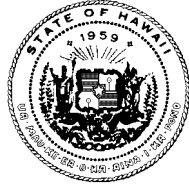


DAVID Y. IGE
GOVERNOR



RACHAEL WONG, DrPH
DIRECTOR

PANKAJ BHANOT
DEPUTY DIRECTOR

**STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES**

P. O. Box 339
Honolulu, Hawaii 96809-0339

February 10, 2016

TO: The Honorable Della Au Bellati, Chair
House Committee on Health

FROM: Rachael Wong, DrPH, Director

SUBJECT: HB 1788, Relating to Child and Maternal Death Reviews

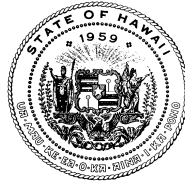
Hearing: Wednesday, February 10, 2016 at 8:30 a.m.
Conference Room 329, State Capitol

DEPARTMENT'S POSITION: The Department of Human Services (DHS) supports the bill and is committed to improving the health and safety of Hawaii's children and families.

PURPOSE: The purpose of the bill is to provide ongoing funding to the Department of Health (DOH) to conduct both child and maternal death reviews.

The DHS has collaborated with the DOH on child death reviews in the past, and appreciates and recognizes the value and importance of the review process.

Thank you for the opportunity to testify.



STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. Box 3378
Honolulu, HI 96801-3378
doh.testimony@doh.hawaii.gov

**Testimony COMMENTING on H.B. 1788
Relating to Child and Maternal Death Reviews**

REPRESENTATIVE DELLA AU BELATTI, CHAIR
HOUSE COMMITTEE ON HEALTH

Hearing Date: February 10, 2016

Room Number: 329

1 **Fiscal Implications:** H.B. 1788 appropriates \$150,000 to the Department of Health (DOH) for
2 fiscal year 2016-2017 to conduct child death reviews and implement a program for the
3 performance of maternal death reviews. DOH defers to the Governor's Supplemental Budget
4 Request for its fiscal priorities regarding the general fund appropriation.

5 **Department Testimony:** The purpose of this measure is to conduct child death reviews and
6 implement a program to perform maternal death reviews and submit an annual report to the
7 legislature related to child and maternal death reviews in the State.

8 The Department agrees that comprehensive multidisciplinary reviews are needed to improve
9 systems of care and prevent child and maternal deaths. It is a vital public health component in
10 the State.

11 In the last Hawaii child death review report 2001-2006, out of 1,079 child deaths, 34% of both
12 resident and non-resident were comprehensively reviewed and 73% of them were determined to
13 be preventable. Since this report, fewer deaths have been reviewed with no reviews occurring
14 since 2013 when resources to oversee these reviews ended. Out of an average of 19,000 births
15 per year, between zero and ten maternal deaths are documented each year. The Department has
16 not conducted maternal mortality reviews in the past.

17 Both maternal mortality reviews and child death reviews, as a combined maternal and child
18 mortality framework described in H.B.1788, will provide the foundation for a coordinated
19 approach to address local systems and policies to improve maternal and child health.

1 Thank you for this opportunity to testify.

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3 **Offered Amendments: None**

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Date: February 8, 2016

To: Representative Della Au Belatti, Chair
Representative Richard Creagan, Vice Chair

From: Lin Joseph
Director of Program Services
March of Dimes Hawaii Chapter

Re: In support of
HB 1788
Hearing: Wednesday, February 10, 2016
Conference Room 329, State Capitol

Chair Belatti, Vice Chair Creagan, Members of the Committees:

I am writing to express strong support for HB 1788: Child and Maternal Death Review

For 75 years, the March of Dimes has been a leader in maternal and child health. Our mission is to *improve the health of babies by preventing birth defects, premature birth, and infant mortality.*

The death of a child or a pregnant woman is a sentinel event that requires proper investigation to understand the underlying causes and opportunities for prevention. Currently, Hawaii is one of only 13 states not conducting maternity reviews, and since 2013, one of only two states not conducting Child Death Reviews. Findings from review panels guide the creation of treatment protocols, education campaigns and standardization of care and have been shown to reduce child and maternal deaths.

The State of Hawaii reports in the Child Death Review Report 1997-2000 that there were 726 deaths of infants, children and adolescents up to age 18 during that period, approximately 200 deaths each year. Many of the deaths were preventable with the largest number due to motor vehicle incidents and sleep environment.

According to the Centers for Disease Control and Prevention (CDC), maternal mortality in the United States declined markedly during the 20th century. Unfortunately, this progress has stalled and the maternal mortality rate has steadily increased in recent years. The earlier, historic decline was led largely by medical and technological advances. In addition, interest and concern at the local, state, and federal levels led to developing systems for identifying, reviewing, and

February 8, 2016
Honorable Della Au Belatti
Honorable Richard Creagan
Page 2

analyzing maternal deaths. These systems have determined causes of deaths, identified gaps in services, and disseminated findings and recommendations.

Child and maternal death reviews should be part of every state's core public health function of assessment. The purpose of reviewing pregnancy-related and child deaths is to gain insight into the medical and social factors that lead to these events in order to decrease such deaths in the future.

Senate Bill HB 1788 provides for the Department of Health to begin again to conduct child death reviews and to implement maternal death reviews in Hawaii.

The March of Dimes supports HB 1788 for its potential public health surveillance to improve monitoring of maternal and child health and better inform prevention and intervention strategies. Mahalo for your support.



February 9, 2016

TESTIMONY: Written only

To: The Honorable Della Au Belatti , Chair
The Honorable Richard P. Creagan, Vice Chair
Members of the House Committee on Health

From: **Hawaii Public Health Association**

Subject: **SUPPORT - HB 1788** RELATING TO CHILD AND MATERNAL DEATH
REVIEWS

Hearing: February 10, 2016 at 8:30am at State Capitol Room 329

The Hawaii Public Health Association (HPHA) is an association of over 600 community members, public health professionals, and organizations statewide dedicated to improving public health. HPHA also serves as a voice for public health professionals and as a repository for information about public health in the Pacific.

HPHA supports the passage of HB 1788 which appropriates funds to the Department of Health to conduct child death reviews and implement a program to perform maternal death reviews.

The Hawaii Child Death Review (CDR) system was established in 1997 by the Legislature through Hawaii Revised Statute §321-345. The CDR teams conducted comprehensive and multidisciplinary reviews of child deaths 0-17 years to understand risk factors of child deaths. The reviews focused on prevention of future child deaths and have also led to recommendations in ensuring child safety and providing optimal child health. CDRs require adequate resources to conduct the reviews and passage of this bill would enable this process to resume, since it has been inactive since 2011.

The United States maternal mortality ratio has increased and the Centers for Disease Control and Prevention (CDC) states that maternal mortality review committees are necessary for ensuring all pregnancy-related deaths are identified and reviewed, and that effective prevention actions are developed. The Association of Maternal and Child Health Programs also supports a maternal mortality review process as

pregnancy-related deaths are an indicator of the overall health of women of reproductive age. Many of these deaths are preventable. According to the American Congress of Obstetricians and Gynecologists, state-level maternal mortality review committees are an important obstetric care and maternal public health function. Hawaii is one of fourteen states that does not conduct maternal mortality review in a comprehensive statewide system.

Child death and maternal death reviews would provide critical data to support prevention efforts to reduce child and maternal mortality and morbidity in Hawaii.

Thank you for the opportunity to testify in support of **HB 1788**, which would resume child death reviews and implement a program to conduct maternal death reviews.

Respectfully submitted,

Hoce Kalkas, MPH
HPHA Legislative and Government Relations Committee Chair

**American Congress of Obstetricians and Gynecologists
District VIII, Hawaii (Guam & American Samoa) Section**

Greigh Hirata, MD, FACOG, Chair
94-235 Hanawai Circle, #1B
Waipahu, Hawaii 96797



To: Committee on Health
Representative Della Au Bellati, Chair
Representative Richard P. Creagen, Vice Chair

DATE: Wednesday, February 10, 2016
TIME: 8:30 A.M.
PLACE: Conference Room 329

FROM: Hawaii Section, ACOG
Dr. Greigh Hirata, MD, FACOG, Chair
Dr. Jennifer Salcedo, MD, MPH, MPP, FACOG, Vice-Chair
Lauren Zirbel, Community and Government Relations

Re: HB1788 Relating to Child and Maternal Death Reviews

Position: Strongly Support

Dear Representatives Bellati, Creagen and Committee Members:

The American Congress of Obstetricians and Gynecologists, Hawaii Section (Hawaii ACOG) strongly supports the establishment of a Hawaii Maternal Mortality Review Panel as well as the reinstatement of Child Death Review to conduct comprehensive, multidisciplinary reviews of maternal and deaths towards improving maternal-child health in our state. Deaths of a child or a pregnant woman are sentinel events that require proper investigations to understand the underlying causes and opportunities for prevention. The mortality reviews identify missed opportunities and remediable factors in cases of child and maternal deaths.

There currently is **no allocation of resources** to ensure the ongoing conduct of maternal and child death reviews. **Establishment of a permanently funded unit within the MCH Branch at the DOH addresses program sustainability. Many factors responsible for infant mortality are shared with maternal mortality.** These include socio-environmental factors, appropriate accessing of medical care and timely response by the healthcare system. In addition there is considerable overlap in the methodologies for determining factors contributing to deaths and preventability. **It just makes sense to combine resources for these reviews. The Hawaii State Department of Health (DOH) is supportive of this legislation.**

Hawaii is one of only 13 states without a multi-disciplinary professional panel to review pregnancy-related deaths. There are approximately 10 maternal deaths in the state of Hawaii. Maternal mortality rates are increasing and up to 50% of all maternal deaths may be preventable. **We know that review panels work: unlike overall United States data with rising maternal death rates, the United Kingdom and the state of California have decreased their maternal mortality** by instituting programs aimed at preventable causes of death. Findings from review panels guide the creation of treatment protocols, education campaigns and standardization of pregnancy care.

Hawaii, as of 2013, is one of only two states not conducting child death reviews. Previous reviews have found that up to 75% of child deaths in Hawaii were preventable. There are approximately 170 child deaths per year in the state of Hawaii. A series of recommendations from prior Child Death Reviews launched policy changes in licensed daycares and stimulated public service campaigns directed at reducing sleep related deaths. This summer's outbreak of infant deaths, with 7 being sleep related and another 5 also preventable, highlights the importance of ongoing surveillance and active responses to minimize preventable deaths.

The appropriation for core fatality unit staffing at the DOH is fundamental to ensuring the sustainability of child and maternal death reviews. The review panels for separate child and maternal death reviews will consist of voluntary expert members, allowing for significant in-kind support from health care providers and public health specialists.

Mahalo for the opportunity to testify, and for your support of Hawaii Women's Health.

February 10, 2016 at 8:30 AM
Conference Room 329

House Committee on Health

To: Representative Della Belatti, Chair
Representative Richard Creagan, Vice Chair

From: Janet Burlingame, MD
Chair, Quality Council
Kapi'olani Medical Center for Women & Children

Re: HB 1788 - Testimony in Strong Support

My name is Janet Burlingame, MD Obstetrician and Maternal-Fetal Medicine specialist at Kapi'olani Medical Center for Women & Children (KMCWC). Kapi'olani Medical Center is the state's only maternity, newborn and pediatric specialty hospital with 207 beds and 66 bassinets. Kapi'olani is also a tertiary care, medical teaching and research facility. The not-for-profit hospital is an affiliate of Hawai'i Pacific Health.

Kapi'olani **strongly supports HB 1788** which makes an appropriation to the Department of Health to conduct child death reviews and implement a program to perform maternal death reviews.

Comprehensive reviews of child and maternal deaths have been a subject of ongoing concern and effort. Comprehensive reviews of maternal deaths are needed to understand for and to prevent the deaths of mothers during pregnancy, labor and the year following the birth of a child. Hawaii is one of only 13 states without a multi-disciplinary professional panel to review pregnancy-related deaths. Meanwhile there are approximately 10 maternal deaths in the state of Hawai'i with up to 50% of all maternal deaths may be preventable. Findings from review panels guide are essential towards the creation of a common platform to guide treatment protocols, education campaigns, standardization of pregnancy care and future advocacy efforts.

Additionally, this bill does also addresses a concern I expressed in testimony to on a related bill - SB 2317 regarding the lack sustainability of a one-year appropriation to support all the efforts required to reinstate the maternal mortality review in a resource-conscientious, endurable manner.

There currently is no reliable allocation of resources to ensure the ongoing conduct of maternal and child death reviews. Establishment of a permanently funded unit within the MCH Branch at the DOH would address program sustainability. The appropriation for core fatality unit staffing at the DOH is fundamental to ensuring the sustainability of child and maternal death reviews.

Understanding the limitations of the budget process, I appreciate that this bill does provide a greater level of funding needed to accomplish its goals and is a step in the right direction.

Thank you very much for the opportunity to testify on this measure. I ask that you pass this very important measure.

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February 10, 2016 at 8:30 AM
Conference Room 329

House Committee on Health

To: Representative Della Belatti, Chair
Representative Richard Creagan, Vice Chair

From: Michael Robinson
Vice President, Government Relations & Community Affairs

Re: HB 1788 - Testimony in Strong Support

My name is Michael Robinson, Vice President, Government Relations and Community Affairs at Hawai'i Pacific Health (HPH). Hawai'i Pacific Health is a not-for-profit health care system, and the state's largest health care provider and non-governmental employer. Hawai'i Pacific Health is committed to providing the highest quality medical care and service to the people of Hawai'i and the Pacific Region through its four hospitals, more than 50 outpatient clinics and service sites, and over 1,600 affiliated physicians. Hawai'i Pacific Health's hospitals are Kapi'olani Medical Center for Women & Children, Pali Momi Medical Center, Straub Clinic & Hospital and Wilcox Memorial Hospital.

HPH **strongly supports** HB 1788 which makes an appropriation to the Department of Health to conduct child death reviews and implement a program to perform maternal death reviews.

We support the effort of this bill to integrate the efforts and resources of both the infant and maternal mortality review boards and to provide adequate resources needed to enable comprehensive multidisciplinary reviews of maternal and child deaths under a single piece of legislation.

Given the likelihood of commonly shared socially determined risk factors related to both infant and maternal mortality, we appreciate the effect this bill will have in creating a sound and coordinated systems approach to establish accountability and awareness of this public health issue. By addressing the issue from a combined infant and maternal mortality framework, this approach will also better facilitate the ongoing dialogue and effort occurring between maternal and pediatric medical specialists.

This bill also provides a more adequate level of resources to ensure its goals are met.

Thank you very much for the opportunity to testify on this measure.

KAPI'OLANI
MEDICAL CENTER
FOR WOMEN & CHILDREN



PALI MOMI
MEDICAL CENTER



STRAUB
CLINIC & HOSPITAL



WILCOX HEALTH

AFFILIATE OF



AMERICAN COLLEGE
of NURSE-MIDWIVES

With women, for a lifetime®

House Committee on Health
Representative Della Au Belatti, Chair
Representative Richard P. Creagan, Vice Chair

February 9, 2016

Dear Representatives Au Belatti, Creagan and Committee Members,

The Hawaii Affiliate of the American College of Nurse-Midwives strongly supports the passage of HB1788 for the establishment of a Hawaii Maternal Mortality Review Panel as well as the reinstatement of a formal child death review process to conduct comprehensive, multidisciplinary reviews of maternal and child deaths as a means of improving maternal-child health in our state. The death of a child or a pregnant woman is a sentinel event that requires proper investigations to understand the underlying causes and, thereby, provide opportunities for the prevention of such events. The mortality reviews identify missed opportunities and remediable factors in cases of child and maternal deaths.

Currently there is no allocation of resources to ensure the ongoing conduct of maternal and child death reviews. The establishment of a permanently funded unit within the Maternal-Child Branch at the State of Hawaii's Department of Health (DOH) will ensure sustainability for these reviews. Many factors responsible for infant mortality are shared with maternal mortality. These include socio-environmental factors, appropriate accessing of medical care and timely response by the healthcare system. In addition, there is considerable overlap in the methodologies for determining factors contributing to deaths and preventability. Therefore, it is more feasible to combine resources for these reviews.

Hawaii is one of only 13 states without a multi-disciplinary professional panel to review pregnancy-related deaths. There are approximately 10 maternal deaths in the state of Hawaii annually. Up to 50% of all maternal deaths may be preventable. We know that review panels work. For example, unlike overall United States data with rising maternal death rates, the United Kingdom and the state of California have decreased their maternal mortality by instituting programs aimed at preventable causes of death. Findings from review panels guide the creation of treatment protocols, education campaigns and standardization of pregnancy care.

As of 2013, Hawaii is one of only two states not conducting child death reviews. There are approximately 170 child deaths per year in the state of Hawaii. Previous child death reviews found that up to 75% of the deaths in Hawaii were preventable. A series of recommendations from prior child death reviews launched policy changes in licensed daycares and stimulated

public service campaigns directed at reducing sleep related deaths. This summer's outbreak of infant deaths, with 7 being sleep related and another 5 also preventable, highlights the importance of ongoing surveillance and active responses to minimize preventable deaths.

The appropriation for staffing of a core fatality unit at the DOH is fundamental to ensuring the sustainability of child and maternal death reviews. The review panels for child and maternal death reviews will consist of voluntary expert members, allowing for significant in-kind support from health care providers and public health specialists. In addition, the DOH is supportive of this legislation.

We appreciate your support of this bill and your support of the health and safety of women and children in Hawaii.

Respectfully,

Executive Board of the Hawaii Affiliate of the American College of Nurse Midwives

Maureen Shannon, CNM, FNP, PhD – President

Annette Manant, CNM, MSN, PhD – Secretary

Joan Thompson, CNM, MSN – Treasurer

Hawaii Association for Infant Mental Health

FIRST RELATIONSHIPS

February 5, 2016

Representative Della au Belatti, Chair, House Health Committee
Representative Richard Creagan, Vice Chair House Health Committee
Hawaii State Capitol,
Honolulu, HI 968 13

Re: HB 1788: Relating to Child and Maternal Death Reviews

Dear Representatives au Belatti, Creagan and Committee Members

As President of the Hawaii Association for Infant Mental Health, I am testifying in strong support of HB 1788.

With every year that passes, many families within the State of Hawaii experience traumatic losses through child and maternal deaths. It is reported that more than 1,700 children in the US die of child abuse and neglect each year, and the actual number of abuse and neglect deaths is estimated to be much higher than that reported by vital statistics data (www.childdeathreview.org January, 2016). Additionally, according to a CNN reporter, the rate of US women dying due to pregnancy and childbirth more than doubled in the past 25 years, per the Centers for Disease Control (Wallace, December 2015). It is because of these statistics, that the need appropriate funding to reinstate Hawaii's Child Death Reviews and establish a Maternal Death Review is an ethical imperative.

Having participated in several Child Death Reviews in the early 2000's, I have become a strong advocate for the process. Having an opportunity to bring professionals that have had a vested interest at some level with the affected child is crucial in the analysis of the preexisting factors that lead to the child's death. It helps providers in all capacities learn from past events, and work toward making changes to our systems, policies, and practices so we may instill hope that Hawaii's most vulnerable are protected and the risk of further child deaths are reduced or eliminated.

I have over 15 years of Early Intervention experience providing everything from direct service practice to program implementation and leadership. I have a great understanding for the risks that our mothers face during their prenatal months and throughout the first year postnatal. If there is ever a way to prevent maternal deaths through understanding past deaths, then we should consider it a high priority within our State.

Both the Child and Maternal Death Review process provides a rare opportunity for health and social service providers, and community members to learn from a tragic and in some cases a preventable death. We have an opportunity to learn from our past to improve the quality of services and ensure no mother or child has to live without the other whenever preventable.

President

Joey Keahiolalo

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Taba

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Leilani Kahoano

Chris Jackson

Jodi Johnson

Linda Rich

Mahalo for the opportunity to testify in strong support for HB 1788.

Sincerely,

A handwritten signature in black ink that reads "Joey Keahiolalo". The signature is written in a cursive style with a large, stylized initial 'J'.

Joey Keahiolalo, President



Friday, February 10, 2016, 8:30 AM
Conference Room 329

healthy
mothers
healthy
babies
COALITION
OF HAWAII

TO: House Committee on Health
Representative Della Au Belatti, Chair
Representative Richard P. Creagan, Vice Chair

FROM: Lisa Kimura, Executive Director, Healthy Mothers Healthy Babies Coalition of Hawaii

RE: HB1788 - RELATING TO CHILD AND MATERNAL DEATH REVIEWS

POSITION: Strongly Support HB 1788

Dear Chair Belatti, Vice Chair Creagan, and Committee Members:

A woman should not have to fear for her life in the event of childbirth. As the leader of a maternal health organization who cares and advocates for pregnant women and new mothers, **we strongly support HB 1788**, establishing a Hawaii Maternal Mortality Review Panel to perform comprehensive reviews of Hawaii maternal deaths and an appropriation to the Department of Health to reinstate Child Death Reviews.

Whereas the CDC, American Congress of Obstetricians and Gynecologists, World Health Organization, Association of Maternal & Child Health Programs, and many other organizations strongly recommend that all states have a formal review process of maternal deaths to decrease maternal mortality and morbidity, Hawaii does not review maternal deaths. Additionally, the lack of data from child death reviews in our state since 2013 has left a large void in our understanding of the contributing causes of preventable infant and child deaths.

We need to be able to evaluate and work to improve our rates of maternal and child deaths, as an established maternal mortality review will have the ability to make a sizable impact on standards of care and prevention efforts.

Maternal mortality reviews highlight possible areas for system improvements and changes that can lead to better pregnancy care for all women and have been proven to work in other states and countries. Hawaii's maternal death rate is comparable to the overall US rate, but unfortunately, the United States is the only developed country with an increasing maternal death rate.

Taking steps to evaluate the causes and implement steps to prevent the incidence of maternal death is vital to our health system of care. Please support Hawaii's women and keiki with this bill.

Thank you for the opportunity to submit testimony on this important women's health issue.

310 Paoakalani Ave., Suite 202A, Honolulu, Hawaii 96815
(808) 737-5805 lisak@hmhb-hawaii.org www.hmhb-hawaii.org



DATE: February 10, 2016

TO: The Honorable Della Au Belatti, Chair
The Honorable Richard Creagan, Vice Chair
House Committee on Health

FROM: The Kapi'olani Child Protection Center
A Program of Kapi'olani Medical Center for Women and Children

RE: Testimony in Strong Support of H.B. 1788
Relating to Child and Maternal Death Reviews

Good morning Chair Au Belatti, Vice Chair Creagan, and members of the House Committee on Health.

The Kapiolani Child Protection Center (KCPC) strongly supports H.B. 1788, which appropriates funds to the Department of Health to conduct child death reviews and implement a program to perform maternal death reviews, and further requires the Department of Health to submit an annual report to the legislature relating to child and maternal deaths and death reviews in the State.

Child and Maternal Death Reviews are processes in which multidisciplinary teams of professionals meet to share, discuss, and analyze case information on deaths in order to understand how and why children and mothers die, and make recommendations to prevent future deaths through well-informed, effective public policies and programs. These processes recognize that the deaths of children and mothers are sentinel events, and proper investigation can save lives as well as help to avoid severe non-lethal injury and life-long disability in the many other cases where would-be causes of death result in "near misses."

Conducting Child Death Reviews (CDR) is a nationally recognized best practice for approaching important child health issues, and programs for their consistent performance have been established in every state and the District of Columbia. Presently, Hawaii is the only state in which such reviews are not currently occurring on a regular basis in order to identify preventable deaths and their specific causes, and develop countermeasures. This is deeply troubling, given that as many as 75% of child deaths from external causes in Hawaii are likely preventable, and the fact that an average of 170 child deaths are occurring in Hawaii each year.

Act 369, Session Laws of Hawai'i 1997, granted the Department of Health the authority to conduct CDR, and reports were generated covering all child deaths in the State between 1996 and 2006. However, despite achieving such successes as initiating safe sleep requirements for licensed childcare providers and assisting in the development of a state plan for suicide prevention, the program lapsed in 2013. The last report was published in December 2011 and covered child deaths from 2001 through 2006.

This represents a significant deficit in Hawaii's understanding of what has been killing and injuring our children and young people for the past decade, and lost opportunities to design

programs to prevent deaths and serious harm from a range of sources, including but not limited to child abuse, unsafe sleep practices, drowning, and other emerging health and safety issues.

Likewise, Hawaii is one of only 13 states that are not currently conducting Maternal Death Reviews (MDR) for women who pass away during pregnancy or in the year following pregnancy, even though such maternal mortality is increasing nationwide and it is recognized that up to 50% of maternal deaths are preventable. In Hawaii, approximately 9 maternal deaths are identified each year, corresponding to an average of 19,000 births per year. Unfortunately, it is our understanding that although Hawaii law authorizes the performance of MDRs and Hawaii once possessed a program to conduct such reviews, that program has also been long defunct.

H.B. 1788 would allow the Department of Health to establish a funded unit with its Maternal and Child Health Branch to ensure the ongoing performance of maternal and child death reviews through a sustainable program, while keeping the Legislature and the public reasonably informed of the unit's activities and the progress of the review processes.

Moreover, it is our understanding, based on ongoing discussions with Department of Health personnel and other agency and community stakeholders, that the combined child and maternal death review unit envisioned by H.B. 1788 makes sense for several important reasons. Many factors responsible for infant death and serious injury are shared with maternal mortality, and so there is subject matter overlap between the two review processes. Moreover, coordination and medical abstracting skills and knowledge can be cross applied to both types of death review; there is overlap between the internal Department of Health and other state agency resources which would likely be called upon for consultation and assistance in both processes; and the number of maternal deaths (about 9 per year) relative to child deaths (about 170 per year) supports establishing and sustaining a shared unit that is empowered to organize the performance of both review processes.

With the resumption of consistent, comprehensive multidisciplinary reviews of child and maternal deaths, Hawaii will be empowered to make well-informed, responsible decisions regarding how to allocate limited resources and create effective programs, treatment protocols, education campaigns, and standardized care. Over time, this will accomplish the ultimate goal of meaningfully reducing child and maternal deaths in our state.

Therefore, we respectfully urge you to join us in strongly supporting H.B. 1788.

**American Congress of Obstetricians and
Gynecologists
District VIII, Hawaii (Guam & American Samoa)
Section**

Greigh Hirata, MD, FACOG, Chair
94-235 Hanawai Circle, #1B
Waipahu, Hawaii 96797



To: House Committee on Health
Representative Della Belatti, Chair
Representative Richard Creagan, Vice Chair

DATE: Wednesday, February 10, 2016
TIME: 8:30 A.M.
PLACE: Conference Room 329

FROM: Hawaii Section, ACOG
Dr. Greigh Hirata, MD, FACOG, Chair
Dr. Jennifer Salcedo, MD, MPH, MPP, FACOG, Vice-Chair
Lauren Zirbel, Community and Government Relations

Re: HB1788 Relating to Child and Maternal Death Reviews

Position: Strongly Support

Dear Representatives Belatti, Creagan and Committee Members:

The American Congress of Obstetricians and Gynecologists, Hawaii Section (Hawaii ACOG) strongly supports the establishment of a Hawaii Maternal Mortality Review Panel as well as the reinstatement of Child Death Review to conduct comprehensive, multidisciplinary reviews of maternal and child deaths towards improving maternal-child health in our state. Deaths of a child or a pregnant woman are sentinel events that require proper investigations to understand the underlying causes and opportunities for prevention. The mortality reviews identify missed opportunities and remediable factors in cases of child and maternal deaths.

There currently is **no allocation of resources** to ensure the ongoing conduct of maternal and child death reviews. **Establishment of a permanently funded unit within the MCH Branch at the DOH addresses program sustainability. Many factors responsible for infant mortality are shared with maternal mortality.** These include socio-environmental factors, appropriate accessing of medical care and timely response by the healthcare system. In addition there is considerable overlap in the methodologies for determining factors contributing to deaths and preventability. **It just makes sense to combine resources for**

theses reviews. The Hawaii State Department of Health (DOH) is supportive of this legislation.

Hawaii is one of only 13 states without a multi-disciplinary professional panel to review pregnancy-related deaths. There are approximately 10 maternal deaths annually in the state of Hawaii. Maternal mortality rates are increasing and up to 50% of all maternal deaths may be preventable. **We know that review panels work: unlike overall United States data with rising maternal death rates, the United Kingdom and the state of California have decreased their maternal mortality** by instituting programs aimed at preventable causes of death. Findings from review panels guide the creation of treatment protocols, education campaigns and standardization of pregnancy care.

Hawaii, as of 2013, is one of only two states not conducting child death reviews. Previous reviews have found that up to 75% of child deaths in Hawaii were preventable. There are approximately 170 child deaths per year in the state of Hawaii. A series of recommendations from prior Child Death Reviews launched policy changes in licensed daycares and stimulated public service campaigns directed at reducing sleep related deaths. This summer's series of infant deaths, with 7 being sleep related and another 5 also preventable, highlights the importance of ongoing surveillance and active responses to minimize preventable deaths.

The appropriation for core fatality unit staffing at the DOH is fundamental to ensuring the sustainability of child and maternal death reviews. The review panels for separate child and maternal death reviews will consist of voluntary expert members, allowing for significant in-kind support from health care providers and public health specialists.

Mahalo for the opportunity to testify, and for your support of Hawaii Maternal and Child Health.



Hawaii
Children's Action Network
Building a unified voice for Hawaii's children

February 10, 2016

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Address

850 Richards Street
Suite 201
Honolulu, HI
96813

P: (808) 531-5502

To: Rep. Della Au Belatti, Chair
Rep. Richard Creagan, Vice Chair
House Committee on Health

From: Deborah Zysman, Executive Director
Hawaii Children's Action Network

Re: **HB 1788 – Relating to Child and Maternal Death Reviews - Support
Hawaii State Capitol, Room 329 – February 9, 2016 – 8:30 AM**

On behalf of Hawaii Children's Action Network (HCAN), formerly Good Beginnings Alliance, we are writing in support of HB 1788, Relating to Health.

HCAN is committed to improving lives and being a strong voice advocating for Hawai'i's children. Last fall, HCAN convened input in person and online from more than 50 organizations and individuals that came forward to support or express interest for a number of issues affecting children and families in our state that resulted in the compilation of 2016 Hawai'i Children's Policy Agenda, which can be accessed at <http://www.hawaii-can.org/2016policyagenda>.

HB 1788 would authorize an appropriation for and resume child death reviews and establish a maternal death review program within the Department of Health (DOH) to provide annual report of child and maternal death reviews in the state.

Hawai'i is one of 13 states not conducting maternal mortality reviews; and as of 2013, is one of only two states not conducting Child Death Reviews. Up to 50 percent of maternal mortality is preventable and 75 percent of child deaths in Hawaii were found to be preventable.

The lack of mortality reviews for maternal and child deaths are missed opportunities to remedy the causes by taking preventative actions to educate our community. Securing data on the causes helps to address and prevent unnecessary deaths from happening.

For these reasons, HCAN respectfully requests that the committee vote to pass this bill.



February 10, 2016

To: Representative Della Au Belatti, Chair
Representative Richard Creagan, Vice Chair and
Members of the Committee on Health

From: Jeanne Y. Ohta, Co-Chair

RE: HB 1788 Relating to Child and Maternal Death Reviews
Hearing: Wednesday, February 10, 2016, 8:30 a.m., Room 329

The Hawaii State Democratic Caucus writes in support of HB 1788 Relating to Child and Maternal Death Reviews. Deaths of a child or a pregnant woman require proper investigations to understand the underlying causes and opportunities for prevention. The mortality reviews identify missed opportunities and remediable factors in cases of child and maternal deaths.

Hawaii is one of only 13 states without a multi-disciplinary professional panel to review pregnancy-related deaths. Maternal mortality rates are increasing and up to 50% of all maternal deaths may be preventable. We know that review panels work to reverse these bad outcomes.

The causes of maternal deaths are a public health issue. Taking steps to evaluate the causes and implement steps to prevent the incidence of maternal death is vital to our health system of care.

We respectfully request that the committee pass the bill and thank the committee for the opportunity to provide testimony.

Kelly Yamasato, MD
740 Sunset Avenue
Honolulu, HI 96816

To: House Committee on Health
Representative Della Belatti, Chair
Representative Richard Creagan, Vice Chair

DATE: Wednesday, February 10, 2016

TIME: 8:30 A.M.

PLACE: Conference Room 329

FROM: Kelly Yamasato, MD

Re: HB1788 Relating to Child and Maternal Death Reviews

Position: Strongly Support

Dear Representatives Bellati, Creagan and Committee Members:

As a provider of high-risk obstetrics and an advocate of maternal-child health, I strongly support the establishment of a Hawaii Maternal Mortality Review Panel as well as the reinstatement of Child Death Review to conduct comprehensive, multidisciplinary reviews of maternal and child deaths towards improving maternal-child health in our state. Deaths of a child or a pregnant woman are sentinel events that require proper investigations to understand the underlying causes and opportunities for prevention. The mortality reviews identify missed opportunities and remediable factors in cases of child and maternal deaths.

There currently is **no allocation of resources** to ensure the ongoing conduct of maternal and child death reviews. **Establishment of a permanently funded unit within the MCH Branch at the DOH addresses program sustainability. Many factors responsible for infant mortality are shared with maternal mortality.** These include socio-environmental factors, appropriate accessing of medical care and timely response by the healthcare system. In addition there is considerable overlap in the methodologies for determining factors contributing to deaths and preventability. **It just makes sense to combine resources for these reviews. The Hawaii State Department of Health (DOH) is supportive of this legislation.**

Hawaii is one of only 13 states without a multi-disciplinary professional panel to review pregnancy-related deaths. There are approximately 10 maternal deaths annually in the state of Hawaii. Maternal mortality rates are increasing and up to 50% of all maternal deaths may be preventable. **We know that review panels work: unlike overall United States data with rising maternal death rates, the**

United Kingdom and the state of California have decreased their maternal mortality by instituting programs aimed at preventable causes of death. Findings from review panels guide the creation of treatment protocols, education campaigns and standardization of pregnancy care.

Hawaii, as of 2013, is one of only two states not conducting child death reviews. Previous reviews have found that up to 75% of child deaths in Hawaii were preventable. There are approximately 170 child deaths per year in the state of Hawaii. A series of recommendations from prior Child Death Reviews launched policy changes in licensed daycares and stimulated public service campaigns directed at reducing sleep related deaths. This summer's series of infant deaths, with 7 being sleep related and another 5 also preventable, highlights the importance of ongoing surveillance and active responses to minimize preventable deaths.

The appropriation for core fatality unit staffing at the DOH is fundamental to ensuring the sustainability of child and maternal death reviews. The review panels for separate child and maternal death reviews will consist of voluntary expert members, allowing for significant in-kind support from health care providers and public health specialists.

Mahalo for the opportunity to testify, and for your support of Hawaii Maternal and Child Health.

Autumn Broady, MD, MPH
1259 Laukahi St.
Honolulu, HI 96821

To: House Committee on Health
Representative Della Belatti, Chair
Representative Richard Creagan, Vice Chair

DATE: Wednesday, February 10, 2016
TIME: 8:30 A.M.
PLACE: Conference Room 329

FROM: Autumn Broady, MD, MPH

Re: HB1788 Relating to Child and Maternal Death Reviews

Position: Strongly Support

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United Kingdom and the state of California have decreased their maternal mortality by instituting programs aimed at preventable causes of death. Findings from review panels guide the creation of treatment protocols, education campaigns and standardization of pregnancy care.

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The appropriation for core fatality unit staffing at the DOH is fundamental to ensuring the sustainability of child and maternal death reviews. The review panels for separate child and maternal death reviews will consist of voluntary expert members, allowing for significant in-kind support from health care providers and public health specialists.

Mahalo for the opportunity to testify, and for your support of Hawaii Maternal and Child Health.

Date: February 6, 2016

To: Representative Della Au Belatti, Chair

From: JoAnn Farnsworth
Farnsworth Consulting

Re: In support of **HB 1788**
Hearing: February 10, 2016

Chair Au Belatti, Vice Chair Creagan, Members of the Committees:

My name is JoAnn Farnsworth and I have worked in the field of child and maternal health for thirty years here in Hawaii and I am writing to express strong support for HB1788: Child and Maternal Death Review. Child and maternal death reviews should be part of every state's core public health function of assessment and improving health care access and quality. The purpose of reviewing pregnancy-related and child deaths is to gain insight into the medical and social factors that lead to these events in order to decrease such deaths in the future.

Passage of HB 1788 is critical for the following reasons:

- Deaths of a child or a pregnant woman are sentinel events that require proper investigations to understand the underlying causes and opportunities for prevention.
- Mortality reviews identify **missed opportunities** and **remediable factors** in cases of child and maternal deaths
- There is **no allocation of resources** to ensure the ongoing conduct of maternal and child death reviews. Establishment of a **permanently funded** unit within MCH, DOH to conduct regular reviews of all child and maternal deaths addresses sustainability.
- Many factors responsible for infant mortality are shared with maternal mortality. **It just makes sense to combine resources** for these reviews.
- Findings from review panels guide the creation of treatment protocols, education campaigns and standardization of care and will **reduce child and maternal deaths**.
- **Hawaii is one of only 13 states not conducting** maternal mortality reviews
 - Maternal mortality is **increasing**
 - Up to **50% of maternal mortality is preventable**
- There are approximately 10 maternal deaths/year in Hawaii; our state maternal death rate mirrors national rates
- **Hawaii**, as of 2013, is **one of only two states not conducting** Child Death Reviews
 - **75% of child deaths in Hawaii** were found to be **preventable**
 - There are approximately 170 child deaths/year in Hawaii

From: mailinglist@capitol.hawaii.gov
Sent: Friday, February 05, 2016 5:45 PM
To: HLTtestimony
Cc: joyamarshall0416@gmail.com
Subject: *Submitted testimony for HB1788 on Feb 10, 2016 08:30AM*

HB1788

Submitted on: 2/5/2016

Testimony for HLT on Feb 10, 2016 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Joy Marshall	Individual	Support	No

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 7, 2016

Representative Della Au Belatti

RE: HB1788

Aloha Chair Belatti and Health Committee members

My name is Momi Kamau. I retired from the Department of Health after 40 years of service in the Maternal and Child Health arena. During my employment with the Department, the Maternal and Child Health Branch oversaw a vibrant Child Death Review Program.

I am in strong support of HB1788. Fatality reviews are a core public health function and in fact are conducted by the majority of states across the nation. Hawaii is remiss, at present, in failing to provide this core public health function. Budget constraints have curtailed this critical maternal and child health service in Hawaii.

The death of a child or a pregnant or recently pregnant woman requires a proper investigation to understand and then determine the causes and circumstances surrounding the death and opportunities for intervention and prevention. It is the responsibility of the health agency to pursue these avenues to the fullest extent and then follow through with system improvements and preventive strategies. Fatality reviews are an integral part of the safety net system that protects our vulnerable women and children who are at greatest risk in society. It is notable that in Hawaii and nationally the reviews have found most of the deaths [that are reviewed] preventable. Deaths continue to occur here, especially in infants. These reviews may have provided information to prevent some of these deaths and future deaths.

The allocation of resources to a combined maternal and child death review will not only support program sustainability but strengthen efforts between two programs that share common factors, values and community goals. The insight gained from these reviews and the resultant actions benefit the community at large. Supporting HB1788 is the right thing to do.

Mahalo for the opportunity to address this critical issue.

