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Testimony in Support of HB 4133
February 7, 2018

Dear Chair Greenlick and Members of the House Health Care Committee,

Thank you for the opportunity to share Kaiser Permanente's support for 4133, which establishes a Maternal Mortality Review Committee (MMRC) to conduct studies and reviews of incidence of maternal mortality and severe maternal morbidity. The goal if this committee is to improve processes, systems and knowledge that are lacking and then to remedy gaps in order to avoid another maternal death or near-miss.

Maternal mortality is an important indicator for quality – in the health of our communities, our patient populations, and our health systems. Unfortunately, there has been **no** significant improvement in maternal mortality in the US **for more than 25 years**. Maternal deaths jumped more than 25 percent from 2000 to 2014 (18.8% in 2000 to 23.8% in 2014). California is the exception, showing a declining trend; and Texas had an alarming spike in maternal deaths in 2011-12.

The international trend among other industrialized countries is in the opposite direction. The US lags way behind other industrialized countries in maternal mortality, even though half of all maternal deaths in the US are believed to be preventable.

The Centers for Disease Control and Prevention and the American College of Obstetricians and Gynecologists prioritize the reduction of the maternal deaths in the U.S. Over a decade ago, the CDC and ACOG called for the establishment of state review teams and currently recommend that all states have an active, confidential MMRC that uses standardized, uniform data collection and reporting tools.

About 30 states have an active MMRC in place or are in the process of establishing one. Reviewing maternal deaths in a systematic manner for the purpose of taking action can reduce the risk of women dying from complications of pregnancy.

Oregon needs to join this initiative. No process exists in our state for the confidential identification, investigation and dissemination of findings and recommendations on maternal deaths. HB 4133 is an important step in preventing poor health outcomes for countless mothers.

In the past decade, there have been major advances in the approach to obstetric emergencies. There are national initiatives underway that seek to mobilize clinical and public health resources to improve safety in maternity care. Maternal safety bundles and standardized protocols for conditions such as obstetric hemorrhage exist and have been shown to reduce the rates of hysterectomy and blood use. A state MMRC helps to support

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these important initiatives and would provide specific, data-driven recommendations to prevent future maternal deaths.

These committees identify, study and review cases of maternal deaths. They examine the medical and non-medical circumstances of deaths that occur during pregnancy up to one year post-delivery by reviewing medical records and other relevant data. The MMRCs then develop recommendations for the prevention of maternal deaths and disseminate findings and recommendations to policy makers, health care practitioners, health care facilities and the public. These reviews are confidential and performed within a culture of promoting safety. The focus is on identifying opportunities for improvement of systems – not on assigning blame.

By identifying gaps in services and systems, MMRCs help to prevent future deaths and near misses. They raise awareness and educate health professionals and others on appropriate actions to improve care.

Oregon has always been a leader in health care. Passing HB 4133 would demonstrate Oregon's commitment to excellence in maternal health care and would align Oregon with best practices in obstetric care being implemented across the country to reduce maternal mortality and morbidity.

Respectfully Submitted,

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