HAWAII MEDICAL ASSOCIATION
1360 S. Beretania Street, Suite 200, Honolulu, Hawaii 96814
Phone (808) 536-7702 Fax (808) 528-2376 www.hmaonline.net

DATE: Thursday, February 21, 2013
TIME: 9:00 a.m.
PLACE: Conference Room 211
State Capitol

To:
COMMITTEE ON WAYS AND MEANS
Senator David Y. Ige, Chair
Senator Michelle N. Kidani, Vice Chair

From: Hawaii Medical Association
Dr. Steven Kemble, MD, President
Dr. Linda Rasmussen, MD, Legislative Co-Chair
Dr. Joseph Zobian, MD, Legislative Co-Chair
Dr. Christopher Flanders, DO, Executive Director
Lauren Zirbel, Community and Government Relations

Re: SB 1238 Relating to Health (Maternal Mortality Review Panel)

Position: Strongly Support

Dear Chair Green, Vice Chair Baker and Health Committee Members:

The Hawaii Medical Association strongly supports SB1238, which establishes a maternal mortality review panel to conduct comprehensive, multidisciplinary reviews of maternal deaths in Hawaii for the purpose of identifying factors associated with those deaths to improve services for women in our state.

As you may know, Hawaii's Maternal and Perinatal Mortality Review Committee was an active group until about 15 or more years ago when this committee ceased to exist due to lack of administrative support. During that time, protection from discovery or legal action for the review process and committee participants was provided by Hawaii Revised Statutes 324-1 to 4, and this law is still current today. This law requires updating and revision.

Hawaii is one of only 14 states in the nation that does not have a Maternal Mortality Review Committee (ACOG Annual Clinical Meeting, May 2011). Despite advances in medical care, the maternal mortality rate in the U.S. appears to rising, and has reached a rate that is now four times higher than the federal government's Healthy People 2010 goal.

The U.S. pregnancy-related mortality ratio was 14.5 per 100,000 live births during 1998-2005 (Centers for Disease Control and Prevention-CDC). This is higher than any other period in the past 20 years. U.S. officials had hoped to decrease this rate from 8.4 in 1997 to 3.3 deaths per 100,000 live births by 2010 (Healthy People 2010), and instead the actual rate was 4 times that number. According to World Health Organization (WHO) estimates for 2008, 47 countries had lower maternal mortality ratios than the U.S. (WHO, Trends in Maternal Mortality: 1990-2008)

Hawaii's maternal mortality ratio from 2001 through 2006 was estimated by the CDC as 13.9 deaths per 100,000 live births (CDC, National Center for Health Statistics-NCHS, 2001-2006 data). According to Hawaii Department of Health data, there were 102 maternal deaths from 2001 through 2011, or an average of 9 deaths per year. These numbers are thought to be under-reported not only in Hawaii, but across the nation. Many experts caution that there is a 30% to 100% under-reporting of maternal deaths. Experts also estimate that only 30-40% of the rise in national maternal deaths can be attributed to new data collection techniques and better reporting.

Nationally, women of color, particularly African American women, have a higher maternal mortality ratio than white women in the U.S. (CDC, NCHS, 2010). No current similar data are publicly available or analyzed for our multiethnic state.

As an example of how comprehensive maternal mortality reviews can contribute to improved quality of care, the United Kingdom reports targeting particular pregnant populations for earlier prenatal care, education campaigns for care providers and other interventions based on their maternal mortality review data with a subsequent decrease in maternal mortality (Saving Mothers' Lives, Reviewing maternal deaths to make motherhood safer: 2006-2008. British Journal of Obstetrics and Gynaecology. Volume 118, Supplement 1, March 2011). In the United States, the Illinois Maternal Mortality Review Committee (MMRC) found that obstetric hemorrhage was the leading cause of death, with 69% thought to be potentially avoidable. The Illinois MMRC was instrumental in mandating that every obstetric hospital in their state undergo mandatory Obstetric Hemorrhage training [Reducing Maternal Deaths through State Maternal Mortality Review. Kilpatrick SJ, etal. 2012 Sep;21(9):905-9. Journal of Womens Health (Larchmont)].

Hawaii Medical Association is grateful to Senators Green, Baker, Ruderman and Shimabukuro for the introduction of SB 1238 which will establish a maternal mortality review towards improving women's services.

From: mailinglist@capitol.hawaii.gov
To: WAM Testimony
Cc: lkamemot@hawaii.edu
Subject: Submitted testimony for SB1238 on Feb 21, 2013 09:00AM
Date: Wednesday, February 20, 2013 7:03:20 AM

SB1238
Submitted on: 2/20/2013
Testimony for WAM on Feb 21, 2013 09:00AM in Conference Room 211

Submitted By	Organization	Testifier Position	Present at Hearing
Lori Kamemoto, MD, MPH	Am. Congress of Obstetricians & Gynecologists, HI	Support	Yes

Comments: Thank you for allowing Hawaii ACOG to submit our comments.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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February 21, 2013 - Thursday
9:00 AM
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To: Senator David Y. Ige, Chair
Senator Michelle N. Kidani, Vice Chair
Senate Committee on Ways and Means

From: Bliss Kaneshiro, MD, MPH

Re: SB 1238 SD1 Relating to Health (Maternal Mortality Review Panel)

Position: Strongly Support

Dear Chair Ige, Vice Chair Kidani and Ways and Means Committee Members:

I am writing in strong support of SB1238 SD1, which establishes a maternal mortality review panel to conduct comprehensive, multidisciplinary reviews of maternal deaths in Hawaii for the purpose of identifying factors associated with those deaths to improve services for women in our state.

Information provided by the American College of Obstetricians and Gynecologists (ACOG, Annual Clinical Meeting May 2011) revealed that Hawaii is one of only 14 states in the nation that does not have an active Maternal Mortality Review Committee.

Other states, such as Illinois, have used information provided from maternal mortality review to identify groups of women most at risk for morbidity and mortality from pregnancy. They have used this information to develop targeted interventions. For example, the Illinois MMRC was instrumental in mandating that every obstetric hospital in their state undergo mandatory Obstetric Hemorrhage training after they identified that maternal hemorrhage was the leading cause of death in their population [Reducing Maternal Deaths through State Maternal Mortality Review. Kilpatrick SJ, et al. 2012 Sep;21(9):905-9. Journal of Womens Health (Larchmont)]

For every woman who dies of a pregnancy-related cause, many more suffer morbidity related to pregnancy. Comprehensive review of maternal death can therefore lead to improvement in general women's care and decrease morbidity, in addition to decreasing mortality. This morbidity and mortality place a significant burden on women, their children and families, and on society in personal, social and economic terms.

We urge you to support the establishment of the Hawaii Maternal Mortality Review Panel which can lead to system changes leading to decreased maternal mortality as well as improvement of services to all of Hawaii's women. Thank you for the opportunity to present this testimony.

Sincerely

Dr. Bliss Kaneshiro, Obstetrician Gynecologist

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Conference Room 211
State Capitol

To: Senator David Y. Ige, Chair
Senator Michelle N. Kidani, Vice Chair
Senate Committee on Ways and Means

From: Pai-Jong Stacy Tsai, MD, MPH

Re: SB 1238 SD1 Relating to Health (Maternal Mortality Review Panel)

Position: Strongly Support

Dear Chair Ige, Vice Chair Kidani and Ways and Means Committee Members:

I am writing in strong support of SB1238 SD1, which establishes a maternal mortality review panel to conduct comprehensive, multidisciplinary reviews of maternal deaths in Hawaii for the purpose of identifying factors associated with those deaths to improve services for women in our state.

Information provided by the American College of Obstetricians and Gynecologists (ACOG, Annual Clinical Meeting May 2011) revealed that Hawaii is one of only 14 states in the nation that does not have an active Maternal Mortality Review Committee.

Other states, such as Illinois, have used information provided from maternal mortality review to identify groups of women most at risk for morbidity and mortality from pregnancy. They have used this information to develop targeted interventions. For example, the Illinois MMRC was instrumental in mandating that every obstetric hospital in their state undergo mandatory Obstetric Hemorrhage training after they identified that maternal hemorrhage was the leading cause of death in their population [Reducing Maternal Deaths through State Maternal Mortality Review. Kilpatrick SJ, etal. 2012 Sep;21(9):905-9. Journal of Womens Health (Larchmont)]

For every woman who dies of a pregnancy-related cause, many more suffer morbidity related to pregnancy. Comprehensive review of maternal death can therefore lead to improvement in general women's care and decrease morbidity, in addition to decreasing mortality. This morbidity and mortality place a significant burden on women, their children and families, and on society in personal, social and economic terms. As an obstetrician, I have personally taken care of high-risk pregnant women who have suffered significant morbidity directly related to their pregnancy. Many of these morbidities may have been prevented through systematic changes on the hospital or community level. The first step in identifying potential improvements in caring for high-risk pregnant women is by having comprehensive review of the problems. I believe the Maternal Mortality Review Panel can accomplish this.

We urge you to support the establishment of the Hawaii Maternal Mortality Review Panel which can lead to system changes leading to decreased maternal mortality as well as improvement of services to all of Hawaii's women. Thank you for the opportunity to present this testimony.

Sincerely

Pai-Jong Stacy Tsai, MD, MPH
Maternal Fetal Medicine Fellow