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

DATE: Wednesday, March 13, 2013
TIME: 8:30 A.M.
PLACE: Conference Room 329

To:
COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Dee Morikawa, 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

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.

morikawa2 - Shaun

From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 11, 2013 1:39 PM
To: HLTtestimony
Cc: hjoseph@marchofdimes.com
Subject: *Submitted testimony for SB1238 on Mar 13, 2013 08:30AM*

SB1238
Submitted on: 3/11/2013
Testimony for HLT on Mar 13, 2013 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Lin Joseph	March of Dimes	Support	No

Comments:

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March 11, 2013

TO: Rep. Della Au Belatti, Chair; Rep. Dee Morikawa, Vice Chair; and Members of the House Committee on Health
FROM: Lisa Kimura, Executive Director, Healthy Mothers Healthy Babies

RE: Testimony in Support of SB 1238 SD2, Relating to Maternal Mortality Review

HEARING: Wednesday, March 13, 2013 at 8:30 A.M.

Healthy Mothers Healthy Babies Coalition of Hawaii is testifying today in support of SB 1238 SD2.

This bill would establish a maternal mortality review panel to conduct comprehensive, multidisciplinary reviews of maternal deaths in Hawaii for the purposes of identifying factors associated with the deaths and making recommendations for system changes to improve health care services for women in this State.

Maternal mortality is a key indicator of health and reflects the ability of women to secure not only maternal health care services but also other health care services.

Hawaii's maternal mortality rate averages 15.1 per 100,000 live births, which is higher than the national average, and falls short of the Healthy People 2020 goal of no more than 11.4 per 100,000 live births. To protect the health of women in Hawaii, it is important to determine what factors are contributing to maternal deaths and how we can improve outcomes.

Thank you for the opportunity to testify.

845 22nd Avenue, Honolulu, Hawaii 96816
phone: (808) 222-0165 e-mail: lisak@hmhb-hawaii.org
www.hmhb-hawaii.org

American Congress of Obstetricians and Gynecologists
District VIII, Hawaii (Guam & American Samoa) Section
Lori Kamemoto, MD, MPH, FACOG, Chair
1319 Punahou Street, Suite 990
Honolulu, HI 96826

THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

March 13, 2013 - Wednesday
8:30 AM
Conference Room 329
State Capitol

To: Representative Della Au Belatti, Chair
Representative Dee Morikawa, Vice Chair
House Committee on Health

From: Lori Kamemoto, MD, MPH, Chair
Greigh Hirata, MD, Vice Chair
American Congress of Obstetricians and Gynecologists, Hawaii Section

Re: SB 1238 SD2 Relating to Health (Maternal Mortality Review Panel)

Position: Strongly Support

Dear Chair Belatti, Vice Chair Morikawa and Health Committee Members:

The American Congress of Obstetricians and Gynecologists (ACOG), Hawaii Section strongly supports SB1238 SD2, 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 towards improving services for all women in our state. We urge you to support Women's Health and amend the effective date from July 1, 2050 that effectively defeats this bill, to January 1, 2014.

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, protections for patients, and from discovery or legal action of the review process was provided by Hawaii Revised Statutes 324-1 to 4, and this law is still current today. This law requires updating and revision to establish the Maternal Mortality Review Panel. The review panel's clinical health professionals, such as physicians and nurses, are all non-compensated volunteers dedicated to improving Hawaii's maternal and perinatal care.

Hawaii is one of only 14 states in the nation that does not have an active Maternal Mortality Review Committee (ACOG Annual Clinical Meeting, May 2011) and there are currently several states in the process of establishing a maternal mortality review.

Despite advances in medical care, the maternal mortality rate in the U.S. appears to be 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 noted that certain ethnic populations had comparatively increased maternal mortality rates. Using this information, they targeted 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 which benefits all pregnant women [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.

The HHS-HRSA Maternal and Child Health Bureau, Centers for Disease Control and Prevention (CDC), the Association of Maternal and Child Health Programs (AMCHP), and the American Congress of Obstetricians and Gynecologists (ACOG), all recommend that maternal deaths in each state be investigated by a multidisciplinary peer review protected Maternal Mortality Review Panel. Review of every maternal death by a qualified, multidisciplinary committee in each state is critical to understanding the role in maternal death of geography, age, preexisting conditions, access to appropriate care, as well as race, ethnicity, community education, and services.

We urge you to support the establishment of the Hawaii Maternal Mortality Review Panel and to amend the effective date to January 1, 2014. Reviewing maternal mortality can guide us towards system changes unique to Hawaii's population, which lead 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. Please contact us if you have any questions regarding this important bill.

morikawa2 - Shaun

From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 11, 2013 12:50 PM
To: HLTtestimony
Cc: jbsestak@prodigy.net
Subject: *Submitted testimony for SB1238 on Mar 13, 2013 08:30AM*

SB1238
Submitted on: 3/11/2013
Testimony for HLT on Mar 13, 2013 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Betty Sestak, RN, CCM	Individual	Support	No

Comments:

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morikawa2 - Shaun

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 12, 2013 8:05 AM
To: HLTtestimony
Cc: praley44@hotmail.com
Subject: Submitted testimony for SB1238 on Mar 13, 2013 08:30AM

SB1238
Submitted on: 3/12/2013
Testimony for HLT on Mar 13, 2013 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Patricia McKenzie	Individual	Support	No

Comments: 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, protections for patients, and from discovery or legal action of the review process was provided by Hawaii Revised Statutes 324-1 to 4, and this law is still current today. This law requires updating and revision to establish the Maternal Mortality Review Panel. The review panel's clinical health professionals, such as physicians and nurses, are all non-compensated volunteers dedicated to improving Hawaii's maternal and perinatal care. Hawaii is one of only 14 states in the nation that does not have an active Maternal Mortality Review Committee (ACOG Annual Clinical Meeting, May 2011) and there are currently several states in the process of establishing a maternal mortality review. 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. The HHS-HRSA Maternal and Child Health Bureau, Centers for Disease Control and Prevention (CDC), the Association of Maternal and Child Health Programs (AMCHP), and the American Congress of Obstetricians and Gynecologists (ACOG), all recommend that maternal deaths in each state be investigated by a multidisciplinary peer-review protected Maternal Mortality Review Panel. Review of every maternal death by a qualified, multidisciplinary committee in each state is critical to understanding the role in maternal death of geography, age, preexisting conditions, access to appropriate care, as well as race, ethnicity, community education, and services. We urge you to support the establishment of the Hawaii Maternal Mortality Review Panel and to amend the effective date to January 1, 2014. Reviewing maternal mortality can guide us towards system changes unique to Hawaii's population, which lead to decreased maternal mortality as well as improvement of services to all of Hawaii's women.

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From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 12, 2013 8:08 AM
To: HLTtestimony
Cc: vbalaraman@hawaiiantel.net
Subject: Submitted testimony for SB1238 on Mar 13, 2013 08:30AM

SB1238
Submitted on: 3/12/2013
Testimony for HLT on Mar 13, 2013 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Venkataraman Balaraman	Individual	Support	No

Comments: Honorable Chair and Senators: I strongly support this bill to be in place effective January 1, 2014. Thanks Venkataraman Balaraman, MD Neonatologist

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From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 12, 2013 8:09 AM
To: HLTtestimony
Cc: wfmckmd@hotmail.com
Subject: Submitted testimony for SB1238 on Mar 13, 2013 08:30AM

SB1238
Submitted on: 3/12/2013
Testimony for HLT on Mar 13, 2013 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
William McKenzie	Individual	Support	No

Comments: 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. The HHS-HRSA Maternal and Child Health Bureau, Centers for Disease Control and Prevention (CDC), the Association of Maternal and Child Health Programs (AMCHP), and the American Congress of Obstetricians and Gynecologists (ACOG), all recommend that maternal deaths in each state be investigated by a multidisciplinary peer -review protected Maternal Mortality Review Panel. Review of every maternal death by a qualified, multidisciplinary committee in each state is critical to understanding the role in maternal death of geography, age, preexisting conditions, access to appropriate care, as well as race, ethnicity, community education, and services. We urge you to support the establishment of the Hawaii Maternal Mortality Review Panel and to amend the effective date to January 1, 2014. Reviewing maternal mortality can guide us towards system changes unique to Haw aii's population, which lead to decreased maternal mortality as well as improvement of services to all of Hawaii's women.

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March 13, 2013 - Wednesday
8:30 AM
Conference Room 329
State Capitol

To: Representative Della Au Belatti, Chair
Representative Dee Morikawa, Vice Chair
House Committee on Health

From: Nathan Fujita MD

Re: SB 1238 SD2 Relating to Health (Maternal Mortality Review Panel)

Position: Strongly Support

Dear Chair Belatti, Vice Chair Morikawa and Health Committee Members:

The American Congress of Obstetricians and Gynecologists (ACOG), Hawaii Section strongly supports SB1238 SD2, 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 towards improving services for all women in our state. I urge you to support Women's Health and amend the effective date from July 1, 2050 that effectively defeats this bill, to January 1, 2014.

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Hawaii is one of only 14 states in the nation that does not have an active Maternal Mortality Review Committee (ACOG Annual Clinical Meeting, May 2011) and there are currently several states in the process of establishing a maternal mortality review.

Thank you for the opportunity to present this testimony. Please contact us if you have any questions regarding this important bill.

morikawa2 - Shaun

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 12, 2013 9:57 AM
To: HLTtestimony
Cc: jensapp@wcchc.com
Subject: *Submitted testimony for SB1238 on Mar 13, 2013 08:30AM*

SB1238
Submitted on: 3/12/2013
Testimony for HLT on Mar 13, 2013 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Jennifer Sapp	Individual	Support	No

Comments:

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