

Good afternoon. I am Dr. Shannon Dowler, Chief Medical Officer for North Carolina Medicaid and a Family Physician. It is a real privilege to speak to you today about maternal health. As a family doctor, obstetrics training was a core part of my curriculum and before I joined Medicaid I practiced family medicine with pregnancy care for years in both a health department and a community health center, both foundational healthcare safety nets across the country that care for some of our most vulnerable women.

Any death in a woman in the time near or following delivery of a child is tragic. Looking in the eyes of a new father, who is cradling a tiny newborn, and explaining that he now will be parenting alone, and that child will grow up without mom's love, is unspeakably difficult. But the fact of the matter is, too many doctors, midwives and nurses must do just that across our country. Today I hope to provide some insights into how we might turn the tide on maternal deaths, most of them completely preventable. Data from the CDC reveal that the majority of pregnancy-related deaths occur outside of the day of delivery or even the first postpartum week and while the leading causes of pregnancy-related deaths vary by race/ethnicity the data show us that as many as 2 out of 3 maternal deaths were determined to be preventable.

Nationally we have begun tracking maternal deaths with the Pregnancy Mortality Surveillance System and it reveals that the number of reported pregnancy-related deaths in the United States has steadily increased from 7.2 deaths per 100,000 live births in 1987 to 16.9 deaths per 100,000 live births in 2016. Why? Why are so many more women dying related to childbirth now, in one of the world's most developed countries? Tragically, the reasons for the overall increase in pregnancy-related mortality are unclear due to a combination of factors---inconsistent data collection, billing and coding irregularities, and variable information on death certificates all contribute to a failed methodology to consistently and accurately study maternal deaths across a national field.

We do know that increasing numbers of pregnant women in the United States have chronic health conditions at the time they become pregnant, such as hypertension, diabetes and heart disease, conditions that put a pregnant woman at higher risk of pregnancy complications. While the contribution of hemorrhage, hypertensive disorders of pregnancy (i.e., preeclampsia, eclampsia), and anesthesia complications have declined as a cause of pregnancy-related deaths, the contribution of cardiovascular, cerebrovascular accidents, and other medical conditions have notably increased. When combined, cardiovascular conditions (i.e., cardiomyopathy, other cardiovascular conditions, cerebrovascular accidents), conditions which impact historically marginalized populations at a higher rate, alone were responsible for greater than **one-third of pregnancy-related deaths** between 2011-2016.

In fact, considerable racial and ethnic disparities in pregnancy-related mortality exist and event persist when you control for socioeconomic status and medical co-morbidities. During 2011–2016, the pregnancy-related mortality ratios at the **national level** showed significantly higher---as much as four times the rate of white women--- for black, African American, American Indian and Alaskan Native women.

When we look specifically at our data in NC, we made improvements and black women are narrowing the gap to white women in maternal deaths. Unfortunately, that is not an indicator of improved care for black women—it is a story of worsening outcomes for white women.

One of the rare positives from our current pandemic is the way in which the field has responded to technology and opened access to healthcare from home utilizing telehealth. Not only is this incredibly consumer centric, but we have seen it increase visit completion rates and utilization across race and gender lines. Unfortunately, in our study on telehealth use by NC Medicaid beneficiaries, we see use decrease as rurality increases and, not surprisingly, increase as geographic access to Broadband increases. Where I live in rural Appalachia, my neighbor down in the holler must drive her four-wheeler way up to the top of cow pasture to upload her second graders homework. Even if she could afford the internet---which costs us twice what it did in our urban home with 1/10th of bandwidth---she would not have enough bandwidth to upload the material on rainy, foggy, snowy days or if one of the 6 towers the signal has to pass through has an issue. The digital divide is alive and real. For pregnant women to access telehealth care, antepartum or postpartum, could be a tremendous tool in our toolbox if it can be provided equitably.

Recently, a Maternal Health Quality Improvement Act was proposed, a bill that expands initiatives to address maternal health in rural areas and promote innovation in the field. North Carolina is, like many states, largely rural. Accessing prenatal and postpartum care just by virtue of your zip code shows tremendous disparities. Six delivery units have closed in WNC alone since 2012. In my rural WNC county there are no ob-gyns or nurse midwives practicing medicine and women must travel almost an hour to get to a hospital or free-standing birthing center. Thankfully our local health department and federally qualified health center pick up the slack for prenatal care, but that still leaves complicated and high-risk pregnancies at a clear disadvantage, and someone else to pick up the deliveries. There is no public transportation in this mountainous community, where landslides will shut down major roads for over a year at times, making a thirty-minute drive take almost twice the time and gas.

This bill, among other things, encourages training of providers in rural area. When I was the CMO of a large FQHC we opened a teaching health center that trained family physicians in full scope family medicine including full obstetrical care. Our goal was by training doctors in a rural community, and

particularly caring for a vulnerable population like you see in FQHCs, they would be more likely to practice in these types of locations. In the first 5 years, the % of graduates are almost 85%, a dramatic rate compared to the rest of the country. Expanding training programs and all the resources that come with training could greatly help.

One of the most impactful things yet is now on the table. The **Helping MOMS Act of 2020 allows states** to provide one year of postpartum coverage under Medicaid and the Children's Health Insurance Program (CHIP). Current law only requires 60 days of postpartum coverage. Why is that important? For many women of childbearing age, a pregnancy is the first time in years a young woman has access to healthcare coverage, especially in states like NC where Medicaid Expansion has been blocked. Many women develop health conditions that persist after pregnancy or in pregnancy you identify a chronic condition, she was previously unaware of. Imagine a mom with a baby in the Neonatal Intensive Care Unit who is trying to keep up breast feeding, going back and forth to the hospital many times a day---planning for her next pregnancy is simply not on the top of her worry list! She has lost coverage before she cares for her own health needs. Just when a low risk, healthy mom is adapting to life with a new baby and finally feels like has some time to concentrate on herself, she loses coverage. So, things like dental care cannot be concluded. Diabetes that persists after pregnancy goes unchecked, making her risk exponentially higher in her next pregnancy. When speaking with Dr. Kate Menard, a Maternal Fetal Medicine Specialist, she says, "It absolutely breaks my heart when I see a women for the first time at 8-10 weeks of pregnancy with poorly controlled diabetes, especially when due to lack of access to affordable care. At this point there is nothing one can do about the preventable fetal anomalies that can result, not to mention the known affects on mom's long-term health." Care for heart failure, high blood pressure, anemia, postpartum depression...so many things that impacts a woman's ongoing health are suddenly dropped in this country two months after a baby is delivered. The Helping Moms Act of 2020 would allow a more meaningful time to engage new moms in caring for themselves after delivery, to plan for future pregnancies intentionally, and reduce their risk of serious illness or death in the current, and future, pregnancies.

Federally, the Department of Health and Human Services has at least 13 ongoing efforts aimed at reducing pregnancy-related deaths. Success in these ventures is heavily dependent on having access to a workforce to partner with. Independent practices and safety net providers in rural and poor America cannot afford to shoulder the disproportionate burden and be expected to add on layer after layer of new innovations and demonstrations without support. They simply don't have the bandwidth. Block grants like the Maternal and Child Health (MCH) Services Block Grant Program provides additional federal funds to support or complement other federal initiatives, such as maternal mortality review committees, quality collaboratives, and use of maternal safety bundles. Developing regional centers that are funded to support smaller or more rural hospitals keeps the care local and rather than recreating the wheel, the efficiency of regional collaboration is a far more effective driver of equity.

If we don't know why women are dying or experiencing terrible complications of pregnancy it is much more difficult to create solutions. Creating mandates that pregnancy complications are reported, and deaths related to pregnancy are tracked and studied will allow us to get upstream and prevent these tragic outcomes. At a very minimum, collecting race and ethnicity data must be a standard practice and become normative in this country if we hope to understand and drive health equity.

Understanding complex social needs is critical. NC has been very successful in implementing a care risk screen to identify SDOH needs and to link pregnant women with care management resources. Funding for providers for this time-intense screening tool covers their cost of implementing it and allows the state to engage in pregnant women's care early and often. A statewide collaborative tool called NCCare360 links resources in every county of the state to close care gaps. Taking learnings from states, and providing opportunities to reproduce effective models, is key.

Finally, in addition to rural workforce development, technology equity, extended access to pregnancy care and improved data, I have some other suggestions for how we can impact maternal morbidity and mortality for our most vulnerable and historically marginalized women.

Something simple. Why doesn't the government subsidize and provide free prenatal vitamins to all women of reproductive age? The increased folic acid taken before pregnancy protects the future fetus from birth defects and it would cost pennies on the dollar of what it would save.

Something harder, but incredibly urgent. We must reverse Title X edicts that do not allow our nurses to complete the all-options counseling for family planning. This change shifts the burden onto higher cost, less accessible providers which means many women go without the resource. Additionally, Title X dollars should **only** go to entities that can counsel on and offer **ALL** types of FDA approved contraceptives, not just the select ones they want to promote which is coercive in nature.

We should require states to mandate that hospitals provide maternal levels of care. We do this for NICUs---why don't we offer the same clarity for the delivery? Seamless paths for referral in regional collaborations would allow larger centers to support smaller hospitals.

Not only funding for BH and substance use services, but investment in marginalized populations, is critical. This will require trust building for many of the populations of pregnant women who continue to be adversely affected by deeply rooted systemic racism. Recognizing and supporting additional team members, and building a diverse workforce, is a high priority. Reimbursement for team members like community health workers and doulas is a strategy we can employ. To overcome health inequities, we must be prepared to commit a disproportionate share of resources to our historically marginalized populations. That may mean further enhanced reimbursements for provider teams who care for large population of women to overcome the densely prevalent social drivers of health needs. It is simply more challenging, intense, and resource heavy to run an inner-city clinic filled with uninsured than it is to run a clinic that supports high income earners.

My parting comments are this---continuing to listen to the field. Specifically, I would point out the report from 9 states Maternal Mortality Review Committees and ACOGs work with Alliance for Innovation on Maternal health. And let us not forget the very women we are talking about and the enduring mantra, "Not about them without them!" This country is full of dance partners whose dance card is not yet full and I would wager a bet that they would happily take your extended hand.