Yale University

Amanda Kallen, M.D.
Division of Reproductive Endocrinology & Infertility
Department of Obstetrics & Gynecology
Yale University School of Medicine

310 Cedar Street, LSOG 304D
New Haven, Connecticut 06520-8063

Telephone (203) 737-5465
Fax (203) 785-7819
Email: Amanda.kallen@yale.edu

American College of Obstetricians and Gynecologist Connecticut Chapter
Connecticut State Medical Society
Testimony on Senate Bill 304 An Act Establishing A Maternal Mortality Review Committee
Within The Department Of Public Health
Provide to the Public Health Committee
March 5, 2018

Senator Gerratana, Senator Somers, Representative Steinberg and members of the Public Health Committee, on behalf of the physicians and physicians in training of the American College of Obstetricians and Gynecologists Connecticut Chapter (CTACOG) and the Connecticut State Medical Society (CSMS), thank you for the opportunity to provide this testimony to you today in support of **Senate Bill No. 304 An Act Establishing a Maternal Mortality Review Committee Within The Department of Public Health.** We greatly appreciate the Committee's attention to and recognition of the importance of Maternal Mortality Review (MMR) committees.

The US lags well behind other industrialized countries in maternal mortality. Maternal deaths are defined as the death of a woman during or within 1 year of pregnancy that was caused by a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy. Leading causes include cardiovascular disease, cardiomyopathy, thromboembolism, obstetric hemorrhage, preeclampsia, sepsis, hypertension and obesity. Maternal deaths shatter lives, families, and communities. Approximately 650 U.S. women die each year during pregnancy, childbirth, or shortly after giving birth, according to the Centers for Disease Control and Prevention. Maternal near-deaths are also on the rise – for example, from preeclampsia and high blood pressure. Increasingly, more pregnant women in the U.S. have chronic health conditions and are overweight or obese. These conditions put pregnant women, especially those 40 years of age and older, at higher risk of adverse outcomes. For every maternal death, there are an estimated 50 pregnant women who have near-death complications. There are also significant and widening disparities in maternal mortality among black, Hispanic and white women. This highlights the need to better understand how social determinants of health and barriers to risk-appropriate care can be addressed to promote optimal outcomes for all women.

About **half of all maternal deaths in the US are believed to be preventable.** The Centers for Disease Control and Prevention and the American Congress of Obstetricians and Gynecologists have long prioritized the reduction of the maternal deaths in the U.S., and recommend that all states have an active, confidential MMR Committee that uses standardized, uniform data collection and reporting tools. MMR Committees identify, study and review cases of maternal deaths, and give us specific, data-driven recommendations to prevent future maternal deaths. Committees conduct their confidential reviews of medical records and interviews within a culture of promoting safety. The focus is on identifying opportunities for improvement of systems – not on assigning blame.

Yale University

Amanda Kallen, M.D.
Division of Reproductive Endocrinology & Infertility
Department of Obstetrics & Gynecology
Yale University School of Medicine

310 Cedar Street, LSOG 304D
New Haven, Connecticut 06520-8063

Telephone (203) 737-5465
Fax (203) 785-7819
Email: Amanda.kallen@yale.edu

Unlike many states, which have not even yet established MMR committees, **Connecticut's own MMR Committee, housed by the Connecticut State Medical Society (CSMS), has been staffed by dedicated, volunteer physicians for many years.** However, our committee operates at a backlog, without budgetary funding and with several years' delay between the occurrence of maternal deaths and the collection of information for analysis, preventing timely review of events and implementation of recommendations. Improvement of our current MMR Committee process by streamlining the process of data collection and strengthening legislative and legal protections is an important step in preventing poor health outcomes for countless mothers. Specifically, clearly specifying via legislation the authority of the committee to collect these records in a timely fashion, and pointing to that authority during records requests, can facilitate compliance with the request and mitigate any concerns by the record providers. **Importantly, we support the current MMR Committee structure within CSMS and wish to keep this basic structure in place with improvements as noted above.**

We again thank the Committee for their time and attention to this important matter. We look forward to working with members of this committee to ensure that final legislation accomplishes our mutual goal.