers and babies cannot wait any longer. We must act now to save the lives and the health of pregnant women, new mothers, and their babies. Thank you.

[The prepared statement of Ms. Stewart follows:]

**********INSERT 5**********

Mr. Burgess. Thank you, Ms. Stewart.

Dr. Coslett-Charlton, you are now recognized for 5 minutes, please.

STATEMENT OF LYNNE COSLETT-CHARLTON

Dr. Coslett-Charlton. Chairman Burgess, Ranking Member Green, Chairman Walden, Ranking Member Pallone, and distinguished members of the Energy and Commerce Subcommittee on Health, thank you for inviting me to speak with you today on behalf of the American College of Obstetricians and Gynecologists at this hearing entitled, Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S.

ACOG, with a membership of more than 58,000, is the leading physician organization dedicated to advancing women's health. Today's hearing will focus on a discussion draft of H.R. 1318, the Preventing Maternal Deaths Act, sponsored by Representatives Jaime Herrera Beutler, Diana DeGette, and Ryan Costello. I want to extend a special thank you to the bill sponsors for working so diligently on this bipartisan legislation, a critical first step in improving maternal health outcomes for women in this country.

A special thanks also to you, Dr. Burgess, my colleague OB/GYN, for your leadership highlighting this critically important issue and making maternal mortality a top priority.

As many of you know, the United States has a maternal mortality crisis. Too many women die each year in the United States from pregnancy-related and pregnancy-associated complications. We have higher maternal mortality rates than any

other developed country. At a time when 157 of 183 countries in the world report decreases in maternal mortality, ours is rising. Black women are disproportionately affected and are three to four times more likely to lose their lives than white women. And for every maternal death in the United States there are a hundred women who experience severe maternal morbidity or near misses. This is all unacceptable and the time for action is now. We know that over 60 percent of maternal deaths are preventable. Common causes include hemorrhage, cardiovascular and coronary conditions, cardiomyopathy or infection. Overdose and suicide, driven primarily by the opioid epidemic, are also emerging as the leading causes of maternal mortality in a growing number of states including my own. If we have a clear understanding of why these deaths are occurring and what we can do to prevent them in the future, we can save women's lives.

The Preventing Maternal Death Act assists states in creating or expanding maternal mortality review committees through the Center of Disease Control and Prevention. MMRCs are multidisciplinary groups of local experts in maternal and public health as well as patient and community advocates that closely examine maternal death cases and identify locally relevant ways to prevent future deaths. While traditional public health surveillance using vital statistics can tell us about trends and disparities, MMRCs are the vehicle best positioned to comprehensively assess maternal deaths and identify, most

importantly, opportunities for prevention.

As ACOG's Pennsylvania Section Chair and incoming District III Legislative Chair and a practicing physician for over 20 years, addressing maternal mortality is of critical importance to me. As an OB/GYN, seeing a woman die while pregnant or after delivering a baby is something that sticks with you for life and has stuck with me throughout my career. Preventing that kind of tragedy and ensuring the health and safety of the women we care for is central to our mission. When I took over as ACOG's Pennsylvania Section Chair, Pennsylvania did not have MMRC, though the city of Philadelphia did. And over the past 2-1/2 years I have worked diligently to organize the campaign with other OB/GYNs and other advocates in my state and the Department of Health to urge the state legislators to pass legislation to form our first statewide MMRC. Finally, on May 9th, Governor Wolf signed the Maternal Mortality Review Act. Our first meeting is next week. Enthusiasm like this for MMRCs is growing all over the country. Today, approximately 33 states have MMRC and as many of those 33, including Pennsylvania, are brand new this year.

But states like ours need help. The CDC plays a vital role in assisting these states to ensure their MMRCs are robust, multidisciplinary, and using standardized reporting, which is why it is important to have this federal legislation as mechanisms. The Building U.S. Capacity to Prevent Maternal

Deaths Initiative, a partnership between the CDC's National Center for Chronic Disease Prevention and Health Promotion, the CDC Foundation, the Association for Maternal & Child Health Programs, and Merck for Mothers has made tremendous progress giving technical assistance to states to help them establish MMRCs or ensure established MMRCs are operating with evidence-based practices.

In Pennsylvania we need to ensure that this type of technical assistance is amplified so that we can get our MMRC off the ground and working correctly. Once MMRCs are up and running they lead to opportunities for quality improvement. For example, to participate in the Alliance for Innovation on Maternal Health, or AIM, a state must first have an MMRC. AIM convened under ACOG's leadership is a national alliance of clinicians, hospital administration, patient safety organizations, and patient advocates that work to reduce maternal mortality and severe morbidity by creating condition-specific bundles which are evidence-based toolkits to improve maternal outcomes. Some of these bundles include severe hypertension, maternal mental health, obstetric care for women with opioid use disorder, obstetric hemorrhage, and racial disparities in maternity care. To participate in AIM, a state must first have MMRC. The data recommendations from MMRCs instruct states where they need to invest to address specific conditions that affect women in their community and ensure proper appropriate targeting of limited

resources. For us to clearly understand why women are dying from preventable maternal complications across the country and make lasting improvements, every state must have a robust MMRC. The Preventing Maternal Death Act will help us reach that goal and ultimately improve maternal health across this country. Thank you very much for the opportunity to speak to you about this pressing issue and in support of this very important legislation.

[The prepared statement of Dr. Coslett-Charlton follows:]

**********INSERT 6**********

Mr. Burgess. Thank you, Dr. Charlton.

Dr. Crear Perry, you are recognized for 5 minutes, please.

STATEMENT OF JOIA CREAR PERRY

Dr. Perry. So, thank you fellow ACOG member, Dr. Burgess.

Mr. Burgess. And if you will suspend for a moment, in the interest of full disclosure I am a dues-paying member of the American College of Obstetricians and Gynecologists.

Dr. Perry. Here we go.

Mr. Burgess. And I am current on that. And I don't do the emeritus stuff, I pay the full freight. You may proceed.

Dr. Perry. And Ranking Member Green, thank you as well, and to my fellow colleagues on the panel. I really feel like going last is always a great way to go because you can hear what the gap might be in explaining this.

I get to work with the 33 states who are doing the MMRCs. As an organization we provide technical assistance. We also get to work in places like Philadelphia. We have been doing it for awhile. So a concrete example would be in Philadelphia they had a lot of women who were dying from cardiomyopathy, which sounds really medical, right, because your heart fails it won't pump as well. When they actually reviewed the deaths, many of the women had heroin addiction, right, so it was something you could prevent if you actually put in mental healthcare services for addiction. So it is important for us to have a broader view.

Someone brought up California, which is really important. So California has decreased their deaths, but they still have

a racial disparity. Still, in California despite having these great outcomes, they have had increased deaths for black women. So what they are doing now is really going back to look at implicit bias that was mentioned, making sure that their providers are culturally cognizant and having really some rules around what does it mean if you don't value a woman and she is not seen for several hours, how does that system respond to that and what can we do differently to ensure that people are seen in an appropriate amount of time.

So just wanted to give some teeth to how important this is and how having the ability to actually look at the deaths individually and to talk to family members and to have mental health there really can help us to get to some answers.

So now I want to tell you a little bit of my own story, so, because every woman's story needs to be heard and this is what the MMRC allows you to do. So when I was a third-year medical student in my home of Louisiana after attending Princeton for undergrad, my then-husband and I were expecting our planned second child. At about 5-1/2 months pregnant, my water broke. My mother, who is here and a pharmacist, still recounts how panic-stricken she was when she was counseled by my physician about the risk of infection to my son and I that included death.

I had access to excellent health care for him provided by my health insurance coverage, but the stress of racism was my only risk factor for the premature birth of my son. The hospital

where I was training was named Confederate Memorial just 20 years prior to this. Luckily, my 22 year old son and I survived, but the sad reality is that my 25 year old daughter has a higher risk of dying in childbirth than I did when I had her. The same is true for all of us who have daughters in the United States. We are failing our daughters, especially our black daughters who are dying at three to four times the rate of their white counterparts.

So, ultimately, what we are asking for this bill, when you think about what Charles said and what all of us have said, is we can no longer delay acting. This bill has been reiterated many times in Congress and I am excited to hear that maybe we can have it done by the end of this year, because it is important for us to say that we as a country -- I mean I got to testify at the U.N. about this very issue -- the world is watching us. The world sees us. I get flown to Geneva to talk about how important it is for the United States to actually value women and to pay for and look at why women are dying, so this is an opportunity for us to say yes, we do value women and yes, we do want to see what is actually happening to them.

So ultimately what women, especially black women, in the United States need is accountability. We need to know that our lives are valued. We need to know that this accountability might be difficult, it might be complicated, but government still has an obligation to act. Accountability is a value that all

Americans can agree upon, yet racism, classism, and gender oppression are killing all of us from rural to urban America. This is not about intentions. Lack of action is unintentionally killing us. It is a human rights imperative. We just ensure that prevention efforts and resources are being directed towards the areas of greatest need and be willing to name the problem directly. Much can be accomplished through improving monitoring and data collection.

Me and my big writing because my eyes are getting bad, I am getting old.

H.R. 1318 is a tremendous step forward in showing that we do recognize, yes, black mamas matter. That is it.

[The prepared statement of Dr. Perry follows:]

**********INSERT 7**********

Mr. Burgess. Thank you, Dr. Perry, Dr. Crear Perry. I appreciate your testimony and appreciate all of our witnesses for being here.

I will move to the question part of the hearing and I will recognize myself 5 minutes for questions. And Dr. Coslett-Charlton, let me ask you as a -- I mean, we have heard the stories and yes, the review committees are important, legislation is important. But honestly, doctor to doctor, it is decisions that are made at the bedside and I honestly don't know how you legislate correct decisions to be made at the bedside.

So as part of this effort and as a fellow member in the American College of OB/GYN, it is really incumbent upon our professional societies, medical societies, our specialty society. I mean this is where the rubber meets the road. We have to be -- I mean, I don't know how I can legislate something that stops what Mr. Johnson went through. I just don't know how I can do that. I mean, here was a situation where all the signs and symptoms pointed to exsanguination and he describes unfortunately in very painful detail what the natural consequence of exsanguination is, and I don't know how I write legislation to stop that from happening. I mean that is on the -- that is on us as a profession, right?

Dr. Coslett-Charlton. I totally agree. And I think that is why we are here and that is why we are sitting beside Mr. Johnson because those stories, I think, affect. And I know, Dr. Burgess,

because you practiced for so long, I look at my intern year, I was on my internal medicine critical care rotation, probably the second month of rotation and I was called for a code for one who had a very rare condition called an amniotic fluid embolism, which I don't know if you have seen one in your career, but I was like what could this be -- one in 300,000 -- and she died in front of me.

You know, I was an intern observing, I wasn't actively participating in the care at that time, but I seriously questioned whether or not I wanted to go into this field at that time because -- and I am so glad I did, because the joy of being an OB/GYN far outweighs the, you know, the unfortunate things that happen to patients sometimes. But I think seeing that, if we can prevent one death, if we can educate our members, and really the best way to do that is to understand where the problems lie.

And, you know, the AIM programs are a great success story and if we are able to roll them out across the country and really see where we can use best practices to prevent things from happening that couldn't otherwise, and really obstetric hemorrhage is a perfect example where having, you know, the beauty of the AIM program is that it is, really, you know, readiness first, so the four Rs, readiness and then recognize that there is a problem. So the readiness includes things like having suture available, having medication available on the labor floor so that you are not calling a pharmacist to come, you know, I need this

medicine now not an hour from now while you approve it.

So being ready, being able to recognize that there is a problem and educating staff members. Not just physicians, but also people that are on the front lines caring for the patients first. And also the response and having protocols for response that are appropriate, having blood products readily available for women when they are in transfusion protocols we have shown to be effective.

And, finally, reporting, because when we talk about maternal mortality and we talk about the deaths that is very important, but also the near misses are equally devastating and equally important that we know how to identify them. And not only, you know, we are seeing the iceberg, you know, if we can really get to the crux of that where we are truly going to improve the way we care for women in this country and I am positive we are going to see less maternal deaths.

Mr. Burgess. Well, and that I mean that is what is critical about this. Maternal mortality review committees, I think that is an excellent idea. I am all in favor of that. I will just say in the 1970s at Parkland Hospital it was called grand rounds. And you didn't ever want to present at grand rounds. That was -- probably meant your patient hadn't done well, but what it really meant was you weren't going to do well for the next couple of hours. And Dr. Jack Pritchard was the head of the department back then. He was pretty critical and had a way of asking those

insightful questions that exposed any perhaps weakness in your clinical judgment or your thought process as you worked through a complicated issue.

Let me just ask you, I mean have we gotten away as a profession from that type of introspection that you probably were exposed to in residency, I know I was.

Dr. Coslett-Charlton. No, I think if you speak to any residents those processes still happen, but they happen mainly in academic centers. And, you know, really a part of this problem is that we have to better reach the communities. I practice in a small community hospital right now and it is very different. You know, I think and educating practitioners in the community hospitals we know is equally as important, you know, and access to care obviously as we have spoken to is equally important.

So I think being able to collect the data, being able to see where the deficiencies and having a mechanism and a vehicle and support, you know, nationally down to the state levels and the tentacles that can get, you know, the boots on the ground to make sure that none of these things happen anywhere in the United States is critical.

Mr. Burgess. Well, Mr. Green gets extremely critical of me if I run over, so I will yield back my time and recognize the gentleman from Texas for 5 minutes for questions.

Mr. Green. I just ask equal time, Mr. Chair. I want to thank all our witnesses. And, Mr. Johnson, being a father of

two children and now a grandfather, I just, you know, and as the chair said, I don't think there is anything we can do. Of course there is no shortage. We have a lot of doctors in Congress but we also have a lot of lawyers. And so people say well, you can go to the tort system, and but that is not going to bring back your wife or your second baby. And it just, you know, how do you do that? But we understand, those of us who have children and I know physicians particularly. So I want to thank all of our witnesses today being here and discussing the U.S.'s maternal mortality rate, which I would be remiss if I didn't acknowledge my home state's maternal mortality crisis as well. As widely reported in 2016, published in Obstetrics & Gynecology found the Texas maternal rate was doubled between 2010 and 2012. The studies study's authors acknowledge these statistics were unexplainably high.

In the wake of this report, Texas' Maternal Mortality and Morbidity Task Force underwent review of all pregnancy-related deaths in Texas to determine the accuracy of these findings. What the task force found was that data collection errors and lack of standardization in reporting has resulted in varying statistics. If we can't depend on the research, that is a problem.

Dr. Coslett-Charlton, can you explain why the standardization of data collection is so critical when discussing maternal death rates?

Dr. Coslett-Charlton. That is a very important question, Representative Green. And I think the crux of the issue is that the vehicles of looking at vital statistic records we are able in the pregnancy checkboxes, if someone pregnant within a year or 42 days in Texas of delivery that those measures certainly can identify and are inherent to error.

But the important thing and why we are here today is to make sure that all of those deaths are reviewed so that we can have accurate data. And that is why these maternal mortality review committees are essential, because not only are they going to review the deaths but they are going to be able to say, you know, determine if they could have been preventable deaths and that is where the impact truly could be made.

Mr. Green. What can we learn from this study in Texas, and tell me Texas is not the only state that has that kind of statistics that you can't depend on. Is it other states, in Pennsylvania, or other states in the country?

Dr. Coslett-Charlton. Well, in Pennsylvania we have had the checkbox for the past 5 years and I think that in Philadelphia there has been a small community that they have been able to focus on that data. But I think like I was saying, the essential part of this is that having accurate data is really, really, truly important and the Texas studies truly exemplify that how important these MMRCs are.

The Texas committee at that time was not as sophisticated

as it is now and their means of collecting aren't as sophisticated, so I think that going forward it is a perfect example of why this is essential.

Mr. Green. The Texas Maternal Mortality and Morbidity Task Force put out a series of recommendations on ways to improve maternal health and prevent pregnancy-related complications. Just this last month, the task force released its joint biannual report for our Department of State Health Services. Their first recommendation is we increase access to healthcare services to improve the health of women, facilitate continuity of care, and enable an effective care transitions and promote safe birth spacing.

Dr. Crear Perry, would you agree with the recommendation to improve maternal health we must improve the access to care?

Dr. Perry. Sure. And I want to also piggyback on the last question a little bit about the data because it is important that we -- it is a common phenomenon across the country, so it is not just Texas and it is not just Pennsylvania. A lot of states need this money to help with collect more accurate data, it would be really helpful.

And as far as access it is a big barrier. We see that places where closing rural hospitals in Texas, in Georgia, that when women have to travel an hour to have a baby they are more likely to hemorrhage. They are more likely to have a heart attack. They are more likely to have these medical conditions. So if

you don't have a systemic review you can't look at the match between where your access is being denied and where women are also dying in the same place. So having a more robust review of the deaths will allow you to look at that.

Mr. Green. From my perspective coming from Texas, one way to improve access to care is expanding access to Medicaid and ensuring low-income individuals have the care that they need. And do you agree with that?

Dr. Perry. Sure. I mean I am from the great state of Louisiana and so we have seen actual data since Louisiana expanded Medicaid. We are one of the few deep southern states that expanded Medicaid where we have had improved outcomes. Our governor, really it was important for him to ensure that we had access to Medicaid expansion. Women are getting preventive services so you know that you have diabetes before you become pregnant and you don't show up at the hospital pregnant with uncontrolled blood sugars. So it is important that we have expanded Medicaid.

Mr. Green. And in my last 9 seconds, there is no replacement for prenatal care and having a mother who has a relationship with their doctor and that is why we need to have that access no matter who pays for it -- Medicare, private sector or whatever.

So, Mr. Chairman, thank you for your time.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from

Kentucky, Mr. Guthrie, the vice chair of the committee, 5 minutes for questions.

Mr. Guthrie. Thank you, Mr. Chairman, and I appreciate everybody being here.

Mr. Johnson, I appreciate you coming here and being willing to share your story. I know that a lot of times we have policy developed and things develop because people went through tragic things and they are willing to bring that to our attention and share. And I know it is difficult to do, but it is one way that they live on and it is a way that it actually changes what is going on in the country, so we appreciate that.

And this is something that has been on the mind of the committee, I know the chairman, I know from his background, but also I remember being in a meeting earlier and we were trying to just get down to the policy that needs to happen. And your story, I remember one of the roundtables that the chairman has talking about the -- it is not just access to care. It sounds like your wife was in a fantastic hospital situation and everything and it seems C-sections were something that could be common.

And we are the most, it is not that people aren't getting care. A lot of people are getting C-sections. And my wife has had -- I have three children, we have had three, so it really made me cringe when I heard that in your story, because it seems the second or third or whatever, C-sections seem to be something

that is something we need to address in moving forward and that gets to just finding the right data. And Dr. Coslett-Charlton -- Charlton or Charlton? Charlton. I know you are with ACOG and in this bill today we are looking at data and how to move data. I know ACOG has endorsed -- a number of medical societies and ACOG has endorsed this bill and it is my hope that we can get sound data to see exactly the actions that we need to take. So can you speak to ACOG's perspective on the role of data in your efforts to reduce maternal mortality?

Dr. Coslett-Charlton. So I think to some degree when you are speaking about specific situations like C-section rates and talking about, you know, once a woman has a first C-section, second C-section, third C-section, we know each time that a woman has a C-section risk can increase with subsequent pregnancies. And those are important reasons why, number one, we need access to good care.

But also, the part of the AIM bundles where we talk about preparedness or readiness is that when we know a woman has a third C-section, knowing that you could -- if she has the ability to have important prenatal care to recognize the potential complications and be ready for those complications, that is critical and essential.

And the last thing, if we talk about the AIM bundles, one of the bundles is looking at how to improve primary Caesarean section rates so that is something that is -- that is good data

that is coming out of California that we hope can translate, you know, sharing data across state lines. Women are women, you know, in Pennsylvania the same as in Arizona. So, you know, it really isn't rocket science. We should be able to share data and establish best practices and the way to do that is to have the vehicle or the mechanism to accurately be able to identify and, you know, look through that data.

Mr. Guthrie. It just seems standard -- not being a physician at all, I am a manufacturing person -- but it just seems to be standard now that if somebody is having their second or third C-section that the symptoms your wife showed seems to be clear from what you said that maybe there should be a team waiting to see if something happens and being ready for any type of those. You said you wanted -- I would love if you wanted to comment.

Mr. Johnson. Absolutely. I think that the astronomical C-section rates are something that needs to be examined. When we talk about Kira's case, there was a C-section, indeed, but it wasn't the C-section that led to her ultimate passing. And I will share this with the committee and I didn't share -- what I had shared earlier was a very condensed version of what was happening to Kira.

But what we found subsequently when we go back and look at the medical records, which I shared as part of my record, is that in Kira's case she was exceptionally healthy, she went in for a routine scheduled C-section. And from what I understand, and

Dr. Burgess and some of the medical people here, is what I understand is that for a woman who is having a Caesarean section, the cut timing and the time that they make the incision until the time that the baby is born, for a healthy woman and the baby is not under stress should be between 12 and 15 minutes. Is that fair, Dr. Burgess? Okay. And in a situation where a woman has had a previous Caesarean you should add another 3 to 5 minutes so that you can cut around the scar tissue.

Mr. Guthrie. The problems with scar tissue in the second or third, Dr. Burgess explained that to me.

Mr. Johnson. Yes. So I mean this is the point I would like to make is, so we are talking about between 15 to 20 minutes, ballpark, for a woman that is healthy, second Caesarean section, the baby is not in distress. When we received the medical records from Cedars-Sinai Hospital, the cut time on the delivery for my second son, Langston, was less than 2 minutes. Less than 2 minutes. And in the process of him rushing he lacerated her bladder.

But once again, and so the way that has been described is that this was not a medical tragedy, this was a medical catastrophe meaning that everything that could have gone wrong did go wrong.

So let's talk a minute about AIM which is a phenomenal program. And I want to salute ACOG for the work that they are doing in conjunction with AIM and being rolled out in various states. California, where we were where my son was delivered,

is one of the trademark states for AIM and what they have done to reduce the maternal mortality rate with their hemorrhage bundle. But as long as we have these tools that are a suggestion and they are not a protocol, women are going to continue to pass away.

So the AIM bundle was available in Kira's case. It is one of the -- it is ground zero for the wonderful work they have done reducing the maternal mortality rate in California, but they just chose to ignore it and I continued to beg and plead while her condition deteriorated.

So Caesareans are a challenge, but in Kira's --

Mr. Guthrie. Different.

Mr. Johnson. She was extremely healthy and they just let her continue to deteriorate. So we have got to have a fundamental standard of care that is not just a suggestion as AIM, as it is in the situation with AIM -- and it is phenomenal -- but if we can make a fundamental standard of care across the board that will make a big difference.

Mr. Guthrie. Thank you. Thank you for sharing and my time has expired. I yield back.

Mr. Burgess. Thank you, Mr. Guthrie.

Mr. Cardenas, you are recognized for 5 minutes, please, for questions.

Mr. Cardenas. Thank you very much. And to Mr. Johnson it is just amazing and incredible that you are doing what you are

doing and thank you so much. You are saving lives and I appreciate that very much and so does everybody in this country and the world who will benefit from hopefully good decisions that we make, all of your efforts.

First, I would like ask some questions if the doctors would -- I recently read about a program in California that has been very successful since both the March of Dimes and the College of Obstetricians and Gynecologists are part of the California Maternal Quality Care Collaborative. I am hoping that both Dr. Coslett-Charlton and Ms. Stewart can tell us more about this program.

But in California's private-public partnership it was stressed that it was because of the views from a diverse panel of experts that they could avoid missing important details on women's deaths. And one of the things that I think it is important for us to understand is -- I have been given a chart about the red line shows the mortality rate across the country while the highlighted yellow line actually shows California's. And we see a dramatic drop since 2007 when California has implemented the process of teaching each other, learning from each other, sharing data. And you are looking at California that has a mortality rate of 7.3 per 100,000 and across the country it is still up at 22.

So what I would like to see happen is we as Congress and those of us who are involved, or those of you who are involved

on the day-to-day process that we can come together and create a national best practices, and I hope that that is the outcome not only at this hearing but of this Congress. Dr. Coslett-Charlton and Ms. Stewart, if you can, can you talk a bit about how the diversity of these panels has changed and improved the maternal outcomes?

Ms. Stewart. Well, let me just start with a couple of points, which is I think that it is notable that California has had so much success, obviously, and I think the idea of the committee that has been formed, the way they have come together to look at data, to design interventions, identify where the problems are within the state and really design interventions that have made a meaningful difference has been important. And that is important to say at a high level, but again when it comes down to each individual person who still may be affected by the gaps in the system like Charles and like his wife Kira, then we still have a problem.

I want to say one thing about diversity in general and the importance of how this issue shows up and the disparate outcomes that many women of color experience as a result of the gaps in the system. And I agree with the chairman we can't legislate morality, but what we can do is ensure that we are tracking the performance of the system, we are tracking those women that are impacted disproportionately by the system, and that we are intentional in designing interventions that will make a

difference.

The gaps in the system don't just start though when women show up in the hospital. They start well before then. We know that for example to make sure that we have healthier babies it doesn't just happen in the 9 months of pregnancy. And I am not a physician. I am not an OB/GYN, but I think I have known that in my own experience having had two babies and leading the March of Dimes, which is the leading organization in the fight for the health of moms and babies. The same is true for healthier mothers. We have got to make sure that women have access to health care before they are pregnant especially if they have chronic diseases, chronic health challenges that might risk their health or the health of their baby. We have got to make sure they have access to good affordable care during pregnancy and what we know now is that is important that women have access to excellent care after.

And it is especially important and we have had research and studies to show that women of color also feel less trust and less well-served by the system. They feel less listened to and respected in terms of their symptoms when they articulate those symptoms. And these are women that are not only low-income women of color, these are women that are affluent women of color, women that are highly educated who simply have reported -- and again studies show this -- that their needs are not being met at the same level at the same rate as white women and other women.

So I just want to say that I think this issue of diversity is really important not just in the panels but across the board in listening to the issues of disparate outcomes that we see across all communities.

Mr. Cardenas. So best practices are something that we can improve and hopefully will become more prolific so we can have the outcomes that you just described. My time is limited, but hopefully during the testimony some of you can talk about the toolkits and how these toolkits are free.

But a quick, quick question to Mr. Johnson is since you have lost Kira, it has been 2 years, how has this affected you and your family, if you could describe that for us, so we can understand the true responsibility that we have and we can, we can make sure that this happens less and less and less. Thank you.

Mr. Johnson. Well, you know, this has been the most challenging experience that I could ever -- even more challenging than anything that I could ever comprehend. That being said, the true blessing in all of this is the two tremendous gifts that Kira left us and that is my son Charles and my son Langston. They really, truly are what keeps myself, my mother who is seated behind me, all of us going. And, you know, it is difficult as they mature and as they are, you know, now 2 and just turned 4 years old, their ability to process and understand the absence of their mother evolves. And like I said, you know, when you

talk to a 2 year old he wants to know why his mommy is not coming home. And you explain to him, well, your mother is in heaven and she is doing important work with God. And he tells you, well, I want to go to heaven too.

And so there is nothing that I can prepare for, there is nothing that I can do to fix that and I hope that over time that -- you know, the heart is saying to just be completely honest with you is I am proud to be here representing these families, but at the end of the day I am just a father that whose heart aches for his sons and a husband that misses his wife desperately. And so while there is every day I search for answers and how to support these amazing gifts, what I am clear about is that what I have to do is, although there is nothing I can do to bring Kira back I have to do everything that I can whenever I can to make sure that I send other mothers home with their babies.

And that if I can prevent another father from going through this, if I can prevent another child from having to understand why his mother isn't showing up at school -- and I will share this with the committee. This is something that I have never even shared with my family, is when a 3-year-old asks you, Daddy, is Mommy mad at me? I want Mommy to come home. Why won't she come home? And I have never shared that with anybody because it is just too painful for me to articulate.

But I am clear that the work that we are doing here is going to prevent this to continue to happen to other women and it is

going to make sure that other women get to go home with their babies.

Mr. Cardenas. Mr. Chairman, if you will allow me a few seconds to thank Mr. Johnson, my time has expired. Thank you so much. Thank you for your courage, your strength, and your commitment to community and to others and God bless you and your family. And know that your wife is doing good work in heaven, but you are doing tremendous work on earth. Thank you. I yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman from California referenced the California Toolkit to Transform Maternity Care. I did print off a copy of that and at the conclusion of the hearing I will ask unanimous consent to make that as part of the record.

The chair now recognizes the gentleman from Ohio, Mr. Latta, 5 minutes for your questions, please.

Mr. Latta. Thank you very much, Mr. Chairman. And thanks so much for our panel of witnesses and for being with us today because it is so important for the work that you are doing in getting this message out.

Ms. Stewart, if I could start my questioning, I am also concerned for soon-to-be mothers and new moms that live in our rural areas of our country. The national data indicates that more than half of all rural U.S. counties are without hospital obstetric services. With an increase of women dying due to

pregnancy-related complications, how does access to care and hospital services affect pregnancies and postpartum recovery and is this issue exacerbated for women in our rural communities?

Ms. Stewart. Thank you very much. It is a very serious issue and thank you for the question. And as I mentioned in my statement earlier, the March of Dimes is working currently on a report that would really show this issue of maternity care deserts. The issue of the closing of community hospitals in rural areas has been well documented. One of the things that we are missing is that it is not just the closing of hospitals. It is the closing of hospitals compounded by the lack of obstetrical services and OB/GYNs, the lack of midwives and doulas in areas, the distance that women often have to travel just to receive care, and it is particularly acute not just -- in rural areas there is a major challenge, but one of the things we are looking at is even where in urban areas there can be maternity care deserts as well.

I will give you a good example of this. Here in the District of Columbia there is no hospital that provides obstetrical services east of the river in Wards 7 and 8. So east of the Anacostia River, tens of thousands of women who live there who have no hospital to go to, who then have to travel. If they have no transportation they have to go on the Metro often an hour or more to even go to a prenatal visit. If you are a high-risk pregnancy or you have a high-risk pregnancy, the complications

that are then exacerbated or the complications that can result because of that distance, because that lack of access is increased significantly.

So one of the things that we really need to talk about in the system is the fact that even in the District of Columbia, for example, where there may be the number of beds may be sufficient for the number of women, that doesn't mean that those beds or that care is available to all the women that need it when they need it, and that is a very significant problem.

So I think one of the things that we are doing in the March of Dimes is to try to work with our friends in health care, our partners -- ACOG has been a longtime partner of ours -- working with hospitals and others to make sure that services are available.

The last thing I will just mention is that because all these issues that we are talking about today really just disproportionately again impact women of color. Women of color, African American women, are three to four times more likely to die as a result of childbirth. We also need to look at other ways in which services can be provided. We know that African American women, for example, are far more likely to want to receive services and care from a doula working within the formal healthcare system. And we have got to make sure that those services are also available so that women have places they can go they can trust. They know they go to places that will listen

to them and that will respond to their needs and that will deal with their situation if they have high-risk needs as well. And what we are seeing today is that there are significant gaps in rural areas as well as in urban areas too.

Mr. Latta. Dr. Coslett-Charlton, you know, our country is facing an opioid epidemic and especially in the state of Ohio we are, unfortunately, about the third worst in the country. And while Congress and especially this committee has done a lot of work and we have passed a lot of bills trying to reverse this devastation, I can't help but think of the pregnant women and the new mothers who struggle with addiction.

And how prevalent is opioid abuse in maternal deaths?

Dr. Coslett-Charlton. Well, I would comment that it is very significant and that is why it is so important that these maternal mortality review committees include diverse members including mental health professionals, substance abuse professionals and I know when we established our panel in Pennsylvania it was imperative that we had representatives from communities where -- because that is a very significant issue and I know Philadelphia has seen a large increase. That they have done a good job of looking at their data, almost a doubling of maternal deaths over a short period of time related directly to the opioid abuse process.

And, you know, ACOG really appreciates all of the work that government is doing to make sure that -- pregnant women are a

special population that sometimes have different needs, so the pregnant addicted mother, number one, it is a great population to invest in because women that are pregnant that have opioid use disorders are often motivated to get better. You have a reason to get better. I mean, not that everybody doesn't, but a pregnant woman is a special population.

And the other thing that we have seen is that doing, not only paying attention to different prescribing needs as we are limiting prescriptions, I see in my state things like that to make the special considerations for pregnant women that may have difficulties with access and need and to make sure that they continue on treatment during pregnancy and postpartum.

The last thing is that there is special pilot projects that are coming out of these committees looking at the special population of pregnant women, and like soft landing centers where we are not separating moms and babies, and, very importantly, not making punitive decisions based on maternal care and that because we know that women, the fear of losing their child or going into a system are not going to seek prenatal care and how imperative that is for the health of the woman and the child that she is carrying. So those are all things that ACOG is working very passionately on to try to improve the health care of women related to opioid use disorder.

Mr. Latta. Well, thank you very much. And, Mr. Chairman, my time has expired and I yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentlelady from Colorado, Ms. DeGette, 5 minutes for questions, please.

Ms. DeGette. Thank you so much, Mr. Chairman, and I want to thank all of our witnesses, but especially you, Mr. Johnson. I just can't even imagine what it must be like raising those two boys and I am glad your mom is here to help you. But, you know, I want to come over and help myself, but I am not sure what I -- and I think probably most of us feel that way if there is anything we can do.

I think the first thing we can do is pass this bill. And I have been working with my co-sponsor, Representative Herrera Beutler to try to get this bill passed by the end of the year and I think your testimony is what will bring us over the line. So if, you know, people wonder, does it make a difference that answer would be yes, so thank you.

I want to ask you -- am I pronouncing it correctly, Crear Perry? Crear Perry, okay. I want to ask you, Doctor, according to the CDC, the nation's maternal mortality rate rose by 26 percent between 2000 and 2014; is that correct?

Dr. Perry. Yes.

Ms. DeGette. One of the most striking aspects that I have been researching of this uptake is that African American women are nearly four times as likely to experience a pregnancy-related death than other women; is that right?

Dr. Perry. It is. In some places it is higher.

Ms. DeGette. It is higher in some places?

Dr. Perry. Yes. In New York City it was 12 to 1.

Ms. DeGette. Wow. And can you explain to me why this is? But it goes across --

Dr. Perry. It does.

Ms. DeGette. -- socioeconomic lines, which is stunning. Can you explain a little bit about that for me?

Dr. Perry. Well, and I think, for me, Charles' story really reflects this idea, right.

Ms. DeGette. Yes.

Dr. Perry. Like in general in the United States we have not really grasped the idea that women, when they are pregnant, are special populations and it is important that we value them. So to have someone in the hospital for a long time without evaluating them, it means there is a fundamental lack of valuing them as a person and wanting to come and check on them. And saying she is not a priority right now and what we don't do when we just look individually at the doctor, it wasn't just the doctor. So a lawsuit, when you have an entire system and a structure --

Ms. DeGette. Just the whole hospital.

Dr. Perry. And it is the whole structure. So how do we get to a space where black women and women in general, right? Because the reason that the gap is high in New York and not in Texas is because white women in Texas are dying. So it is not

so much that black women are doing so great in Texas, so in general across this country.

Ms. DeGette. There is just fewer of them.

Dr. Perry. Right, exactly. So across this country we don't value women. We don't have paid leave. We have to go back to work really quick, but we don't have child care so all those things impact our ability to have a healthy pregnancy. So how we then get into the hospital and need to rush out or if someone is doing a fast, something quickly, it makes it more difficult for us to live. So that happens really acutely for women of color and so you see that impact of implicit bias.

So what you can legislate is rules around training on implicit bias. What you can legislate is accountability for the entire system to look at every death and make sure that all the structures that they need to have in place are put there so there is not just one individual nurse or doctor but it is the entire structure.

Ms. DeGette. Yes, yes.

And Ms. Stewart, many nations have actually been able to cut the rate of maternal mortality in half. I talked about that in my opening statement. I wonder if you can give us some ways that they have been able to do that, that we can model our own behavior on in the U.S.

Ms. Stewart. Well, in many of those countries, Congresswoman, all of the outcomes relative to moms and babies

are far better than they are here in the U.S. So one the things about what is going on here in the United States is we are focusing on maternal mortality today as we should and maternal morbidity as we should. But if you look at all the outcomes around moms and babies, whether it is around premature birth, infant mortality, our outcomes are far worse than many other, most other developed countries in the world.

Ms. DeGette. And many underdeveloped countries too.

Ms. Stewart. And some in many underdeveloped, emerging countries. I mentioned in my opening statement our maternal mortality rates are worse than even countries like Slovenia and --

Ms. DeGette. So what are some of the things these countries have done?

Ms. Stewart. So I think it starts at the highest level of a policy environment and an environment that respects and cares for and prioritizes women and women's health and women and babies. So when you look at certain countries, Scandinavian countries for example, there are a range of policies that are far more supportive of women having a healthier lifestyle before being pregnant, having healthier pregnancies, and then having the kind of support even after pregnancy to make sure that they recover from their pregnancies well, that they feel supported, that they don't feel overwhelmed.

And we know the issues of stress in this country. Chronic

stress, for example, can have a devastating impact on the health of women and the health of moms that impact not only them but their babies as well. So I think it starts with making sure that women have the healthcare coverage that they need, have access to the care we need. We have talked about that. Half of the pregnancies in this country are covered by Medicaid. We need to make sure that all women have the kind of coverage they need. We need to make sure there are services in their communities that are accessible as we mentioned earlier around the deserts that exist.

And then I think we need to make sure that postpartum, Medicaid doesn't stop within 60 days of delivering the baby. That it extends so that moms have the kind of care and health care and support that they need even as they recover from their pregnancies.

Ms. DeGette. Thank you. Thank you so much. I yield back, Mr. Chairman. Thanks to all of you.

Mr. Burgess. The chair thanks the gentlelady. The chair recognizes the gentleman from Virginia, Mr. Griffith, 5 minutes for your questions, please.

Mr. Griffith. Thank you very much, Mr. Chairman, and I thank our panelists for being here.

Mr. Johnson, I am just so sorry. Nobody should have to go through that. And of course I am sitting there while you are testifying thinking about my wife, her C-section with my first

son. So I am very, very sorry. And as Ms. DeGette said, if there is anything that we can do I am sure we would try including passing this bill.

So here is a question for you all. I like the bill, and I like the bill because it will have us looking at it from a national perspective. If we just do it on a state perspective it may not work. Because I represent the corner of Virginia that is outside Appalachia and the Allegheny Highlands and so, you know, I border four states.

The Bristol Herald-Courier did a series of articles last year on neonatal abstinence syndrome because we have a high number at the hospital in Tennessee, but those are my constituents even though they are going to a hospital in Tennessee. I believe that hospital serves at least three states. And so if you are looking at it from a state perspective, Virginia is going to look a whole lot better on substance abuse and other things than Ohio. But if you compare Ohio just with my section of the state, we are probably in pretty good similarity. We are in sync along with West Virginia because we have similar problems and similar backgrounds. And I have got to have some of the deserts on your map because I have an area that two of my counties have lost their hospitals.

And so, you know, I want to see this data from a regional perspective not just a state perspective because my part of Virginia is not like Arlington or even Virginia Beach or Richmond.

It is completely different and if you are just looking at it from a state perspective you get a skewed picture from my region. So I like the bill.

So then the questions become, you know, do we overload the bill, and you don't want to do that. Sometimes you can put too much on it. Do we overload it by trying to include prenatal and neonatal care into the study? If we don't and if Ms. Beutler is in agreement, I would say expand it. If it is going to overload it and we might not get it passed by the end of the year, let's get this one passed and do something else.

But how, Ms. Stewart, how do we fix it? I mean I am a big advocate of telemedicine. Obviously can't deliver the baby by telemedicine, but maybe some prenatal or pre-birth care, some neonatal care could be done that way. What do you think of that?

Ms. Stewart. Yes. Actually, we think the prospects of telemedicine especially for prenatal care can be very exciting and very productive. There have been several studies to show that rural, women in rural areas, in urban areas, low-income women are very comfortable actually receiving care. And we also know that in the postpartum, we have some programs going on right now in the postpartum stages where uploading data, checking, taking blood pressure at home, uploading that data has actually reduced maternal deaths significantly in places like Philadelphia and can do the same in rural areas.

So we think the aspect of telemedicine in this space can

be extremely helpful to overcome some of the gaps and barriers that we have. You know, I will say that we, for sure, believe very strongly that this area and the period of time postpartum is the most critical period for this bill and for these issues that we are talking about. So whatever we can do to make sure that women have the care they need during that period.

We are measuring maternal deaths up to a year, so we need to make sure that women have the support they need after the baby. We are so, we are rightfully so, and we still need to focus prenatal, but what we are talking about now is the care postpartum that is now so critical and is contributing to so many of these deaths. So thank you for raising these issues.

Mr. Griffith. Thank you all for being here. You know, I think as technology moves forward we may have different answers, but I do think we have to embrace everything we can for those areas that are underserved or have deserts as you call it. And I appreciate you all being here. Thank you all so much for what you do and I yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for questions, please.

Ms. Castor. Well, thank you, Mr. Chairman, for holding this very important hearing on maternal mortality. And I really want to thank my colleague, Diana DeGette, and Congresswoman Herrera Beutler, for their work on the Preventing Maternal Deaths Act.

1678 And thank you to all of the witnesses who, you all have all devoted
1679 your careers to this, and Mr. Johnson, I take your story to heart
1680 especially.
1681 This is a long overdue hearing and I do hope that this is
1682 just a start on an important focus on policy regarding maternal
1683 health because I don't believe that most people in the United
1684 States of America today understand that we are not doing so well.
1685 That women in the United States are more likely to die from
1686 childbirth or pregnancy-related causes than women in other parts
1687 of the developed world. That is not acceptable and the racial
1688 disparities are particularly disturbing. In Florida, we have
1689 our Pregnancy-Associated Mortality Review committee. In Tampa
1690 we are home to at the University of South Florida, the Lawton
1691 and Rhea Chiles Center for Healthy Mothers and Babies, and I have
1692 some wonderful experts there who help me. They have shared with
1693 me the latest Florida pregnancy-related mortality rates.
1694 Since 1999, Florida's pregnancy-related mortality rate has
1695 been flat with no significant trend. How can that be that since
1696 1999 things have not gotten better? I just, I think that is
1697 outrageous. The committee found that hemorrhage-related deaths
1698 are the leading cause of pregnancy-related deaths in Florida by
1699 far. And of course we know that more than half of these deaths
1700 are preventable. Florida's most recent review committee has the
1701 statistics for 2016. They have identified 157
1702 pregnancy-associated deaths, 21 died during the postpartum

period. That has been the focus of many of your remarks.

Dr. Coslett-Charlton, I understand in May that ACOG released a number of recommendations on ways to optimize postpartum care for mothers including that new moms should have contact with their OB/GYN or other obstetric care provider within 3 weeks postpartum in a comprehensive, postpartum visit no later than 12 weeks after birth. Why is focusing on that fourth trimester or postpartum period important for the health of new moms and what are the barriers? We talked a little bit about it, but let's go into greater detail. What are the barriers that you and your colleagues see to prioritizing the fourth trimester? Transportation, child care -- give us a little update on that.

Dr. Coslett-Charlton. So that is a wonderful question and that is one of the exciting things that ACOG has developed, like you said, over the past several months is reevaluating the fourth trimester or postpartum care. And we know that when we look at preventable deaths that about half of those preventable deaths occur within that year within delivery.

So it is really important that we continue to engage patients on the importance of postpartum care and also reduce those barriers that you are discussing. Number one being access, number two being, you know, in Pennsylvania I am fortunate to practice in a state that I did residency and medical school and practice in Pennsylvania, and in Pennsylvania when you are pregnant you are covered. And I cannot imagine a woman not being

covered during pregnancy. But that coverage for Medicaid patients ends at 6 weeks postpartum and we know that things can happen afterwards. And it isn't just the issues with -- I have had plenty of women have preeclampsia or hypertensive disorders that need very close follow up. I have seen women seize 6 weeks after delivery in the emergency room related to preeclampsia. So those identification of patients that are at risk, number one. Number two, having important communications in a manner such as telemedicine within the first several weeks after delivery and especially in high-risk patients is critical.

And also, you know, we talk a lot about postpartum depression and mental health disorders and how important it is that we screen women adequately and continue screening and keeping them within that period and also educating patients of the importance of the postpartum period. And we think that that might come during the prenatal period and that we need to do work to emphasize the importance of postpartum to women when they are having their babies because, you know, I am a mother of four children.

I don't think I -- I am embarrassed to say it. I don't know if I went back for a postpartum visit. I know I am an obstetrician and I know that, you know, are privy to knowing the signs, but I was caring for children and having important maternal and parental leave, it is very important having the transportation. So there are so many policy things that are exciting and that, you know, going forward hopefully we can look to all of you to

make those favorable changes a reality.

Ms. Castor. Yes. One of the major gaps I see in my state and other states, Florida is one of -- in the minority of states that did not expand Medicaid. And I worry about the continuity of care for young families, for young women especially if they are not taking care of themselves early on and then they reach a gap after they have their baby. Has Medicaid been expanded long enough for there to be any studies on the differences on maternal mortality in states that have expanded Medicaid and states that have not, do you all know?

Dr. Perry. I know for health in general, but not specifically maternal mortality and that is why this bill will be really helpful for us to be able to drill down on more details on maternal mortality.

Ms. Castor. Thank you very much and I yield back.

Mr. Griffith. [Presiding.] The gentlelady yields back. The gentleman from Missouri, Mr. Long, is recognized for 5 minutes.

Mr. Long. Thank you, Mr. Chairman. And I have heard a lot of testimony over my years on the committee here and, Mr. Johnson, I don't know that I have ever heard any more heartfelt or any more important testimony that what we heard from you here today. So thank you for being here and I know it is hard to do, and but hopefully your voice will add a voice and will garner more attention to this, so thank you for being here.

A quick question for you, your first son, was that -- I understand that was a C-section also?

Mr. Johnson. Yes, sir. That was a C-section.

Mr. Long. Was that a planned C-section like the next one or an emergency?

Mr. Johnson. No, that was not. So that was an emergency C-section so we went in for, we didn't expect it and so that was part of the reason that the C-section was recommended during the delivery of Langston, our second son.

Mr. Long. Okay, okay. Because I am curious, but yes, I am a little familiar with the emergency part of that situation, so yes.

Ms. Stewart, I just want to thank you for what you do at March of Dimes and the big event you hold every year here in Washington, D.C. The cook-off I call it. What is the official name of it?

Ms. Stewart. It is called a Gourmet Gala.

Mr. Long. That is what I was going to say if you hadn't interrupted me.

Ms. Stewart. It is a lot of good food there.

Mr. Long. Gourmet Gala.

Ms. Stewart. Gourmet Gala.

Mr. Long. It is a dandy and it raises a lot of money every year for March of Dimes and I appreciate that.

Ms. Stewart. Absolutely. And we appreciate all of your

support for that. Thank you.

Mr. Long. Right. Dr. Coslett-Charlton, as you note, only 33 states have a maternal mortality review committee, many of which are newly created. Could you talk about the important role the Centers for Disease Control and Prevention is giving technical assistance to states to either help them establish MMRCs or ensure that they are operating effectively and getting appropriate data?

Dr. Coslett-Charlton. I would be happy to speak of that. As the state that has a very newly formed committee, I mentioned earlier that our MMRC is meeting for the first time at the end of October and I am very excited to see the outcomes of our getting together and being able to collect this data effectively. The CDC Foundation has actually reached out to us and has been integral in not only determining the makeup of the committee and working well with our Department of Health and members on the committee, but also ensuring again standardization and by knowing best practices from other states. So having that cooperation is essential.

The other thing is that through the CDC there is data collecting tools, the MMRIA, collecting tools which will standardize the reporting part of the MMRCs so that we would be able, you know, if the reports are looking different from every state it is a difficult task to try to come to a consensus. So we keep talking about the importance of making sure we keep standardization and the support through the CDC with the MMRIA

application is an excellent example of that.

Mr. Long. Okay. In your testimony you discuss Pennsylvania's efforts to establish MMRC this year. What has been your experience so far in getting it up and running?

Dr. Coslett-Charlton. Well, fortunately we have an extremely supportive Department of Health for this issue and some of it has been, you know, similar to our efforts here is recognizing that there is a problem. And some of the national attention to the problem has really given some interest to members that have been very interested in participating in this bill.

Our bill was supported unanimously -- House, Senate, and by the Governor's Office. So this was an easy ask at this time, but it really, it was more momentum initiative and a lot of the reports coming out that this truly is a problem that, you know, opened the eyes of many and we realized that we need to tackle this. And it is not a hard thing to tackle if you do it the right way and there are best practices already established.

Mr. Long. And getting data on why pregnancy-related deaths are happening is essential of course, but what can we do to improve outcomes once we receive that data and can you talk about the role MMRCs have once that data is collected?

Dr. Coslett-Charlton. So some of collecting the data is important so that we can use it to see where it needs not only nationally but also in communities. And we talk about these perinatal collaboratives that, you know, the CDC and the national

effort to collect data will be the mothership and hopefully we will be able to send out the tentacles to go out in the communities and find where there is deficiencies and where there is disparities and do better to be able to connect patients and meet those needs and to hopefully a realization where access really is an issue.

Maternity care is difficult to deliver and, you know, we talk even about Philadelphia that has closed half of its maternity hospitals in the past decade. The only hospitals that are delivering right now are university institutions because a lot of hospitals find the reimbursement not adequate for the care and liability exposure and a multitude of things which is not for the conversation here.

But we -- it is really important that we are able to identify where these deserts are -- I think that is wonderful -- in care and be able to improve upon that.

Mr. Long. Okay, thank you. And once again thank you all very much for being here. I appreciate your time in taking time out of your day and week to come up here and testify. And, Mr. Chairman, I yield back.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentlelady from Illinois, Ms. Schakowsky, 5 minutes for questions, please.

Ms. Schakowsky. Thank you. I want to join my colleagues who have thanked you so much for this, all of you. I want to

thank you, Mr. Johnson, for turning this tragedy into something positive. It took a lot of courage and probably a lot of time away from being a dad. And so I just want to express my appreciation to all of you and just mention that in particular.

I think that the WHO and the CDC reports, et cetera, were really a wake-up call for people. I have been aware of communities near me, in Milwaukee for example, where we have seen this rise in maternal mortality, infant mortality as well, and it has really been unacceptable that we in a country, the richest country in the world, would see these kinds of results. It is really, it is absolutely shameful. So I wanted to -- and I think there is a lot of ways that we are failing mothers and children, especially African American women who are three to four times more likely to die from childbirth. We just simply have to do better. But I am concerned about the new proposals, the Trump Public Charge Rule that puts maternal and infant health in grave danger. By targeting legal taxpaying immigrants in this country, this rule seeks to discourage immigrants from using the government services that pay for -- that are paid for with their tax dollars -- Medicaid, CHIP, SNAP, WIC, and the Earned Income Tax Credit, just to name a few.

So let me ask Dr. Coslett-Charlton and Dr. Crear Perry, women who qualify for Medicaid that would cover pregnancy care and labor and delivery may face the impossible choice of jeopardizing their legal immigration status in this country or go without needed

care. And let me just add that right now in my very diverse district, we are finding that people who qualify are not signing up for benefits, right now, because they are so fearful. So if women are forced to go without needed prenatal care, what could that mean to her health and risk of maternal mortality?

Dr. Perry. So it is an opportunity for us to use the same empathy we have when we talked earlier about with the opioid addiction moment we are having where we don't want to criminalize moms who are addicted to opioids so we ensure that they have access to health care. If we criminalize women for using SNAP or Medicaid, we are also harming their ability to have a healthy pregnancy.

So we should be able to use that same feeling of empathy for all mothers that everyone who is in the United States deserves to have a healthy pregnancy and a healthy baby and so how do we make sure that they don't miss their prenatal care? For example, in Louisiana we didn't for a long time cover immigrant mothers and after Katrina it was a big push of new immigrants.

Ms. Schakowsky. This is even legal.

Dr. Perry. Yes. And so we had to add that to the bill when we got more citizens coming because it was important for us to ensure that the babies had access and the babies had care. We saw an uptick in baby --

Ms. Schakowsky. But this would prohibit even citizen children of those parents from getting the benefits.

Dr. Perry. Right. So we have to think about what are value is, right, so if we don't value citizen children, what do we value? If we don't think it is important for them to have treatment from a physician then what are we asking for as a country. So it is just we have to think about our own values as a country.

Ms. Schakowsky. I agree.

Yes, Doctor.

Dr. Coslett-Charlton. And I would just like to add, ACOG strongly opposes any efforts to provide any barriers to any kind of care for pregnant women and postpartum and prenatal, and this rule obviously would do such. So and as a practitioner too, you know, the woman is going to deliver the baby no matter what, so she is going to deliver. You can't -- no matter what she is going to deliver. And, you know, it is common sense that she needs prenatal care or, you know, for fear of having rising morbidities and mortalities related to this.

Ms. Schakowsky. Yes, go ahead.

Ms. Stewart. I was going to say, Congresswoman, we have made a strong statement against that Public Charge Rule as well.

Ms. Schakowsky. Thank you. And I yield back. Thank you so much, all of you.

Mr. Burgess. The chair thanks the gentlelady. The gentlelady yields back. The chair recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for your questions, please.

Mr. Bilirakis. Thank you, Mr. Chairman. I appreciate it.

Thanks for holding this very important hearing.

Ms. Stewart, as a parent I remember the birth of my children was such a joyful event. The idea that rates of maternal mortality are on the rise is horrifying as far as I am concerned. In our state it is on the rise. I read that women are dying from hemorrhage complications in the state of Florida. How does the Preventing Maternal Deaths Act help reverse the trend of women who are losing their lives to these typical medical complications?

Ms. Stewart. Well, I will defer to my medical colleagues to describe the issues around hemorrhage and how it is contributing, but I will say that what this bill is designed to do is to establish across the country maternal mortality review committees that are designed to collect data on every maternal death and to make sure that every state understands the underlying causes of death for each woman that dies as a result of childbirth.

But even beyond that what it is designed to do is to not just collect the data but to help states and to help the participants and the healthcare system design interventions that can actually eliminate deaths in the future. And that is one of the things that is really important about this bill is not only collecting the data, but then designing interventions.

And of course if we collect data consistently across the country and if the sharing of interventions can also be shared we can certainly accelerate our ability to reduce and even eliminate maternal deaths. I will give you a couple of examples

of how collecting data in MMRCs has been really helpful.

In Colorado, for example, data was collected and what was found is that women that experienced maternal death had also been experiencing suicide and depression and they were, in Colorado, able to find and identify where there were gaps in mental health services and actually close those gaps and give more mental healthcare services to women where they needed it.

In Ohio, they actually did something, which I think is really important, which is do additional training for hospital staff beyond just the doctors themselves, hospital staff where they went through simulations of training in obstetrical emergency situations so that they could actually be more responsive in the event of an emergency situation. So MMRCs are not only about collecting the data, but actually putting into action the things that can actually eliminate maternal deaths. And that is why this bill is so important and that is why a national bill and a national effort is also so important, so the data can be consistent, can be collected, we can see the data, we can actually track the interventions more successfully.

Mr. Bilirakis. Thank you very much for that answer.

Dr. Coslett-Charlton, according to the Centers for Disease Control and Prevention, it lists indicators. Severe maternal morbidity has steadily been increasing in the years. What are the key drivers of this increase and how can it be addressed?

Dr. Coslett-Charlton. Well, some things are recognizing

and be able to maintain proper prenatal care and care of women throughout their reproductive years and identifying comorbidities such as, you know, we talk about obesity and smoking cessation and where we see a rise in comorbidities with heart disease. So having active interventions before a pregnancy we find is critical to having a healthy labor and delivery for all women.

Mr. Bilirakis. So you feel that they are increasing. I mean, in this day and age with all the technology we have or is it just that we are getting more data on this or there definitely are increases in maternal deaths?

Dr. Coslett-Charlton. Well, so far that is part of the purpose of this review is so that we were talking earlier about the accuracy of the data. So some speculation has been made that perhaps because for the past 5 years we were actually recording on death certificates whether or not a woman was pregnant when she died, or within a year after delivery whether or not that has caused a rise in the actual numbers that we are seeing. But when comparing to other countries that have had similar checkboxes on their certificates where they have seen a stabilization or a decrease, we have actually seen an increase.

So these committees are really imperative to really, exactly what you are saying, really know and be able to assess and accurately determine if those disease entities as well as, you know, maternal death if there is a change and make sure that we

have accurate data so that we can successfully, you know, portray appropriate interventions.

Mr. Bilirakis. Yes, exactly. So, you know, whether it is increasing or what have you, we have to focus on the issue. There is no question.

And, Dr. Johnson, you have my sympathies. I was in the VA Committee so I didn't get a chance to hear your testimony, but I know how difficult it must be for you.

Let's see, Dr. Crear Perry, please, our maternal mortality data has been described again as limited, unreliable, and even embarrassing by top researchers. Do you agree with these characterizations? And I know, let's expand upon this. Are there concerns with the research community regarding the integrity of the data being collected in states? What are those concerns and how might they be addressed federally?

Dr. Perry. That is me. That is okay. Hi.

Mr. Bilirakis. Oh, you are over here. I am sorry.

Dr. Perry. And so it is important, Dave Goodman and the folks at CDC are doing a great job of doing the data. They have been doing it for a very long time. They have dedicated their life to it. And they have looked at if the increase is due to error in data versus if it is an increase, that is true, and all the studies so far have come back saying no, there is an increase and it is from the data.

And so the robustness with which the CDC is working on to

look at this issue is something that we should all value. And if they are part of this bill, they are not here testifying, but CDC is a really integral to getting this work done and it is important that we understand that they are -- that yes, there have been researchers that have given us pushback around the data over the years, but we have gotten better and better and this is just another way to get even more clear about how women are dying, because beginning at a granular level and look at the hospital level what is happening.

So yes, it has been -- there have been a lot of articles about the data, but we truly know through the CDC that the rates are increasing and that we can do something together to do it better with this bill.

Mr. Bilirakis. Very good. Thank you and I yield back, Mr. Chairman.

Mr. Burgess. The chair thanks the gentleman and the gentleman yields back.

The chair would just make the observation that I believe it was Dr. Callaghan from the CDC who came and spoke at one of our roundtables about a year ago. And you are correct. They are very thorough and they have been at this for a long time. They have a lot of good insights.

The chair recognizes the gentleman from Massachusetts, Mr. Kennedy, 5 minutes for your questions, please.

Mr. Kennedy. Thank you, Mr. Chairman. I want to also thank

you for your, obviously lifelong and personal dedication to this issue given your profession before coming to Congress and still the work that you do. I want to also thank Representative Herrera Beutler who was here earlier and obviously our distinguished panel for joining us.

Dr. Johnson -- Mr. Johnson, excuse me. I will apologize. I have been in and out. Your words are extremely powerful, sir. Kira sounds like quite a woman. I have two kids under 3. I was in a delivery room about 9 months ago. Thoughts are with you and your family, sir.

In 2018, the United States of America has the highest rate of maternal deaths in the developed world. Every single year we mourn roughly 700 mothers who are lost to complications during their pregnancy, and at least 350 of those deaths are preventable. Most alarmingly, profound racial disparities exist in these statistics. Black women today are three to four times more likely to die of pregnancy or delivery complications than white women.

Before we try to explain that away on socioeconomic terms, just access to care, access to education, and higher income, we have to be clear that even when you control for those factors a wealthy black woman with an advanced degree is still more likely to die or to have a baby die than a poor white woman without a high school diploma. In the United States, a black woman is 22 percent more likely to die from heart disease than a white woman, 71 percent more likely to die from cervical cancer. Those are

haunting statistics, but they still pale in comparison to the one we discussed here today, for black women are 243 percent more likely to die from pregnancy or childbirth-related causes, 243 percent. So we can't have a discussion about how to address a larger crisis in maternal mortality without having a discussion about how to confront the pervasive, systemic inequities that are buried deep within our system of health care in America.

And the last point I have to make is this, that there are, as we speak, 20 Republican Attorneys General that are attempting to repeal the Affordable Care Act in our court system after most of my Republican colleagues have voted to do the very same thing more times than I can count. So let's remember 9.5 million. That is the number of previously uninsured women that gained healthcare coverage including maternity care which is an essential health benefit under the Affordable Care Act. Coverage for women of color grew at more the twice the rate of women overall in 2013 to 2015. So to have a conversation about maternal mortality at a time when my Republican colleagues are using every tool in the book to roll back access to guaranteed maternal care and maternal coverage is a bit much.

And with that I want to direct my questions to Dr. Crear Perry and by the work that you have done, Doctor, in discussing how we need to move away from seeing race as a risk factor in maternal health and call the real risk factor what it is, racism. So can you extrapolate that a bit for the committee and,

specifically, what do you believe to be the leading cause of those racial disparities I mentioned in maternal mortality rates?

Dr. Perry. So we have done quite a bit of focus groups and work in hospitals around how patients feel disrespected and not heard and not listened to and not valued. And, you know, a great example of that is Serena Williams, right. She gives an amazing story around how she had symptoms. She knew who she was. She is a very wealthy and healthy person as well and she still was not heard or valued.

So what we miss in this country is really being honest about when you don't see someone as being fully equal to you, you are less likely to think about their care in a very serious manner. You are less likely to address their issues in a serious manner, and you are less likely to spend the time that they need ensuring that they are healthy.

And so what we have to be able to do is have some truth around that conversation first and not act as if that is not a true --

Mr. Kennedy. And so is there data that you would point to on this or is this something that is a bit bigger than fits into an Excel spreadsheet and a pie chart and how --

Dr. Perry. This is going to be both a policy fix and a cultural shift, right. Like we have had policy shifts. We have had the civil rights movement, we have had -- we have a lot of things of policy we can have, but as long as the culture still believes that black people are less valuable or inferior, and

women, we are going to keep having the same conversations over and over and over again. So we have to have both a policy conversation and a culture shift.

Mr. Kennedy. Anybody else want to comment on that? Mr. Johnson?

Mr. Johnson. So just talking about this from a personal experience and having an African American, extremely vibrant woman who was not in good health but in exceptional health at one of the top hospitals in the world, and to be quite honest with you, when this first happened and I was asked a question, do you think that this would have been different if your -- do you think this is because your wife was black, or do you think the outcome would have been different if your wife was Caucasian, I was in so much pain I couldn't process that and the thought that the color of my wife's skin contributed to her death?

But what I am clear about is that she was not seen or valued as human. She wasn't. And the people who were responsible for her care that I trusted with her care failed to look at her in the same way that they would their daughter or their sister or their mother. And the reality of the situation is I am asked the question and people sometimes, and, you know, the more I have spent with wonderful groups like Black Mamas Matter and the more I look at the data, people -- and I am very clear about this issue of implicit bias and the contributing factors or racism. And people say you are making it a racial issue. I didn't make it

a racial issue, the statistics did.

So what we have got to do is figure out how these women are valued and looked at as human, because what I said at night, you know, thinking about my wife and I have to think about that question about would she be here today if she was Caucasian? Let me be clear that this is an epidemic that affects all families from all backgrounds and all walks of life, and unfortunately I know that personally because I have talked to these families and I have become very close to some of these fathers and some of these families and they are from all walks of life.

But we cannot address this issue without head-on facing the way that it is disproportionately and horrifyingly affecting African American mothers.

Mr. Kennedy. Thank you, sir.

Chairman, thank you for the extra time. Thank you all for being here.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from Georgia, Mr. Carter, 5 minutes for your questions, please.

Mr. Carter. Thank you very much, Mr. Chairman, and thank all of you for being here. And, Mr. Johnson, thank you for your efforts and your work on this especially, and I echo the comments of all of my colleagues here today. We appreciate your courage.

Mr. Chairman, I believe this hearing was set for another time and I requested and I am sure others did that it be delayed

so that we could have it. It is important to me and I am sorry if it disrupted any of you all or inconvenienced you.

But I am from the state of Georgia. In 2010, there was an Amnesty International report that flagged Georgia as being the number one state in maternal mortality. And that is why I expressed to the chairman, Mr. Chairman, I want to be at this hearing because this is real to me. In fact, when I served in the Georgia State Legislature and we passed Senate Bill 273 that created the MMRC and put it into the Georgia Department of Public Health.

And I wanted to ask you, Dr. Perry, because when we created that, you know, we followed the guidelines and we did what we were supposed to do. But I believe that your group was involved in a study, When the State Fails: Maternal Mortality and Racial Disparity in Georgia; so you are familiar with that?

Dr. Perry. Yes, sir.

Mr. Carter. I know you are. And, you know, I had the chance to look at it and study it and one of the things that it pointed out was the racial disparity in Georgia was the fact that even though the four categories -- access to and quality of care, insurance access and pricing funding, and accountability around data analysis and use, even though we had those in there we are still failing on those, particularly access.

And my question is, what can we do? Tell me what I can take back to my state because this is important to me. I served in

legislature. I was in Health and Human Services, vice chair of that committee, and I helped with this legislation. If, you know, and the point has been made by my colleagues today, you know, what can we do legislatively, but what can I do? What can I take back to the state of Georgia?

Dr. Perry. Thank you so much. And I do work with Dr. Lindsay and the folks at Grady around the Georgia work and they are specifically trying to look at their mental healthcare service structure. So supporting mental healthcare services in Georgia is important. Supporting Medicaid expansion in Georgia is important. Supporting rural hospital closures in Georgia is in support and like supporting support systems that include midwives and doulas in Georgia is important.

All the social structures that we see, all the states where we allow for us to disinvest in women honestly have poor outcomes. Even though you can look and do the study and see, we have, we are working on things inside of hospitals because you have some great doctors in Georgia. You have some phenomenal people and some nurses and midwives. But until we build a structure that holds the entire state together, right, like from rural Georgia from -- then we are not going to be able to see an improvement and we are being separated around ideals that don't allow us to come together. And it is important that we know we value all the moms in Georgia, rural moms, urban, they all need access to insurance.

Mr. Carter. Well, thank you for mentioning that because as you well know, knowing the state we have a disparity between rural and urban.

Dr. Perry. Exactly.

Mr. Carter. I mean to say Georgia is Atlanta and everywhere else. So it really is.

Dr. Perry. Exactly.

Mr. Carter. Well, another part of that study that I was very interested in, because I am a big advocate of this, is the proposition that the state could develop ways to help religious organizations in leadership engage and advocate for quality health education and services.

And I am really big with wanting to include the religious community. And can you give me examples of how we can do that or examples of how that has worked before?

Dr. Perry. Including, because if you think about mental health it is a great example, right, so a lot of religious organizations have access to therapy, access to group places where women can come to make sure they have grievance counseling.

So there has been a lot of work that religious organizations are there to be a safety net and a support for women. They can't replace medical care, but they can be, serve as a safety net. They can provide transportation. They can help with child care. Like all these other things that we are looking for that a community provides, because we know that women who have access

to a community and to each other, the connectedness, have better outcomes.

So how do we create connectedness and community across this country and across Georgia.

Mr. Carter. Right. And one last question and this could go to just about any of you. But the thing that I am wondering here is I know we are accumulating the data and we are, and I believe you said earlier the data is going to CDC. Are they crunching the science of it? I mean can we tie anything into this genetically, regionally?

Ms. Stewart. I will try and then others. You know, CDC has had a surveillance system in place for a number of decades and thankfully we are able to collect a lot of data mainly coming from death certificates. And just recently now, death certificates now include whether or not a woman was pregnant within the last year, and so that information has been helpful.

But what we don't get from all of that -- and by the way that voluntary system, CDC asks states around the country to voluntarily submit the data. There are epidemiologists that then review the data and we learn as much as we can from death certificates. But what we don't understand is that a death certificate does not necessarily tell the full story of how a woman may have died and what were the underlying causes and what were the potential interventions that could have been in place to prevent that.

And that is what this is about is taking the data we collect, improving it, improving the collection, making it consistent, having committees that then can design interventions and having them well-funded so that they can actually see meaningful improvement over time. So that is the difference.

Mr. Carter. Good. Again, thank all of you. And, Mr. Johnson, thank you and God bless you.

Mr. Johnson. And I would just like to say that I am actually a native of Georgia and currently --

Mr. Carter. Did this happen in Georgia?

Mr. Johnson. It actually happened in California but I am a native of Georgia.

Mr. Carter. Okay.

Mr. Johnson. Kira grew up in Decatur, Georgia and I grew up in East Point and we are back living in Georgia.

Mr. Carter. Right.

Mr. Johnson. So we look forward to working together with you --

Mr. Carter. Absolutely.

Mr. Johnson. -- to see how we can help out too.

Mr. Carter. Can I ask you, was your wife originally from Georgia?

Mr. Johnson. Absolutely. Decatur, Georgia. Born and raised.

Mr. Carter. Okay, see this is the point I am getting at

here. I mean, you know, we are the Cardiac Belt. Has anybody looked at any of this to kind of try to tie this into it?

Ms. Stewart. There is a lot of work being done on what is going on that is that are sort of the underlying causes to why so many women of color especially are dying, and there are a bunch of issues. I will mention one of them. By the way I am from Atlanta too. Don't hold that against me.

Mr. Carter. I see a pattern here.

Ms. Stewart. We have known each other a long time.

Look, there is a very important study and we could go through a laundry list of things, but there is a very important study that has really helped all of us understand what are some of the underlying causes to why we see so many disparities among African American women in particular.

A study that was done by a researcher who is now at the University of Michigan but she started this study in New Jersey, I believe, where she started to look at this as your weathering. The fact that African American women's health tends to, and African American women tend to have more challenges the older they get, challenges in pregnancy, challenges in childbirth, challenges maybe post childbirth may be due to this issue of weathering, which is that the impact of chronic stress that may be coming from racism and discrimination over a long period of time.

This issue of weathering which tends to deteriorate one's

health may be a big contributor why we see so many disparities. The fact that women are getting, are older as they are getting pregnant and the fact that if black women are older having babies and they are experiencing this impact from this weathering effect that that could explain in part why we are seeing so many outcomes.

Having said that, we still need to address the fact that we don't specifically have to accept that that is the case, we can actually do something about it. We can actually address those issues. We can actually deal with the underlying stress that exists. We can actually deal with the systems that may be creating the stress in the first place, and we can make sure that we understand when interventions are really effective across all communities.

Mr. Carter. Thank you, Mr. Chairman. I yield back.

Mr. Burgess. As the gentleman's time has expired, the chair recognizes the long-suffering Mr. Engel from New York, 5 minutes for your questions, please.

Mr. Engel. Thank you, Mr. Chairman. I appreciate those words, thank you.

Thank you, Mr. Chairman, for holding today's hearing. Just in listening, it is just shocking that right here in the United States women are dying from preventable pregnancy-related complications. That alone is shocking, but that women are more likely to die from those complications here than in other parts of the developed world, that is shocking. And the fact that this

risk is three to four times higher for black women than white women, that is shocking.

So it is a tragedy and it is an emergency, and thank you, Mr. Johnson, for sharing your story with us.

I want to thank my colleagues, Congresswoman Herrera Beutler and Congresswoman DeGette, for introducing the Preventing Maternal Death Act legislation which I am a proud co-sponsor of. And I hope that after today our committee can move forward on solutions to this problem that we really need to move quicker, more quickly. It is long past time we acted to reverse this horrible trend once and for all.

So let me ask this question. I have long supported investments in family planning and reproductive health and I am particularly interested in the impact that such investments can have on maternal mortality. As the ranking member of a House Foreign Affairs Committee, I have seen that impact on a global scale. In fiscal year 2016 alone, U.S. investments in family planning worldwide provided contraceptive services and supplies to 27 million women and couples, which in turn helped to prevent 11,000 maternal deaths.

So let me ask Drs. Crear Perry and Coslett-Charlton, would you each explain why meeting unmet need for contraception helps to prevent maternal deaths?

Dr. Perry. So there has been some data that shows that the safety and security you get from having access to family planning

and not having to worry about if you are going to get pregnant again because you are not planning to be pregnant at that moment really decreases your stress and your weathering and ensures that you have a healthier pregnancy. We know that we have looked at the states that have more supportive policies around family planning also have better infant mortality rates and better maternal mortality rates. So it is not a coincidence that when you invest in family planning and when you invest in infrastructure for moms and babies, you actually create a safety net where people can live longer and be healthier. So it is important that these policies that are created in this House improve the ability for moms and babies to live.

Dr. Coslett-Charlton. And I would certainly echo that response. But also it has been shown that women that are able to plan their pregnancies by, you know, spacing interval between pregnancies and having access to adequate contraception that it improves the safety. There is very clear data to show that it improves outcomes in pregnancy and delivery also.

Mr. Engel. So thank you. But along those lines, let me ask you if either of one of you would explain why women in the United States specifically have unmet need for contraception. By that I mean they want to use modern contraception but are not currently.

Dr. Perry. Well, because the -- it is a state and local issue, usually, around access to family planning and reproduction

and because when we allow that to be made state-based wide people's personal, you get gaps in what states pay for, things like sex education, what states allow for, things like having birth control inside of high schools.

Once again I will say for my great state of Louisiana, we struggle with getting sex education in the schools. We struggle with getting access to family planning for the people who actually need it very desperately. So I think in an attempt to make for a safe environment for our state sometimes we mislabel what safety looks like. Safety looks like having access to choice when it comes to your reproduction. And when you have that access to choice and information, you can have a safer pregnancy and a safer outcome.

Mr. Engel. Well, thank you. Obviously there is a lot more work to do on this front. Let me mention this. A December report from the Guttmacher Institute estimated that globally, and I quote, fully meeting the unmet need for modern contraception would result in an estimated 76,000 fewer maternal deaths each year. That is 76,000.

So I want to ask either one of you doctors to please, if you agree is it fair to say that improving access to contraception for American women could help address the rates of maternal death in the United States?

Dr. Perry. Yes.

Dr. Coslett-Charlton. Yes.

Mr. Engel. That is a loaded question, but I wanted to put it out on the record. I want to also take this opportunity to briefly talk about legislation. I have introduced with Congressman Stivers, the Quality Care for Moms and Babies Act. The legislation would bring together diverse stakeholders to identify care quality benchmarks, care quality benchmarks for women and children in Medicaid and CHIP as well as fund new and existing maternity and infant care quality collaboratives.

These collaboratives bring together local stakeholders such as doctors and nurse midwives to best share the best practices in improved care for patients, and I am grateful to both the ACOG and March of Dimes for supporting this legislation.

And let me ask you, finally, both -- let me ask perhaps Ms. Stewart. I will ask you this. Wouldn't you agree that we should be measuring and evaluating performances of Medicaid and CHIP caring for America's moms and babies as well as investing in perinatal quality collaboratives which work to implement maternal mortality review committee recommendations at the state level?

Ms. Stewart. Congressman, we are very involved across the country in perinatal collaboratives and they are very effective and we would very much support them. And I would just add just at this point which is that 60 percent of all births are covered by Medicaid and that is a lot of women and a lot of babies.

And whatever we can do to make sure that the quality of care exists for those women as it does for women in the private

insurance market to make sure we are collecting the kind of data to understand what is effective and what is not and that we are sharing that data across states, we would firmly support that.

Mr. Engel. Thank you. Thank you very much. Thanks, Mr. Chairman.

Mr. Burgess. And the gentleman's time has expired.

Seeing no additional members wishing to ask questions, I want to thank all of our witnesses again for being here today. I have some documents I need to read into the record, a statement for the record from Sean Blackwell, M.D.; momsrising.org; and Alexis Joy Foundation. I also have the September report for the Maternal Mortality and Morbidity Task Force from the state of Texas; a letter from Dr. Gary Hankins who participated in one of our roundtables -- Dr. Hankins is from the University of Texas Medical Branch in Galveston; and Dr. Cardenas had mentioned the Obstetric Hemorrhage Toolkit in California and I do have a copy of that I am going to submit for the record.

Also, documents from the March for Moms; Postpartum Support Virginia; Association of Maternal & Child Health Programs; Heart Safe Motherhood; Massachusetts Child Psychiatry Access Program; a letter signed by 1,000 Days and other patient groups; Americans United for Life; Alexis Joy Foundation; Nurse-Family Partnership; Preeclampsia Foundation; Society for Maternal and Fetal Medicine; a letter from Timoria McQueen Saba; American College of Surgeons; KSM Consulting; more California PPH; SAP America; and Forbes

Insight Study.

And just to end on a somewhat positive note, my grandfather was an OB/GYN, an academic OB/GYN at McGill University in Montreal and practiced obstetrics during the decade of the 1930s when the maternal mortality fell from all-time highs to all-time lows, certainly indicative that if we put our minds to it, it has happened before, it can happen again.

Pursuant to committee rules, I remind members they have 10 business days to submit additional questions for the record. I ask the witnesses to submit their responses within 10 business days upon receipt of the questions. Without objection, the subcommittee is adjourned.

[Whereupon, at 12:23 p.m., the subcommittee was adjourned.]