STATEMENT

of the

American Medical Association

to the

U.S. House of Representatives
Committee on Ways & Means

Re: Overcoming Racial Disparities and Social Determinants in the Maternal Mortality Crisis
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May 16, 2019

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The American Medical Association (AMA) appreciates the opportunity to provide testimony to the U.S. House of Representatives Committee on Ways & Means as part of the hearing entitled, "Overcoming Racial Disparities and Social Determinants in the Maternal Mortality Crisis." The AMA commends the Committee for focusing on this critically important issue, which disproportionately affects Black women and Native American/Alaska Native women. The AMA also commends the many advocates who have paved the way for this issue to capture the attention of media, politicians, and the health care sector. As the largest professional association for physicians and the umbrella organization for state and national specialty medical societies, the AMA is committed to working with other stakeholders to support efforts to reduce and prevent rising rates of maternal mortality and serious or near-fatal maternal morbidity, and specifically to address health inequities by race and social determinants of health (SDOH).

The Problem: Rising Maternal Mortality and Morbidity in the U.S.

According to the Alliance for Innovation on Maternal Health (AIM), the U.S. is one of only three countries in the world—Sudan and Afghanistan being the others—where the rate of maternal deaths is on the rise. While maternal deaths are rare—approximately 700 occurring yearly out of 3.8 million births—an additional 50,000 women have serious maternal morbidity. Maternal mortality (pregnancy-related death) is defined as the death of a woman while pregnant or within one year of the end of a pregnancy—regardless of the outcome, duration, or site of the pregnancy—from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (CDC, 2018). Severe maternal morbidity is a life-threatening complication during childbirth, which can include heavy bleeding, kidney failure, and stroke or heart attack during delivery. Experiencing severe maternal morbidity can have serious and life-long consequences for women and their families.

In a new report by the Centers of Disease Control and Prevention (CDC)—which looked at pregnancy-related deaths from 2011 to 2015 and reviewed more detailed data from 2013 to 2017 provided by maternal mortality review committees in 13 states—there were significant disparities in the death rate for different racial, ethnic, and age groups. Alarmingly, the CDC found that Black women were three to four times more likely (42.8 deaths for every 100,000 live births) than white women (13 deaths for every 100,000 live births) to die from a pregnancy-related cause; Native American and Alaska Native women were 2.5 times more likely (32.5 deaths for every 100,000 live births) to suffer a pregnancy-related death. Moreover, the rate differed by location, with the rate much higher in some states. The study also found that pregnancy-related deaths were occurring across a lengthy time span: more than 31 percent of deaths were during pregnancy; 36 percent occurred during delivery or in the week after birth; and 33 percent happened one week to one-year post-partum. Overall, heart disease and stroke were the leading cause of

pregnancy-related deaths each year from 2011 to 2017, but the causes were different depending on when the deaths occurred. For example, obstetric emergencies such as hemorrhage (e.g., severe bleeding) and amniotic fluid embolisms caused most deaths at delivery; hemorrhage, high blood pressure, and infection were most common in the week after delivery; and cardiomyopathy (weakened heart muscle) caused most deaths one week to one year after delivery. Perhaps the most significant and troubling finding in the new study is that the CDC estimates that 60 percent of all maternal deaths are preventable.

Health Equity and Social Determinants of Health

The AMA defines health equity as "optimal health for all" and recognizes the importance and urgency of advancing health equity and addressing SDOH to ensure that all people and communities reach their full health potential. The World Health Organization (WHO) defines health equity as the "absence of unfair and avoidable or remediable differences in health among social groups." This definition clarifies that inequities and disparities do not have to exist, but that inequities are produced; they do not just happen; the people who are negatively impacted by experiencing the injustice are not to blame; and there is something that we can actually do to close the gap.

Health disparities—i.e., differences in health outcomes—in maternal health are the result of conditions that are similar for other disparities that exist. These conditions are widely understood to be the SDOH. According to Healthy People 2020, the "social determinants of health are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risk." These social determinants include education, housing, wealth, income, and employment. We all experience conditions that socially determine our health or the SDOH. However, we do not all experience them equally.

The SDOH are impacted by larger and powerful systems that lead to discrimination, exploitation, marginalization, exclusion, and isolation. In this country, these historic and systemic realities are baked into structures, policies, and practices and produce, exacerbate, and perpetuate inequities among the SDOH, and therefore affect health itself. These larger, powerful systems of racism and gender oppression—also known as the root cause inequities—are upstream to the social determinants of health. They have shaped the social conditions in which women and families live, and they work to produce inequities across society in complex ways, especially for those marginalized at the intersection of race and gender, i.e., Black and Native American women.

Birth inequities arise at the intersection of discrimination by race and gender for Black and Native American women. We know that in some places across the country, Black women with at least a college degree had higher severe maternal morbidity rates than women of other races/ethnicities who never graduated high school. It is clear that racism and discrimination—at the provider, institutional, and societal levels—is an attributable etiology of the increased proportion of Black and Native American mothers inclusive of inequitable access to and quality of care, institutional racism, mistrust for health care institutions, and delayed response to medical emergencies by both medical providers and patients, and a culture of disrespect that can lead to mistrust for health care institutions. Stories from Black women also tell us about a culture of disrespect as well as realities of not being listened to or heard.

At the provider and institutional levels, there is a growing body of evidence demonstrating that implicit and explicit biases exist that negatively impact the quality of health care equity and patient safety and drive these inequities. This was described originally in an Institute of Medicine (now the National Academy of Medicine) report, more than 15 years ago (Institute of Medicine. 2003. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/10260). The evidence shows that Blacks are more likely to receive poorer

quality of care and less likely to receive the standard of care even when controlling for insurance status and income. This was linked with higher death rates for Blacks.

In addition, there has been a growing body of work examining the impact of structural racism on health in this country. In 2017, Dr. Zinzi Bailey et al published a study in the *Lancet*, "Structural Racism and Health Inequities in the US: Evidence and Interventions," that explains structural racism to be the "totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources." And one key example of structural racism included how "residential segregation systemically shapes health care access, utilization, and quality at the neighborhood level, health-care system, and provider levels."

Two weeks ago, the *New England Journal of Medicine* published "Structural Racism—A 60-Year-Old Black Woman with Breast Cancer," exposing the impact of racism, not just race, on health outcomes. One of the authors, our Chicagoan colleague and partner from Rush Medical Center, Dr. David Ansell, says "we must be willing to identify the health impact of racism. The biological differences between groups are tiny, yet the gaps in outcomes are simply too wide to continue to see race as a disease risk factor when the root cause is racism."

While more research is needed on the relationship of discrimination and chronic stress of racism on maternal and infant health outcomes, there is evidence that experiences of discrimination and racism have a "weathering" effect on the body. Dr. Arline Geronimus, who coined the "weathering" hypothesis, explained that "Blacks experience early health deterioration as a consequence of the cumulative impact of repeated experience with social or economic adversity and political marginalization" over one's life course. This physiologic pressure, also later described as allostatic load, can cause stress hormones, such as cortisol, and cause organ and cardiovascular, metabolic, and immune systems damage over time. In addition, chronic stress and trauma due to discrimination that occurs as early in-utero and early childhood, also known as adverse childhood experiences, have been associated with poor health outcomes and early death as an adult.

SDOH impact on maternal mortality and morbidity

Insurance and Access to quality reproductive health care

Almost half of all U.S. births are to women with public insurance (National Center for Health Statistics). Public insurance has large coverage gaps for the poor women who require it: in many states this coverage is not available prior to pregnancy, when women with medical conditions require it. Insurance also terminates in the months following pregnancy when the vast majority of maternal deaths occur (Creanga). In order to assure optimal health care for the women at risk for medical or mental health conditions leading to maternal death, additional insurance coverage is required. Several states, including Texas, Illinois, New Jersey, South Carolina, and California, have proposed bills that would extend Medicaid coverage for a year postpartum, and federal legislation has also been proposed to extend Medicaid.

Relationship of Contraception to Maternal Death

Uninsured women are disproportionately poor and women of color. Unintended pregnancy rates are higher in this same population, and unintended pregnancies are associated with a higher risk of poor maternal and fetal outcomes. It is estimated that contraception averts 44 percent of possible maternal deaths (Saiffuddin). Although the implementation of the Affordable Care Act decreased the number of uninsured women by 20 percent, the number of women in need of publicly funded contraceptive services increased by one million during this time (Frost); the increased number of women over these years is

accounted for by the number of states not implementing the Medicaid expansion whose need increased over this time (Guttmacher Institute). In Texas, maternal mortality rates were stable from 2006-2010. The passage of Texas House Bill 2 led to the defunding of health clinics offering family planning and the closure of half of family planning clinics relied on by poor women and women of color (MacDornan). Following this, the rate of maternal death in Texas doubled, with other states' rates increasing more slowly and California's rates diminishing. Conclusions of this paper hypothesized a connection with these two events. (Ravitz)

Reduced access to quality maternity care

Safe maternity care requires access to hospitals with quality Obstetric units and access to appropriately trained medical teams led by obstetric physicians. Concurrent with the increased focus on maternal care delivery, hospitals with smaller maternity units have been closing. This trend in the US is true for both urban and rural maternity units. For example, there is currently no maternity hospital in Northeast Washington, DC. As a result, women in the affected neighborhoods may need to travel 40-60 minutes on public transit to reach a hospital (Randall). Moreover, data from the American Hospital Association (AHA) reveals that 500,000 women deliver in rural hospitals each year. Women in rural hospitals are less likely to have Obstetric physicians provide care. In 2002, 44 percent of rural counties lacked Obstetric units. The AHA estimated that 760 U.S. hospitals closed their OB services from 1985–2002. Hung reported that low volume maternity units have an increasing risk of closure of maternity units (8.92) and that those with predominantly Black mothers had an odds ratio of 4.52 of maternity unit closures than units with births to primarily white mothers. There is wide variation by state in maternity unit closures, with many states with high rural populations of Black mothers (Florida, South Carolina, North Carolina, and Virginia) disproportionately affected by this loss of access. Hospitals with low volume maternity units are more likely to share nursing staffing with other units and less likely to have trained emergency medicine physicians.

Depression

The CDC reports higher rates of depression in women of color, and lower rates of treatment (CDC). Depression in pregnancy is associated with poor maternal outcomes including maternal death. (BItew). International rates of maternal depression vary greatly and are correlated with maternal mortality rates. Hahn-Holbrook studied the relationship of pregnancy related depression and (fetal and maternal) mortality in 56 countries and demonstrated that economic inequality and prevalence of women working more than 40 hours a week explained 73 percent of the variation in nations.

What the AMA is doing to address SDOH and Maternal Mortality

A commitment to health equity means we must address the SDOH and we must elevate and name the root causes of why health inequities exist and how they came to be—both in society and at the institutional level. The AMA demonstrates its commitment through addressing the social conditions that impact health, increasing health workforce diversity, advocating for equity in health care access, promoting equity in care, and ensuring equitable practices and processes in research and data collection. Although the AMA and physicians cannot control all factors that need to change to achieve health equity, the AMA views as its role to identify their importance and to urge and educate those who can have a direct role to act.

The AMA supports efforts designed to integrate training in social determinants of health and cultural competence across the undergraduate medical school curriculum to assure that medical students are prepared to provide patients with safe, high quality, and patient-centered care. In 2013, the AMA launched the "Accelerating Change in Medical Education" initiative. Today, the 32-member consortium,

which represents almost one-fifth of allopathic and osteopathic medical schools, is delivering forward-thinking educational experiences to approximately 19,000 medical students—students who will provide care to a potential 33 million patients annually. One of the earliest innovations to come from the Consortium was the new and innovative curriculum on health systems science, which includes a chapter on the social determinants of health. Nearly all of the 37 schools in the consortium are addressing the social determinants of health with a focus on ensuring that students recognize the impact of social determinants on health outcomes and are working with inter-professional colleagues to address them.

In 2019, the AMA announced its Reimaging Residency Initiative, designed to transform residency training to best address the workforce needs of our current and future health care system. Many of the applications to the graduate medical education initiative have included health systems science training in their proposals.

For practicing physicians, the AMA launched STEPSforward,™ an interactive practice transformation series offering innovative strategies that will allow physicians and their staff to thrive in the evolving health care environment by working smarter, not harder. This series includes a continuing medical education module on "Addressing Social Determinants of Health: Beyond the Clinic Walls." The interactive module helps physicians identify how to best understand the needs of their community, define a plan to begin addressing social determinants of health, and explains the tools available to screen patients and link them to resources.

The AMA also supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems. Last month, the AMA and UnitedHealthcare announced a new collaboration to better identify and address social determinants of health to improve access to care and patient outcomes. The goal is to standardize data collection, processing, and integration regarding critical social and environmental factors that contribute to patient well-being through the creation of nearly two dozen new ICD-10 codes related to SDOH. By combining traditional medical data with self-reported SDOH data, the codes trigger referrals to social and government services to address people's unique needs, connecting them directly to local and national resources in their communities.

On the policy side, specifically related to addressing maternal mortality and morbidity, the AMA supported legislation enacted into law last year, H.R. 1318 (P.L. 115-344), the "Preventing Maternal Deaths Act," that supports state maternal mortality review committees (MMRCs). MMRCs bring together local experts—ob-gyns, nurses, social workers, patient advocates, and other health care professionals—to review individual maternal deaths and recommend specific ways to prevent them in the future. We appreciate that Congress appropriated $50 million in Fiscal Year 2019 to support prevention efforts. MMRCs are a critical first step in efforts to make pregnancy safer for women.

In addition, the AMA is supporting legislation introduced in the 116th Congress, the "Mothers and Offspring Mortality and Morbidity Awareness (MOMMA's) Act" (H.R. 1897/S. 916), which would improve data collection, disseminate information on effective interventions, and expand access to health care and social services for postpartum women. The bill would enhance federal efforts to support states in collecting, standardizing, and sharing maternal mortality and morbidity data, and authorizes and expands existing federal grant programs dedicated to scaling best practices to improve maternity care. The MOMMA's Act would also authorize states to expand coverage under Medicaid, CHIP, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) through a longer post-partum period for women. The bill would also ensure improved access to culturally-competent care training and workforce practices throughout the care delivery system.

To improve health equity, the AMA's strategic and focused approach includes a multi-pronged, multi-year investment, strategic partnerships, and advocacy. Our goals are to champion health equity and promote greater diversity within the medical workforce. To date, our most recent and greatest demonstration of a commitment to health equity is creating a new role and hiring our first Chief Health Equity Officer, Aletha Maybank, MD, a pediatrician with extensive experience championing health equity who most recently worked in the New York City Public Health Department and was the founding director of the city's Center for Health Equity. In her new role, Dr. Maybank will launch the Center for Health Equity at the AMA, initiating our new and explicit path to advance health equity.

In response to advocacy by our Board and management arms of the organization, Dr. Maybank's role at the AMA as their first Chief Health Equity Officer is to embed health equity across the AMA so that health equity becomes part of the practice, process, action, innovation, and organizational performance and outcomes. The best measure of our long-term success and most desired outcome is meaningful, relevant, and impactful inclusion of health equity into the strategic and operational objectives of the AMA.

Providers' and Health Care Systems' Role in Maternal Morbidity and Mortality

Providers, hospitals, and health care systems play a critical role in ensuring that all mothers and families have healthy and safe experiences around the time of birth. We applaud the growing number of places and people that are making significant investments to meaningfully engage health care systems and providers to improve the quality and safety of care for women. This is being done by enhancing data tracking and analysis of maternal and pregnancy-related morbidity and mortality events in order to stop preventable complications; integrating structural competency, cultural sensitivity, and implicit bias training opportunities; and working with partners from different sectors and with patients to better inform system changes and improvements. Narratives from the lived experiences of Black women indicate there is a rupture of trust between Black women and the health care system that must also be addressed.

Medical education curriculum incorporates teaching and training on implicit and explicit biases, to provide tools and build skills to recognize and eliminate bias, and integrate structural competency education, which as described by Jonathan Metzel "is a framework for conceptualizing and addressing health-related social justice issues that emphasizes diagnostic recognition of economic and political conditions producing and racializing inequalities in health."

We encourage health care systems to work alongside other partners such as women, community-based organizations, public health systems, and insurers to identify and adopt standards for respectful care at birth. We note specifically programs similar to NYC's Maternal Hospital Quality Improvement Network and collaborative efforts with 38 hospitals and clinical providers and 100 community-based organizations fostering a sense of team work and shared–decision making to ensure respectful, safe, and quality care at the time of delivery and after. Also, key to NYC's model are enhancing meaningful community engagement and data quality and timeliness for collection and review as well as hospitals implementing Trauma and Resilience Informed Systems to provide a shared language and understanding of how stress and trauma affect individuals, institutions, and communities and provide tools for clinical setting and promote resilience within the workforce and patient population.

Conclusion

The pursuit of health equity is a pathway towards excellence in our health care system, one that ensures the valuing of human experience and rights. It is one that recognizes that we must do more as institutions to protect people. We have been active on Access to care, Gun Violence, Immigration, Women's Health, and LGBTQ Rights. All are critical to health equity. We strongly supported the Affordable Care Act and

continue to defend it today even as we work to improve it. We look forward to working with many in this room to build and continue on a path forward to more holistically and effectively advance health equity and to improve maternal health.