

Overcoming Racial Disparities and Social Determinants in the Maternal Mortality Crisis

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

FIRST SESSION

May 16, 2019

Serial No. 116-21

COMMITTEE ON WAYS AND MEANS RICHARD E. NEAL, Massachusetts, Chairman	
JOHN LEWIS, Georgia	KEVIN BRADY, Texas, Ranking Member
LLOYD DOGGETT, Texas	DEVIN NUNES, California
MIKE THOMPSON, California	VERN BUCHANAN, Florida
JOHN B. LARSON, Connecticut	ADRIAN SMITH, Nebraska
EARL BLUMENAUER, Oregon	KENNY MARCHANT, Texas
RON KIND, Wisconsin	TOM REED, New York
BILL PASCRELL, JR., New Jersey	MIKE KELLY, Pennsylvania
JOSEPH CROWLEY, New York	GEORGE HOLDING, North Carolina
DANNY K. DAVIS, Illinois	JASON SMITH, Missouri
LINDA SÁNCHEZ, California	TOM RICE, South Carolina
BRIAN HIGGINS, New York	DAVID SCHWEIKERT, Arizona
TERRI A. SEWELL, Alabama	JACKIE WALORSKI, Indiana
SUZAN DELBENE, Washington	DARIN LAHOOD, Illinois
JUDY CHU, California	BRAD R. WENSTRUP, Ohio
GWEN MOORE, Wisconsin	JODEY ARRINGTON, Texas
DAN KILDEE, Michigan	DREW FERGUSON, Georgia
BRENDAN BOYLE, Pennsylvania	RON ESTES, Kansas
DON BEYER, Virginia	
DWIGHT EVANS, Pennsylvania	
BRAD SCHNEIDER, Illinois	
TOM SUOZZI, New York	
JIMMY PANETTA, California	
STEPHANIE MURPHY, Florida	
JIMMY GOMEZ, California	
STEVEN HORSFORD, Nevada	

**Overcoming Racial Disparities and Social Determinants in the Maternal Mortality
Crisis**

Thursday, May 16, 2019

House of Representatives,

Committee on Ways and Means,

Washington, D.C.



House Ways and Means Chairman Richard E. Neal announced today that the Committee will hold a hearing entitled “Overcoming Racial Disparities and Social Determinants in the Maternal Mortality Crisis” on Thursday, May 16, 2019 at 10:00 a.m. in room 1100 Longworth House Office Building.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record can do so here: WMdem.submission@mail.house.gov.

Please ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Thursday, May 30, 2019.**

For questions, or if you encounter technical problems, please call (202) 225-3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but reserves the right to format it according to guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and

submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you require special accommodations, please call (202) 225-3625 in advance of the event (four business days' notice is requested). Questions regarding special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories are available [here](#).

###

Witness List

PANEL 1

The Honorable Robin Kelly, Member of Congress, 2nd District of Illinois

PANEL 2

Ms. Allyson Felix, U.S. Track and Field Olympian

Dr. Patrice A. Harris, President-Elect, American Medical Association

Dr. Michael Lu, Senior Associate Dean for Academic, Student and Faculty Affairs, Milken Institute School of Public Health, George Washington University

Dr. Melanie Rouse, Maternal Mortality Projects Coordinator, Virginia Department of Health, Office of the Chief Medical Examiner

Dr. Loren Robinson, Deputy Secretary for Health Promotion and Disease Prevention, Pennsylvania Department of Health

Dr. Lisa M. Hollier, Immediate Past President and Interim CEO, American College of Obstetricians and Gynecologists

The Committee met, pursuant to notice, at 10:04 a.m., in Room 1100, Longworth House Office Building, Hon. Richard Neal [Chairman of the Committee] presiding.

*Chairman Neal. The committee will come to order.

With over 700 women in America dying of pregnancy-related deaths each year, experts view the United States as one of the most difficult places in the industrialized world to give birth. This should not be the case. Pregnancy should be one of the happiest times in a woman's life, not an experience based on fear.

The CDC estimates that three-fifths of pregnancy-related deaths in America are preventable. The most startling reality is the clear disparity in the maternal mortality rate between women of color and non-Hispanic white women, with women of color notably less likely to survive pregnancy. Sadly, African American women are three to four times more likely to die from pregnancy-related complications than white women.

This racial disparity plays out across women of all income and educational backgrounds. The problem is so common that I need not look further than my own staff for a deeply personal experience. At 32 years old, an African American attorney who works for the committee became pregnant with her third child. Initially she and her family were excited, but their joy soon turned to worry.

Shortly after her first trimester, she fainted, falling down a flight of steps. In the emergency room, specialists determined her fainting was the result of cardiac and other issues and admitted her to the intermediate care unit. She remained there for some time, and after being discharged, was placed on extended bed rest with close monitoring by a team of specialists, including in-home nursing care.

During a doctor's visit at 35 weeks, another complication was discovered, and she was admitted to a hospital with a high-risk antepartum unit in ICU. Within days, specialists determined that her life was at risk at her child needed to be delivered early. Her daughter Kaylin was born preterm at 36 weeks.

My staff member was fortunate to have access to quality healthcare and a team of specialists caring for both her and her new daughter. Every woman should have the same opportunity. As a Nation, despite all the money directed towards medical care, we have not seen a complementary reduction in illness or improvement in the overall healthcare of many Americans.

Ideally, medical treatment and care in the United States would be closer to being equal for all. But the reality is that medical care tends to favor some people over others, and pregnant women of color are at risk for issues that many other women are not.

For too long, policymakers have failed to properly account for a range of personal, social, economic, and environmental factors known as social determinants of health. The poor maternal health outcomes across the country, especially for women of color, are a clear example of this problem.

A tremendous amount of research across the country can help us to combat this problem. Congress has the tools to make real change in maternity care and eradicate these disparities to lower the maternal mortality rate and to save lives.

I want to thank Ms. Felix and my staff for coming forward and sharing their extremely personal stories to help make progress on this issue. I welcome our distinguished witnesses and look forward to their testimonies.

And with that, let me recognize the ranking member, Mr. Brady, for an opening statement.

*Mr. Brady. Thank you, Chairman Neal, for calling this hearing today.

Welcoming a new child into this world should be one of the most rewarding times in a woman's life. It is nearly impossible to put into words the joy that comes from seeing a new baby for the first time. But sadly, the U.S. is one of three countries globally where the maternal mortality rate is actually on the rise. In other words, it is getting worse. As it stands today, it is more dangerous to give birth in America than it was two decades ago. According to the Centers for Disease Control, the rate of maternal mortality has increased nearly 26 percent from the year 2000 to 2014.

This means that for all women today, they are more at risk of dying when giving birth than their mothers were. And the statistics are even more alarming for women of color. African American women are three to four times more likely to experience pregnancy-related deaths than Caucasian women.

It is not entirely clear why maternal mortality and severe maternal morbidity is increasing in the U.S., but we all know one thing for certain: This is unacceptable. Our country should be the healthcare leader of the world. And every single mom deserves to know they will be in safe hands while giving birth.

Which is why last year Republicans on this Committee, and I as chairman, launched an investigation into this dilemma. The goal of our investigation was to find out why these deaths are happening, where Congress can take action, and how as a Nation we can reverse this trend.

Legislative "we" together for the first time in program history reauthorized the Maternal, Infant, and Early Childhood Home Visiting Program for 5 years. And we asked States to review how those resources are being deployed to best target moms and babies who are at risk. And as of October 1, 2019, States now will be able to draw down matching funds for home visiting, limited only by their contributions and expanding the reach of this successful intervention.

I applaud Chairman Neal for continuing our efforts on this tragic national issue, and while today's hearing will not solve the problem entirely, I am looking forward to working together toward bipartisan solutions to support America's moms.

Recent investigations from advocacy groups have highlighted this growing issue. CDC has determined that over 50,000 moms experience serious injury during the child birthing experience, as the chairman said, 700 women died of pregnancy-related complications in the U.S., and 60 percent of these deaths are preventable, regardless of race, regardless of ethnicity, and regardless of when they occur.

This statistic should force us all to pause because the truth is we know these findings most likely only scratch the surface. And as we work toward solutions, we first have to acknowledge there is a shortage of information on this problem.

The U.S. is deficient of consistent data reporting across States, and we lack an official U.S. maternal mortality rate. Without such information, it is more difficult to identify the causes of this national problem, and more data is needed in order to develop the appropriate response for this growing crisis.

I know this firsthand in Texas, as a State legislator, because of local constituents Dave and Anne Andis, who had a baby born with anencephaly, without a brain. I took on the cause of creating a Texas birth defects registry because what we realized, if we do not know when and where these birth defects were occurring, we could not identify the cause. Now, more than two decades later, we have better chances of a healthy baby because we started with what we needed most, the right information at the right time.

We also have to recognize the areas of improvement in our current health system, particularly access to affordable care, and sometimes strained doctor-patient relationships. We also need to examine geographical disparities regarding maternal health.

Pregnant women in rural America face significant challenges, including high

poverty rates, more chronic conditions, all with less access to healthcare providers. In fact, in more than half of all rural counties, currently no hospital exists that provides maternity care, so forcing many women to drive hours to get to the closest hospital. This makes it even more challenging for a woman who goes into labor to get to the hospital on time.

And on top of this, research has found that some black and Hispanic women report receiving discriminatory practices in the course of their prenatal care. That is just wrong. These are big issues that Congress needs to address with an all-hands-on-deck effort, and we can work to ensure best practices to address this issue and make sure that our moms are getting the care they deserve.

Republicans were glad to initiate the effort to investigate why our country's maternal mortality rate is so high and what lawmakers can do to remedy this. Let's work together in continuing the investigation because as our witnesses will attest today, there is much more work to be done.

And I am hopeful, Chairman, working together in a bipartisan manner, we can tackle this so every mom can be secure in knowing she will be safe while giving birth. Thank you, Chairman.

*Chairman Neal. Thank you, Mr. Brady. And without objection, all members' opening statements will be made a part of the record.

Before we move to witness testimony, I want to advise members that we expect today's hearing to go long and do not expect votes to be called until after 5:00 p.m. Therefore, in order to accommodate member conflicts and to give our witnesses a break, we will recess shortly before noon and then promptly reconvene at 1:00.

So let's proceed to hearing from two of our Members of the House, our first two witnesses. And we will have two panels again that will be accompanied by other distinguished witnesses as well. Let me welcome our colleagues. First, Congresswoman

Robin Kelly is a Democrat from the Second District of Illinois. And Congresswoman Jaime Herrera Beutler is a Republican from the Third District of Washington.

Each of your statements will be made part of the record in its entirety. I would ask that you summarize your testimony in five minutes or less.

Congresswoman Kelly, would you please begin?

STATEMENT OF HON. ROBIN KELLY, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF ILLINOIS

*Ms. Kelly. Good morning, everyone, Chairman Neal, Ranking Member Brady, and to my colleagues. My deepest appreciation to you for granting me time to testify today to talk about the complex issue of naming solutions to drivers of maternal mortality.

In terms of maternal health, as you have heard, the United States suffers from an alarming rate of maternal mortality. Seven hundred to 900 American moms die every year, more than any other developed nation. Women in the United States stand the risk of death during their pregnancies and childbirth.

America is the only developed Nation where the rates of women dying during childbirth is 26.7 mothers per 100,000 births, and is rising. Women of color bear the brunt of burden across a myriad of health outcomes, especially with respect to maternal wellness.

Black and Native American mommas die due to birthing complications at higher rates than any other mothers. They are 300 to 400 percent more likely to die from childbirth or pregnancy-related complications than their white counterparts.

Mommas like Kira Johnson, the daughter-in-law of Judge Glenda Hatchett, a mother who raced cars, flew planes, and spoke five languages, still died soon after giving birth to her second son, Langston. Mothers like Dr. Shalon Irving, a lieutenant commander in the Public Health Services Corps, an epidemiologist who dedicated her career to studying the stresses associated with racism; she died only weeks after giving birth to her daughter. Preventable conditions such as hemorrhaging, pre-eclampsia, and other acute conditions stunted these bright lives and that of others.

So what do we do to answer this call of this hearing? What do we do to overcome racial disparities and social determinants and maternal mortality? I have had the pleasure

of working alongside many of you in this room to put forth a legislative remedy to protect the health of women who desire to become mothers. These efforts are strong, and I believe it will change the course of maternal care inside and outside of clinical settings.

However, the hard truth is that no laws can legislate away racism or sexism. No laws can change the hearts and minds of people who operate on, deliver care to, or just look at women and people of color from the lens of unconscious bias.

But our laws can change how care is delivered within our hospitals by equipping our providers with standardized emergency obstetrical protocols. Our laws can support providers across the training continuum with tools that help them become more reflective about how their own biases play out in the care they provide to women of color. Our laws can extend care to mothers who are Medicaid beneficiaries throughout the entire postpartum period. Our laws can support full collection of consistent data about who dies on the way to motherhood and why.

This is a women's health issue. Women from all backgrounds, walks of life, classes, education levels, and races are dying. But as with all health disparities, women of color, especially black women, are overly impacted. We can only do the very hard, collaborative, thoughtful work of making sure we find out why and correct this situation.

As chairwoman of the Congressional Black Caucus, Health Braintrust, and co-chair of the Congressional Caucus on Black Women and Girls, of prime importance to me is equitable healthcare access and delivery, and the healthcare system's impact on those who, before the ACA, historically experienced barriers to care, whether due to cost, geographic isolation, insurance coverage, and especially due to egregious forms of exclusion, such as race, and the residuals of racism.

In closing, I extend a happy belated Mother's Day to all the mommas in the room, and wish my colleague luck as she is ready to deliver any minute now.

[Laughter.]

*Ms. Kelly. And to those who are with us in spirit. In two days. As a mother, my heart goes out to those families who have lost their momma. Starting or growing one's family should not cost a mother of color or any mother her life. All mommas deserves a chance to be a momma. Together we can make sure this is always the case for black and brown women and for all women.

Thank you, and I yield back.

[\[The prepared statement of Ms. Kelly follows:\]](#)

*Chairman Neal. Thank you, Ms. Kelly.

Let me recognize Jaime Herrera Beutler from the State of Washington for five minutes.

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

*Ms. Herrera Beutler. Thank you, Chairman Neal and Ranking Member Brady. It is a privilege to get to be here today in front of you all. And I promise not to go into labor while I am testifying.

[Laughter.]

*Ms. Herrera Beutler. Unless you really get tired and it is a long day and you need me to.

Thank you for holding this hearing. The increasing maternal mortality crisis and the morbidity crisis in the U.S., and the racial disparities and the rural disparities that persist within those rates, is truly alarming.

Charles Johnson, widowed father, lives by the motto, "Wake up, make Mommy proud, repeat." As a single father of two boys, Charles strives to honor his late wife by raising awareness of maternal mortality in the U.S. Charles' wife Kira died hours after giving birth to a healthy baby. And they chose the best hospital that you can find.

As we will hear today, the statistics are shocking, and difficult to even comprehend how this can be happening right now in 21st century America in a country whose medical care and technology sets the standard for the rest of the world. Despite these technological advantages, the U.S. ranks 47th in maternal mortality; 7- to 900 women a year die.

This means that more mothers die from pregnancy, childbirth, and postpartum here in our Nation than in any other developed nation in the entire world, and the maternal death rate increases every year. Perhaps the most heart wrenching of all this is that the CDC

estimates 60 percent of those deaths can be prevented.

I want to specifically thank the committee for shedding light on the racial disparities that exist within maternal mortality rates. It is hard to comprehend. Black mothers are three to four times more likely to die from pregnancy-related deaths as other women, and really, depending on the State they are in, that number goes up.

Women in rural areas face higher than average death rates as well. And these disparities exist across all socioeconomic levels. As a citizen, as a mother, this alarms me, and I know we can do better as a country.

As members of the committee are aware, we know that many conditions that contribute to high maternal mortality rates such as cardiovascular disease, obstetric hemorrhage, hypertension, these are contributing factors. However, the reality is the available data on maternal mortality is woefully inadequate. I am sure the first question in your mind is: Why? We cannot answer that fully.

In working with key leaders in the field of maternal health as co-chair of the Maternal Mortality Caucus with my colleague Lucille Roybal-Allard, all these key leaders have come to us and pointed to say that maternal mortality review committees are critical. In fact, they are the first step in combatting this health crisis.

These committees will investigate every single maternal death or pregnancy-related death and make recommendations so that future moms' lives can be saved. And I think it is going to be different in each area and region and instance. There is not a one-size-fits-all fix.

I am proud to say that Congress has taken an important first step. The President signed into law my bipartisan Preventing Maternal Deaths Act last December. I know a number of you were very supportive in that effort. This bill marks the largest step that Congress has taken to date to address this crisis.

The bill supports and establishes State Maternal Mortality Review Committees so that we can begin to just understand why moms are dying and what is behind the racial disparities. It is exciting to me to see how this bill has incentivized States to take quick action; in fact, we have already, as a member of the Appropriations Committee, put funding into this. The money is being let out. And the momentum is building.

For instance, New Jersey and Nevada both recently passed bills to establish Maternal Mortality Review Committees. Just last week my own State of Washington enacted legislation to strengthen and expand maternal death investigations and reporting. And this is critical.

To close, I want to remind each of us that you either are a mom or you have one. So this issue impacts you. Everyone should care about the tragic reality of maternal mortality in the U.S. Right here in our own communities, mothers are dying. And we must take action to save them.

America should be a safe, welcoming place for every woman to have a baby. It is well past time we stand up and advocate for women across our country who choose one of the highest callings, motherhood.

With that, I yield back. Thank you.

[\[The prepared statement of Ms. Herrera Beutler follows:\]](#)

*Chairman Neal. I thank both of our witnesses. And consistent with committee practice and out of respect for your schedules --

[Applause]

*Chairman Neal. -- and out of respect for your schedules, we will not ask you to remain for questioning. Thank you both for your time and your work on this important issue.

Let our next witnesses please take their seats.

[Pause]

*Chairman Neal. Thank you to our second panel of distinguished witnesses for taking the time to appear before us today to discuss these very important issues.

First let me welcome Ms. Allyson Felix, a United States track and field star, nine-time Olympic medalist and world champion who competes in 100-, 200-, and 400-meter events. Next, Dr. Patrice A. Harris, president-elect of the American Medical Association. Then Dr. Michael Lu, senior associate dean for academic, student, and faculty affairs at the Milken Institute School of Public Health at George Washington University.

Dr. Melanie Rouse is the maternal mortality projects coordinator in the Office of the Chief Medical Examiner of the Virginia Department of Health. Dr. Loren Robinson is the deputy secretary for health promotion and disease prevention for the Pennsylvania Department of Health. And finally, Dr. Lisa Hollier, the immediate past president and interim CEO of the American College of Obstetricians and Gynecologists.

Each of your statements will be made part of the record in its entirety, and I would ask that you summarize your testimony in five minutes or less. To help with that time, there is a timing light at your table. When you have one minute left, the light will switch from green to yellow, and then finally to red when the five minutes are up.

Ms. Felix, please begin.

STATEMENT OF ALLYSON FELIX, U.S. TRACK AND FIELD OLYMPIAN

*Ms. Felix. Good morning, Chairman Neal, Ranking Member Brady, and members of the committee. My name is Allyson Felix, and I am Camryn's mom. That is the title I am most proud of. But I have also represented our country in four Olympic games and have won six Olympic gold medals.

I have stood side by side with President and Mrs. Obama in the fight against childhood obesity. I am a proud African American woman, the daughter of an elementary schoolteacher and a minister. But today, I am simply Camryn's mom. And I would like to share the story of the two most terrifying days of my life.

At the time, I did not realize just how many other women just like me were experiencing those same fears and much worse. My hope is that by sharing my experience with you, it will continue a conversation that needs much more attention and support.

Thirty-two weeks into my pregnancy I was going into a routine prenatal appointment, and I thought that everything was right on track. I think it was healthy, and I thought that my daughter was healthy. I noticed swelling in my feet, but I thought that was normal for pregnancy. Right?

I asked my mom and my aunt, who are both black mothers, if they had experienced this as well. One had, one had not. And they just told me to ask my doctor at my next appointment, which fortunately was just a few days away. No one seemed too concerned, so I was not, either. I mean,, I really trusted that my doctors would have told me to look out for it. I found comfort in knowing that I was a professional athlete and, I had continued to train and exercise throughout my pregnancy and was in great shape.

When I walked in to my appointment, I was met with a friendly smile and genuine care and concern about how I was feeling. I really am so fortunate that I had such a

thorough doctor. She took a look and checked on Camryn, but then she stepped out of the office for a little while. Those moments sitting in her office alone felt like one of those moments in life that are full of anxious anticipation, one of those moments that people describe as "time standing still."

Waiting to hear the voice on the other end of the phone tell you exactly why they are calling at 3:24 in the morning -- those few moments lasted an eternity. But the doctor finally came back in, and she told me that I would need to go to the hospital.

I did not quite understand the seriousness of her request. I said, "Sure, but I have a photo shoot with ESPN immediately after this. So I will just run by, knock that out, and then I will head to the hospital." I got into my car without any -- the doctor let me know that that was not going to be an option. I got into my car without any idea what was wrong, but knowing that something was not right.

I called my husband, Kenneth, who was at work. I told him to meet me right away. And I was scared. I felt alone, and not just because my husband was at work and my family was 1500 miles away. I felt alone because I thought I had done something wrong. I felt like I was one of very few women that something so unpredictable was happening to.

That morning started like any other day, like every other day, but now I was sitting at the hospital waiting to hear what was going on with my unborn daughter. The news I received was even worse than I was respecting. My doctors told me that not only was my baby at risk, but I was at risk, too. All I cared about in that moment was that my daughter would survive, and I did not really understand about my life as well.

Mothers do not die from childbirth. Right? Not in 2019, not professional athletes, not at one of the best hospitals in the country, and certainly not to women who have a birthing plan in a birthing suite lined up. I thought maternal health was solely about fitness, resources, and care. If that was true, then why was this happening to me? I was

doing everything right.

My husband arrived at the hospital, and my doctor told us that I would need to be on bed rest for the rest of my pregnancy, which meant staying in the hospital for the next eight weeks. The thought of staying in bed for that amount of time was awful, but it would be okay because my baby would be okay.

Just as we started settling into our new home, the doctor came back in and gave us even worse news. She told me that I had a sectors case of pre-eclampsia and that if they did not act fast, this could prove fatal. I called my family. I asked them to fly in. And I asked my doctor if he could wait until they got here. He told me that he would do his best.

Ten hours later, I was being taken in for an emergency C-section at 32 weeks. I kissed my husband goodbye, not knowing what would happen next. And it all really happened so fast. I heard her cry; I could not see her, though. Who wouldn't they let me see her? I strained and reached, but my body did not really work.

I could not see her. I could not hear her cry any more. I clenched my husband's hand tighter, and there was. She was the most beautiful thing I had ever seen. She was not crying, but she was breathing, and that was okay. I only saw for no more than 15 seconds before they rushed her away, and I closed my eyes.

The next month was spent in the NICU, and I learned that my story was not so uncommon. There were others like me, just like me -- black like me, healthy like me, doing their best just like me. And they face death like me, too.

The more that I did my research and the more other moms that I talked to, I realized that they also had these experiences. I learned that black women are nearly four times more likely to die from childbirth than white mothers are in the United States, and that we suffer severe complications twice as often.

The data was teaching me that risk is equally shared by all black women, regardless

of income, education, or geographical location. So all the ways that made me think I was prepared and doing things the right way still are not for black women.

And as this committee meets to discuss overcoming the racial disparities in the maternal mortality crisis, I ask you to consider writing down a few names and keeping that list somewhere safe. Please write down the name of my friend, Serena Williams, Olympia's mom and tennis champion. Please, write down the name of my friend Andrea McBride, Meursault's mom and half of the first African American sister duo to found and establish a wine company.

These are just a couple of the names of women who are just like me. Even though we may have entirely different backgrounds and lives, some have more access to resources than others. Some are more healthy than others. But each of us has faced losing our lives and the lives of our unborn children.

What I have learned is that there is something that we should all be doing about this. We need to provide women of color with more support during their pregnancies. There is a level of racial bias within our healthcare system that is troubling and will be difficult to tackle, but that does not mean that we should not be tackling it.

Racial bias is difficult because it is not as easy to spot as outright racism. But examples can be just as devastating. Research shows that racial bias in our maternal healthcare system includes things like: providers spending less time with black mothers, underestimating the pain of their black patients, ignoring symptoms, and dismissing complaints.

Practical next steps are to look at ways that we can provide women of color access to doulas and midwives. This not only increases support, but it helps to educate women of color on pregnancies and healthy ways we should be monitoring our bodies during this beautiful time. I believe we also must look at how we can support organizations who are

committed to the work of lowering minority maternal mortality rates.

I have been learning that our current healthcare system is not set up specifically to provide support to these at-risk women, and the organizations that have taken up this cause are intentional in their work. I came here to share my story, a story that I thought was unique, but quickly learned was not.

I am grateful to you, Chairman Neal, and to this committee for hearing that story, and for also encouraging me to learn even more about this very important problem. As a result, I have decided to further lend my voice to organizations who have taken up this work, and I hope that I can not only share my story but be intimately involved in this work and fight to make a difference.

[\[The prepared statement of Ms. Felix follows:\]](#)

*Chairman Neal. Thank you, Ms. Felix.

Dr. Harris is recognized.

STATEMENT OF PATRICE A. HARRIS, M.D., M.A., PRESIDENT-ELECT,
AMERICAN MEDICAL ASSOCIATION

*Dr. Harris. Thank you. Good morning, Chairman Neal, Ranking Member Brady, and committee members. The American Medical Association commends you for holding today's hearing. My name is Dr. Patrice Harris and I am the president-elect of the AMA. I am a practicing child and adolescent psychiatrist from Atlanta, and an adjunct assistant professor in the Emory department of psychiatry. I thank you for the opportunity to testify today. And I also want to thank all the advocates who have been working on this issue for many years.

You have heard the data, and the data on maternal mortality in the U.S. are deeply disturbing. The U.S. is one of only three countries in the world where the rate of maternal deaths is rising. Again, you have heard the statistics, and will hear more data this morning. But most alarmingly, 60 percent of pregnancy-related deaths are preventable. This is simply unacceptable when we know these inequities are unjust and avoidable.

What is causing these deaths, and why is the rate so much higher, particularly for black and Native American women? Among the factors that play a role are as follows:

Although coverage has expanded under the ACA, millions of women still lack insurance or have inadequate coverage prior to, during, and after pregnancy;

Increased closures of maternity units, both in rural and urban communities, have reduced access to quality care;

In addition, the lack of interpersonal and interprofessional teams trained in best practices also impacts quality of care.

Structural determinants of health, which include public policies, laws, racism, reduce inequities in the social determinants of health, such as education, employment,

housing, and transportation;

Discrimination and racism exacerbate stress, which can result in hypertension, heart disease, and gestational diabetes during pregnancy;

And as we have heard, black women are not being heard, and clinician and institutional biases can lead to missed warning signs and delayed diagnoses.

So how do we move forward? The AMA is committed to ensuring health equity, which we define as optimal health for all. Our work in this area includes:

Convening medical schools to create learning opportunities, to integrate training in the social and structural determinants of health, implicit biases, and cultural humility;

Developing educational opportunities for practicing physicians on the social and structural determinants of health;

Working with UnitedHealthcare to utilize diagnoses codes linked to the social determinants of health, which we believe with incentivize physicians to screen for and provide the necessary referrals to social services and community supports; and

Welcoming Dr. Aletha Maybank as the AMA's first chief health equity officer, who is initiating our new and explicit path to advance health equity.

Regarding special solutions to address maternal deaths and morbidity, we support the expansion of State Maternal Mortality Review Committees. We support the MOMMA's Act to improve data collection, spread information on effective interventions, and expand access to healthcare and social services for postpartum women.

We encourage health systems to work with other partners, to identify and adopt standards to ensure safe and quality care at delivery and afterwards. It will certainly take all of us working together in partnership to address this issue, and the AMA is committed to doing so. We are committed to building and continuing on a path forward toward more holistically and effectively improved maternal health and advance health equity. Thank

you.

[The prepared statement of Dr. Harris follows:]

*Chairman Neal. Thank you, Dr. Harris.

Let me recognize Dr. Lu.

STATEMENT OF DR. MICHAEL LU, M.D., ASSOCIATE DEAN FOR ACADEMIC,
STUDENT AND FACULTY AFFAIRS, MILKEN INSTITUTE SCHOOL OF PUBLIC
HEALTH, GEORGE WASHINGTON UNIVERSITY

*Dr. Lu. Chairman Neal, Ranking Member Brady, and members of the committee, my name is Dr. Michael Lu. I am currently a senior associate dean at George Washington University. In July I will assume my new role as the dean of the School of Public Health at U.C. Berkeley. I am formerly the director of the Federal Maternal/Child Health Bureau, and I am pleased to have this opportunity to share with you today my personal views on what we must do as a Nation to eradicate maternal mortality.

So let me start by saying that in 21st century America, the most powerful Nation on the Earth, no woman should ever die from pregnancy and childbirth. And yet, as you have heard, every year more than 700 women die and more than 50,000 women suffer a life-threatening complication.

Recent media stories have shined a spotlight on the problem, but at times they make it seem like there is not much that we can do. In fact, I believe that much can and must be done. I believe that we can cut maternal mortality in half by 2025 and eradicate maternal death in this country by 2050 by doing three things right.

First is to learn from every maternal death. I will not say much of what you are about to hear, but I just want to add my support to the work that the CDC is leading to create a national system of Maternal Mortality Review Committees in every State. We need to learn from every maternal death so we can prevent it from happening to other mothers.

Second is to assure the quality and safety of maternity care for all women. This is a low-hanging fruit because, as you have heard in a view of a recent CDC report, 60 percent

of maternal deaths are preventable. Most are the results of inadequate preparation, of delayed diagnosis, ineffective treatment, or poor communication and coordination across providers and facilities.

This is where the "maternal safety bundles" come in. These are bundles of best practices, protocols, toolkits, drills, simulations, and other resources designed to improve the quality and safety of maternity care. These bundles work, and I saw it work firsthand in California.

I was part of a small group of doctors, nurses, and public health professionals who piloted prototypes of these bundles. We went around the State hospital by hospital. We did in-service for labor and delivery staff, and we did grand rounds for providers. We engaged hospital CEOs in quality improvement in this, and built a culture of safety. And up until about 2006, California's maternal mortality trended with the rest of the United States. It just kept going up.

With the implementation of these bundles, California's maternal mortality decreased by 60 percent in 6 years, and African American maternal mortality was also cut in half. So when I became the director of the Federal Maternal/Child Health Bureau, we worked with ACOG and many of the other public and private partners to launch the Alliance for Innovation in Maternal Health, or AIM, to spread and scale California's success to other States.

I will share more about AIM later, but the idea is that if we can get these safety bundles into every single birthing hospital in the United States, I believe we can maternal mortality by half by 2025.

The third and probably the most important thing we must do is to improve the health of girls and women in our country across their life course. We can start by assuring the access to quality healthcare for all women, not only during pregnancy but before,

between, and beyond pregnancy.

Today many low-income women lose their Medicaid coverage at 60 days postpartum. Considering that 1 in 8 maternal deaths occur between 42 and 365 days postpartum, extending Medicaid coverage to up to one year postpartum could be an important first step toward reducing late maternal deaths.

Healthcare is important to health, but so are the social determinants of health. Adverse childhood experiences and violence against girls and women have been linked to chronic health problems. The cumulative stress of poverty for girls and women in low-income households can take a physiological toll on their long-term health.

The experience of racism in the lives of many women of color can lead to "weathering," or accelerating aging, which can contribute to higher rates of chronic health conditions as well as maternal mortality among even college-educated African American women.

Your committee has jurisdiction over a number of tax and income support programs which could buffer against the impact of these social determinants. A recent proposal by the National Academies of Sciences, Engineering, and Medicine to cut child poverty in half in the next decade through a combination of expanded tax credits, food stamps, and housing vouchers exemplifies the kind of evidence-based policy approaches that could go a long way to improving maternal/child health in this country.

So lastly, let me close by just giving a shout-out to my mom, Ming-Yueh Lu, and wish her a belated happy Mother's Day. My mom has not got a whole lot of public shout-outs in her life just because she never got to go to college, or high school, or even junior high.

See, my mom was only 11 when her father died, so as the oldest girl in the family, she had to drop out of fifth grade to go work in the sewing factory. She and my dad

worked hard all their lives to put food on the table and put their four children through college.

That in one generation her youngest son is about to become a dean in the greatest public university in the world is a testament to all the love and sacrifice that she has shown me, the same kind of love and sacrifice that is played out nearly 43 and a half million times every day in this Nation. America can do better by our mothers.

[\[The prepared statement of Dr. Lu follows:\]](#)

*Chairman Neal. Thank you.

Dr. Rouse?

STATEMENT OF MELANIE J. ROUSE, PH.D., MATERNAL MORTALITY
PROJECTS COORDINATOR, VIRGINIA DEPARTMENT OF HEALTH, OFFICE OF
THE CHIEF MEDICAL EXAMINER

*Dr. Rouse. Chairman Neal, Ranking Member Brady, and members of the Ways and Means Committee, thank you for the opportunity to testify at this hearing. I am Dr. Melanie Rouse, the maternal mortality projects coordinator in Virginia's Department of Health, Office of the Chief Medical Examiner, and I would like to commend you for holding this hearing on this important topic.

Virginia's Maternal Mortality Review Team was established in 2002 as a partnership between Virginia's Department of Health, Offices of Chief Medical Examiner, and Family Health Services. It is a multi-disciplinary group of representatives from academic institutions, behavioral health agencies, hospital associations, state chapters of professional associations, and also violence prevention agencies. We have representatives from forensic pathology, maternal/fetal medicine, nurse midwifery, obstetrics, pharmacy, nutrition, psychiatry, patient safety, and public health all precipitating in our team.

The team collects data on and reviews the death of all Virginia residents who were pregnant within a year of their death, regardless of the cause of death or the outcome of the pregnancy. We refer to these deaths as "pregnancy-associated" deaths.

We use consensus decision-making to determine the community, patient, facility, and provider factors that contributed to the mortality in each case. And then the team assesses and determines whether or not the death was related specifically to the pregnancy and whether or not it was preventable. For deaths that we determine were able to be prevented, we discuss ways and changes that could have been made that could have ended up in the better outcome instead of a death.

Between 2004 and 2013 in Virginia, 462 women died of pregnancy-associated deaths. The numbers of death and the rates of death varied from year to year, and there were no clear signs of whether it was increasing or decreasing. Our preliminary numbers for 2015 and 2016 suggest that those rates are continuing to increase.

Overall, approximately 53 percent of our pregnancy-associated were due to natural causes. Accidental deaths represent the next largest manner of the among pregnancy-associated deaths in Virginia at 26 percent. Among the leading causes of death were: cardiac disorders, followed by accidental overdoses, motor vehicle accidents, homicides, and then suicides. Nearly 55 percent of these deaths occurred 43 or more days following the end of the pregnancy.

There were several risk factors that have been identified in pregnancy-associated deaths in Virginia. The most prevalent of these risk factors are: chronic mental illness, chronic substance abuse, and chronic medical conditions. Over 25 percent of maternal decedents in Virginia had been diagnosed with depression, and approximately 20 percent had been diagnosed with anxiety at some point in their life. Nearly 25 percent of the maternal decedents were found to have a chronic substance abuse issue.

Throughout the years of maternal mortality we reviewed in Virginia, we have noticed significant racial disparities. There have been disparities identified in the rates, causes of death, as well as the manners of death and the contributors to these. The disparities have been found to extend across all socioeconomic status and educational backgrounds.

In general, the maternal mortality rate for black women is over twice as high as it is for white women. And we look at specifically to the pregnancy-related cases, black women die at a rate three times higher than white women. There has also been significant differences found by race in regards to the manner of death. Black women were more

likely to die from natural causes, whereas white women were more likely to die from accidental deaths.

In addition to the racial and ethnic disparities that we found, we have also found disparities between urban and rural areas. In our rural areas, the leading causes of death were typically from violent causes, including motor vehicle accidents, which accounted for approximately 20 percent of all of our deaths in the rural areas. This was followed by homicides and then accidental overdoses.

In our urban areas, the leading cause of death was cardiac disorders, followed by homicides. Additionally, motor vehicle accidents and overdoses were prevalent in our urban areas at approximately 10 percent.

Maternal mortality at the State and National level has been increasing over the last two decades. Maternal Mortality Review Teams offer the opportunity to review these deaths to determine factors that contributed to this and to make recommendations for interventions and policies that can improve maternal health outcomes.

The team's review of pregnancy-associated deaths in Virginia has demonstrated the need for a system of affordable, coordinated, and standardized care in the United States as a cultural value, a medical standard, and a human right. Improving the health and outcomes of pregnant and postpartum women involves changes at all levels, including the community, the provider level, the facility level, and the system level.

[\[The prepared statement of Dr. Rouse follows:\]](#)

*Chairman Neal. Thank you, Dr. Rouse.

Dr. Robinson?

STATEMENT OF LOREN ROBINSON, M.D., DEPUTY SECRETARY FOR HEALTH
PROMOTION AND DISEASE PREVENTION, PENNSYLVANIA DEPARTMENT OF
HEALTH

*Dr. Robinson. Good morning. I am Dr. Loren Robinson, the deputy secretary for health promotion and disease prevention within the Pennsylvania Department of Health. I am a physician trained in both internal medicine and pediatrics. I would like to thank Chairman Richard Neal, Ranking Member Kevin Brady, and all members of this committee for the invitation to address issues surrounding the importance of women's health, healthcare, and wellness for mothers during perhaps one of the most vulnerable periods of their lives.

I would also like to thank Ms. Felix for giving her testimony today because so much of my story over the last month has been reflected in her words. Just three weeks ago I was promoted to the rank of mother myself, and --

[Applause]

*Dr. Robinson. -- thank you-- and it is thanks to my mother, who is watching my son today, that I can be here.

In Pennsylvania, we have aligned programming to federal outcome measures to increase access to quality prenatal to postpartum care, all of which are critical to reducing pregnancy-related complications and maternal morbidity and mortality. While many people know of Pennsylvania and know about Philadelphia and Pittsburgh, our State is also made up of a rich collection of small and mid-sized cities such as Erie, Pennsylvania, and vast rural areas that contribute much to our Nation's rich agricultural markets.

The narrative of maternal mortality has different faces across the Commonwealth, and women in our rural areas are also bearing the brunt of these healthcare disparities that

we have talked about today. The opioid epidemic has caused significant impact in both maternal and infant morbidity and mortality, especially in our rural areas and our small- to medium-sized cities.

In many cases, however, these communities have started to rally and organize to implement practices that are saving lives, such as linking home visiting services to our Centers of Excellence, which provide treatment and counseling for the disease of addiction.

However, these efforts have not yet been enough to overcome the grave disparities in outcomes borne by minority women, especially black women. The complex interplay of individual, relationship, community, and societal factors necessitate addressing issues across the range of factors to optimize the health of black women and the health of their children, as the choices that a person makes are shaped by the choices that a person has, which are themselves shaped by structural policies and processes.

Prenatal care is widely recognized as a practice acclaimed to improve maternal and information health outcomes. While the general trend in accessing adequate prenatal care is increasing for all areas in Pennsylvania, black women are less likely to have received early and adequate prenatal care, with only 65 percent of black women as compared to 79 percent of white women.

The "Healthy People 2020" target is 78 percent of women receiving early and adequate prenatal care. And although prenatal care is important, it may be received too late or not be enough to positively impact pregnancy outcomes. Pre-conception and health, as Dr. Lu indicated, can provide opportunities to promote the health of girls and women before they become pregnant.

State governments have incredible convening power, even while there are restrictions on how, when, and for whom our Federal dollars can be spent. By bringing together our community organizations, payers, insurance companies, large academic

healthcare system, and smaller community-based hospital, State governments can be the bridge for idea exchange. The imperative that comes from such an exchange is the creation of interdisciplinary policy and programs that reach communities that have typically not yet benefitted from Federal funding and programming.

In Pennsylvania, the Department of Human Services administers both the social services block grant and the Maternal, Infant, and Early Childhood Home Visiting, or the MIECV program. Currently over 6,000 individuals representing 3200 households are served through the MIECV program, with a total of 40,000 home visits being conducted in 2017.

And while these programs provide services for many Pennsylvanians, the Department of Health often fills the gaps for supports and home visiting for families who may not qualify for the above-mentioned programs.

The implementation of MMRCs have promoted progress in reversing the trend of maternal mortality. I am proud to say that in Pennsylvania in May of 2019, Governor Tom Wolf enacted -- or signed Act 24 into law, which created the Pennsylvania Maternal Mortality Review Committee.

The language of this act was modeled off of important work that was passed in Chairman Neal's home State of Massachusetts, where their MMRC has been in place for over 20 years. Pennsylvania is now equipped with an MMRC that will produce a report within three years of its first meeting, which was last October.

Examples of ways to implement changes and recommendations of Maternal Mortality Review Committees are through organizations known as Perinatal Quality Collaboratives, or PQC. Another promising practice that is flourishing in States such as North Carolina and Massachusetts, a Perinatal Quality Collaborative is a network of teams that work to improve the access and quality of care for both mothers and babies across

prenatal, labor and birth, newborn, and postpartum services. These teams can identify processes that need to be improved, and quickly adopt best practices to achieve their collective aims.

In closing, ways that we can move forward and address maternal mortality -- currently, the Preventing Maternal Death Act is providing applications or an opportunity for States to apply offer funding to create their MMRCs. As a next step and as we look forward, the MOMMA Act, which was introduced by Congresswoman Robin Kelly just one year ago this month, identifies priorities that we can address and achieve:

First, by expanding Medicaid access to cover the postpartum period up to 1 year as opposed to the routine 42 to 60 days across States;

Second, to ensure the sharing of best practices across these Perinatal Quality Collaboratives and across hospital systems;

Third, establishing and enforcing our national emergency obstetric protocols; and

Lastly, and possibly most importantly, to improve access to culturally competent care by addressing institutional racism and the training of hospitals and community health providers on the needs of all American mothers.

We continue to follow and be thankful for the dedicated time and energy of this committee and our elected officials here in Washington. I would like to thank you for your time this morning, and I look forward to working together to improve the health of mothers of our great Nation. Thank you.

[\[The prepared statement of Dr. Robinson follows:\]](#)

*Chairman Neal. Thank you, Dr. Rouse.

Dr. Hollier?

STATEMENT OF LISA M. HOLLIER, M.D., IMMEDIATE PAST PRESIDENT AND
INTERIM CEO, AMERICAN COLLEGE OF OBSTETRICIANS AND
GYNECOLOGISTS

*Dr. Hollier. Chairman Neal, Ranking Member Brady, and distinguished members of the committee, thank you for inviting me to speak with you today.

ACOG, with a membership of more than 58,000, is the leading physician organization dedicated to advancing women's health. Key to that mission is our core value, that all women should have access to affordable, high-quality, safe healthcare. I am Dr. Lisa Hollier, an OB/GYN specializing in high-risk obstetrics, and I have dedicated my career to improving the health of my patients. You have already heard the United States has a maternal mortality crisis, and the disparities in mortality are unacceptable. ACOG is committed to eliminating preventable maternal deaths, and we are eager to continue our strong partnership with you to achieve this important goal.

We applaud the passage of Congresswoman Herrera Beutler's bill last year. As you have heard, MMRCs are best positioned to understand the causes and contributing factors of maternal deaths and to identify opportunities for prevention.

The Alliance for Innovation on Maternal Health, or the AIM program, is helping to translate maternal mortality review committee findings and recommendations into action. Launched in 2015, the AIM program is funded through a cooperative agreement with HRSA and ACOG. The goal of AIM, a voluntary program, is to eliminate preventable maternal mortality and morbidity in every U.S. birthing facility.

MMRC data identifies gaps for improvement. State Perinatal Quality Collaboratives assist with the implementation, and AIM provides the programs which get us to our goal. AIM promotes a culture of safety in hospitals through evidence-driven best

practices, called "bundles," including obstetric hemorrhage, severe hypertension, opioid use disorder, and the reduction of racial and ethnic disparities.

Early evidence shows that AIM is shifting culture. Initial AIM States, including Illinois, Florida, and Michigan, observed a 7 to 21 percent reduction in severe maternal mortality between 2015 and 2018. California had a 21 percent reduction in severe complications from hemorrhage. And in Illinois, timely treatment of sectors hypertension rose from 41 percent to 85 percent. AIM is now in 27 States, applied to about 75 percent of the total U.S. birthing population, and with your support, we hope to reach all 50 States.

Work on the AIM disparities bundle is happening in real time, and we are both encouraging States to implement bundle elements and working toward incorporating mechanisms to address disparities in all of our AIM bundles. To help achieve that, ACOG is working with our partners on Mothers' Voices Driving Birth Equity, a project funded by the Robert Wood Johnson Foundation to incorporate patient voices and lived experiences in our patient safety work. Black women's feedback must be a driver for quality improvement initiatives. ACOG also supports the Action for Safe Maternity Care Initiative, with the goal of empowering and equipping black mothers to obtain respectful, person-centered care. We and all care providers have work to do, and we are committed to addressing implicit bias and increasing the provision of culturally competent care to our patients.

News reports of the maternal mortality rate in my home State of Texas put this issue in the national spotlight. Our MMRC helped to ensure that we had an accurate counting of maternal mortality, which was lower than initially reported, and an understanding of the causes in our State.

Our latest Texas MMRC report noted the leading causes of death were cardiovascular conditions, obstetric hemorrhage, infection, and cardiomyopathy. We found

that black women bear the greatest risk for maternal death, and that risk exists regardless of income, marital status, or other health factors.

These finding-informed recommendations, such as the promotion of a culture of safety through the implementation of best practices, like those developed by the AIM program, and increased efforts to eliminate heart disparities. In addition, I was co-chair of the Harris County Community Plan to Improve Maternal Health, convened to address Harris County's high rate of maternal morbidity. I encourage other cities to consider this public-private partnership model.

As Congress considers its next step, ACOG urges you to advance four key initiatives, all elements of Congresswoman Robin Kelly's MOMMA's Act to accelerate evidence-based patient safety changes, authorize the AIM program, support State perinatal quality collaboratives, support efforts to end racial and ethnic disparities in maternal outcomes, and extend Medicaid coverage to 12 months postpartum.

Thank you for the opportunity to share our work with you today. We are truly making meaningful progress on the path to better maternal outcomes, and we look forward to working together with you to eliminate maternal mortality. Thank you.

[\[The prepared statement of Dr. Hollier follows:\]](#)

*Chairman Neal. Thank you, Dr. Hollier.

We will now proceed to questioning under the five minute rule. Consistent with committee practice, I will first recognize those managers present at the time of the gavel in order of seniority. Let me begin by recognizing myself.

Ms. Felix, would you like to convey to expecting mothers who may be watching this hearing, especially African American women who might not always feel included in such conversations, your feelings?

*Ms. Felix. Yes. I would definitely want them to know, first of all, to be aware. I was not aware. I did not know that I was at a greater risk. Really to advocate for yourself. You can be intimidated sometimes in a doctor's 'office, but if something does not feel right, you need to speak up. We need to be heard.

And I would just encourage them to do that. I hope that in the future this problem is not as great as it is now. And until then, I just really encourage African American mothers to have a voice and to really use it.

*Chairman Neal. Thank you.

And Dr. Lu, how can we better and consistently collect data, as you have outlined, on social determinants of health and risk factors so that we can make informed improvements that yield better results for millions of minority women in this country who rely upon our hospitals for safe delivery?

*Dr. Lu. First thing first. Let's make sure that we get a Maternal Mortality Review Committee in every State. Maternal Mortality Review Committees do collect a lot of data on social determinants of health.

I think we also need to be better tracking severe maternal morbidity, that for every single maternal death, there are at least 50 to 75 near-misses -- women did not die, but suffered a life-threatening complication. I think there are a lot of things that could be

learned on these severe maternal morbidities.

I also think that we need to be doing a better job in terms of monitoring the quality and safety of hospital care, which really begs for performance measures, either JCAHO performance measures on the inpatient side or a HEDIS performance measure on the outpatient side.

And lastly, and probably most importantly, I think we need to be doing a better job in terms of listening to mothers, and especially understanding their birthing experience, whether they feel listened to, whether they feel disrespected or discriminated against. And one possible way of doing that is to expand the CDC's PRAMs, which is the CDC survey of mothers across the country in terms of capturing their pregnancy experience.

*Chairman Neal. Thank you.

Let me now recognize Ranking Member Brady for five minutes.

*Mr. Brady. Chairman, again thank you for hosting this hearing.

The reason Republicans on this committee launched an investigation last year was that this problem has been growing for more than 30 years, from about the time, Ms. Felix, you were 2 years old. And the question was: Why has this not been addressed before? Why has this gone on so long?

Women should not have to fear giving birth, especially when they have done everything right, as you did. What I think is important is that Washington likes to be simplistic. It is really important we are not. We have to get to the root causes of this mortality and get serious about it.

Medical factors do play a role. Obesity is higher in some races than others. Hypertension, the same. Diabetes, the same -- all of which lead to early births and C-sections, all of which can help, unfortunately, drive mortality for moms.

And we cannot just accept that as genetic. We have to go to the root causes and

solve it, make it better for them. Socioeconomic factors matter. Poverty is a risk factor. Mental health is a risk factor, and overdoses in Texas, and suicides in Texas and around the world.

So it is really important we go deep here. I have been encouraged by the investigation as we launched it by how many local communities, States including Texas, responded. They are identifying better data so we understand it. Dr. Lu, they are identifying certain better practices, best practices, all of which, I think, help along the way.

And I want to point out, Dr. Lu, I was pleased to see in your testimony you highlight the need for a national stage to help accomplish eliminating -- that should be our goal -- eliminating moms dying in birth. Dr. Hollier, do you agree that we need a national comprehensive stage to eliminate deaths at births? And in your community plan in Harris County in our back yard, what was working to lead us toward that.

*Dr. Hollier. One of the things that we have seen work best across all of our efforts is collaboration. By working together by organizations, patient groups, advocacy groups, all coming together to work for a single goal, to eliminate maternal mortality.

We have made significant progress. Specifically in the Harris County work that we did, we had a wonderful opportunity to bring together leaders in our local government, private entities, hospital systems, insurance providers. And in working together, we were able to come up with a strategic plan that had multiple different prongs to address the problems that were specific to Harris County. That collaboration was --

*Mr. Brady. And Harris County, just to put it in perspective, the third largest county in America. Very diverse. Has a broad range of these factors that impact maternal mortality. Do you agree we need a national comprehensive strategy here?

*Dr. Hollier. I think, again, it is very important for us to be able to work collaboratively across all of our groups so that we do not have duplication of effort and we

are working together.

*Mr. Brady. Yes. So I guess, Mr. Chairman, I would like to pose a question to my colleagues today: Is there any reason why we cannot all support a national strategy to address maternal -- eliminate maternal mortality? And further, I would suggest we all work together to continue our investigation as a committee that we started last fall. We have got some bright people on this committee who are absolutely dedicated to this. I bet you we can make a difference.

With that, I yield back, Mr. Chairman.

*Chairman Neal. Thank you. Let me recognize the gentleman from Georgia, Mr. Lewis, to inquire.

*Mr. Lewis. Thank you very much, Mr. Chairman. Mr. Chairman, first of all I want to thank you for holding this hearing. This panel, in my estimation, makes up one of the most diverse panels that I have witnessed since I have been a member of this committee. And I want to thank you again, Mr. Chairman.

I would like to thank each and every one of you for taking the time to share your stories and your expertise with us. Mr. Chairman, in my home State of Georgia, we face a crisis, and I would like to enter into the record a news article about why Georgia ranked last in the Nation on this matter.

*Chairman Neal. So ordered.

[\[The newspaper article follows:\]](#)

*Mr. Lewis. I would also like to express my gratitude for Ms. Piper Reed from Atlanta, Georgia. She shared her story with me about the reality of hardened depression and the challenges of trying to access health service as a woman of color.

Dr. Harris, thank you for being here. I am so glad we have a doctor from Atlanta, Georgia.

[Laughter.]

*Mr. Lewis. We need more like you. You are well aware of the crisis in Georgia. It is worse in our State than in any other. We fell behind. We need to do better. We need to catch up. What should the Congress do to encourage better maternal care for women of color? What should we do?

*Dr. Harris. Thank you for your words. And Congressman Lewis, I think there are many things that Congress can do. I would say, at a basic level, it is funding and infrastructure. Congressman Brady talked about a national road map. Congress, and at the national level, can develop funding again for a infrastructure from which a local and community-based solutions can arise.

Again earlier we talked about supporting the MOMMA Act. We talked about making sure that there is funding. Several panelists have mentioned the importance of Maternal Mortality Review Committees. In order to develop solutions, we need to first identify the problems, and we cannot always identify those problems without the accurate data. So funding to make sure that these review committees are adequately operationalized will be key.

The other issue, and you mentioned depression, and as a psychiatrist, I think I would be remiss if I did not mention the fact that we see women suffering increased levels of postpartum depression, and we see that at even higher rates in African American women.

And unfortunately, the infrastructure for mental health and for substance use disorders has just been woefully underfunded for several years. So funding a basic infrastructure for treatment for mental illness as for postpartum depression will be key as well. So those are just a few suggestions.

*Mr. Lewis. Ms. Felix, thank you for your courage. Thank you for being here today. I know you are a great athlete, can run very fast. Why would you want to come in and tell your story and be so personal? why?

*Ms. Felix. Well, thank you so much. It was very important for me to be here. For a living, I get to do what I am passionate about, and that brings me h joy. But to me there is no more important issue than what we are talking about today.

I consider having my daughter my greatest achievement. And was such an eye-opening experience, what I went through. I was not aware. I was completely not educated on this topic. And so I was not happy to go through what I went through, but I am thankful that I was able to come out and learn so much because now I feel like with the platform that I do have, I can use my voice to try to have an impact. So I am extremely happy to be here and to share my story today.

*Mr. Lewis. Thank you for being here.

I yield back, Mr. Chairman.

*Chairman Neal. Thank you, Mr. Lewis.

Let me recognize the gentleman from Nebraska, Mr. Smith, to inquire.

*Mr. Smith of Nebraska. Thank you, Mr. Chairman, and certainly to all of our panelists. Your personal story and professional perspectives, we certainly appreciate.

It is clear that the increasing rates of maternal mortality represent a major national challenge that needs to be addressed. When I chaired the Human Resources Subcommittee of the Ways and Means Committee in the last Congress, we acknowledged and worked to

address the challenges faced by pregnant and new mothers during our work reauthorizing the MIECV program.

Because of the proven benefits this program provides to at-risk mothers, I pushed for a five-year authorization of MIECV, the longest reauthorization of its kind, to ensure mothers and children get appropriate support they would otherwise be able to access. We also included language in the Jobs for Success Act last year which would have allowed States to recognize this need by using TANF dollars toward home visiting in MIECV.

Mothers in rural districts such as mine often face the greatest difficulties in accessing maternal care, a problem exacerbated by the closure and consolidation of rural hospitals and clinics. One avenue for providing pregnancy testing as well as antepartum and postpartum care new mothers need is through rural health clinics, frequently the nearest source of primary care for those in rural America.

In fact, because of the importance of rural health clinics in the provision of necessary primary and preventive care in rural areas, today I am introducing the Rural Healthcare Clinic Modernization Act, a bipartisan package which will help stabilize rural health clinics and STEM the recent tide of closures.

Another important aspect of overcoming rural health challenges, including maternal mortality, is the adoption of innovative approaches to transform care delivery to rural populations.

Dr. Hollier, what healthcare challenges would you say your observations would include in terms of noticing pregnant and new mothers and their experiences in rural areas?

*Dr. Hollier. ACOG believes that that access to maternity care in rural areas is of critical importance, and our organization is working with the American Academy of Family Physicians and the National Rural Health Association to come together to find solutions that we can put into place that will enhance the access to care for women in maternity areas

so that women have access to the same quality care regardless of where they live.

We urge you to keep access in the front of your minds as you are considering future implementations, so that we can ensure that women have access to safe, high-quality care.

*Mr. Smith of Nebraska. And do you see telehealth, perhaps, as being an option in this delivery of healthcare?

*Dr. Hollier. The American College of Obstetricians and Gynecologists convened a telehealth task force last year. They have been working to come up with recommendations on best practices for our membership, and we look forward to the publication of that report in the coming months.

*Mr. Smith of Nebraska. Okay. Very good. Anything else you would wish to add relating to that? Okay.

Dr. Robinson, would you perhaps be able to elaborate on telehealth and your perspective on the delivery of healthcare, certainly to rural areas? It does not even have to be just rural areas that could benefit from telehealth, but urban areas as well. Can you reflect on that?

*Dr. Robinson. Sure. So I think especially if we think about telehealth and we think about just the wait for a doctor even in urban areas, I think that telehealth could play a significant role. It helps for triage, so when a woman or a pregnant woman has a concern and is not sure if this is something that requires them to go to the hospital or just have a question like Ms. Felix referred to, telehealth provides that opportunity to have a face-to-face consultation via the internet or via telehealth.

And I think the other piece of that that is important and that contributes is that we can think about telehealth as it relates to social determinants. So what is it that a mother or a pregnant woman is in need of? It may not be that she needs to go to the hospital, but it may be that she is having a concern about accessing child care or trying to figure out how

she can access child care so that she can go to her provider appointment. How can she access transportation?

So in Pennsylvania in a lot of our rural areas, transportation is a big issue. There are communities that do not have sidewalks. When you talk about safe areas to walk, live, and play, we want to make sure that through telehealth, we can have those consultations, figure out what challenges a specific woman is facing, and figure out -- it may not just be her.

So if there are a lot of these same concerns from one community, that allows us as a State to say, how can we leverage resources that we have in existence to address the concerns that may be in particular community? And if we do not have those resources, how do we call on our Federal partners to say, "This is what we are seeing in our State, and while our current funding allows us to do X. What we really need to be able to do is Y, and are we able to do that?"

*Mr. Smith of Nebraska. Thank you. Thank you, Mr. Chairman.

*Chairman Neal. I thank the gentleman.

Let me recognize the gentleman from Texas, Mr. Doggett, to inquire.

*Mr. Doggett. Thank you so much. I really appreciate your valuable insights this morning. As chairman of the Health Subcommittee, I think this is a very good place to start. But recognize that we need a more in-depth exploration across the board of healthcare disparities that affect people in all conditions and in all ages and in both genders.

I think it is particularly important that we look at the reforms that have been outlined in legislation that was filed last session, the, Health Equity and Accountability Act by Mr. Lewis, Ms. Sanchez, Ms. Chu, Representative Davis, Gomez, and Blumenauer from this committee. There is much more work to do here about the broader issue of healthcare disparities.

In Texas your zip code is such a strong predictor of the health of mother and child. In San Antonio, Bexar County, which I represent, the disparities are really stark. Overall, Bexar County has the highest infant mortality rate in the State, and the greater San Antonio region has the second highest maternal mortality rate. And almost 40 percent of the live births involve women who did not receive any prenatal care or received it only very late in their pregnancy.

The numbers show why giving the State of Texas more responsibility by block granting Medicaid would be such a terrible mistake and the harm that has already been caused by the State's failure to accept available Federal funds to expand Medicaid, as well as its continued outrageous attacks on Planned Parenthood.

Even for those Texas women who receive Medicaid coverage during pregnancy, coverage, as Dr. Hollier pointed out, has been terminated at 60 days after childbirth under the State's very stingy Medicaid program. I am pleased with your testimony, Doctor, and the work that is being done in the Texas legislature now to try to extend that 60-day period to a more reasonable level.

But overall, while it is very important to work on the data, and I want to inquire more about that. We need not only good data but we need good care, and we need it for all economically disadvantaged Texans, and particularly to address this issue of disparities.

Bringing a child into the world is of course a combination of joy and stress. But that stress is enhanced when the women who travel through our healthcare system do not see many medical professionals that look like them. And so we need to work on our workforce in the healthcare system as well as one way of addressing this matter.

In San Antonio, a nurse, Veronica Heywood, and a group called Latch Support is one of those groups that is working to address this whole issue and to empower moms and break through some of the cultural barriers. The San Antonio Express has editorialized a

number of times about data problems because we had a declaration that Texas had the higher maternal mortality rate in the world. But it turned out that the data had been inflated, and that entire process really interfered with our ability to get at this problem.

There are so many other groups that are in coalition in Bexar County, working to try to address this problem. But I want to ask, I guess, Dr. Rouse and Dr. Harris. Give your comments about institutional racism, about what else we need to do to get the care there to help address this problem.

*Dr. Robinson. Thank you so much for that question, Mr. Doggett. I think I would start by saying that training providers in what systematic or systemic and institutional racism is the first step. So often we talk about race or racism in this country. It is about a personal attack. And I think when we think about systemic racism, there are very few people who would argue that any policy that is geared toward keeping a group of people down needs to stay in existence.

And so sometimes those are things that we just do not know about, and when we have training and can understand that there are things that have been in place for generations that we can all work together, we can work across States, across aisles, to address -- once we know what they are. I think that is the first piece of it.

We can think about providers at the hospital and health system level, which is important; but then, as Ms. Felix and some of the other panelists have said, talking about some of our community organizations. And so when we think about nurse midwives, when we think about doulas, making sure that people can get care where they are, that there is coverage for that -- because those services are not cheap and they are not currently covered by insurance.

And then when patients understand that piece of it and understand how to access services and are met with health system that supports them and understands how

institutional racism plays a role, there's a better chance that we can work to eliminate maternal mortality.

*Mr. Doggett. Thank you very much. And because I see our time is up, we welcome additional written submissions from any of the witnesses on these issues.

*Chairman Neal. I thank the gentleman.

I recognize the gentleman from Pennsylvania, Mr. Kelly, to inquire.

*Mr. Kelly. Thank you, Chairman, and thank you all for being here today.

First of all, Camryn's mom, also Ms. Felix, thank you so much for being here. You are totally relevant in this, and I think that the fact that you were willing to come forward and talk about your story -- what I am puzzled with, though, is in your case, it was not a matter of not having proper care. It was not a matter of not being in great shape. It was not a matter of so many different things.

And yet you encountered this. I have got to tell you, in my life, we have been blessed with four children. But between number 1 and number 2, we had an ectopic pregnancy, and never would have known it if it had not been for visits to the doctor's office. And I had absolutely no idea at that time what an ectopic pregnancy was. But my wife went through that, and then we went on to have three children after it.

But it just puzzles me because I am trying to understand. You had the best care you could possibly have. You were aware of everything in your life -- what you ate, your vitamins that you were taking, everything to getting ready to give birth. And yet you still had this problem and it just puzzles me. What else can we do?

But again, I want to thank you for doing that. You have got to be a real -- my daughter was a long-distance runner. But it is incredible, the role that you play and the voice that you have. So what else could you have done differently?

*Ms. Felix. I am puzzled as well. And I think that is the problem. For me as an

athlete, like you said, I know how to be healthy. I know all of the things. I know how to take care of my body. And I did do everything right. And so I think that is really what is scary. Right? I was still at a higher risk.

And I went through all these complications. And I wish that I could give you an answer. I do not know. But I know that this conversation is a great place to start, and hopefully we can actually come up with some answers. But I think the fact that I did do everything right, and I know how to be healthy but still faced this. "Faced this" is very, very alarming.

*Mr. Kelly. Well, the role you are playing is incredibly important. I wanted to talk to Dr. Robinson for a minute. And Ms. Sewell and I have a lot in common because Pennsylvania has been described as "Philadelphia in the East, Pittsburgh in the West, and Alabama in the middle," because we face -- and the reason I bring this up is because of the fact that so much of our State is rural.

And I wonder sometimes, as I look and because of the role you are playing in Pennsylvania right now, and Governor Wolf signing the piece of legislation, that we are getting more involved with this and we are of it. You talked to somebody about sharing data.

So when we talk about healthcare and we talk about the access to healthcare and the availability, actually, of healthcare providers. So in Pennsylvania, what we are trying to do -- because we see that all the time where people just do not have access to the providers that they need to have. And then the question becomes: Well, why can they not? in a lot of cases, it is just that there is no way to get there from where they are.

So what else can we do, looking at where it is that we are going? And I love it. We started this in the last session, and we are moving it forward right now. We are aware of it. When Mr. Lewis and I first talked at the beginning of this session, he said the one thing we

want to start right away on oversight was about the mortality of mothers because I could not believe, in the United States of America, we had that problem. But we share the same interest and the same beliefs that there is no greater role in America than to be a mother and to take care her for future generations.

So Doctor, what else can we do? And tell me what the data are that you can share. All States are facing probably a lot of the same situations. What can we do differently, or what do we need to do differently, or going forward, what have you seen?

*Dr. Robinson. Thank you very much, Mr. Kelly. So I think our first piece is getting the data. So you have heard a lot of data, and when you look at the headlines, everyone is talking about what is going on with black women. And that is so important.

And as a black woman, I am glad that we are a headline and we are paying attention. But you do not know what you have not studied. And so I cannot give you data about rural versus urban areas in Pennsylvania. And we will not know that until we study it.

And when we talk about diagnoses like a pre-eclampsia or the very high blood pressure that is dangerous for mother and baby, until we can have data about how many people have that and then start doing research -- about how early can we detect it? How can we prevent it? How can we get moms able to look for signs even earlier than their swollen feet? Those are the things that we need data on.

When we think about our rural areas, some of the things that can help are things like community health workers. So early in the pregnancy, a lot of the visits are about eating well, doing not a lot of medical tests but just checking in on a regular basis, and not on a very, very frequent basis.

And so when we have community health workers who can do some of that work, when we have nurse midwives who can go out into communities and who can do some of

the work that our OB/GYNs have done, and share in that work, and then thinking about, as women get closer to delivery, what services absolutely have to be delivered out of the hospital?

And help women understand: When you see any of these things, you definitely need to get to a hospital. And we have got policies and procedures in place to help them get there. And I think that is the piece that we need to communicate because so much of this period, it is a long nine months and there are a lot of knowns. But there are still a lot of unknowns. And so reassuring moms that they know their bodies well, and if something is different, who do they call and where do they go, are ways that we can make sure that we can make sure that we can reduce maternal mortality.

*Mr. Kelly. Thank you. Let's stay in touch because anything we can do, let's do it all together. There is nobody on this panel that is looking at what is going on and saying, you know what? It is not a problem. It is a huge problem. We have got to address it. Thank you all for being here. We really respect you for coming in and doing what you are doing.

Thank you so much. I yield back .

*Chairman Neal. I thank the gentleman.

Let me recognize the gentleman from California, Mr. Thompson, to inquire.

*Mr. Thompson. Thank you, Mr. Chairman. And thank you very much for putting on this very important hearing. And thanks to all the witnesses. You folks have just done an outstanding job.

This is other witnesses -- the witnesses have stated before, and colleagues on the panel have stated it is a woman's health issue. But I think it is important to point out that it is also a community health issue. This is something that affects all of us, and the better handle we get, the more our entire community is going to benefit from this.

A couple of witnesses -- Dr. Lu for sure, and I think someone else mentioned it also -- talked about the success that California has had. And I want to focus on that a little bit. We started making our progress -- it was just in 2006 when we established the CMQCC.

Seven years after that program was started, our maternal mortality rate in California was cut in half. Seven years, cut in half. And that is pretty incredible if you think about that. The other thing is that the rest of the country, their rate skyrocketed during those same 7 years. So we have done well in California, but I think we have a long way to go.

In particular, the gains that we have made in California have not been shared equally. The mortality rate for African American mothers in California is still three or four times greater than it is for white women. Dr. Lu, what are some of the lessons Congress and other States could take from our experience in California? And how can we make sure the benefits of our efforts are equitable, that women of color are not left behind?

*Dr. Lu. So yes, I think, first of all, that the key lesson here is quality matters and safety matters. And we were able to really show that kind of result in California because we created a culture of quality and safety in the hospitals throughout California. And that is really the idea behind AIM. It has really tried to spread that culture safety across all birthing hospitals in the United States.

I think the other really important thing for Congress to be aware of is about the social determinants of health. I think improving quality and safety of maternity care will get us halfway to zero maternal deaths. But if we truly want to eradicate maternal mortality in this country, we really have to work on improving the health of girls and women across their life course.

And that has a lot to do with healthcare access, but that also has a lot to do with creating the kind of social conditions in which girls, women, and families could be healthy.

And this is why I am so excited that this committee is holding the hearing on this. It is because within your jurisdiction, you actually hold many of the levers that could really lift up children and families in this country.

*Mr. Thompson. Thank you very much. It is also clear that there is a link between social factors -- unemployment, education level, income, social support, et cetera. In one of my counties, mothers without a high school degree experience higher rates of obesity, domestic violence, homelessness, food insecurity, and other related issues.

Dr. Harris, what can healthcare providers be doing to better incorporate the social factors into their work?

*Dr. Harris. I think we continue to do the work that we are currently doing at the AMA in partnership with UnitedHealthcare -- incentivizing physicians, developing diagnoses and codes that link higher reimbursement, to address these issues.

It is important to identify the issues, as you just mentioned. Issues around lack of transportation, lack of access to healthy, nutritious foods, lack of excess to a quality-built environment -- those are all the social determinants of health that do impact healthcare.

Again, someone on the panel mentioned zip codes. And we know that we need to again address the quality and address healthcare, but 80 percent of what impacts health is beyond healthcare. And so we absolutely have to address those issues. And it is job training. It is workforce development. It is looking at the built environment. It is making sure that we do not have food deserts. So all of those issues are critical in addressing the social determinants of health.

And then on the other side, we certainly have to start with our own implicit biases. We all have implicit biases. They are our blind spots. But first we have to name them, and then some of the training we will be doing at the AMA is to have folks name their own implicit biases and then move forward in knowing how that impacts care.

*Mr. Thompson. Thank you all very much.

*Chairman Neal. I thank the gentleman.

Let me recognize the gentleman from South Carolina, Mr. Rice, to inquire.

*Mr. Rice. Thank you. This is certainly eye-opening, and it is shocking that in this age of expanding technology and more people being covered by healthcare and all these each other things, that we are experiencing this terrible trend, one of the highest in the organized world.

I want to follow up Dr. Harris on the question we were just asking. When you said that implicit biases play such a large role in this, I am looking at the trends here, and they are really frightening in terms of -- it has gotten every year with the number of deaths per 100,000 people since the 1980s.

So where I struggle with what you are saying is: Do you think that implicit biases are higher, they are getting worse? Because I would think they would be getting better instead of worse. Are you saying that the implicit biases are getting worse over time? I mean, the number of deaths is way up. Why is that?

*Dr. Harris. Well, many factors. But specifically, to your question about implicit bias, I do not think we have measured that before. I think we are just beginning to have the conversations around implicit biases and how they affect care. We are just beginning to get the data.

Just on a related issue but paying, we know that some clinicians believed that African Americans feel pain less. That is one reason they may have been prescribed interventions for pain less.

*Mr. Rice. Well, your question about that is, it has been getting worse for 30 years. So do you think -- the thing that makes me struggle with what you are saying is, do you think the number of physicians who believe that has increased in the last 30 years? I just --

I do not understand.

But I want to move off of that for a minute. I heard Ms. Felix and Ms. Robinson both say that this problem is at all education levels, married or not; that women of color have this struggle. And that is so troubling and bothersome. And I want to understand why, and I hear everything saying, "Well, we really do not know why."

Dr. Rouse, you were listing statistics on the number one causes of death for maternal mortality by rural and urban. Can you list those again, please?

*Dr. Rouse. When we are looking at the rural areas, the leading cause is -- the number one cause is motor vehicle accidents, followed by homicides, and then accidental overdoses. And then cardiac disorders actually occurred at the same rate as accidental overdoses in rural areas. In urban areas, the leading cause of death were cardiac disorders, followed by homicides, and then motor vehicle accidents.

*Mr. Rice. Okay. So medical practices, are we going to affect homicides and motor vehicle accidents by changing our medical practices. Dr. Lu?

*Dr. Lu. Sorry. Can you repeat the question?

*Mr. Rice. Okay. She just said that the top causes of death for maternal mortality in urban areas were: motor vehicle accidents and homicides. Are we going to affect those top causes of death and maternal mortality with changed medical healthcare practices for people that are pregnant?

*Dr. Lu. There are certainly things that we cannot fix from a medical perspective, from a public health perspective, something like motor vehicle accidents. I certainly think we can improve upon.

But I do think that things like homicides that often result from inter-partner violence, or suicides that often result from mental health problems and depression, drug overdose -- those are all things that I think, yes, there is a role for medical providers to

detect early and to support.

And the concern right now is that 4 million low-income women, they will lose their Medicaid --

*Mr. Rice. Okay. I am sorry, but I am almost out of time and I want to ask one more questions.

Dr. Harris, have y'all looked at what part of this increase is from the opened epidemic?

*Dr. Harris. We certainly need more data on the intersection.

*Mr. Rice. Okay. So you are saying no.

Dr. Robinson, have you looked at what portion of this increase is due to the opened epidemic?

*Dr. Robinson. We do not have that data available yet but we will be looking at it.

*Mr. Rice. Dr. Hollier, have y'all looked at what percentage of this increase is due to the opioid epidemic?

*Dr. Hollier. We are gaining the data to be able to do that type of assessment.

*Mr. Rice. Thank you. I yield back.

*Chairman Neal. I thank the gentleman.

Let me recognize the gentleman from Connecticut, Mr. Larson, to inquire.

*Mr. Larson. Thank you, Mr. Chairman, and thank you for holding this hearing.

Thanks to our witnesses.

I would for the record, Mr. Chairman, like to submit an article, "Mothers Are Dying in Childbirth; Why Isn't Anyone Talking about It?" by Susan Campbell and Christine Stewart.

*Chairman Neal. So ordered.

[\[The article follows:\]](#)

*Mr. Larson. I would also like to thank the chairman. And I would like to thank the Republican leader as well and everybody here on this panel. I think this stands in stark contrast as a hearing, speaking of people talking about it, to what has taken place in Alabama. And so I appreciate the witnesses and the desire, and I want to go back to something that Mr. Brady said.

The goal here should be to eliminate and the CDC has recently issued a report that said these can be reduced by 60 percent but, that leaves in my mind that that means that there are 40 percent more that this is impacting that we cannot get our arms around.

And it is this incrementalism that really disturbs me, I know, as much as it disturbs everybody here. And I am wondering, because I know there may not be a silver bullet. But certainly there has got to be the following steps that need to be taken immediately to eradicate and eliminate this.

Dr. Lu, I will start with you. Do we have steps that we could take immediately?

*Dr. Lu. I think the first step is for y'all to offer a national stage to eradicate maternal mortality, which I think it is long overdue. No, I --

*Mr. Larson. So, for example, having a national task force that was dedicated and focused on this with all the nation's leading experts to say, "The goal is, we are going to eliminate this." We are not going to be -- what is it, a woman in my district has three more times a chance of dying than a person in the United Kingdom or in Canada. And even people in China fare better than Americans do.

If this is not a call to arms, I do not know what is. And instead of focusing on eliminating the Affordable Care Act, we have got to be talking about how we can provide more healthcare and better access to people. Is that part of the solution?

*Dr. Lu. Yes. And so I do think, starting with that national strategy and making sure that we are aligning UK resources with the strategy. Yeah. I remember first reading

about the maternal mortality crisis in this country, in the wealthiest Nation on Earth, when I was a medical student. And this problem has been going on for such a long time, and the problem has been getting worse over time.

But we are now finally in that historical moment where it seems like the Nation is coming together to finally do something about maternal mortality. So I do think it is important for y'all to call for a national strategy to make sure that we have that fist ever National strategy to eliminate and eradicate maternal mortality in our generation.

*Mr. Larson. Dr. Harris?

*Dr. Harris. I agree with the national strategy. But I agree that we can do some things right now. You heard folks talk about the AIMs work and the work of the Mortality Review Committee so we can know immediately what is causing the problems in particular localities and try to address those.

And then, as I have said --

*Mr. Larson. AS a follow-up, would you say in a written statement to us, "I recommend you do the following"?

*Dr. Harris. Yes.

*Mr. Larson. Dr. Robinson?

*Dr. Robinson. Yes.

*Mr. Larson. What would you recommend?

*Dr. Robinson. I agree with my colleagues on the panel. And I would say also the extending of Medicaid provision up to one year postpartum for women to make sure that after that 60 days or after that 42 days, that women are still able to get medical care to help prevent those deaths that we know occur in that postpartum period.

*Mr. Larson. Dr. Hollier?

*Dr. Hollier. implement the AIM program in all 50 states in all of our hospitals so

that everyone is implementing the best practices.

*Mr. Larson. Dr. Rouse?

*Dr. Rouse. Absolutely implementing Maternal Mortality Review Boards in all the States so that we are able to assess what the problem is. And once we know what the problem is, we can work to address it.

*Mr. Larson. Ms. Felix? You should be the national face of this.

*Ms. Felix. I think I am the only one up here who is not a doctor.

[Laughter.]

*Ms. Felix. So I will have to agree with all of them.

*Mr. Larson. Good answer.

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

*Chairman Neal. I thank the gentleman.

Let me recognize the gentleman from Arizona, Mr. Schweikert, to inquire.

*Mr. Schweikert. Thank you, Mr. Chairman. And I wanted to give a few seconds to Mr. Brady because I think he had something he wanted to put in the record.

*Mr. Brady. If I could, Mr. Schweikert. First, one, Ms. Felix, I neglected to say my family and I have cheered you from our living room. So it is fun to cheer you from the hearing room. Thank you for being here.

*Ms. Felix. Thank you so much. That means a lot.

*Mr. Brady. Secondly, Mr. Rice asked about what the direction of bias is going because that is a serious issue. A Harvard study recently found implicit bias based on race has decreased -- that is good, 17 percent -- explicit by 37 percent, again better. But the answer is zero. no bias Is acceptance in medical treatment or time spent on person, period.

But the other point I would like to add is, look. Zip code and race will tell us who is impacted. Well, you are helping us identify is why we are losing those moms. I think

your testimony as well as our States and local community can help us do that.

Mr. Schweikert, thank you for yielding.

*Mr. Schweikert. A long 15 seconds.

[Laughter.]

*Mr. Schweikert. There is almost no hearing I have been involved in that has in some ways laid more heavy on our Staff and myself because we are used to grabbing the math and being able to slam through it and have the math say something to us.

And Ms. Rouse, in many ways your documents were most helpful to us. But still, you struggled because there is still so much noise in the data. You want something to pop out and say, "This person with this ethnic background from this area, this zip code, had this history of hypertension so this outcome." And I could see a percentage. And I know the population data is still too thin.

Thank you for what you are doing in Virginia. But we desperately need more because somehow we are also going to have to bounce what is happening out there with national trends of the average -- the age of a first birth, as we see in our society, is getting much older.

Is that affecting our math? We just -- if we can find out where we have a genuine problem, we can put policy and resources to it. We are struggling right now trying to say, where do we put policy resources? And Ms. Hollier, I partially was going to bounce a personal story off you.

I have the world's greatest little girl. I have a 3-1/2-year-old. And yes, she's the best little girl ever. We have a mug that says so. Twenty-eight-year-old mom. Not a single visit on prenatal care. Fully enrolled in our State's access system, which is the majority of births in Arizona. That is our Medicaid system.

in a discussion with her and some of the medical professionals around her, it turned

out that was not uncommon. In their case they said it was a transportation issue. But we all have the button on our phone, whether it be Lyft or Uber or something else. In a weird way, that is not a medical; that is sort of an access to modern life and technology and resource concept.

But I am hoping over time we will see in the data, hey, this appeared to be not the proper prenatal visit. Maybe we can fix that with a transportation or telephone or some sort of outreach, but some sort of solution there. But there is one that I really struggle with, and for Dr. Harris: The only way you can truly do an AB test, population test, of does our society still have, whether it be soft or some sort of culture or some sort of racism in the decision-making of our medical professionals.

You are going to have to set up some sort of system where this population, they get their medical advice from an algorithm, from something that has almost a nonhuman decision-making so it does not have an inherent bias that comes from us as living, breathing creatures. And I know that is very controversial in the medical world.

But it is -- you can train and train and train, but illness you have that that AB test, we will never know an honest baseline. And so I encourage you, and it's a really culturally difficult thing for your organization, saying, maybe we need to turn to the algorithm to make many of these medical decisions.

I would love a comment on that. And I know I am over time.

*Dr. Harris. May I respond?

*Chairman Neal. Please.

*Dr. Harris. I will try to be brief, but we can give you additional answer. But we at the AMA are very involved in looking at what we call assisted intelligence. Most people are using --

*Mr. Schweikert. Yes.

*Dr. Harris. I am sorry. We call augmented intelligence and help. Most people are using artificial intelligence. I will say, though, one thing, and we will give you more data: There are people developing the software and the programs. And those people have biases.

*Mr. Schweikert. But there is --

*Dr. Harris. So I think we will have to keep that in mind.

*Mr. Schweikert. But you can audit the -- it is really easy to audit an algorithmic design to remove that. I know it is controversial, but thank you for at least letting me go through that because I see no other path other than to test something of that nature.

*Chairman Neal. You cleverly recaptured your time from Mr. Brady.

[Laughter.]

*Chairman Neal. The chair would recognize Mr. Blumenauer to inquire.

*Mr. Blumenauer. Thank you, Mr. Chairman. And I appreciate the note on which this hearing started, with Ms. Kelly and Ms. Herrera Beutler putting a very personal face on this, and evidenced by some of our witnesses here today.

I would note that we had one of our other colleagues, Lauren Underwood from Illinois, a Member of Congress with, I think, two nursing degrees, who was recently in my district, and as part of her visit made a very powerful presentation on this issue. It is very profound. I think it illustrates some of the complexities and dysfunction of our healthcare system. It is no secret we spend more by about a factor of two than any other country, rich country, in the world. And we have too many outcomes that are troubling and mediocre.

Some of us have access to the finest healthcare in the world in our communities, but we are falling short on very important markers that you are sharing with us today. And it is not just economics. We are watching some of the outcomes, where the racial disparities are pretty stark, even amongst people of higher income. There is stuff going on here.

And I deeply appreciate, in particular, some of you sharing personal stories. And it

seems to me that this is a subject for new and expectant mothers that is personal, that is -- perhaps they're not used to talking AB or entirely comfortable, and where having the appropriator staff, training, the diversity, would make a big difference.

And so I would hope that any of you who want to dive in here to just talk a little bit about what difference that will make in terms of our getting our arms around better answers to being able to seize on what was a bipartisan note here of interest, concern, and willingness to work together.

Could you talk about that personal dimension?

*Ms. Felix. I could definitely just speak briefly about it.

For someone who was really excited to be pregnant and did a lot of research and read so many books, I can say that I was not aware that I was more at risk. And I think that says a lot. It is not really talked about. Even amongst my friends and when you're chatting, it is not something that is very cheery, when you first out that you are pregnant that you want to bring up, but it is a real issue.

And I think that had I been more aware, maybe I would have had better questions to ask. Maybe when I first saw my swollen feet, I would have rushed in instead of thinking, this is just a very common issue that everyone experiences. So I think you are absolutely right in that awareness that that can make some difference, just to be on alert, of things to look at.

*Dr. Harris. I would follow-up to say that I think it is important for providers -- like we said, it is uncomfortable to talk about race and racism in this country, and there is a definite piece of race and racism in the conversation about maternal mortality. But I think we have to be able to talk to patients about it.

I think for me, being a physician and being healthy, I thought that I was like really at the top of my game and was going to sail through this. Obviously, I am still learning,

not sleeping. But I thought --

*Chairman Neal. And that will continue for the next 20 years.

*Dr. Harris. Exactly. Never again. It is never slipping again.

But, you know, I was surprised that as someone who was leading maternal mortality efforts in Pennsylvania, that I too ended up with an unplanned C-section. And that one, I had talked to my doctor about concerns I had, that I was rapidly reassured without some follow-up testing.

And so I think it is really important that providers listen to all their patients, but especially when we know that black women are more at risk of maternal mortality, that we listen to black women and that it is better to err on the side of caution, especially as it relates to trying to make sure that we have positive outcomes for moms and babies.

But really, listening to patients and addressing what could be biases among providers around, thinking that patients our patients are too healthy, or they think that because someone is healthy when they went into pregnancy, that they will automatically be healthy on the other end of it.

And so I think listening to patients is key. And it should -- if we learn all of that in med school. But I think sometimes a gentle reminder and talking to patients about what they may be at risk for can save lives here.

*Mr. Blumenauer. Good advice. Thank you, Mr. Chairman.

*Chairman Neal. I thank the gentleman. As I noticed at the outset of the hearing, we will now recess, and we will promptly reconvene at 1:00 p.m. The committee stands in recess.

[Recess.]

*Chairman Neal. I want to thank Dr. Harris. She has been to my office to visit with me prior to this. But I do want to thank you for your expert testimony today, and it is

indeed very valuable. Thank you.

So with that, let me recognize the gentlelady from Indiana, the new ranking member of the committee, Ms. Walorski, to inquire.

*Mrs. Walorski. Welcome to this historic moment. Thanks, Mr. Chairman.

[Laughter.]

*Mrs. Walorski. So much appreciate it. And you know, I just think it is interesting, and I have been thinking about it even during this recess. Listening to all of you on the panel -- and again, so thankful that you are here -- but I think it is interesting that you are actually hearing us as members talk about how horrible our State is.

My State of Indiana has one of the strongest economies in the country, and we are third from the bottom on this issue. It is just appalling. And as I am sitting listening to my colleagues and we are all sitting here saying, "if this is such an issue".

And I cannot help but think a couple of things. Number one, that when we look at the success of the MIECV program, and I am the ranking member on what is now like the worker and service employee subcommittee that this actually falls under; we are going to be looking at this in depth, I know, as the year continues.

But I think it is really interesting that one of the things that is an advantage here is this is a bipartisan bill, so everybody up here is on board already with the MIECV program, funded into 2022 now. But I am wondering if we are not, as we are talking about this, finding a solution to this at the same time because I am sitting here thinking to myself, we are already -- we have already funded MIECV.

We could be looking at a potential expansion of this in the very near future because one of the things that MIECV relies on is training, to go into homes and to visit. And MIECV already basically tells States and has mandates out there, establish your most vulnerable people, and start funneling all those resources into vulnerable people groups,

and start there and then expand out of there.

And the other advantage we are talking about is people looking like people. And the other advantage of MIECV is a lot of the people that actually are the trainers in MIECV are right out of the MIECV program. Somebody came in and trained them, too. And then after they had their kids and were successful and were healthy, they go back into these same homes because they live in the same neighborhoods. And it really is almost a friend-to-friend kind of relationship.

But I think that -- I am very interested in it. I did some investigation in the State of Indiana as well as to why do we have the strongest economy, one of the strongest economies in the country, and why are we third in the Nation? It is a problem. And the lot of the local organizations on the front line that I talked to talked about just the pandemic use in our State and in our area of drugs.

And so, Dr. Hollier, I just wanted to address to you the question of, as you look at these stats and these numbers and as we continue to talk about this. And I look at this with a great optimism because I think we could use a -- we could certainly start quickly with expanding a program or looking at really pointing our attention on the MIECV program.

But there is an article in the American Journal of Obstetrics and Gynecology, talking about the fact that between 2007 and 2016, pregnancy-associated mortality involved opioids more than doubled. And I know you guys said that you guys had reports you were waiting for on the opioid problem.

But what models of treatment have you seen to be the most effective in helping a pregnant woman with a substance abuse disorder get actually healthy and stay clean. Is there anything you have seen so far that you can lend that wisdom to us?

*Dr. Hollier. Medication-assisted treatment is one of the best ways to address opioid use disorder for pregnant women. There is also a recent study looking at maternal

mortality from drug overdose in the State of Massachusetts, and they provide some very interesting information that talks about the year after delivery being a very vulnerable period for these women.

They are also looking for additional data, but programs that implement medication-assistance treatment. I also want to mention to you that the Alliance for Innovation on Maternal Health also has a bundle for obstetric care of women with opioid use disorder. And one of the really important things about this particular bundle is it extends participation outside of the hospital system into the clinical care of women. So this is one of the broader bundles that addresses care during pregnancy and not just at the time of delivery.

So implementation of the opioid use bundle is something that could be recommended.

*Mrs. Walorski. Got you. And I just wanted to say this to all of you who are in this fight. Thanks for your expertise. I just really think that the MIECV program, as it is right now, is a hope for us for solution in the future because of the human-to-human connection as well, not just government pamphlets and education kind of things, but literally inserting people back in this to support the dignity of humans as we continue to get to a solution.

Thanks for what you are doing.

*Chairman Neal. I thank the gentlelady.

Let me recognize the gentleman from Wisconsin, Mr. Kind, to inquire.

*Mr. Kind. Thank you, Mr. Chairman. I want to thank our panelists today for your excellent testimony. I want to thank the chairman for teeing up such an important issue and, as timing would have it, there was a very pertinent and good article that appeared in the New York Times dated May 7, 2019, and it is titled, "Huge Racial Disparities Found in Deaths Linked to Pregnancy." The subtitle is, "African American, Native American, and

Alaskan Native women are about three times more likely to die from causes related to pregnancy compared to white women in the United States."

Mr. Chairman, I would ask unanimous consent to have the article inserted in the record at this time.

[\[The article follows:\]](#)

*Chairman Neal. So ordered, and I would remind the members that, based on precedent, we will now go two-to-one in terms of witness testimony.

*Mr. Kind. Okay. Great.

In a moment I want to yield to my friend and colleague from Wisconsin, Ms. Moore, given all the work and the attention she has provided on the issue.

But first I want to thank Ms. Felix for your personal testimony today and sharing the personal story. It brought back a flood of memories for myself and the tough pregnancies that my wife and I went through with our two boys, the first one being the most difficult because it was so unexpected and unpredictable and scary at the same time.

Because we thought, like you, that we were doing all the right things, checking all the right boxes, doing the LaMaze. We read "What to Expect When You Are Expecting." I read as a guide "The Expectant Father," which I recommend to all men out there. And we were listening to our doctor and nurses and we were eating healthy, exercising. We thought we were doing everything right.

Then when it came time for the delivery, it was game on. We are reading for this. Let's deliver a boy. And we went in, and things went bad real fast. It was an extremely difficult delivery. The fetal heart monitor started plummeting. The oxygen intake monitor was plummeting. All the fetal distress signs were spiking.

And then we heard the fateful words, "We need to do an emergency C-section now." And within moments, we were being whisked away, our heads spinning, going into

an operating room. And it was a moment of probably the most terror I have experienced in my life because I was fearful I was going to lose my wife and my baby at the same time -- only to be followed a few moments later with one of the happiest moments of my life as it was a successful C-section. I was holding a healthy baby at the end of the day.

But they put that screen up across my wife's chest so she could not see what was happens. And I was holding her hands, and I was standing next to the doctor so I could watch the procedure and seeing everything that he was doing. And it was amazing that they were able to do it as quickly and as well as they did.

And then having a baby boy to show her right afterward -- but she was so heavily sedated she could not remember much of it. And I took Johnny in to get him cleaned up. Later on that day we went back to our recovery room, and of course she wanted to know. She wanted me to fill in what happened. What was it like? What did you see?

And being the guy that I am and giving an honest response, I said to her, "Well, you know, dear, having stood there and watched this doctor perform a C-section, I really think that if we're ever in a pinch, I could do this procedure now. I think I -- "

[Laughter.]

*Mr. Kind. She looked at me and said, "What? Are you kidding me? That is what you got from all this?"

But having said that, let me yield the remainder of my time to my friend from Wisconsin, Ms. Moore, and congratulate and thank her for the work that she has done on this issue in particular.

*Ms. Moore. Thank you. You know I have met this young man Johnny, and the most terrifying part of it is he looks exactly like you, Ron.

[Laughter.]

*Ms. Moore. But that is a happy ending. And I just wanted to lean into some of the

questions. Maybe I'll just a statement with this short amount of time.

I want you guys to think about the structural racism part. And many of you have said, "Well, we don't have much data on this. We don't have much information on this." And I am thinking that so much of what we know about healthcare is based on the Framingham model.

And there has not been enough research done on women and black women, Hispanic women, so that Allyson, when you asked your mama and your aunties was this common in your family, what you may not have realized at that point is that African Americans are very predisposed to high blood pressure because of the middle passage.

Those Africans who made it to the shore were the ones who retained water. And so, ergo, we have a propensity toward higher blood pressure. So if an African American woman presents still pregnant, that is automatically a risk factor, our genetics an our background. And so you are absolutely right. More information is needed.

So I just want to use this short time to say, I think that R&D is very important. Also, I just have introduced yesterday a doula bill. We had doulas, and they provided services to women, black women and white women. But when we had our institutional hospital care, midwives and doulas were put down.

So we need to introduce that kind of care. And I will yield back the gentleman's time, and I cannot wait until my time comes. Thank you.

*Chairman Neal. I thank the gentlelady.

Let me recognize the gentleman from Illinois, Mr. Davis, to inquire.

*Mr. Davis. Thank you, Mr. Chairman. And I was sitting here thinking that my colleague from New Jersey was next. But --

*Chairman Neal. You know what? I think he probably was. But it is too late. You are recognized. We will go ft back to him.

[Laughter.]

*Mr. Davis. Let me just thank you for this incredible hearing. And I certainly want to thank all of our witnesses, who have simply been outstanding.

I am trying to get at this issue. I represent a community, Bellwood, Illinois. It is a working class, suburban area. Neat bungalows line the streets. They have a good town, well-run. I just love going out there for town hall meetings and that kind of thing.

Lo and behold, they had 65.4 deaths per 10,000 deliveries in 2016 and 2017. Not a poverty town. Not a whole lot of social problems. Not a lot of street games. People have jobs. They go to work. And yet they had the highest rate in the whole area.

There is a great university medical center right there, Loyola University. There is a great big Veterans Administration hospital right there, Hines. There are other hospitals. There are physicians. And so it is an area that you would not necessarily expect this kind of mortality and morbidity.

We have talked a great deal about a number of things. My colleague from Wisconsin just injected the whole idea of research, and that is kind of where I am going with my question. Since there is so much that we do not know and trying to figure out, these are not poverty-stricken people. This is a good town. It is a great community. And yet we have this problem.

Do you think that there is a role for research to try and help us to better understand the why of the issue we are discussing? And why don't I just start with you and go right down the line. And thank you so much.

*Ms. Felix. I will definitely have to defer to all of my new doctor friends. But I would think that, of course, that research would definitely play a part in helping the programs so that when you get to people like me who are the patients and just your everyday person who is coming into care, that all of that would be able to help better than

the situation.

*Dr. Lu. Yes.

I am all about research, and I did not -- when you have African American women with more than 16 years' schooling, instead of hiding from a maternal and information mortality rate, what about women with less than 12 years of schooling? So we are talking about African American doctors, lawyers, and business executives. And they still have higher maternal mortality rates than white women who are high school dropouts. There are still a lot of unanswered questions.

Now, the leading hypothesis around chronic stress, and maybe he gets chronic stress from the structural racism there in equal treatment that they experience in health care and other areas. But I do think that a lot more research needs to be done both in terms of understanding why but also, more importantly, what can our Nation do about it?

*Dr. Rouse. Research is absolutely one of the most important things we can do at this point. Even among States that already have Maternal Mortality Review Teams, we need to expand the scope when we research these cases.

*Dr. Robinson. I agree with my co-panelists. And I would also say that in addition to doing the research, we have to disseminate the findings so that folks who are on the ground who may not have time to do the research or read the latest articles are aware of what is being found in the research and what they can do about it in our community settings.

*Dr. Hollier. We really do need to expand the data that we are collecting in the maternal mortality reviews to assess those community factors so that we have a better understanding of what factors it is in the communities that are putting women at risk.

*Mr. Davis. Thank you, Mr. Chairman, and I yield back.

*Chairman Neal. I thank the gentleman.

And with that, let me recognize Dr. Wenstrup to inquire.

*Mr. Wenstrup. Thank you, Mr. Chairman, and thank you all for being here. I think I could sit and talk with y'all for a good hour or so, at least.

But let me just start. I served on Cincinnati Board of Health, and one of the things that we engaged in was infant mortality because we recognized our numbers were going up in infant mortality. And we started looking at things. And we found the trends, like zip codes and race and things like that, that seemed to be factors or common denominators.

The problem, and what was interesting, too, is as we are looking at things, we are saying, "Well, why is this happening? Is it because of access? Is it because of education? Is it because of lack of perinatal care?" We found that some of the mothers did not even come in to see a doctor until it was a month before they were due. So then you really recognized, okay, we have got a problem here.

So there are so many factors. Dr. Rouse just said, "The more data we get, the more we have got to look at." And there is -- not everything is medical. Right? It's transportation. It is a lot of things that go on. And I think we have to look at that.

And Ms. Felix, I was struck. You said, "I was unaware of the risk." And I think that especially in this age of liability and we always get a consent for things. It is kind of amazing that we are not doing that, that someone is not saying, "Oh, and by the way, you are African American so there is a higher risk for pre-eclampsia; I want you to be aware of that. Look for these signs." We need to do a better job of that. That was very eye-opening to me, that that was your situation.

And especially if there is a predominance of something, either from your geographic area or your ethnic background. I think it is important that we do that. And obviously, we always have to look at comorbidities and other factors. Is the patient -- are they smoking? Are there drugs involved? Is nutrition adequate? Obesity? Is their home

safe? I mean, all of these things come into play.

So when I got elected, I not only got an urban area but rural area. And there was actually a priest in my district who was a family practice doc. He had two parishes, a full-time family practice, and he did deliveries, and he did all the high-risk pregnancies. And in our area, there was a lot of the drug addicts.

But I will tell you, he was the example of trying to make sure everything was done. I had a car dealer tell me, "This guy comes in and buys used cars for the mothers so that they can get to their appointments." But, you see, he recognized that this is more than just one component. It is all these factors that come into play in dealing with -- what a great example, and I was glad I got to know this doctor before he passed away.

In surgery -- so I am from a large orthopedic group, and we do not want to do readmissions. Right? We are penalized for readmissions. But we are doing elective surgery most of the time. Right? You are getting a knee, a hip, and this and that.

So one of the things we started doing is you are going to stop smoking before we do your surgery. You are going to lose weight. You are going to do physical therapy beforehand. We are going to do everything so that the outcome is at its best.

Well, delivering a baby is not an elective procedure. Right? So you do not have that -- I guess what I am just asking, thinking outside the box, how do we embrace all of these factors, try to bring it together so we optimize our results, that we make people aware of the risk? Which if you are not aware, then it is hard to stop it.

So there are a lot of things we can bring together. and I am really looking forward to working on all of this with you. And I think if some of the -- like Children's Hospital in Columbus, they said, "We take a Medicaid ACO, we get paid so much per child."

So how do we succeed? We make sure they are healthy. We make sure they get their vaccinations. We will go to their house if we have to, to make sure that they get taken

care of. So how do we do that in this environment, and what are your thoughts on that prospect?

I think we are talking in the right track. Can we do more? Whoever wants to weigh in on that. Dr. Felix? (sic) I am just kidding.

*Dr. Hollier. If you do not mind, I would like to speak to that briefly. We have a very similar model with a Medicaid health plan, working with our facility, and have a pregnancy medical home model with that same goal. Right? when moms are healthier and when their children are healthier, the entire system works better.

And that model has definitely shown improved outcomes for our pregnant women and their children, reduced rates of Caesarian delivery, reduced rates of NICU utilization, and better outcomes using care coordination, increased touches with both telephonic and in-person. So the model that you mentioned is something that could be useful.

*Mr. Wenstrup. Thank you all very much.

*Chairman Neal. Thank you, Doctor.

With that let me recognize the gentleman from New Jersey, Mr. Pascrell, to inquire.

*Mr. Pascrell. Thank you, Mr. Chairman.

Mr. Chairman, I was very interested in remarks from my good friend from Ohio. And I want to ask a question to begin with in that spirit.

Dr. Lu, you work at a great university. You are an obstetrician. You have a lot to offer here, as all the other panelists have. But I want to ask you something. There was the report from the Institute of Medicine back in 2003, and it was regarding unequal treatment and racial and ethnic disparities.

So the providers are on the front lines of ensuring that healthcare is equitable. What are physicians doing? Because you do a lot of education with our residents to improve their knowledge of social determinants and health equity in order to provide better care.

What are physicians doing? Dr. Lu?

*Dr. Lu. Yes, right. We have decades of research that really document unequal treatment in various areas of healthcare. But it took someone like Serena Williams to actually call it out, to bring some public attention to this.

I think that we can definitely do better in terms of training the next generation of physicians, about social determinants and so forth. I think that really needs to start really early, perhaps even before medical school. I was fortunate to be encouraged to pursue a broad liberal education at Stanford, where I was encouraged to take classes in communication and psychology and anthropology, which I think really made me a much better doctor.

In my medical training, I was in a special program, the joint medical program, between Berkeley and UCSF, and we spent that first year doing home visiting. I still remember visiting that elderly couple in Little Italy in San Francisco, and they were just like the nicest people. They baked cookies for me every time I visited. I didn't have a whole lot of medical knowledge. They loved to tell their life stories. So I just learned to listen really well and really be able to see how the home environment and community environment really impact on patients' health.

So I think some of those things are really important to standardize across all medical trainings to make sure that future doctors are kept more aware of the implicit bias of social determinants of health.

*Mr. Pascrell. Thank you.

We know, Mr. Chairman, that individual health is influenced by many factors, including race, ethnicity, sex, age, socioeconomic status, and geographic location. And that is just to start. In the past, I have introduced legislation called the REDUCE Act, REDUCE standing for Reducing Disparities Using Care Models and education. It works to

reduce health disparities. I am going to introduce it again very soon. I am working on it, bringing it up to date.

The bill which will work to provide updated data on our most vulnerable populations, and giving States and localities schools to better understand laws and projects that impact public health. I think this is critical to the issue, listening here today, reading your testimony, what all of you have said.

What do very different districts have to do with the major problem here? An individual's long-term health status is determined by poor health status, by disease risk factors, and by limited access to care. And yet many of these cases, there is not a problem of access to care.

The last predicate is so painful because it should be preventable. Tragically, women in this country are more likely to die from childbirth or pregnancy-related causes than women in other high-income countries. We have heard that many times today.

An American mom today is 50 percent more likely to die in childbirth. And Mr. Chairman, that simply is not acceptable to any of us. But in order to say that, you say, "Well, then, what are you going to do about it?" See, we are good, maybe, at times analyzing, and we are very poor responding to the problems and getting something changed for the better. I yield. Thank you.

*Ms. Sewell. [Presiding] Thank you.

The chair now recognizes herself for five minutes.

Let me just start by saying what a privilege it is to serve on a committee, the House Ways and Means Committee, that has taken seriously such an issue that affects, disproportionately, women of color.

And I am honored that the chairman, Mr. Neal, was so gracious to yield his seat to me for a little bit of time so that I can just say how profoundly important it is that we have

women of color in every position, but especially a dose, as researchers, and it is critically important to have us as lawmakers and policymakers as well.

On the screen there is a map that I would like to point your attention to. I represent the Seventh Congressional District of Alabama. The district includes the City of Birmingham, Montgomery, Tuscaloosa, as well as parts of Selma, Alabama, which is my home town. And there are just 16 rural Alabama counties that have hospitals that provide labor and delivery services, 30 fewer than did in 1980. So if you would look at the map that I am showing, 1980 shows the number of labor and delivery services, rural counties in red, that did not have labor and delivery services.

in 2008, 31 rural counties did not have it, and in 2017, 38 rural communities in the State of Alabama do not provide labor and delivery services. So over the years, less and less rural counties were losing labor and delivery services. In fact, in my district alone, we have seen the closure of OB/GYN wards and maternity wards throughout my district, especially the rural parts of my district. People have to drive one, two hours away. Can you imagine, Ms. Felix, if you in your state of pre-eclampsia, had to drive an hour and a half, two hours? What those women have to go through in order to have a baby!

I am particularly acutely aware of the social determinants of health and health disparities in this country. When I think about the fact that transportation, just one socioeconomic condition that affects one's healthcare and the delivery of healthcare -- but so does poverty. So does unemployment. So does food deserts, lack of nutritional foods.

So we have a lot of work to do. But I think that what we have come to realize in this committee this day is that there is bipartisan support to do something about maternity mortality in this Nation. You heard Ranking Member Brady proudly talk about the investigation that began under the Republicans' watch on this. Now you see it being furthered by Chairman Neal.

I think that what we need, and I am honored to be sitting up here now with my Republican colleague, who is also a medical doctor, from Ohio -- we need to do something about this. And I think that a good start was made by having the approval of Congresswoman Herrera Beutler's bill. But we also need to go further, I think, and consider the MOMMA Act by Congresswoman Kelly.

So I wanted to just say to you, Ms. Felix, what an honor to watch you on television, but more importantly, to watch you here today in this hearing to give your testimony, your personal testimony. And I would just like for you to remark on what you think was the biggest learning experience that you had from this whole episode. It is a crisis, but I think your voice is such an important voice in this, I would love to hear your thoughts about what advice you would give to other women.

*Ms. Felix. Well, thank you so much. I would say the biggest lesson that I have learned in all of my experience was being aware, being educated on this, and I guess to make other women aware. If I do not know, someone who I felt like I did do research and I was excited and talked to a lot of people, then a lot of my friends don't know and their friends don't know; and so making sure they know the right questions to ask, what to look out for. So that is the biggest thing that I have really learned.

*Ms. Sewell. Well, thank you. I want to thank you for your courage.

In my last few minutes I wanted to ask Dr. Robinson to talk about the importance of having a diversity of voices in the medical profession to help with this crisis. Would having more African American and women doctors also be something that could help this crisis?

*Dr. Robinson. That is a great question. And I think even beyond having more women of color and black women as doctors, I think, across the medical specialties. So we definitely need black women as nurses. We need doulas. We need midwives. I was

stunned to find out in Philadelphia there is one black certified nurse-midwife for the whole City of Philadelphia.

So there is work that we need to do, and I think that there are some really great programs. I think the 10-F program that helps to use money to help train people to go into the health field is very important. But we need to expand on those existing programs and make sure that they can access them.

*Ms. Sewell. Thank you. The chair noticed that she is out of time, but I would like to enter into the record several articles about the closures of hospitals in Alabama and its effect on maternal mortality. And so ordered. I will make that happen.

[\[The articles referred to follow:\]](#)

*Ms. Sewell. Next we have Ms. Chu from California is recognized for inquiry.

*Ms. Chu. Thank you, and it is so momentous that Chairman Neal has called for a hearing on this critical topic. I think it is clear that maternal health in this country is in a state of crisis, especially for women of color.

And I would like to enter into the record a statement that addresses this so well, which is by Debra Ness, President of the National Partnership for Women and Families.

*Ms. Sewell. So ordered.

[The statement of Ms. Ness follows:]

*****COMMITTEE INSERT*****

*Ms. Chu. I was so dismayed to find that this statistic -- today we are talking about the impact of maternal mortality on women of color. And there is an effect on this in the Asian-Pacific Islander population as well. I was dismayed to find that API women are twice as likely to die from pregnancy-related causes as white women, according to the Center for American Progress, and that young AAPI mothers also have a higher infant mortality rate than the general population, which is 7.4 per 1,000 births compared to 5.6 for the general population.

Also, I was stunned to find that in California, Asian-Pacific Islander women on Medicaid had the highest rates of C-section of any racial or ethnic group at 45 percent. In practical terms, that means that half of AAPI women on Medicaid end up receiving C-sections, which is 60 percent higher than the C-section for those with private insurance.

And so I would like to ask Dr. Robinson, what is a consequence to having such a high C-section rate?

*Dr. Robinson. That is a great question, and that is something that I think -- especially as Ms. Felix said about knowing what data and what information we need to know as mothers and as women going into care.

I think it is important to understand that there are benefits and risks to any procedure, whether it is what people call a "normal" delivery, which would be a vaginal delivery, or a C-section. And so I think educating patients about the risks that can go along with having a surgical procedure -- any surgical procedure, there is a risk of infection. But just understanding that, I think, from the beginning gives women an understanding of the risk of going into childbirth with having a surgical procedure.

I think one of the things that OB/GYNs can do is really help address some of the fears and misconceptions around C-sections so that people are away of what the benefit of that can be. Because sometimes patients are so afraid of having a C-section because they

think it is wrong, but sometimes that is the only way to ensure a safe delivery.

And so I think the goal for safe deliveries and to let women and providers know how we, on a one-on-one basis but then on a population health level, can address what it means to have a safe delivery.

*Ms. Chu. Okay. Well, thank you so much.

And Dr. Lu, we know that there are racial and ethnic disparities that result in higher maternal mortality. Are there barriers for AAPI women, like language access barriers, especially in this community which represents over 40 ethnic groups that speak over 100 languages?

*Dr. Lu. Unfortunately there just has not been a whole lot of research of maternal health for AAPI populations. We do know that AAPI women have higher rates of maternal mortality and severe maternal morbidity. There was a study in California, that showed that AAPIs were also likely to be poor, feeling disrespected in healthcare settings compared to white women based on either their ethnicity or based on their language status.

The other thing I just want to point out also is just that often, when AAPI data gets presented, they get lumped altogether. And the overall number may look good, but it may mask certain problems that certain groups of AAPIs experience. So, for example, in terms of infant mortality, we know that infant mortality is twice as high amongst Filipino-Americans and Native Hawaiians than it is amongst Chinese Americans.

So I do think that when it comes to data amongst AAPIs, it is important to disaggregate the data so that we could more precisely address the specific issues of our very diverse communities.

*Ms. Chu. And then I would like to ask Dr. Hollier whether better family planning can lead to better pregnancy outcomes. And the reason I ask this is most low-income women and women in general get their family planning from Title X funds. But these

funds have been under attack from the Trump administration, under cuts and restrictions and gag orders on physicians.

And so, for instance, is it true that doctors recommend that women space out their pregnancies by at least 18 months in order to ensure the most healthy pregnancy outcomes?

*Dr. Hollier. Yes, ma'am.

*Ms. Chu. And can you say why?

*Dr. Hollier. The birth spacing, allowing a birth spacing of approximately 18 months, reduces complications in subsequent pregnancies, improves outcomes for women, and improves outcomes for their newborns as well.

*Ms. Chu. Thank you. I yield back.

*Ms. Sewell. The chair now recognizes the gentlelady from Wisconsin, Ms. Moore, for five minutes.

*Ms. Moore. Thank you so much, Madam Chair. And I just want to thank this distinguished, distinguished panel for the insights you have provided. We do not have research on that. We do not have data for that. We do not know. We do not have research.

Folks, we need to research this. And I have introduced a bill that I hope gets passed that would also help us lean into why there is a disproportionate amount of Sudden Infant Death Syndrome and Sudden Unexpected Infant Death Syndrome among women of color as well.

As I indicated in my -- the time that I bequeathed from my colleague from Wisconsin. I think research and development is really at the root of this. And I think that a lot of our resistance to really funding a robust research and development component, maybe because we always kind of want to blame the victim.

"Oh, they must have been on drugs."

"Oh, they just neglected themselves and did not show up for healthcare coverage."

And we want to deny the structural barriers, the structural racism that is involved in this. So I want to lean into this for a moment.

Things like nutrition, for example, when you cut food stamps and cut budgets, I know. I run a household. Food costs a lot of money, and good food costs even more money. I remember my daughter whispering on the phone when she had her first child and was breastfeeding. "I just have never eaten so well in my life." And I was spending a fortune on food.

When you start talking about the map that the gentlelady from Alabama showed us, and if you have got to travel 15 miles, maybe pay for an Uber because there is no bus that gets out there, you might ignore swollen feet and just take it from your mama that, "Oh, girl, all of us had swollen feet back as long as we can remember."

And when you think about stuff like diabetes among Hispanic women, that is an educational process as well. American Indians who have a propensity toward diabetes that far exceeds other people -- these are structural things that we are not leaning into.

And I guess cardiac disease -- if you are -- I had the good fortunate of becoming good friends with a black woman cardiologist. I mean, she is the first one that told me, "Girl, you may not feel the pains coming up your arm and hitting you in chest because women do not present that same way."

So I just want you all to -- environmental factors. I had my first asthma attack shoveling coal into a furnace. So if you live in the city, doctor your results and women in the city, you get asthma, and roaches in the house, and other factors that are not dealt with. Lead in the water. Lead poisoning -- these are factors that we need to research. And I just want you guys to agree with me in my last one minute and 30 seconds.

We have got to do the research and pin this down because it is not just that women do not care about themselves. There is the environment. There is nutrition. And we need

to -- and access to birth control, and not having people tell us that we cannot space our pregnancies. We need to make sure that we take some of the elements of structural racism out.

And if we were to do the research, we would find out that these things are predominately the factors. I will yield back since you guys do not have anything to say. Anybody got anything to say in 30 seconds?

*Dr. Lu. Agreed.

*Ms. Moore. Agreed.

[Laughter.]

*Ms. Moore. And I just want thank you again, Allyson, because the thing is that, yes, you are a middle class woman, but you are a black woman. And the history of black women developing eclampsia -- my daughter had it. And the doctor turned her loose, and I ran back in there and said, "She needs to deliver this baby."

"Well, when would you do it, Dr. Moore?"

I said, "How about today?" And she had a C-section the next day. Her legs were big as tree trunks. She had eclampsia. And it is only because I bullied the doctor that she and her child are alive today.

Thank you. I yield back.

*Ms. Sewell. Thank you.

The chair now recognizes, for five minutes of inquiry, the gentleman from Virginia, Congressman Beyer.

*Mr. Beyer. Chairman Sewell, thank you for holding these good hearings two days in a row. You are a tremendous chair. I want to know that I agree with Dr. Moore on almost everything that she says.

[Laughter.]

*Mr. Beyer. I would like to first -- she is also my bridge partner -- I would like to address the anti-abortion legislation which is out there. And it is linked to infant mortality because you have got this sectors of unconstitutional forced birth bills that are making their way through State legislatures. The most egregious is what the Alabama governor signed yesterday, which actually makes it a greater criminal offense by penalty for the rape victim who seeks an abortion than the rapist himself who raped her. It is totally crazy.

And women's reproductive freedom is under attack. Their livelihood is under attack. But even more importantly, their very sexuality, as mysterious and as some would even say sacred as that is, something that should always be under one person's own autonomy is being attacked. Access to a safe and legal abortion is a healthcare issue, and women are going to have abortions whether it is legal or not. We need to make sure that it is safe and legal.

But here is the connection to this. Increased forced birth, anti-abortion bills increase maternal mortality and infant mortality. And Texas is the best case. The reported rate of maternal deaths in Texas doubled when the State closed their abortion clinics and cut funding for Planned Parenthood. In fact, if Texas was a country, it would have the highest maternal mortality rate of any developed world in the country -- in the world -- developed country in the world.

So Dr. Hollier, I want to turn to you and ask you about the stress to women's reproductive freedom and their connection to maternal mortality.

*Dr. Hollier. I can speak to the data from the State of Texas. When our Maternal Mortality Review Committee analyzed the data from 2012, we identified that there was significant over-reporting of deaths based on the death certificate data. The death certificate data was inaccurate, and so the actual maternal mortality rate in that year of 2012 was not as high as what was previously reported. So we are looking at rates closer to

18 as opposed to the rate that was reported of about 38.

We do not have data from prior years to compare to because the task force did that detailed analysis only on that year, from 2012. It is important, however, to mention that restricting access to the practice of evidence-based medicine interferes with the patient-physician relationship, and our organization is very concerned about that.

*Mr. Beyer. And it only makes sense that it would drive up maternal mortality because you are talking about an unwanted pregnancy in the first place. You are talking about people that often do not have access to a lot of healthcare.

So let me pivot, Dr. Rouse. I am thrilled to have somebody from the Holy City of Richmond here. Thank you for serving our great Commonwealth.

If women never get sick in their life, the only healthcare interactions they are really going to have is maternity care. And so we look at Obamacare and realize that with the provision of low-cost or non-cost contraception, the abortion rate is the lowest it has been since *Roe v. Wade*, and the unplanned pregnancy rate among teens and women in their 20s, the lowest it has been in decades.

That is why I am -- and most of this is signed up with Colin Allred at Texans Measure to intervene in the Trump lawsuit to kill the Affordable Care Act. And I would just like to know how you can talk about the importance of the Affordable Care Act, Obamacare, to maternal mortality.

*Dr. Rouse. Affordable Care Act has absolutely been important to maternal mortality. A lot of times, what we found is that women have had inadequate healthcare prior to pregnancy. They have inadequate healthcare during pregnancy, and following the postpartum period up to 365 days following delivery. So having access to care is extremely important. It is not all, it is not the only solution, but it is a big piece of being able to address maternal mortality.

*Mr. Beyer. Allyson, I was very proud last week with Annie Custer from New Hampshire and Joe Courtenay from Connecticut to lead the Protecting Americans with Preexisting Conditions Act, which even got a couple of Republican votes on the House floor, because, as you know, CMS is trying to make the junk healthcare plans available that would eliminate protection from preexisting condition or make it incredibly unaffordable. I bring that relevance up here because so many people consider pregnancy a preexisting condition.

Madam Chair, I yield back -- or Mr. Chairman, I yield back.

*Chairman Neal. I thank the gentleman.

And with that, Mr. Lewis has asked to have items included in the record. And without objection, we will do precisely that. Thank you, Mr. Lewis.

*Mr. Lewis. Thank you, Mr. Chairman.

*Chairman Neal. And let me recognize the gentleman from Pennsylvania, Mr. Evans, to inquire.

*Mr. Evans. Thank you, Mr. Chairman, and thank you for giving us all this opportunity to have this discussion.

For one, I want to thank the entire panel for just being here and offering your insight to help us all, I think. But Dr. Robinson, I would first like to thank you for the work you are doing with the Department of Health in my home State of Pennsylvania.

Thank you for making the trip here because I think this is very important to these members also. So you live in my congressional district, so I thank you also for that. The importance of addressing this mortality crisis and disparity is something that we all are truly concerned about, as you have heard.

Can you please describe, Dr. Robinson, the risk factors and complications that occur for mothers and infants as a result of "weathering"?

*Dr. Robinson. Sure. So backing up a bit, "Weathering" is, for those who may not have read it in my testimony, weathering -- and I think Dr. Lu also referred to this as well -- weathering is the result of years of the wear and tear on the body due to systematic racism, discrimination, and prejudice. That then shows up in someone's life as a chronic disease or as an adverse health outcome. And so that is, generally speaking, what weathering is.

When we talk about maternal health and infant health, and the negative impact of weathering. We see women who -- for all other reasons, it seems like they would be healthy -- can present to care on time, can get all the care that is packaged and recommended, and still have a negative health outcome.

And it is difficult, as I think several of the members and some of my testifiers here today have said. It is difficult to measure the impact of weathering because there are so many other factors that contribute to maternal and infant health.

But when we look at all things considered and we do have someone who is otherwise healthy, who then happens to be a person of color or a woman of color who has a negative outcome, that is something that we need to consider to say, "What is it that we could have done differently here if, all other things considered, this woman is healthy and her child should be healthy? She has some negative outcome that is not related to a simple medical diagnosis."

*Mr. Evans. What I would like to do, follow up for the entire panel, is being that you just heard that description about Dr. Rouse? What do all of you think recommended to Members of Congress? What can we do to fill that gap? It has been described as weathering, but describe to me what you think we can do -- and I want to do the entire panel -- the kinds of things you have this opportunity to tell Congress. What do you think we can do?

*Ms. Felix. Well, I think, as far as me, this is a good start, being heard. That

means a lot to me. I feel like I have a voice that is very similar to a lot of African American women. And just being here and for you to listen to my story definitely means a lot.

*Dr. Lu. Yes. The concept of weathering has a lot do with the impact of chronic stress on your biology. And when you think of some of the sources of chronic stress and whether that is a poverty kind of word or whether it is from having to hold multiple jobs to make ends meet, or whether it is just to have to work harder than anybody else just to prove to yourself. I think those are all important sources of weathering for either poor women or for women of color.

Again, I will call on the jurisdiction of this Committee in terms of the programs that you have in your jurisdiction in the weathering, and whether it is TANF, whether it is earned income tax credits, whether it is housing vouchers, these are all potential programs that could really reduce the day-to-day stress in a woman of color.

*Dr. Rouse. When we look at weathering, it is impacted by multiple factors on multiple different levels. And so it is really going to take a collaborative effort to really address all of these issues that occur on multiple levels.

*Dr. Robinson. I think the piece I would add would be to mandate the "implicit bias" training.

So implicit bias training addresses the issue of weathering so that providers, whether it is a nurse practitioner or an OB/GYN or a family practitioner, will be aware of what weathering is and start to have those conversations with their patients about it and what they can do to help address it together.

*Dr. Hollier. I would add continuation of programs that provide support services to women. We have heard a lot about the nurse-family partnership and nurse home visitation and other home visitation programs. Those are important.

And then to optimize best care within our hospital system, I would recommend authorization of the AIM program.

*Mr. Evans. Thank you all. Thank you, Mr. Chairman. I yield back.

*Chairman Neal. I believe the gentlelady from Alabama would like to have an item inserted into the record.

*Ms. Sewell. Thank you, Mr. Chairman. I ask for unanimous consent to enter into the record a letter signed by over 120 maternal and children health professionals affiliated with the Black Ladies in Public Health, and the National Association of Certified Professional Midwives, and the Orange County Women's Health Project.

Likewise, I also would like to enter into the record an opinion from the American College of Gynecologists and Obstetrics called, "The Benefit of Women of Medicaid Expansion through the Affordable Care Act."

*Chairman Neal. So ordered.

[\[The documents follow:\]](#)

[\[Document 2 follows:\]](#)

*Chairman Neal. With that, let me recognize the gentleman from Illinois, Mr. Schneider, to inquire.

*Mr. Schneider. Thank you, Mr. Chairman, and I am grateful for you having this hearing. I want to thank the panel for your patience today. I know it has been a long day.

To the four doctors on the panel, thank you for what you do every day, the work you are pursuing to make sure that everyone in our communities has the healthcare they deserve and that every mother can have the life she expects and deserves with her family.

Ms. Felix, I want to turn to you. First, thank you for the work you do representing our Nation. And we are proud of you, and you have brought a lot of pride and joy to us. But as you mentioned, the greatest pride we have is that title of parent. There is nothing like it.

And sharing your story, as you talked about your story, especially when you said you asked yourself the question, "What did I do wrong?" No one in your situation should ever feel that question. No mother or father should ask that question, "What did I do wrong?"

What we need to make sure is that we have a healthcare system that provides the prenatal, natal, and postpartum care that leads to healthy families. That is in all of our interests. So I appreciate it. I know -- and my own experience with my oldest son, like Mr. Kind said earlier.

My wife had something called a placental abruption. It was a serious condition. She got excellent care. I had no idea what was happening and the risk she was in. She lost half of her blood volume. But she got that care, and we now have two sons, 26 and 24, I could not be prouder of them, and I wish the same for you with your daughter.

I also want to thank my colleagues, Robin Kelly and Lauren Underwood, for tireless work to improve maternal health in particular. Robin Kelly's MOMMA Act, it is

an excellent bill that I am very proud to cosponsor. And especially representative Underwood, Lauren, it is her first term and she is leading this caucus in a wonderful way.

But I also want to express my frustration. As we think about this, we live in the richest country on Earth. We have some of the most extraordinary healthcare facilities, the most wonderful healthcare professionals, medical advances. And yet our maternal mortality and morbidity rates continue to rise.

We are in unpleasant company. The only other two companies that have that rise, as was noted earlier, are Afghanistan and Sudan. We cannot get around the fact that we are failing our mothers.

So my question this time, move on, is -- and this may not have any easy answer: To anyone on the panel, what makes our country unique? As other countries are grappling with this and bringing down their maternal mortality rate, why over the last 20 to 30 years has the U.S. rate increased? No one wants to answer? Anyone?

*Dr. Hollier. I think it is a combination of all of the things that we have been talking about today. It is not any one of them, but it is all of them. And everything is intertwined. And so we are seeing the effects off the social determinants of health, and we are seeing the effects of factors that have been in play for quite some time, and policies that do not often enhance the health of women. And I think it is all of the things that we have talked about here today.

*Mr. Schneider. Dr. Lu?

*Dr. Lu. I think you sense the hesitation because it is a really complicated question without really easy answers. But I do think that one possible answer is that other countries invest so much more social determinants than perhaps our Nation does.

And we spend more money on healthcare than just about any other patient, and we are not getting the outcomes of that that we want to see. And I do think that as we think

about a national strategic toward eradicating maternal mortality, let's make sure that we pay attention to social determinants.

Going back to the mission of this Committee, that is why I also think what kind of levels around tax policies and income transfer programs and so forth, that this committee has a very important leadership role to play in eradicating maternal mortality in this country.

*Mr. Schneider. Well, I will make the observation we are celebrating this year the 50th anniversary of landing a man on the Moon and returning him home. We can handle complex problems. We need to handle complex problems.

And the idea that every mother in this country, whether she lives in the city or in the country, whether she comes from a wealthy background or a poor background, whether she is black, white, or otherwise, we need to make sure that every month in this county has the care she needs, the care that her family deserves, and that no child is left without a mother because they did not get the care that the richest Nation in the world should be able to deliver.

I am out of time. I have many more questions. But again, I thank the chairman for having this hearing, and I look forward to working on addressing this issue.

*Chairman Neal. I thank the gentleman.

With that, let me recognize the gentleman from Texas to inquire, Mr. Arrington.

*Mr. Arrington. Thank you, Mr. Chairman. And thank you all for spending a good part of your day here answering questions. And it is clear you are very passionate about this and very knowledgeable, and I always appreciate a great panel of folks who can help us try to solve problems.

And so Mr. Chairman, it has been a very productive committee hearing and I have learned a lot. And I had to step out, so I am getting reoriented in my notes because as I was

taking copious notes throughout your presentations.

I represent a big swath of rural West Texas. And I refer to it as the "food, fuel, and fiber capital of the United States." A lot of farmers and ranchers, a lot of energy producers, a lot of folks think of us as the largest oil patch in the country. But we are also the largest wind farm. We actually produce more wind energy than even the entire State of California.

But in order for these small towns to be sustainable, we need access to healthcare, basic care. And even when that basic care is offered, oftentimes -- and I had the data, I think -- only 6 percent of these rural hospitals have OB/GYN maternal care access. And yet rural folk represent 20 percent of the country. So you have rural hospitals going away, a hundred since 2010. Almost half are operating at a loss. So we have a real crisis in healthcare in small town USA.

And I remember, Dr. Robinson, in your testimony -- it seemed like yesterday because I have done a few things since then -- but you mentioned rural, and a few of you have. How do we get there? Can we use technology to do it? Can you just talk about the rural aspect of this?

And I recognize, again from listening and taking notes, that we have a lot more to dig into, a lot more to learn, before we are really smart and responsible about solving the problem because we want to be very focused and very responsible with the taxpayer money if the Federal Government is going to be involved.

And I heard from Dr. -- is it Hollier? -- that you'll be working in partnership with community groups and local provider groups, and some States are getting involved. And I think that is great. I think it should be all the above. I certainly am very careful when we are talking about taxpayer monies: Who is the best? Which groups are the best at addressing it? Right? Because we have got \$22 trillion in debt. But this is one that I think the Federal Government has a role. The question is, what role and how do we encourage

other partners to participate?

Dr. Robinson, would you talk a little bit about the rural aspect to maternal mortality and how we address that?

*Dr. Robinson. Sure, absolutely. So I think first and foremost, like we have talked about here today, I think with the Maternal Mortality Review Committees, we need to make sure that every State has one, and that we can drill down and get the data so we can say exactly what is going on in rural America. Because I think that is going to be the next wave of headlines in terms of what maternal mortality looks like in our rural communities.

I think ways that we can start to address it -- sometimes I think technology is a great benefit, but sometimes death starts also from the ground up. And so sometimes these counties, which have been incredibly resilient through things that really only God can throw at you, come up with solutions that are saving lives.

And so some of those involve using community health workers, sometimes using community health workers to do those home visiting programs; to think about ways that we do -- in Pennsylvania in one of our rural areas, we have a program called "Centering Pregnancy," where it is a group prenatal care provision, meaning that women come together in a group and can share their stories and concerns and get group prenatal care, and get those things, and get their concerns answered.

But then it also creates this support network which women really need, not only during pregnancy but especially, I think, in the postpartum period. But those type of programs and supporting those type of home visiting programs, "Centering Pregnancy" programs, and use of community health workers, is a way that we can really reach and turn the tide in the rural communities.

*Mr. Arrington. Thank you. With my remaining time, let me say to our ranking member, as chair in the last session, I commend you for investigating this. I agree it is

unacceptable that it is more dangerous to have a baby than it was 20 years ago, and to be on that very unpopular short list of high maternal mortality rates.

It is unacceptable in this country, and I am going to work with our chairman and my colleagues on both sides to try to solve this. So God bless you. Thank you. I yield back.

*Chairman Neal. I thank the gentleman.

Let me recognize the gentleman from Nevada, Mr. Horsford, to inquire.

*Mr. Horsford. Thank you very much, Mr. Chairman. And thank you for holding this hearing, and on the impacts that healthcare of all women play, but especially women of color. And the opening testimonies by our witnesses here today, as well as Congresswoman Kelly and Congresswoman Herrera Beutler and Ms. Felix, your stories are powerful. And I appreciate very much you being willing to share them with us today.

I also want to thank Congresswoman Underwood for leading the Black Maternal health Caucus, of which I am a member. And I also want to recognize my home State of Nevada, which Dr. Robinson noted recently signed legislation for a Maternal Mortality Review Committee. Assemblywoman Danielle Moreno, who is our assistant majority leader in the Assembly, was the sponsor of that legislation. It is very, very important to us.

Mr. Chairman, I would like to enter into the record written testimony from Dr. Melba Thompson Robinson. She is the executive director of the Center for Health Disparities Research and a professor of social and behavioral health at UNLV School of Public Health.

*Chairman Neal. So ordered.

*Mr. Horsford. Thank you.

[\[The testimony of Dr. Robinson follows:\]](#)

*Mr. Horsford. In her research, Dr. Thompson Robinson identifies contributing factors of pregnancy-related death, and she found that Nevada faces one clear challenge: a healthcare workforce shortage. According to the Health Resources and Services Administration, all 17 counties in Nevada face a primary healthcare shortage.

The workforce shortage is compounded when it comes to treatment of pregnant women and new moms. Nevada simply has too few OB/GYNs. Data from a Pew Charitable Trusts report showed that for 2016, there were only 259 OB/GYNs in the entire State of Nevada. This is untenable. Even before addressing quality of care, the mere scarcity and limited number of providers threatens the health and well-being of expectant mothers.

Dr. Robinson, what do you recommend we do to address these severe workforce shortage areas that exist?

*Dr. Robinson. Thank you for that question. There are several programs that exist that help to incentivize young students in their medical training to go into different fields. There have been -- specifically in primary care there have been loan repayment problems that have been in place for years that have been shown to be successful in primary care, which helps us to address the issue of creating women who are healthier before they become pregnant.

OB/GYN, I believe, is a specialty field, and so sometimes when you are in a specialty field, you may not qualify for the same programs that a colleague who goes into a primary care specialty does. And that makes it a bit harder. And so there are -- if you would look at our urban areas, there are definitely higher concentrations of OB/GYNs in those urban areas.

But I think, as we think about our rural areas in our States where we have that health profession shortage, we do need to train not only more physicians in general who

can deliver our babies and keep our mother safe, but we also need to make sure that our doulas, our medical students, that we have got diversity across the service provision for medical care --

*Mr. Horsford. Thank you.

*Dr. Robinson. -- to ensure that.

*Mr. Horsford. Thank you. I know this committee will be looking at graduate medical education. I also think we need to be looking at loan forgiveness and debt elimination for students pursuing these critical shortage areas.

Another way we can combat and prevent the deaths of mothers is through protecting and expanding programs like the Maternal Infant and Early Childhood Home Visiting Program, MIECV. And I would like to ask Dr. Lu: I understand you previously helped oversee the home visiting program during your tenure at HHS. Can you explain how home visiting can help promote better maternal and infant health outcomes?

*Dr. Lu. First of all, let me just thank this committee for your support of the home visiting program. There are different models, but the idea is that you have a home visitor -- a nurse, a social worker, an early educator -- that visits the woman and her family in the home during pregnancy and for the first few years of the child's life.

They form very close relationships. The home visitor can teach a mom about self-care and caring for her family. They help build parenting skills. And they help detect problems earlier on, problems with depression, problems with substance abuse, and so forth, and refer them to the care that they need.

There was really a study in 2014, a randomized controlled trial that followed predominately African American women in Memphis, and found that women who received nurse home visiting during pregnancy and the first couple years of their child's life were about three times less likely to die from any cause over the next two decades. And they

were eight times less likely to die from external causes such as homicides, suicide, and intentional injury.

So again, I appreciate the support that this committee has given, and I do hope that you will continue to expand this program because certainly a lot more families can benefit from it.

*Mr. Horsford. Thank you very much.

Thank you, Mr. Chairman.

*Chairman Neal. I thank the gentleman.

Let me recognize the gentleman from Georgia, Mr. Ferguson, to inquire.

*Mr. Ferguson. Thank you, and thank you all for sitting through a very long hearing today, and we certainly appreciate the work that you are doing in this area.

Two questions for you. Number one -- and Dr. Hollier, I will ask you this -- is there a lot of underlying research looking at the correlation between underlying health issues and this mortality rate? And really, what I am getting at, if we seem to -- do we know -- are we looking -- is there a correlation to the underlying health -- is it an increase in those underlying health diseases that are normally associated with mortality? Are we coordinating that and looking at that in the same 20-year period that we are looking at this increase in mortality?

*Dr. Hollier. We do see an association with chronic medical conditions and maternal mortality. So when we look at women who have maternal death compared to those that do not, women who have maternal death are more likely to have had another medical condition like chronic high blood pressure or diabetes.

*Mr. Ferguson. Sure. So the question is: Are we looking at that? Do we see an increase in those conditions? Can we correlate that? I mean, first of all, do we know that that is happening as well?

*Dr. Hollier. I can speak specifically to my home State of Texas, where we see increases in those chronic medical conditions, specifically diabetes, high blood pressure, and obesity

*Mr. Ferguson. Okay. So it almost seems to me that if we are going to be more effective in dealing with this, one of the things end to look at is reducing those underlying medical conditions. Better treatment, better access, better awareness of blood pressure, diabetes, hypertension.

Is there any effort there or is there any kind of cause and effect to be done to say, if we did a better job of preventing those, that maybe we would see better outcomes on the other side? I mean, it makes common sense, but I am just asking. Are we looking at it through that lens?

*Dr. Hollier. It does make common sense. Right? If we have better healthcare, if we are able to prevent the development of diabetes in a woman who may have had diabetes, pregnancy-related diabetes that can go away, if we are able to intervene and prevent subsequent diabetes, that does remove a potential factor increasing her subsequent risk.

I cannot speak to specific studies that are actually saying, "Does reducing chronic hypertension in the population reduce maternal mortality?" But certainly the health of women prior to a pregnancy is incredibly important. The time period of pregnancy is such a small part of a woman's life, we really have to be thinking about her health prior to pregnancy, and intervene throughout her lifespan to ensure the best health of women throughout that entire lifespan. Because we cannot change all that just in the short nine months of pregnancy.

*Mr. Ferguson. Correct. Okay. So one of the other challenges that we have got in rural America, and I have heard each of you mention this, is it is even tougher in rural

America to address this issue. Number one, as we have all talked about, lack of providers, lack of access to care, food deserts that exist in these rural communities where the families might not have access to the healthier diet choices.

All of those kinds of things play into it. I believe one of the things that we have got to be able to do is change the dynamic in how preventive and diagnostic care is delivered in rural America, and deployment of broadband into these areas is such a critical component so we can connect patients back to the providers and to the medical centers where they otherwise may not have access to it.

I want to leave, I want to close, on this point. I want us to make sure that we are focusing on the mother's health before she becomes pregnant because we really need to coordinate that, and look back in that same 20-year order and look at the overall health of these young women prior to the pregnancy to see if we can correlate that their underlying health conditions play a significant role in this.

It would make sense that it does. But if that is the case, then we really are going to need to put more emphasis on the health sooner rather than in that very time timeline of when the individual finds out that she is pregnant.

With that, Mr. Chairman, I yield back.

*Chairman Neal. I thank the gentleman.

Let me recognize the gentleman from Georgia for a point of personal privilege.

*Mr. Lewis. Thank you very much, Mr. Chairman, for recognizing me. And I know you recognized me before. But I want to recognize one member of the panel, but thank each of you for being here. It is Dr. Robinson.

Dr. Robinson is a graduate of Spellman College in the heart of my district, where hundreds and thousands of black women attended. And now she is a member of the board of trustees, the youngest member of the board of trustees of Spellman College. Originally

from Buffalo, New York, where I visited when I was only 11 years old, and I still have a lot of relatives I Buffalo.

I know you got education at Duke, but you got your early education at Spellman College in Georgia. And now you are working in Philadelphia. As I said to Mr. Evans, we claim you.

[Laughter.]

*Chairman Neal. We thank the gentleman.

And with that, let me recognize the gentleman from California, Mr. Gomez, to inquire.

*Mr. Gomez. Thank you, Mr. Chairman. First let me thank all of you for being here to have this important discussion. I also just want to give a shout out to Congresswoman Robin Kelly for leading the fight on this important issue.

I am glad to see that our committee is really tackling these connected, interrelated topics of the maternal mortality crisis in our country, racial bias in our country's health system, and the social determinants of health that shape our health and quality of life. These issues are too big for just one hearing. They are issues that we shape the future of healthcare in the 21st century.

In my district -- my district is one of the most diverse and multilingual districts in the country. I represent Central Los Angeles, downtown, East Side. For immigrant communities like the ones I represent, language barriers between doctors and patients can be a real problem and a major source of health disparities. Without language access and culturally competent care, many patients do not have meaningful access to care, and health outcomes are measurably worse

Dr. Hollier, what can we do to improve language access in the care settings where it is most needed?

*Dr. Hollier. I think it is really important for care settings to have readily available interpretation services. That is a key component to a truly meaningful discussion between a healthcare professional and the patient that they are caring for. There needs to be a good understanding of all of the information that is being conveyed.

And so having those variances readily available -- telephonic certainly is one option and in-person is another option, particularly when you are dealing with very sensitive topics.

*Mr. Gomez. Very true.

Dr. Lu, switching topics a little bit, you have written that "Achieving zero maternal deaths will require improving women's health, not only during pregnancy but also across their life course." That is a direct quote from you.

I am also proud to stand up for women's health, especially for women who rely on the safety net. That is why I will soon be reintroducing the Jeanette Acosta Invest in Women's Health Act, named after a former Hill staffer and a constituent of mine who lost her battle with cervical cancer. Jeanette was a strong advocate for preventive lifesaving women's health screenings, and the bill would create a new grant program and demonstration programs to ensure that all women have access to preventive care.

I guess this question -- sorry. Back to Dr. Hollier. Can you tell me about the correlation between preventive health screenings and maternal mortality?

*Dr. Hollier. Health screenings give us an opportunity to identify women so that we can ensure that women at higher risk get appropriate care. For example, we have talked about how cardiovascular disease is a leading cause -- is the leading cause -- of maternal mortality. And so screening would give us an opportunity to identify a woman who may have preexisting cardiovascular disease so that she can receive risk-appropriate care throughout her life and during her pregnancy.

*Mr. Gomez. Thank you. One of the questions that came to me -- I was listening to some of my colleagues -- is that people assume that the ACA and maternal mortality are not connected. I will just take a short in the dark.

Is there any correlation between Medicaid expansion and lowering of maternal mortality rates in States? I can throw that out to the panel.

*Dr. Rouse. I have to say in Virginia we actually just recently expanded our Medicaid, and it was one of the recommendations that our team has made previously. So we are actually to seeing what the data shows once we know people are registered and the expansion gets going to see how it is going to impact it.

But just looking at the data and what we have had previously, I suggest that it should be a positive impact.

*Mr. Gomez. Okay. I just did a quick search, and I found the American Journal of Managed Care that had Medicaid expansion linked to lower maternal mortality rates. So when people say that they care about lowering the rates, they also have to care about expanding Medicaid to the States that need it.

So I thank you for all your testimony and being strong. I think people need to be more outraged about this issue than they currently are. So thank you very much.

And Mr. Chairman, I yield back.

*Chairman Neal. I thank the gentleman. I have already thanked our witnesses for their testimony today. Please be advised that members have two weeks to submit written questions to be answered later in writing. Those questions and your answers will be made part of the formal hearing record. I thought this was very important today, and I thought the witnesses did a terrific job.

With that, the committee stands adjourned.

[Whereupon, at 2:15 p.m., the Committee was adjourned.]

Submissions for the Record follow:

[1,000 Days](#)

[Advocate Aurora Health](#)

[Association of State and Territorial Health Officials](#)

[Austin Peoples Action Center](#)

[Center for Fiscal Equity](#)

[Center for Reproductive Rights](#)

[Dr. Fleda Mask Jackson](#)

[Gynecology Institute of Chicago](#)

[Improving Maternal Health Houston](#)

[Lamaze International](#)

[March of Dimes](#)

[Massachusetts Ellen Story Commission on Postpartum Depression](#)

[Midwives Alliance](#)

[National Healthy Start Association](#)

[Preeclampsia Foundation](#)

[The Joint Commission](#)