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Testimony on House Bill 2573

House Health and Human Services Committee

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February 12, 2018

Chair Hawkins and Members of the Committee, thank you for the opportunity to provide written testimony in support of HB 2573. As proposed, HB 2573 amends existing public health law (K.S.A. 65-177) as necessary to strengthen efforts related to monitoring maternal health including maternal and pregnancy-associated death.

Specifically, the bill grants the Department access to all necessary information to implement a comprehensive process to review each death and protects all people, records, and interviews obtained as part of each review. Additionally, the bill allows for routine compilation and wide distribution of aggregate, non-individually identifiable data to further the study of causes and problems associated with maternal deaths. This comprehensive process leads to informed, data-driven recommendations for actions that reduce death and support health and wellness during the pregnancy, childbirth, and postpartum periods.

Maternal mortality, defined as the death of a woman during pregnancy or within one year of the end of pregnancy, is considered a patient safety event that warrants close attention. Within the population of women of reproductive age, maternal mortality is an indicator monitored by the Department pursuant to K.S.A. 65-177. In 2016, there were 20 maternal and pregnancy-associated maternal deaths reported in Kansas, an increase of eight deaths compared to 2015 (Source: KDHE Bureau of Epidemiology & Public Health Informatics). Maternal mortality in the U.S. continues to increase, and there is not one known cause. Data from the Centers for Disease Control & Prevention (CDC) *Pregnancy Mortality Surveillance System* indicate that pregnancy-related mortality increased by 20% between 2000 and 2013. An increasing national and state trend in maternal mortality indicates the need to conduct maternal mortality review in order to gain insight into the medical and social factors leading to these events and to prevent future occurrences.

Approximately half of states in the U.S. have a comprehensive maternal mortality review process, the gold standard for maternal and pregnancy-associated death surveillance—Kansas aims to achieve the same. As part of the process, a review committee gathers extensive information about each individual case of maternal death and synthesizes information to determine if the death was preventable and what specific and feasible actions, if implemented or altered, might have changed the course of events. Committee membership includes a vast array of professionals and partners engaging with and serving women during pregnancy and the year postpartum. Collectively, they examine patient/family, community, provider, facility, and system factors that lead to a woman's death. More information about the state maternal mortality review process is available online at www.reviewtoaction.org.

Thank you for the opportunity to share the critical importance of this bill.