COUNCIL OF THE CITY OF PHILADELPHIA

COMMITTEE ON PUBLIC HEALTH AND HUMAN SERVICES

City Hall, Room 400
1400 John F. Kennedy Boulevard
Philadelphia, Pennsylvania 19107
Tuesday, October 15, 2019
2:00 p.m.

PRESENT:

COUNCILWOMAN CINDY BASS - CHAIR
COUNCILWOMAN MARIA D. QUINONES-SANCHEZ - VICE
COUNCILWOMAN BLONDELL REYNOLDS BROWN
COUNCILWOMAN HELEN GYM
COUNCILMAN WILLIAM K. GREENLEE
COUNCILMAN DEREK S. GREEN

RESOLUTIONS: 190040

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COUNCILWOMAN BASS: Good afternoon. Good afternoon. This hearing is called to order. This is the Public Hearing of the City Council Committee on Public Health and Human Services. The purpose of this meeting is to hear testimony on Resolution No. 190040. The Members of the Committee in attendance are myself and Councilman Bill Greenlee and we expect others to be joining us throughout the course of this hearing. And now if we could have the Clerk read the title of Resolution No. 190040.

THE CLERK: Authorizing the Committee on Public Health and Human Services to hold hearings on the increase in maternal mortality among African-American women in Philadelphia.

COUNCILWOMAN BASS: Okay. And we are going to have opening remarks from Councilman Greenlee.

COUNCILMAN GREENLEE: Thank you, Madam Chair. I just want to say I think this is an important hearing because I was one that did not know about this issue. I

remember many years ago the wife of one of the Philadelphia Flyer hockey players died in childbirth, and I thought that was so terribly rare. But I'm hearing among certain segments of our community, unfortunately it's not rare.

COUNCILWOMAN BASS: Right.

COUNCILMAN GREENLEE: So I think it's very important and I'm interested to hear some of the background on this. Thank you, Madam Chair.

COUNCILWOMAN BASS: Thank you. And if we could now have the first panel come forward to testify, if we could have the Clerk state the names of the first panel to testify.

THE CLERK: State Rep. Morgan Cephas.

COUNCILWOMAN BASS: Good afternoon, Representative.

MS. CEPHAS: Good afternoon. Long time no see.

COUNCILWOMAN BASS: I know. Five minutes ago. How are you?

MS. CEPHAS: I'm well.

COUNCILWOMAN BASS: If you can state your name for the record and begin your testimony.

MS. CEPHAS: Great. I am State Representative Morgan Cephas of the 192nd Legislative District. So I first want to thank the Committee, the Chairwoman and Councilman Greenlee for having a targeted conversation about an issue that's honestly plaguing the entire country, and we have a series of stakeholders here today that have been in this space longer than I have, so as elected officials we always like to lean on experts when it comes to this level of subject matter to come up with policy recommendations, legislative recommendations and just provide us answers from their perspective because they are on the ground as to what do we need to do on the local, state and federal level.

So again, I am State Representative Morgan Cephas and I serve the 192nd Legislative District in West Philadelphia. As we sit here today to address the daunting issue of maternal mortality, I want to tell

you about Ms. Lashana Gilmore, a 34-year-old woman from my District, who like too many women and far too many Black women died while giving birth just this past summer.

This past June, Lashana celebrated her 34th birthday and just over a month later on July 26th, this very healthy young woman went into labor. She made her way to the hospital to experience what was supposed to be a joyous occasion, the birth of her precious baby girl. But Lashana didn't survive the delivery.

Unfortunately, her story is just one of far too many tragic stories of women in Philadelphia and across our state and country who has succumbed to this crisis. Her death has especially left a void in the life of her now 2-month-old baby girl who must now go for a lifetime without her mother.

Lashan and many women -- Lashana and many women like her are more than a statistic. The harrowing reality is that she leaves behind a 10-year-old son and again a 2-month-old daughter. And

Mr. Edward Gilmore lost a daughter and Ms. Stephanie Gilmore lost a sister. Her family who joins us here today or will be joining us soon is a reminder of this reality and that we are far from any form of solution.

Our City, our state, our nation, our mothers, our families are in midst of crisis. This great nation of the United States has one of the highest maternal mortality rates in developed nations, higher than some undeveloped nations. The U.S. loses approximately 22 women per 100,000 live births each year, whereas neighboring Canada has a rate of 7 per 100,000.

In the U.S. the rates of maternal mortality are three times as higher for Black women as compared to White women. Maternal mortality disproportionately affects women of color even when controlling for factors of education and income levels. And I repeat that because often times when we're having this conversation, some people like to equate the statistics to the environment that that individual is living

in, but we know with listening to just the story of Serena Williams, who more than likely can afford better healthcare than all of us combined, still had challenges with her pregnancy.

The Centers for Disease Control and Prevention reports that 31 percent of the deaths with maternal mortality occur during pregnancy. 16 percent occur during the day of delivery and a majority, I repeat, a majority of the deaths happen during the postpartum period representing 51 percent of the deaths.

What we do know is that our mothers are dying again. We also know that Black women and women of color are at greater risk of maternal death regardless of education level and social economic status. Because of what we know, we must remain committed to addressing the core factors of this issue including the heart-wrenching racial disparities, implicit bias, mental health and substance abuse disorder and access to care.

Over the past several months in

conjunction with the Philadelphia Women's Commission with the leadership of our Executive Director, we've been able to have a series of panel discussions, we've hosted several Public Policy hearings, we've listed testimo -- we've listened to testimony from medical professionals, advocates, affected women, families, we've had conversations with all of the delivery hospitals in the City of Philadelphia and again, under the leadership of Jovida Hill from the Philadelphia Women's Commission, we've done so much to make sure that this issue is elevated, not just in the Commonwealth of Pennsylvania but specifically here in Philadelphia.

Alongside the many stakeholders, these efforts have led to securing millions of dollars in grants at both the local and state level. Just last month Governor Tom Wolf announced a CDC grant funding award for the Pennsylvania Maternal Mortality Review Committee which supports the Philadelphia Review Committee, and we were able to secure $2.25 million.

And last month I stood together with the Philadelphia Department of Health as they announced a million dollars in funding from the Merck Foundation for Mothers for the Maternal Mortality Review Committee in the City of Philadelphia, which I'm sure other representatives here will speak about today.

Now, the experts will talk to you about again the statistics. The advocates will tell you more about the disparities. The practitioners will provide insight as to what can be done better and the victims will share their tragic story. I am here to tell you that for us legislators and policymakers, the time is now to do that -- to do all that is in our power to save the lives of mothers and for the sake of our families.

Conversation after conversation leads us to the same recommendations. It's time for us to help move those recommendations in actions and results. Now again, I am not an elected official pointing the finger at another legislative body. But

one of the things that, you know, we immediately realized while we're up in Harrisburg is that we are in a little thing called the minority, and we are often times at the will of the majority. And when this is not a priority with -- when women of color are not a priority, when our mothers are not a priority, it often forces us and pushes us to look at our elected officials on the county level to see what is it that we can do here that will have an immediate impact on the individuals that we serve here in Philadelphia.

So with that, I come with recommendations of course. So one of those recommendations would be to require implicit bias and cultural competency training for all students in the medical schools in the City of Philadelphia and all students that access our hospitals in the City of Philadelphia to require that training.

The second piece, you know, if a budget always reflects a society's priorities so I'm going to lean into our budget season. So I would recommend to

create a line item for maternal mortality in the City budget to support local efforts and innovative strategies to combat maternal mortality and improve maternal health.

One of the things that was great about the grants that we did receive is that it'll go to our Review Committees, and the sole responsibility of the Review Committees, again which some of the experts will talk about later on, is to do research and to get a better understanding as to what is happening with our mothers and how can we fill the gaps and fill the challenges that exist with those dollars and with, you know, strategic thinking. But one thing that it often doesn't do is fund the actors that are on the ground trying to move the needle -- hi, Councilwoman, that are on the ground trying to move the needle in the populations that they serve.

So I look at a potential line item, a grant program possibly to go to organizations like Maternal Mortali -- I mean, not Maternal Mortality, like different organizations that you'll hear before this

Council and this body that have innovative strategies that they're implementing and they just need the resources on the order to scale. So like I meant the Maternity Care Coalition, some of the practices that they have.

The last piece I would always recommend is just to continuously ask the question what else can we do and how can we be creative in our responses. So I again thank this Legislative Body for taking up this issue. There is a report coming out that reflects our numbers here in the City of Philadelphia for maternal mortality, and I can tell you across Pennsylvania that our rates are increasing. And one of the newest issues -- well, not new, but one of the more prevalent issues in our rates now is substance abuse disorder. So when you think of the opioid crisis and how it's impacting our mothers, they are indeed impacted.

And some of the legislative pieces that we are considering up in Harrisburg, one is to expand Medicaid to cover up to a year postpartum. Right now it only covers

mothers that qualify for Medicaid that are pregnant up to six weeks right now, so we're asking for it to be covered up to a year.

The second piece is again similar to lawyers. They have continued legal education requirements, so we would add implicit bias training to continued medical professional educational requirements so that's a second piece. A third piece is to make maternal morbidity a reportable event. Right now it's just maternal mortality and far too many mothers are still having complications, and maternal morbidity is what essentially represents Serena Williams and her challenges that she had.

The last piece would be to ensure that doulas were both certified and able to be reimbursed by insurance companies as well as Medicaid. One of the things I'm a firm believer in is that if we expand the healthcare footprint to incorporate a lot more women into the healthcare profession, then I'm hoping that we can see a lot less deaths.

So I again thank you for having

this conversation. I look forward to any questions that you might have and again, how we can partner on a local and state level to really move this needle, not just in the Commonwealth of Pennsylvania but within Philadelphia as well. Thank you.

COUNCILWOMAN BASS: Thank you for your testimony. And I want to take a moment and recognize the presence of Councilwoman Maria Quinones-Sanchez and also Councilwoman Blondell Reynolds Brown. And just listening to your testimony, the information that you provided about -- Lashana?

MS. CEPHAS: Yes, Lashana.

COUNCILWOMAN BASS: Lashana, really took me back and reminded me of my own experience during childbirth. And as a woman of color here in Philadelphia who had access to excellent medical care and who had prenatal care, still I found myself in a very scary situation in having preeclampsia.

And it's funny because I heard recently in the last few months or so that Beyonce had preeclampsia as well. It's like everybody wants to be like Beyonce except in

that way. Nobody wants to have preeclampsia. What a horrifying and terrible experience it really was. And, you know, just thinking fast-forward, the moment when I realized -- just going backwards, the moment that I realized that this is something that I might not be here. I just gave birth to a baby and I might not be here to care for that child and how incredibly frightening the very prospect is. And it doesn't help when preeclampsia is related to blood pressure and you are, you know, so in deep worry about your future, that does not help your blood pressure. And so this is a very important issue.

I just thank God that I had excellent medical care from the folks down at Pennsylvania Hospital, but I also recognize that even with that excellent health care there are still a lot of women of color who are still very much adversely affected and who are not being able to pull through. And we need to ask ourselves why, why is this happening. So I want to thank you for your testimony and open it up. Did

anyone else have questions?

Okay, no. Well, thank you very much for your testimony. And we can have the clerk call the next panel.

THE CLERK: Edward Gilmore?

(No response.)

COUNCILWOMAN BASS: Okay.

THE CLERK: Okay. Dr. Wadia Mulla, Dr. Aasta Mehta, Dr. David Jaspan?

(Panel approaches Witness Table.)

COUNCILWOMAN BASS: Good afternoon.

MS. MULLA: Good afternoon.

COUNCILWOMAN BASS: Please state your names for the record and begin your testimony.

MS. MULLA: I'm Dr. Wadia Mulla.

COUNCILWOMAN BASS: Please begin your testimony.

MS. MULLA: Good afternoon, Chairwoman Bass, Members of the Public Health and Human Services Committee. Thank for inviting me to testify on this very important issue of maternal mortality inforence of Resolution No. 190040.

I am an obstetrician and

gynecologist and Medical Director of Obstetrics at Temple University Hospital. I serve as an associate professor of OB/GYN at the Lewis Katz School of Medicine. As you know, Temple University Hospital and the Lewis Katz School of Medicine are located in North Philadelphia in some of the most socially economically-challenged areas in the City of Philadelphia and Commonwealth of Pennsylvania.

In turn, this leads to challenging comorbidities in health care that can lead to mortality. Additionally, our episcopal campus treats many opioid overdoses daily and is located in the community with the highest opioid mortality rate in the City. As a result of the socioeconomic medical challenges many of our obstetrical patients face, they are at a significantly increased risk for maternal mortality.

Medically, the highest rates of maternal mortality are caused by cardiovascular disease, hypertensive disease, thromboembolic events and sepsis. These issues are being addressed by

national, state and local guidelines for emergent treatments and continued care. Participation in the Pennsylvania Perinatal Quality Collaborative strengthen these protocols to provide guidance, education and further treat and prevent medical issues. However, there are many comorbidities such as obesity and diabetes that directly contribute to maternal mortality that are not always addressed by these initiatives.

Access to nutrition services, affordable healthy food options and -- food options and diabetes and overall health literacy education in Philadelphia must be improved. Residents also need access to latest technologies for hypertension and diabetes management which have been proven to reduce morbidity and cost.

In addition to the cost of many medications, in particular insulin can be prohibited for patients who are un and underinsured. Providing additional funding for these initiatives will help to decrease morbidity or mortality in Philadelphia mothers and other residents. The opioid

crisis is also associated with the highest mortality rate in the City.

As I said earlier, our episcopal campus is located in the center of the crisis. To address this issue, Temple Health has worked diligently to establish a multi-prong and integrated approach to substance use disorder, treatment and education. The multi-disciplinary task force have come together to offer medication and treatment and counseling to prevent a one-side-fits-all approach to addressing this complex public health crisis.

Continued support for these programs is necessary to address not only opioid crisis but other substance disease disorders involving substance including things like PCP, cocaine and methamphetamine which are commonly seen at Temple University Hospital.

And when these are not addressed, patients often leave the hospital and they start a downward spiral which will frequently end in maternal mortality or death. Additionally, however there's also

no well-defined risk that accounts for the increased rate of maternal mortality among African-American women including those who are not disadvantaged socio-economically. This may be due to an overall stress women of color experience throughout their lives.

Studies have shown adverse childhood experience or ACE scores are higher among the communities surrounding Temple University Hospital than any other area in the City as well as for women of diverse racial backgrounds. As such, adverse childhood experience affects all aspects of care we provide.

Evaluation of an ACE score, the Temple University Office of Diversity has started programs to evaluate ACE scores that implement trauma-informed care. Dr. Kathy Reeves is set to discuss this later in the hearing. As a result of childhood trauma, mistrust of traditional medical services, lack of childcare, transportation and the daily stress of life, many barriers to maternal health care and education in Philadelphia. It is clear that additional

maternal health services are needed throughout the City to build trust and break down barriers. This includes the investment in community health workers, patient-centered obstetrical care and continuation of Medicare for women beyond the postpartum period as just a start to prevent mortality.

We appreciate City Council's commitment to addressing maternal mortality among our patients we serve. We again thank you for holding this hearing to discuss this important issue and I am happy to answer any questions you might have.

COUNCILWOMAN BASS: Thank you. We're going to hold the questions until the entire panel has testified. Thank you for your testimony. And if we could have the next speaker, state your name for the record and begin.

MS. MEHTA: Dr. Aasta Mehta. Good afternoon, Chairwoman Bass and the Public Health and Human Services Committee. I am Dr. Aasta Mehta, Women's Health Policy Advisor for the Philadelphia Department of

Public Health and a practicing OB/GYN in Philadelphia.

In this role, I serve as the co-facilitator for the Philadelphia Maternal Mortality Review Team. I'm a member of the Pennsylvania Maternal Mortality Review Team and I'm the Policy Chair for the Pennsylvania Perinatal Quality Care Collaborative.

Thank you for the opportunity to provide testimony for Resolution No. 190040 which authorizes Council's hearing on the increase on maternal mortality among African-American women in Philadelphia. The rate of pregnancy-related mortality in the United States has more than doubled in the past 30 years.

The City of Philadelphia has seen an increase in maternal mortality that follows these national trends. In order to address this, the Philadelphia Department of Public Health Medical Examiner's Office and the Greater Philadelphia maternal health community created the first county level Maternal Mortality Review Team in the United

States in 2010.

The Maternal Mortality Review Team brought together six labor and delivery hospitals in the City, now there are five with the closure of Hahnemann University Hospital, along with City-based agencies and non-governmental organizations to develop a more accurate method of identifying and tracking the number of pregnancy-related and pregnancy-associated deaths.

As Representative Morgan Cephas already defined, a pregnancy-related death is defined as a death which occurs during or within one year of the end of the pregnancy from any cause related or aggravated by the pregnancy or its management. A pregnancy-associated death is one that occurs during that same time period regardless of cause.

The multi-disciplinary review of each case helps identify the systematic shortfalls that women of childbearing age face and gaps in community resources. In turn, the review process helps focus limited resources to address these issues in hopes of reducing pregnancy-associated deaths and

improving the overall health and well-being of all women of childbearing ages.

Over the course of over 30 meetings, the Philadelphia Maternal Mortality Review Team has gained knowledge and insight about maternal morbidity and mortality by reviewing over 200 pregnancy-associated deaths of Philadelphia residents. Based on aggravated surveillance data from deaths that occurred from 2010 to 2018, and all of these are preliminary numbers, 30 percent of these deaths were categorized as pregnancy-related.

Of the pregnancy-related deaths, 40 percent were attributed to cardiomyopathies or other cardiovascular conditions, 25 percent to embolisms, 15 percent to infection and 10 percent to hemorrhage. Black non-Hispanic women account for 41 percent of Philadelphian women of childbearing age and White non-Hispanic account for 35 percent. However, Black non-Hispanic women have accounted for 75 percent of Philadelphia's pregnancy-related deaths from 2010 to 2018. While White

non-Hispanic women have accounted for 15 percent.

The Philadelphia maternal mortality data set has thus far revealed that 40 percent of all reviewed deaths had a diagnosis of mental health history and 60 percent have had a previous and/or current substance use disorder. Overdose-related deaths, which have risen dramatically in Philadelphia's general population, has likewise risen rapidly among pregnancy and postpartum women, whereas 25 percent of reviewed maternal deaths between 2010 and 2016 were due to accidental drug intoxications. That percentage has increased to 38 percent of reviewed maternal deaths from 2017 and '18.

The Philadelphia Maternal Mortality Review Team released its first City-wide surveillance report in 2015. The report documented Philadelphia's significant maternal health challenges and included evidence-informed recommendations to reduce maternal deaths and methods to track progress.

While there is no formal system in place to move these recommendations forward, the Maternal Mortality Review Team, the Maternal Health Partners develop collaborative teams to begin addressing recommendations. Successes include the creation of a centralized referral system for home visiting services which is currently in its implementation phase, a prenatal lab-sharing agreement to facilitate health information exchange among all delivery hospitals, Medicaid reimbursement for immediate postpartum long-acting reversible contraception and a City-wide educational program focused on screening, brief intervention and referral to treatment for substance use disorder in pregnancy. Though progress has been made, more investment is needed to scale up and develop innovative interventions to improve the way in which women are cared for during pregnancy and after they give birth.

The Philadelphia Maternal Mortality Review Team in collaboration with the Health Federation of Philadelphia applied for and

recently received funding from the Merck for Mothers Safer Childbirth Cities initiative. The funding support will allow the Maternal Mortality Review Team along with its partners to more effectively implement evidence-informed interventions to strengthen surveillance and reporting, improve clinical care, integrate community voices in developing innovative solutions, address racial disparities and maternal health outcomes and increase community-based support for childbearing women through development of a Community Action Team.

This team will implement formal initiatives that specifically address maternal mortality-related identified contributors to maternal mortality in Philadelphia. Cardiovascular disorders and drug overdoses as well as poor case coordination of prenatal and postnatal care among perinatal providers and associated social service agencies. In particular, this team will focus on activities that aim to reduce significant rate of racial disparities and maternal mortality. Thank

you very much for the opportunity to address you today. I am happy to answer any questions you may have.

COUNCILWOMAN BASS: Thank you for your testimony and for the numbers. They really do -- they're very jolting to hear the numbers, but we're going to hold questions for just a moment. And if you can state your name for the record and begin with your testimony, sir.

MR. JASPAN: My name is Dr. David Jaspan. I am the Chairman for the Einstein Healthcare Network for Obstetrics and Gynecology and, Council, it is a pleasure to be here today and represent Einstein and the people that we serve. Many things were said today prior to myself sitting here and I want to echo the request and ask of Representative Cephas.

It's not that we don't know what is going on and it's not as if we don't want to help. We are handcuffed and our patients have to navigate obstacles that are seemingly impossible. Though there's legislation to allow patients to access

health insurance, navigating the opportunities to achieve health insurance are vast, difficult and cumbersome.

When asked why didn't you get insurance, I couldn't get a day off from work, I had to stand in this line, I needed this piece of paper, the doctor wouldn't fill this out. It seems that insurance is available, it is. But obtaining the insurance is very difficult. And then you have patients who maybe suffer from health literacy that is our responsibility navigating a system that I personally would have struggled to navigate, and then they're labeled as no prenatal care and they're stigmatized because they didn't care about their pregnancy. And when asked, that is absolutely not the case. The case is I had children at home, I couldn't get there, I couldn't get through the system. And that's honestly where it starts but it doesn't end there.

We know intimate partner violence is a major contributor to the fault of our society. But to young women of color who

are pregnant, we see it every day. And the sad part is because of concerns that they have, how they may be perceived, they say, oh, I fell down the stairs; oh, I tripped on the curb. It's our responsibility to dig deeper and find solutions.

The problem that we have is when we find the solutions, the opportunities for intervention for intimate partner violence are limited at best and certainly not reimbursed. So we must rely on grants, philanthropy or just doing the right thing to help patients. We at Einstein deliver 3,000 babies a year.

The statistics will tell us in urban settings, no different than my colleagues here, more than 50 percent of those patients suffer from some form of intimate partner violence. We have one counselor three days a week. Not enough, not enough. Why do we have one counselor three days a week? It's funding. It's services. It's people going into the field. We lack the support to care for the patients.

Same can be said for substance abuse. We know the patient suffers from substance abuse. They want help. Where they can turn for help? There's nowhere to turn. There are limited resources. They have psychiatric disorders. They know they have psychiatric disorders. We know they have psychiatric disorders. We know what medications they need. We are obstetrician gynecologists. We're not psychiatrists. Trying to get an appointment with a mental health physician in this City no matter what your insurance is, is at minimum a three-week wait. Oh, but you can go to the crisis center and be seen immediately. No one wants to do that and that's not a reason to go to a crisis center, and that would further put delays on patients who actually need to be in the crisis center.

Einstein has one of the lowest rates of maternal mortality in the entire country, and it is not because we have different drugs or different surgery. It's because we have taken the time, like my colleagues here, to invest in the resources

that are needed to identify the social disparities of health and address them immediately. It's because we have taken the opportunities to change how we train the residents.

You don't say to a patient, you don't have chest pain, do you? Because what is she going to say, yes, I do? She thinks that you want her to say no. Well, you can't ask the question that way because you won't identify the problem. We have to be able to teach our patients how they can be self-advocates for their own health care and health care of their families. We want them to learn how to navigate the system.

The question that we are here to ask is how can we partner together to move the process forward, to educate patients, to improve healthcare literacy to allow them to advocate for themselves, much like you probably did when you were preeclampsic, and certainly like Serena did when she said, hey, I have chest pain. And they said, you're fine. And she said, no, I'm not. Serena Williams can do that. Our patients

are scared to do that because they don't think they'll be heard.

People often say and the literature supports we should have providers who look like the patients they care for and we need to do a much better job at a medical school level, at a college level of enabling people who look like the people they're going to care for to enter the medical field. It may be as a doula, a midwife, an advanced practice provider or a physician, all are important. It's a healthcare team. But we're not going to solve this by changing one thing or a small little item over here. This is a cataclysmic change. It has to change the medical culture and the people that we care for. Thank you.

COUNCILWOMAN BASS: Well, thank you for your testimony. I agree with you. I think there has to be a real culture shift in terms of the way we approach health care, particularly when it comes to women of color and women of color who are living below the poverty line and who are really struggling and who needs someone to advocate on their

behalf, and we are their advocates.

We stand just as people who are interested. Whether you're a woman of color or not, we have to stand and to say that we are very interested and concerned about what is happening to all of the women in the City of Philadelphia, and I certainly do appreciate that Einstein has done this work and you have really put yourselves out there in terms of making sure that you have a lower rate of maternal mortality.

One of the things that I notice as the Chair in Health and Human Services for Council is as I visit health institutions here in the City of Philadelphia, different hospitals, I noticed that when I went to, I think it was Fox Chase Cancer Center and we had a round table discussion and we were talking about cancer and particularly among the African-American community, and one of the things that I've learned is that there's only about 3 percent of cancer research that is dedicated towards to African-Americans and why is it that cancer is so much more aggressive within African-Americans.

So when you look at that and take that statistic and that information and you look across the board at the other things that affect the African-American community and the Hispanic community, health-wise you have to look at those things and say across the board what is the amount of research and work that is going to affect this issue across the board. So I just say that to thank all of you for the work that you're doing and being vigilant and steadfast on this issue. Thank you so much.

Councilwoman Sanchez?

COUNCILWOMAN QUINONES-SANCHEZ: Thank you, and I want to take a moment and thank Representative Morgan Cephas for her work in this in understanding that there was a role both at the City and state level, so congrats on a conversation. And I know Councilwoman Blondell Reynolds Brown would say it's a long journey on some of these issues, but if you stay focused and steadfast we can get some work done.

One of a couple of questions: Who is the Philadelphia Maternal Mortality Team?

(Panel member raised hand.)
COUNCILWOMAN QUINONES-SANCHEZ: Can you speak to its diversity on some of the issues that are being highlighted here?
MS. MEHTA: Sure. So it's a multi-diversity team. Dr. Mulla actually sits on it. It's a number of different stakeholders from community-based organizations as well as representatives from different areas of the -- both Health Department, we have people from insurance companies that are represented there, we have doctors, midwives and not just OB/GYNs, but we have cardiologists on the team, critical care physicians so mostly concerning the medical community as well as --
COUNCILWOMAN QUINONES-SANCHEZ: Is it diverse? One of the issues we're talking about --
MS. MEHTA: Oh, yes.
COUNCILWOMAN QUINONES-SANCHEZ: -- is people of color.
MS. MEHTA: It is diverse, yes.
COUNCILWOMAN QUINONES-SANCHEZ: Are

there women who have lived-experience who are participating in this process?

MS. MEHTA: Not directly, no. Not in the review process.

COUNCILWOMAN QUINONES-SANCHEZ: Okay. Let me strongly encourage you to include some of the women who have this experience. I think one of the things that we've learned, when you hear some of these terms, evidence-informed interventions, when you hear about best practices going back to what Councilwoman Bass was saying, study by whom for whom, right.

And I think it's hugely important that I'm strongly encouraged by how you've outlined and articulated what the goal of the Community Action Team is, but I strongly encourage you from day one to have the women who experience, are there doulas involved, are there some of the midwives, there's some cultural aspects to childbirth, are those voices being heard because we have such a growing immigrant community with different practices, right?

MS. MEHTA: Yeah, that's already

being considered and we'll be honoring that definitely.

COUNCILWOMAN QUINONES-SANCHEZ: Okay. So operationalize for me what this Community Action Team will be doing.

MS. MEHTA: So I outlined in my testimony, we have specific initiatives that are already happening in the City and so some of the funding will be -- the funding that we'll receive from Merck will be to bolster already-existing initiatives and some of the funding will go towards actually creating this Action Team, the leadership structure, the government structure as well as assisting ability piece of it, so that after the funding is gone we can still continue the work and --

COUNCILWOMAN QUINONES-SANCHEZ: So every woman who is pregnant who uses our health center, how will they will be touched by this Action Team?

MS. MEHTA: Oh, so you mean every woman that is pregnant that gets prenatal care?

COUNCILWOMAN QUINONES-SANCHEZ: So

what's your touch points with women? I want to know how are we going to use this as a touch point.

MS. MEHTA: So this Action Team is really the action arm of the Review Team. So let's say the Review Team reviews cases that come up with recommendations. In the past, these recommendations were hoping that an advocate or somebody that's already working in the community will take that up and do that. So this will more structuralize it. So we'll say, okay, these are the things that are going on right now. How can we move forward these recommendations in a more streamlined fashion. So people on this Action Team will be already members, community members that are working, you know, in these different aspects.

So if we're thinking about prenatal care, we already have a collaborative of all of the labor and delivery hospitals that meet monthly, as the leadership -- the nursing leadership as well as the physician leadership of each of the hospitals, so

they're going to be represented on the team. We're going to have insurance companies being represented on the team so looking at both aspects when it comes specifically to medical care, if that's what you're asking, a touch point to prenatal care.

COUNCILWOMAN QUINONES-SANCHEZ: I'm always concerned with these studies because they stay up here and I'm --

MS. MEHTA: So this is not -- this is not a study.

COUNCILWOMAN QUINONES-SANCHEZ: -- trying to get down to here.

MS. MEHTA: This is a we know what's happening and now we're going to --

COUNCILWOMAN QUINONES-SANCHEZ: So operationalize it for me. What does this look like? What does this mean to pregnant women of color? Is it the women who are in our health centers? Is it --

MS. MEHTA: So the funding is going to go towards increasing doula access in the City.

COUNCILWOMAN QUINONES-SANCHEZ: Okay.

MS. MEHTA: It's going to go towards increasing access to family planning service with women with substance use disorder. We're also going to be developing a model to implement screening brief intervention and referral to treatment that hospital systems can then easily implement, whether it's in the prenatal care side of it, whether it's in the hospital so that we're catching these women that have substance use disorder earlier.

We're also going to be do implicit bias training to our maternal health community. It starts with the residents in the hospitals as all the physicians and nursing leadership or not leader -- nurses that are on the ground as well as implicit bias training for community-based organizations if they've not yet done so. So those are three -- there's going to be more.

Oh, and then one of the bigger ones is as I alluded to, our pregnancy-related mortality when it comes to -- is the highest causes of cardiovascular disorders. So Penn

Medicine actually made an app called Heart Safe Motherhood and we've been implementing that in our health system for over a year, and it's shown to improve hypertension or high blood pressure surveillance in the immediate postpartum period. So basically it's this interactive app that women that are qualified are enrolled in the program and then they sort of talk with this app and they text in their blood pressures. And if it's out of a range that's within normal, then they get that number directly to a high risk physician who will then talk to that patient directly and manage that, so the outcomes of that.

So traditionally prior to this app, people that are diagnosed with high blood pressure in pregnancy or in the immediate postpartum period we recommend to come back in like two days or a week for a blood pressure check and that blood pressure check visit is very unattended, so less than 20 -- less than 30 percent of people really attend that. So our data has shown that with this app more than 90 percent of the people are

engaged and the disparities that we were noticing with the blood pressure postvisit has gone down to 0, so everybody is engaged whether --

COUNCILWOMAN QUINONES-SANCHEZ: We alluded -- and I'm glad to hear that. Again, I'm interested in how we change people's lives and behaviors in preventive medicine, and I had this conversation with Bill Ryan the other day because Einstein has become an important place for some of our opioid work and addiction.

We've mentioned Hahnemann closing, less hospitals who are going to be doing this work. What, if anything, are we doing to accommodate how folks are going to move within the -- what is it, six hospitals left?

MS. MEHTA: Five.

COUNCILWOMAN QUINONES-SANCHEZ: Five who are going to be doing this, how is that being looked at as it relates to this reality, because Hahnemann was the drop-in for a lot of folks for its location?

MS. MEHTA: Yeah. So I trained at

Hahnemann so I'm very familiar with Hahnemann. So we as a collaborative -- so again, Wadia sits on this collaborative as well, the Labor and Delivery Leadership Group as well as all the Chairs were very collegial. Once we knew that Hahnemann was closing, the whole -- all of OB Leadership met with the Health Department and we came together and decided how patients were going to be diverted, what was going to happen in the interim in regards to exchange of information like health information, slots were opened up at all the other hospitals for prenatal care and, you know, we just sort of like an open communication about how that was going to work.

A lot of those patients because of the generosity of Jefferson, they -- a lot of them were rooted to Jefferson for care and Jefferson also was able to get emergency privileges for the doctors and the midwives that worked at Hahnemann to get privileges there so that they could be continuity of care for the patients that were going to be immediately delivering.

COUNCILWOMAN QUINONES-SANCHEZ: And how was this being communicated to the patients?

MS. MEHTA: So through Hahnemann will -- Drexel and Hahnemann sent that information to their patients. I can't speak specifically to that as I'm not part of that organization, but that is my understanding.

MS. MULLA: Temple has also put out an outreach out to reach out to the patients at the health districts. We've provided additional appointments. So some of the patients who have barriers to care and to get transportation and things like that, to get to Jefferson since we are geographically located near some of the health districts, we've accepted those into our practice. We've accommodated them that way.

COUNCILWOMAN QUINONES-SANCHEZ: How have you been able to get around some of the healthcare reform issues with the fact that we have UPMC and Health Partners in the Medicaid market? How is that? Because I know that when that transition happened, we

had a lot of patients who were defaulted into a different plan. How have you been able to work around that for this?

MR. JASPAN: First, allow me to say that Philadelphia is unique in many ways, but one of the areas specific to this conversation that is very, very empowering is that all of the delivering hospitals, all the Chairs and all the Directors of Labor and Delivery, we meet quarterly or monthly in a collaborative fashion to confirm and affirm that the care that's provided at all the hospitals is equal.

It's not a competitive place for us. It's a safety place. And I think we can capitalize on that already-existing infrastructure. The answer to your specific question is we don't care what insurance patients have. We don't care what country they came from. They walk in the door and they get the care that they deserve and we don't deal with it to be very honest with you. Does that make administration happy all the time? No.

COUNCILWOMAN QUINONES-SANCHEZ: No,

it doesn't.

MR. JASPAN: But at the end of the day we don't check the insurance. We don't check if they're eligible for insurance.

COUNCILWOMAN QUINONES-SANCHEZ: I just want to make sure as we go through this healthcare reform and we're thinking around this, because for some hospitals it is about the bottom line, right. If not, Hahnemann wouldn't have closed. And so, how patients get navigated in this system is usually important.

MR. JASPAN: Yeah. I'll speak specifically to the Hahnemann closure and Health Partners and Jefferson. So Jefferson prior to Hahnemann's closure did not accept Health Partners. Understanding that a large percentage of the patients that were seeking care at Hahnemann had Health Partners, there was work done with senior leadership both at Health Partners and Jefferson to create circumstances that would enable patients to not have to deal with that question and to allow Jefferson to have emergency opportunities to accept Health Partners for

these specific circumstances.

So I think that in the end the community really rallied and it was really heartwarming to be honest. It was terrible that Hahnemann closed but the response, at least I can speak, we all here can speak to the obstetical community -- the obstetrical community. It was actually fantastic of how we tried and were able to successfully accomplish creating the system to allow the crisis that was supposedly going to happen never to be seen.

And I do have to just name Dr. Baxter sitting behind us who is the Obstetrical Director at Jefferson, and I think that he did -- I know that he did a significant amount of work around this time to create the seamless opportunities not only for the physicians but for the patients at Drexel to seek a safe place to have care.

COUNCILWOMAN QUINONES-SANCHEZ: Thank you. Thank you. I know we will be monitoring some of this. As I said, the transition is when you transition Medicaid populations and all of that stuff, has not

been as seamless. The doctors are not the problem. It's the back office financing people that are the problem.

I just want to make sure that as we're doing this work we're cognizant of the fact that those dots haven't been connected. I still find myself intervening many times around this stuff. And in this world, in this space where women will have children is usually important, especially poor women who don't always have those options, so we'll be looking at that and we appreciate all the work that you do. Thank you.

COUNCILWOMAN BASS: Thank you, Councilwoman. I want to acknowledge that we've been joined by Councilman Derek Green and Councilwoman Helen Gym. Councilwoman Brown has comments.

COUNCILWOMAN REYNOLDS BROWN: Yes, yes, yes, comments and a couple of questions. So let me start where Councilwoman Sanchez left off and that is to acknowledge and recognize and say thank you for the work that you do for the tiniest little people among us, children, who

hopefully make it beyond their first birthday.

We know that the United States ranks 55 out of 225 countries. And I think the number is 2.5 Black children are more likely to not survive than their nonAfrican-Amercian or White counterparts. For me it begs the question of coordination of effort which you spoke to briefly, Dr. David Jaspan.

And so to hear that you have quarterly meetings is reassuring, although to Councilwoman Sanchez's point, it's equity and assurance of equity and delivery of services. Is that a goal? So that's my first question. And where is that exemplified or illustrated that that's a goal?

MR. JASPAN: That is the goal. The goal is to identify best practices. Specifically, I can speak to several years ago it was noted that if women presented with symptoms of preterm labor, they're just doing a regular physical examination, was not adequate but by doing ultrasound to

check the cervix and the length of the cervix was optimal, but not every Labor and Delivery was able to do that based on resource availability and education. But through this collaborative, we made that a priority and we ensured that each Labor and Delivery Obstetrical Unit has the ability to do the same thing.

COUNCILWOMAN REYNOLDS BROWN: So who's the glue -- I'm learning who the glue is. Who is holding the glue together? Who's responsible for making sure those quarterly meetings happen, those meetings happen on a quarterly basis? Because what matters is partnerships and partnerships because Government is not -- well, let me say the Feds are not where they should be and it requires the state and us to step up.

So who's making sure that these meetings happen if we want to arrest this decline or this increase, incline in the number of --

MS. MEHTA: That would be me, at the Philadelphia Department of Public Health and the Division of Maternal Child and

Family Health. We are the coordinating body that brings everybody together.

COUNCILWOMAN REYNOLDS BROWN: Okay. So that goes to Councilwoman Sanchez's remarks and/or concerns. How do you operationalize what that looks like?

MS. MEHTA: What what looks like exactly?

COUNCILWOMAN REYNOLDS BROWN: The coordination piece.

MS. MEHTA: Yeah, so we've been meeting since 2016. I guess I'm confused. What specifically are you asking?

COUNCILWOMAN REYNOLDS BROWN: Then if it's been -- well, actually that's three years. It's three years, so speak to one, two or three achievements of those meetings that have attacked this issue so that we can begin to see the numbers reversed.

MS. MEHTA: Sure. So we coordinated so that at that time there were six labor and delivery hospitals and often times women will go to one hospital for prenatal care and then go elsewhere to deliver, so there's sometimes a delay in

getting access to records.

COUNCILWOMAN REYNOLDS BROWN: I see.

MS. MEHTA: And you can imagine in an OB/G -- in an obstetrical time, that sometimes a delay is not good enough because things happen very quickly, so we streamlined the records exchange and the lab exchange so at least we would have basic information like ultrasounds and lab work, so that we're able to care for that patient with the most information possible --

COUNCILWOMAN REYNOLDS BROWN: I see.

MS. MEHTA: -- in an emergency setting. So that's one of the sort of --

COUNCILWOMAN REYNOLDS BROWN: Achievements.

MS. MEHTA: -- initiatives, achievements that have come from that group. We've also shared best practices amongst the groups so that we're looking at our hemorrhage protocols, we're looking at our emergency response to things like shoulder dystocia which is when the shoulder gets

stuck in the birth canal during delivery, so there's been a lot of sharing of information in that respect. Then bringing it back to institution so that we're all sort of on the same page when it comes to those types of emergency situations.

COUNCILWOMAN REYNOLDS BROWN: I see.

MS. MEHTA: We also have looked -- and then that's where that hypertension app that I was talking about, the high blood pressure app, that was shared by the Penn system, their hospitals. So that now we have the funding we're going to operationalize that in all the other delivery hospitals.

COUNCILWOMAN REYNOLDS BROWN: Terrific.

MS. MEHTA: So all of us will have that same monitoring system.

COUNCILWOMAN REYNOLDS BROWN: I'm not a medical professional but I would think that everybody needs that app. So, Representative Morgan Cephas, if you can come back to the table.

Thank you for lifting this issue back on the radar screen. When I came here 20 years ago, we were discussing this issue. So I see that --

MS. CEPHAS: Oh, wow. I didn't know that.

COUNCILWOMAN REYNOLDS BROWN: And based on what I've read there's been a decline, but now there's an uptick again. So help us understand or at least update us on where the state might be or should be when it comes to funding.

MS. CEPHAS: So the state, I'm not sure if you were here, they've been going after some federal resources as well to support their Review Committee too. So they were awarded $2.5 million from the Federal Government just this year, Governor Tom Wolf.

We also just recently established a Review Committee so Philadelphia has really been leading the way in this space in a lot of ways, so they were one of the first to establish a Review Committee to actually look at the deaths. So for Pennsylvania we

just established ours in I want to say in 2017 or -- yes, in 2017 of --

MS. MEHTA: 2018.

MS. CEPHAS: 2018, so literally like last year we just established and started reviewing deaths across Pennsylvania --

COUNCILWOMAN REYNOLDS BROWN: Across the Commonwealth.

MS. CEPHAS: Across the Commonwealth.

COUNCILWOMAN REYNOLDS BROWN: So those dollars would be distributed by some formula across the Commonwealth. How --

MS. CEPHAS: So the dollars from the CDC, we got $2.5 million and 20 percent of that will go to Philadelphia's Review Committee, because across the Commonwealth there's only two Review Committees. One in Harrisburg naturally and the second in the City of Philadelphia. But some of the challenges that we've been experiencing on the state level is that it's ridiculously underfunded.

I believe there was one -- I don't

know the proper terminology, but one nurse essentially reviewing all of Pennsylvania's deaths throughout the entire Commonwealth, so we still have a lot of work to do on the state level and some of the things that I recommended was, one, we need a line item on the state level to support the Review Committee as well as report organizations on the ground and Review Committees like Philadelphia so they can do that work as well, so currently we do not have that in the Commonwealth.

The second piece -- and some other states are looking to do this as well. We are 16th in the nation when it comes to maternal mortality deaths, but our neighbor New Jersey I feel like is 44th. And so they've -- so other states have been taking a deeper dive, passing legislation to address this issue. So some of the pieces that we're considering is expanding Medicaid coverage for pregnant women past the original six weeks up to a year --

COUNCILWOMAN REYNOLDS BROWN: Wow.

MS. CEPHAS: -- because again,

majority of the deaths are happening during I feel like we call it the fourth period?

MS. MEHTA: The fourth trimester.

MS. CEPHAS: The fourth trimester. I'm trying to get the lingo myself. So that's one of the areas of interest. Some other states have passed legislation to certify doula care, require insurance companies to reimburse doulas. California naturally is always leading the way on all of these things. They are requiring their medical institutions, providers, practitioners to take on implicit bias training to address some of the racial disparities that we have within this space.

So I mean there are other, you know, Councilman Green just actually talked about it this morning, not reinventing the wheel and looking at best practices across the country to bring --

COUNCILWOMAN REYNOLDS BROWN: Really such a waste of time and waste of money.

MS. CEPHAS: And I think the media likes to portray that we mirror Washington,

D.C. with our republicans in Harrisburg, but there are some issues that we really align around them. And we actually had a republican White male from York County pass legislation to establish the Review Committee in Pennsylvania --

COUNCILWOMAN REYNOLDS BROWN: Wow.

MS. CEPHAS: -- so this is one of the issues that we are able to align around and hopefully we'll see some traction in the upcoming legislative session.

COUNCILWOMAN REYNOLDS BROWN: I'd like to offer up for consideration when you come up with recommendations at the end of those reviews because too often you stay here long enough, you see all of these reviews, you see a document produced and then it sits on a shelf. So the hope is that it's serious implementation around the recommendations.

And Dr. David Jaspan spoke I think very eloquently to how medical schools need to get in at the circle at the table because they have a role in building or growing professionals in that space so that you can

have those who are -- who needs the service, have people around them delivering the service and so that takes real coordination at the higher ed. level and leadership as well to ensure that that happens. That should not go unrecognized in this statement that Dr. Jaspan raised.

You have to create a pipeline of professionals because it's not going to happen organically if it's not some intentional strategy devoted to building those professionals who care about this issue.

MS. CEPHAS: And that's one of the reasons why we're going to go after the Medical Review Board in the Commonwealth of Pennsylvania to require as continuing legal education -- well, you know how lawyers have continuing legal education. Well, so do individuals in the medical field. So we want to require there to be implicit bias training and just bringing up this issue as a requirement of annual education for those professionals.

The opioid issue has been something

that has been incorporated, mental health issue, so why not this issue as well.

COUNCILWOMAN REYNOLDS BROWN: Agreed. Thank you very, very much on your leadership on this issue.

MS. CEPHAS: Thank you.

COUNCILWOMAN REYNOLDS BROWN: Thank you, Madam Chairwoman.

COUNCILWOMAN BASS: Thank you, Councilwoman. Councilwoman Gym?

COUNCILWOMAN GYM: Thank you very much, Madam Chair. So I just wanted to also share, as many of my colleagues have done, about the tremendous impact of the Hahnemann closing one of six maternity wards in the City of Philadelphia and the recognition not only that it's just, it's not just about Hahnemann, but the declining level of OB/GYN care all across the City that has a lot to do with Pennsylvania and other types of healthcare issues that are going on, but it is heightening.

And I think one of the things that I do recognize is that the hospitals coming together in a quarterly fashion and making

sure that the care of the patients you see is an important issue. But I think what I'm most concerned about is the patients you don't see.

And I guess one of the questions that I would have is that as part of that quarterly meeting, as part of the Department of Public Health, who is actually doing an analysis of who doesn't come through the door. So we know that there were, for example, 50,000 emergency room patients a year coming through Hahnemann, there's issues about location. This goes beyond who's coming in through your ER and why they're coming through them.

But I wonder is the Department of Health taking proactive measures to evaluate the impact of the loss of care whether people in general are less likely to seek attention because of the decline in a particular hospital or in terms of access to a particular maternity ward and whether you're doing more kind of on-the-ground understandings of what's happening, because I think a lot of, especially when it gets to

pregnancy and women's healthcare needs in particular, because of the regularity of it and the requirement for it to be so regular, it's hard for people who don't have a continuity of care to get used to a systemic approach for care that you traditionally have or the best kind of care that you would have if you're going through pregnancy and other kinds of reproductive needs that many women face.

So is someone from the Department of Health taking a proactive effort to look at the impact, not how are other systems treating people as they come through the door which I assume should be an equal measure and I'll ask a few more questions about that, but really who is -- what is not happening because of Hahnemann's closure and what do we then need to do? I do think that's the Department of Health's responsibility for sure on this, though.

MS. MEHTA: I guess I'll say that when we met -- so Hahnemann's delivery make-up is that a portion of their deliveries, a majority -- well, a majority

of their deliveries came from the Philadelphia Health Center in conjunction with their Women's Care Center, so the Philadelphia Health Center which was about 800 deliveries in that time period, they were warmly handed off to the same providers but at Jefferson, so there was sort of the same -- it would have been the same way that they would have gone to Hahnemann, they went to Jefferson with the same midwives and everyone caring for them and the midwives still continued to care for them in the health centers.

The Women's Care Center, once they were notified of the closure, provided warm hand-offs to other prenatal care sites in the City and our colleagues at Temple, our colleagues at Einstein, our colleagues at Pennsylvania Hospital, our colleagues at HUP, they all sort of took on some of these warm hand-offs based on what the patient's preference was.

And then in regards to the deliveries because of all the providers got privileges at Jefferson, it was mainly

just -- it was all diverted there with of course there being some patients that maybe not didn't want to deliver at Jefferson that were then warmly handed off to other institutions.

As for the post, it was just closed -- it was two months ago. So I think that we're not going to have as much good data to retrospectively look back and see what the impact of that closure was. I think that's something that was on the radar to do as time goes on, but that's been the action plan and we were very proactive about that. You know, we met -- the Commissioner convened all of the OB leadership to figure out how this was all to going work.

COUNCILWOMAN GYM: So you're saying that if a patient comes through a Philadelphia Health Center, Public Health Center and has their care through there at point of delivery, they can make a choice about whether they want to have a baby at HUP or Jefferson and they're not limited by insurance or --

MS. MEHTA: No. So --

COUNCILWOMAN GYM: -- anything like that so --

MS. MEHTA: No, so I will rephrase that. So the Philadelphia Health Centers, there's seven or eight that -- eight that provide prenatal care, and that prenatal care has been divvied up. So previously Hahnemann was taking care of six of the eight health centers so the practitioners at Hahnemann would go to the Philadelphia Health Centers and provide that prenatal care. And so when they delivered, they were told that they were to deliver at Hahnemann because that's where the providers were to ensure that continuity of care. They had the same access to the records and that sort of thing.

So they could go anywhere technically, but they wouldn't have the same access to records and it would just be like they were going elsewhere, like if you were getting prenatal care at HUP and decided to deliver at Jefferson, it would be that same concept so your doctors wouldn't be at Jefferson, et cetera.

And so the other two health centers are staffed by Einstein and HUP, yeah, right?

MS. MULLA: Right.

MS. MEHTA: Einstein and HUP. So those are left the same way that they were before, but the six that were being -- that delivered at -- would technically deliver at Hahnemann were then diverted to Jefferson basically because of providers were there.

COUNCILWOMAN GYM: So six of the -- the six of the eight health centers that used to send them to Hahnemann are now sending them where?

MS. MEHTA: To Jefferson.

COUNCILWOMAN GYM: To Jefferson. Forever?

MS. MEHTA: Forever. The midwives are also there. They have a contract now with Jefferson and they work for Jefferson. They're Jefferson employees.

COUNCILWOMAN GYM: So I guess I would say this thoughtfully but, you know, they're -- Hahnemann had an accessibility aspect to it that I think we have heard

anecdotally not always a place that other hospitals and other places of care, and I think especially for women who are about to give birth, very personal journey and an incredibly intensive one, as someone who gave birth three times, you know, like that need for personal access of care is deeply important.

Actually, I'm going to hold on that, but I do want to go back really quick and just say I appreciate that summary as well, but really want to emphasize that it's not about the closure of Hahnemann. It's about the declining access care to OB/GYNs, to certainly one of six maternity wards closing all across the City and to lack of access to culturally competent and anti-racist care in working with women in particular and women of color, trans women, LGBTQ families, all of that really matters.

So the Health Department's role in analyzing the landscape of care right now could not be more important. So I know that you, you know, I really just want to underscore how important I think it is for

the Department of Health to undertake a serious City-wide look at women's access to care, overall wait times, accessibility, feelings of inclusivity, welcomeness that goes beyond just like walking their way -- not just based on the clients that walk their way into the rooms, but really on women who are giving birth period, so I just want to emphasize that.

The other area that I want to talk about in relation to how I feel like giving birth is such a personal journey is to ask especially for Temple and Einstein, what is your relationship with doulas in particular and community-based doulas? How do you have -- do you support, do you provide programs that not only support training but ensure like quality wages, access to care, a partnership that can be more formalized?

I know a lot of amazing practitioners who are doulas who struggle for accessible wages who can't get appropriate training, who sometimes have not always felt super welcomed at some of those major institutions and, yeah, so please.

MS. MULLA: I think that the issue with having doulas and community health workers is that we need funding, and Temple Hospital doesn't really have funding. We have to rely on our community, other services like Maternity Care Coalition. If we have the people available, they're more than welcome to come. But we don't have the money to employ doulas.

We don't have the money at this point to employ community health workers. The MCOs don't really provide a way for us to bill the insurance companies for these supports either. We have asked and have gone to different health insurance companies to say we need to get this kind of network established, but we really don't have it.

We don't have access to our own community behavioral people. We don't have access to doulas. We don't have access to community health care because there isn't the funding, so we will have to go through other community systems that are available.

MR. JASPAN: So the good news is that everyone in this room's voice was heard

and at least one of the Medicaid's, Keystone First, will reimburse and actually employs doulas and are accessible. But it's not the perfect scenario but it's better than zero. So a great -- the perfect world is that the doula accompanies the patient throughout the prenatal care and also is at home with the patient and the family as well.

The doulas program that's being utilized by Keystone First is just in the hospital which is fantastic because it is one of the only known scientifically-studied opportunities that diminish the rate of C-section is by having a doula. And I think that every hospital would accept having doulas present. But I do hear what you're actually saying is that though we might say we accept them, is there really acceptance in the community of labor and delivery, and it's not easy. It's not easy because there's a lot of people there and there are a lot of competing priorities and it's important to create a partnership with the doula to understand that we're all part of the healthcare team.

COUNCILWOMAN GYM: Yeah, and I think I'm going to go even a step further than that. As part of the Merck collaborative partnerships, implicit racial -- implicit bias training is part of it, right?

MS. MEHTA: Yes.

COUNCILWOMAN GYM: Is there like a public review of racial diversity amongst the doctors and hospital care practitioners themselves, like do the hospitals have to evaluate their own diversity numbers?

MS. MEHTA: Yes. I mean that's a standard that's been put forth by --

COUNCILWOMAN GYM: Okay. And I think what I would suggest is that actually doulas in particular would be more than just like a community partner or somebody that you could welcome into the room, but actually is necessary for hospitals to demonstrate that there's a diversity of care in terms of who's attending to many of the patients that they may see or even, you know, may not even have to see, right, so that you don't have to -- you can be relying

on that.

And I think what I'm interested in is whether hospitals can see not so much like acceptance of doulas or really like an engaged partnership which includes financial supports, community-wide training, some level of back-and-forth in terms of information, sharing research, gathering information as like a possibility for really addressing, you know, concerns about lack of racial diversity in care, implicit bias issues that are present in too many hospitals in terms of how patients feedback might be, in terms of like a supportive nature.

And I think you said like a really beautiful thing about how doulas are really increasingly seen by community members is just being a really great sign that they feel like they're getting the care that they need. So it's more a question of like do you see the possibility for partnerships, not do you have to have one right now but are hospitals increasingly open to it. I know it costs money.

I'm also looking at HUP's multi-million dollar programs, you know, we're going towards like an increasing stratified system of care where certain hospitals are going to be at the cutting edge of immunotherapy and cancer treatments, et cetera, and like this very basic thing that makes the world run which is like women giving birth and babies being born in the world, like that's just falling by the wayside because it's not -- it's not valued as much.

So it's more like I know it costs money. I'm sure it costs money, but we're talking about a wider initiative as part of the Merck collaboration could, you know, and how are doulas being seen as really a part, not just like a -- not just like a charitable inclusion of but as a real effort to invest in both by the City of Philadelphia but also by our universities.

MS. MULLA: I would say that doulas are essential. I think community health workers are essential and also, something called patient center in care where we

actually bring prenatal care to our patients rather than have our patients come to us, are all things that we are all committed into trying to improve access to care because we, especially those of us in North Philadelphia, understand that there are huge barriers that are out of our patients control, so we need to come to them and help to give them the support of doulas.

COUNCILWOMAN GYM: Thank you. I'll look forward to following up with Temple and with Einstein and the other universities about how they'll incorporate doulas, but thank you.

COUNCILWOMAN BASS: Thank you, Councillady. Councilman Green?

COUNCILMAN GREEN. Thank you, Madam Chair. Actually, I wanted to speak to Representative Cephas real quick.

COUNCILWOMAN BASS: I'm sorry. What was that?

COUNCILMAN GREEN: Representative Cephas, if she could return. Thank you, Representative for your leadership on this issue. I know when we spoke on a panel last

week you made reference to talking to Senator Casey about this issue and also you -- there was some legislation that was done in California regarding implicit bias training.

I'm curious if there's been any other -- any studies that have been done. I saw looking at some of the other testimonies for some of the panelists today that there is basically a city or county level Maternal Mortality Review Team?

MS. CEPHAS: Yes.

COUNCILMAN GREEN: And I'm reflecting on the work that my former boss Councilwoman Marian Tasko did regarding SIDs, and this issue seems to not really a -- I don't want to use the word cure, but it's a number of avenues being taken to address this issue. Has there been any entities on the national level that are doing some funding?

I see that the City of Philadelphia is going to receive about a million dollars for a study, but it seems to be a much larger issue. And is there any funding,

especially considering that Philadelphia is such an eds, meds city?

MS. CEPHAS: Yeah, so you've seen and I think -- again, thank you for the question. You've seen the public sector in the philanthropic community as well as the private sector really put money up to trying to figure out the issue. Again, with the Merck Foundation, that was a resource coming to Philadelphia through Merck the pharmaceutical company. But you also have the CDC that has actually issued grants to a series of states and Pennsylvania was one of them.

So we received $2.5 million to go towards our Review Committees and 20 percent of that will be going to Philadelphia because we run our own Review Committee. I think, you know, it's a great thing to have grants and I feel like the Health Department has this all the time, it's great to have grants, it's great to have the Federal Government acknowledge this with this $2.5 million investment, but we do need to talk about sustainability in long-term impact

with funding.

One of the things with the Commonwealth of Pennsylvania that we're working on is to ensure that there's a line item dedicated to this work at least on the Commonwealth's level. Of course again, when the $2.5 million runs out, which I feel like is only a three-year grant. I mean and that's the same request and encouragement I would have of the City of Philadelphia, to not just rely on the Merck Foundation to, you know, help, you know, come up with innovative strategies to address the issue but also to put some dollars into the budget, into the Health Department to continue the work that they're doing.

And one thing I think is important to pull out that the Review Committee is doing in Philadelphia, so the Commonwealth has an action arm where they come up with a series of recommendations based on trends that they're seeing and they have an actual action arm that can do some implementation and they don't necessarily have to wait until -- for example, in Pennsylvania we

don't have to produce a report for like maybe another year and a half or so, but they have an action arm that if they see early trends, they can actually put things into motion. And with the Merck Foundation grant, that has given the local Review Committee the ability to have that action arm. So things are moving into the right direction.

But again I still stress, I don't think you were here, we did just recently have a constituent of mine just pass away. Her family's here today. She just passed away in June due to her pregnancy. So we are by no means out of the woods with this issue. And again, the infusion of dollars and support is great but we need to start thinking about sustainability.

COUNCILMAN GREEN: Yeah, I think this provides an opportunity for the City of Philadelphia because we have reached a deep healthcare historical dynamic having the nation's first hospital and a number of other institutions that have been around a long time that we can really take the

leadership with having our teaching institutions really having that type of implicit bias training as part of their medical programming and also working with national partners.

I did reach out as a follow-up to our conversation last week, reached out to my sister who's a former president of the Student National Medical Association, very active in the National Medical Association. We just had that conference here a couple of years ago and I asked her to reach out to some of their members to see what work they're doing regarding implicit bias, so thank you.

MS. CEPHAS: I mean I do feel like Philadelphia, again we are uniquely placed because we're working all together and because we're an eds and meds town, that we can really be a leader in this space if we just, you know, make sure that we're working in a collaborative way using best practices that work and covering those gaps that exist.

COUNCILMAN GREEN: Thank you, Madam

Chair.

COUNCILWOMAN BASS: Thank you, Councilman. And thank you so much for being here for your testimony. It's really provided valuable insight and will help us as we come up with public policy on this issue, so I just really want to say thank you so much to everyone who has testified thus far.

And I'd like to have the Clerk to call forward the next panel but also ask that the next panel be as brief as possible. This is a very important issue and we don't want to rush it. But at the same time, we are significantly behind schedule and we want to make sure that we get to everyone who has signed up to testify. We have quite a long list and we want to make sure we get to everyone. Thank you.

THE CLERK: Dr. Kathleen Reeves, Dr. Marisa Rose, Nina Ahmad, Edward Gilmore.

(Panel approaches Witness Table.)

COUNCILWOMAN BASS: Thank you so much for being here. Please state your name for the record and begin your testimony.

MS. REEVES: Hi, my name is Dr. Kathy Reeves.

COUNCILWOMAN BASS: Please begin your testimony.

MS. REEVES: Dr. Marisa Rose will not be able to join us today.

COUNCILWOMAN BASS: Okay.

MS. REEVES: So, Councilwoman Bass, State Representative Cephas and Members of City Council Public and Human Services Committee, thank you for the opportunity to talk with you today about the maternal mortality crisis.

As we are all too aware, the United States' rates of maternal mortality are the highest in the developed world and have been rising since the 1990s to the point that today a woman who's giving birth is more likely to die in childbirth than with her mother.

Black women are at least three to four times more likely than White women to die around childbirth. We all know this. And we know in Philadelphia, the City's Maternal Mortality Review Team has reviewed

more than 160 pregnancy-associated deaths in Philadelphia residents between 2010 and 2018.

Black women accounted for 74 percent of Philadelphia's pregnancy-related deaths while White non-Hispanic women accounted for 15 percent. I currently serve as the Senior Associate Dean for Health Equity Diversity and Inclusion at Temple School of Medicine and I am a practicing pediatrician.

We have done a lot of work in the pediatric realm around something called trauma-informed care. There's been a lot of conversation around what many policymakers feel needs to be done about the mortality crisis. We haven't really been talking about a trauma-informed approach. There's been a lot of discussion around unconscious bias training, maternal child medical homes, expansion of Medicaid services to improve access to prenatal care and extend eligible postnatal care and all of these things have incredible merit.

But today what I'd like to talk to

you about is a different plan. Something that doesn't merely expand or extend the current healthcare system, a system that is failing our mothers and our infants, but a plan that changes how we offer that care to families and to pregnant women, especially for women who find themselves at high risk for complications related to their pregnancy.

Pennsylvania has been moving very quickly towards creating what has become known as trauma-informed practices. We're seeing it in our schools. We've passed laws to require it in our schools. We see it in mental health spaces. We're working with the police and with criminal justice programs just to name a few.

So what would that look like if we tried to apply that to pregnancy care? First, just as a quick review since 1998, we have known that children who experience significant trauma during childhood are more likely to suffer from heart disease, diabetes, auto-immune disease, addiction and mental health disorders. They're more

likely to suffer from the majority of social determinants of health we talk about every day at places like Temple and Einstein and what used to be Hahnemann.

There's economic struggle, less opportunity for education, less access to good food and many other forms of marginalization and impression. Medicine defies trauma as events, trauma events as anything in which an individual experiences, witnesses or is confronted with an actual or threatened death or serious injury.

This includes when an individual may feel threatened or afraid for their safety. So this can be lots of different things, right. This can be children who suffer physical abuse, sexual abuse, emotional abuse, witness trauma. In one of the schools that we're working in today we know that 65 percent of our 7th graders personally know somebody who has been injured through gun violence. Our children witness this each and every day.

It may be someone in the household who has a substance use issue, someone who

has a mental illness, someone who's incarcerated. One out of three of our Black men in North Philadelphia are currently or have been incarcerated. It can mean feeling unsafe, being in a foster care system, being hungry, suffering from poverty.

We also know that one of the biggest adverse experiences any child can experience is racism. Racism makes every other trauma worse and it makes every other solution harder. We know that any adult who has experienced four or more of these events during childhood; they have twice the rate of cancer as other individuals; they're three times more likely to have heart disease; they're four times more likely to have COPD or asthma; they're six times more likely to suffer from addiction; and if their ACE score is 6 or higher, their average life span is shorter.

Where we sit right now in North Philadelphia, the average life span for our population is 68 years. The average life span for people who live in Center City, Philadelphia is 88 years. Only recently

have people began to look at how this cumulative childhood adversity affects pregnancy. We do know that as your ACE score goes up, your risk for pregnancy complications goes up.

We do know for a woman who has an ACE score of 4 or higher, that they're at least twice as likely to suffer major complications in pregnancy. So what do we know about this? What can the science tell us on how we should try to move forward? So imagine you're in a forest and a bear is chasing you. Your body is very smart. You will make adrenaline. You will make cortisol. It will all be about you running away from the bear. You're not going to be thinking about how to solve a problem. You're not going to be thinking about how to make an appointment. You're not going to be planning ahead for anything. You're just going to be trying to survive, and that works great if you're in the forest and the bear is chasing you.

But what happens if this bear comes home every night? What happens if a child's

brain is bathed in cortisol and adrenaline all the time? We know that this changes their physiology. We know that even as adults if we check inflammatory markers in their blood, they're going to be abnormally high. We know that if we do PET scans on their brains, they're going to be different.

They're going to have the parts of the brain that are all about survival and all about immediate response be much more prominent than areas of their brain that are about planning and taking part in everyday social life. But all of this is not lost. We can reverse some of these changes.

There is evidence that if we use a trauma informed resiliency-based approach, we can see these changes in the brain and these changes in the blood test be reversed. And we also know that if we don't do that and we retraumatize people, we make that situation worse.

So what would an OB/GYN office that's trauma-informed, that's a traffic-informed space look like? Well, first and foremost it has to be a space that

sees the person in front of them, the mother, as a patient who may have had bad things happen to them, not as a bad person, not as someone who's noncompliant to what they can do, somebody who has suffered a lot of trauma and that has impacted their basic biology and physiology. And if we just look at the geography, the average percentage of adults who have an ACE score over 4 across the country is 12 percent. Where we sit in the 19140 zip code, the number of adults who have an ACE score of 4 or higher is over 48 percent.

So what would it look like if we created a trauma-informed OB clinic? So we've all experienced health care. So imagine a mother of three who is pregnant, she comes to an academic medical center. She's a single parent. She has to bring all three of her children with her. She walks four blocks to get to the bus. Then she takes two buses. She's 20 minutes late.

The front desk staff is overwhelmed, overworked and tired. They know they have to see her. They fit her in

but their whole day is behind. So she sits and waits. She waits for over two hours. She has her kids with her the entire time. There's no place for her kids to be. They're kids, they make a lot of noise. Again, the staff is looking at her. She feels they're judging her parenting skill.

She finally gets in to see the doctor. She has hypertension. She had hypertension at the last visit. They gave her medication. She couldn't get the medication filled because that certain medication wasn't on her managed Medicaid plan. The practitioner is really worried about her and her child.

You're putting your child at risk, says the practitioner. The mother hears a second sentence in her head, and we may need to get Social Services involved because maybe you aren't worthy to have these children. She's keenly afraid that that's how they're seeing her. Her ACE score is 6. She has suffered all the effects that go along with that.

When it comes time for her next

appointment, she doesn't go. She stops going all together. She's afraid she will lose her children. She will be confronted with all that she is unable to do. The providers really wanted to help, but they're overwhelmed. They don't have the capacity to help. We're not set up for that. We're set up to do really well in suburbia for women who has lots of resources.

What if the experience looked different? Let's say we didn't have a clinic to book a patient every 15 minutes, that we had group visits for women that were planned around the bus schedule. Maybe 10 to 50 women from the same community would meet and talk together in one visit. A practitioner would talk with them, answer their questions, educate them.

A second practitioner would see them individually, check their vital signs, do the exam. The finance people in the back room, they could bill for 10 patients in an hour and a half. That's when they can ever bill at a 15-minute slot. Oh, and there's childcare provided. The children that come

with the mothers, their other children, they have a safe space to be so the mother can really pay attention to her appointment.

The entire staff in the clinic is aware of bias, racism and a historical basis of oppression and they understand the physiological effect of trauma. And then there's outreach members, community members, doulas that are hired from the community as Temple -- as academic medical center employees moving that forward.

So I know it sounds expensive, but I'm confident that if we create this environment, it will save so much more money than it will cost. In my testimony you will see there's billions of dollars spent on the complications of pregnancy, both for the mother and the child. There's no way that this system is going to cost more than what those complications have cost. It would mean an investment up front, but we've seen it in our schools. We've seen it in pediatric practices just with the decrease of the rate of asthma admissions in a trauma-informed practice.

So we believe that academic health centers need to come together and put together the plan of how we could fund trauma-informed spaces to be able to do that. We're running a pilot right now out of Temple. We're also partnering with the School of Public Health where we do have doulas that are going to be trauma-informed doulas that are working with Christie Santoro who's in our Public Health Department who's here, who is working to do just that.

So we truly believe that we have to make big change here. It's not about one certain training for healthcare providers. It's not -- it's about changing the way we deliver care in a way that's actually going to work for the population that needs that care.

COUNCILWOMAN BASS: I want to thank you for your testimony. I really hate to cut you off because your testimony is just really comprehensive and I can assure you that I'm going to really take the time to sit down and digest everything, because

there's a whole lot of information here today. It's all really good and powerful information that we can use to address this issue.

MS. REEVES: Thank you.

COUNCILWOMAN BASS: So I am going to take the time and make sure that I read all the testimony that's here today. I'm likely going to have to leave this hearing in a few minutes, but I want to stay and hear as much of it as possible. So again, I thank you for your testimony.

If we can have you, sir, state your name for the record and begin. I'm asking really if folks could limit their testimony to about two minutes if that's okay.

MR. GILMORE: For the record, I'm Edward Gilmore and I don't have a lot of papers in front of me to flip.

COUNCILWOMAN BASS: Okay.

MR. GILMORE: What I'm going to say is going to come from my heart.

COUNCILWOMAN BASS: All right.

MR. GILMORE: I'm basically here testifying because I recently lost my

daughter 10 weeks ago, so I'm still in grieving, of childbirth, okay. Matter of fact, I don't live in this state anymore. I drove up from North Carolina, a nine-hour drive last night to be here to represent, you know, my daughter, her family that's sitting back there.

My background is I'm 69 years old. Quite naturally, I'm an Afro-American male. Had three daughters, raised three daughters by the same woman. Was married 42 years, okay.

COUNCILWOMAN BASS: Okay.

MR. GILMORE: I'm a Vietnam veteran. I worked for the U.S. Postal Service 37 years, retired as a high-level manager. So when it comes to health care, my kids got the best health care. Yet and still my daughter died at childbirth July 26th. I saw my daughter the day before. She was in perfect health.

Now, I heard a lot of testimony from everybody about not having enough time, you got to take care of the kids. My daughter was not affected by that. She came

from a loving family all her life. She was a fitness expert. She ate the proper foods. She had no symptoms during pregnancy. Matter of fact I saw her the day before, July 25th. I hugged her, Lashana, I'll see you next week; me and the wife going to drive up to see you deliver. And she was very excited about it.

So like I say once again, I don't have any notes. I'm here representing my daughter. And what I'm hearing from everybody else in this room, hopefully what happened to my daughter won't happen to anybody else's. I can't bring her back. I've accepted that. It's hard, but I've accepted it.

And like I said once again, I'm here representing her and I'm her father, still her father. And at this present time I think that's about all I have to say, because as far as prenatal Lashana was special, right, ladies and gentlemen? She was special. She was on top of everything and she got along very well with people. So for this to happen is a total shock, okay,

total shock.

She had no problems leading up to this event. None whatsoever. She had a child before, Lashawn -- I mean Shawnie, he's 10 years old. No problem with that pregnancy. Matter of fact, when you leave outside these walls if you ask anybody on the outside, they will think this is unheard of now, okay. And I get along with everybody. I'm not prejudice. I got White friends, Black friends. And everybody I talk to about what happened to my daughter, they cannot believe it in this day in age. They can't believe it.

So I'm sitting here testifying on behalf of my daughter. Hopefully that we can save other lives and it don't happen again, because I hear all the statistics and it's going over my head right now, because like I said it didn't matter because my daughter followed the rules and regulations.

She was a health expert, zumba instructor, you name it. She ate the proper foods, you name it. But yet and still I had to end up burying her, so that's my

testimony. Thank you very much.

COUNCILWOMAN BASS: Well, I thank you.

(Applause.)

COUNCILWOMAN BASS: I thank you for your testimony and your words are powerful and it goes back to a statement one of my colleagues, Councilwoman Sanchez made earlier which was that as we have all of these conversations and groups and medical teams and experts and research, we really need to make sure that there is a voice for those who have gone through and for the families of those who have gone through a loss such as this because, you know, I agree with you, it shouldn't be happening.

People think it doesn't happen. And until I had my experience, I didn't really believe it could happen. But we need to spread the word. We need to make sure that our young women who have access to excellent health care, that they are heard, that their concerns are validated.

One of the things that was mentioned earlier is the doctor who

mentioned when folks come in, well, you don't feel a certain way, do you? The way the questions and the conversations are leading towards a particular answer as if it's the answer we want rather than the answer that is truthful and it really reflects how the patient is feeling. So I really thank you for being here. I'm glad that you came and told your story, sir.

MR. GILMORE: I want to add to that.

COUNCILWOMAN BASS: Yes.

MR. GILMORE: And I had to come to some kind of peace and I prayed about it and whether we believe it or not, we all get gifts and our gifts come from above whether you're religious or not.

COUNCILWOMAN BASS: Yes.

MR. GILMORE: And my theory about this is whatever gift God gives you, treat everyone the same.

COUNCILWOMAN BASS: That's right.

MR. GILMORE: Don't treat one person different or one race different than the other because one day when you leave

here, you got to answer for that. You got to answer for that. That's my belief.

COUNCILWOMAN BASS: Absolutely.

MR. GILMORE: And before I close, I'm looking at Councilman William K. Greenlee's last name and I'm a tennis instructor and I gave your wife lessons a few years ago at Althea Gibson Tennis Center.

COUNCILMAN GREENLEE: Madam Chair, if I can just say, you must be very good because she brags about you all the time.

COUNCILWOMAN BASS: Thank you so much for your testimony and thank you for being here today.

MR. GILMORE: Thank you.

COUNCILWOMAN BASS: Please state your name for the record and begin your testimony.

MS. AHMAD: Nina Ahmad and I'm here from -- I'm representing the National Organization for Women. I just want to extend my deepest condolences to you.

MR. GILMORE: Thank you.

MS. AHMAD: We must do better.

Good afternoon. I would like to thank Honorable Cindy Bass and Honorable Members of the Committee on Health and Human Services for convening this public hearing on the critical topic of maternal mortality. I'm grateful for this opportunity to testify.

Maternal mortality is a death of a woman during pregnancy or up to one year following the end of pregnancy regardless of the outcome of the pregnancy. The nation and Pennsylvania has seen an alarming rate of maternal deaths. What is more alarming is that nationally African-American women are 3.5 times more likely than White women to die from pregnancy-related conditions.

Until recently the racial disparity in maternal mortality has largely been ignored. The Philadelphia Health Department's report titled Maternal Mortality which was published in 2015 acknowledged the problem, but not once was the fundamental cause of the disparity in the data regarding African-American women discussed in the recommendation.

A recent feature-long New York Times article identified racism as the fundamental cause of what is clearly a public health crisis. The higher maternal death rates of African-American women has been recently in the news since tennis star Serena Williams shared her near-death experience after giving birth to her first child.

Her story underscores the fact that the disproportionate number of Black mothers dying within a year of giving birth is not solely tied to socio-economic factors. As Stephanie Teleki who leads the maternity care portfolio at the California Health Care Foundation stated, the problem is not that pregnant women are undereducated or uninformed. The problem is that those in charge are not listening to them.

What can be done? To start, we have to listen to the women affected and bring critical information straight to the community. At the same time we have to integrate multi-faceted, anti-racist measures in every strata of our medical

institutions. While our entire society struggles to dismantle racist and gender-based barriers, we need to put the spotlight on our medical institutions because these barriers are literally a matter of life and death for African-American women.

We need immediate measures such as ongoing implicit bias training and strong consequences when such bias is detected. Another effective measure that can immediately reduce the number of Black mothers dying is the use of doulas, has been mentioned already, trained birth coaches who provide women with physical and emotional support during pregnancy, preparing them with what to expect and amplifying their voice at childbirth and the postpartum period.

Data showed that with continued support system, doulas positively impact both mothers and babies and help families achieve a healthy and positive birthing experience. From a dollar-and-cents perspective, continuous care from doulas can improve birth outcomes with mothers and

infants resulting in fewer preterm and low birth infants and reduction in caesarean sections, all of which contain costs.

The Association of State and Territorial Health Officials have published a state policy approach incorporating doula services into maternal care. It models savings averaging $986 of Medicaid if covered -- if it covered doula services. I am encouraged by the recent interest of Pennsylvania legislators including our own State Rep. Morgan Cephas who has been spearheading this as well as Governor Wolf regarding this maternal mortality crisis.

There have been recent resources from CDC and Merck awarded for this crisis. I'm hopeful that Governor Wolf's recently created Maternal Mortality Review Committee tasked to collect information and to investigate and disseminate findings related to maternal deaths will use racial equity lens in analyzing this data.

As recommended by Aasta, including doulas as members of the key advisory committee is critical to meaningful reform.

And I hope that some of our notable doulas who are here today are at that table. I did not see their names on that committee as of yet.

But most importantly, we have already had solid data that doulas are an important resource in fighting maternal mortality. In Oregon in 2012 and Minnesota in 2013, they instituted what Pennsylvania should institute, equitable, equitable and underline the Medicaid reimbursement of doulas. Not only will it help mitigate the tragic problem of maternal mortality, it will be a job creator for our communities as well.

It will be critical to ensure that African-American doulas are front and center in addressing the needs and advocating for African-American mothers who are dying due to racism embedded in our healthcare institutions. I thank you.

(Applause.)

COUNCILWOMAN BASS: Thank you for your testimony. And I do apologize. As I said I do have to leave for another

appointment. But again, I want to thank everyone for being here. I really appreciate your testimonies, written and unwritten, sir. And I will certainly review all of the testimony that I have and work with my colleagues to find some sort of solutions that we can do.

There are things I believe that we can do here in the City of Philadelphia. We can do better. We can all do better. So thank you so much. And I'm going to turn it over to my colleague Councilman Greenlee.

COUNCILMAN GREENLEE: Thank you, Madam Chair. Christian, why don't you call the next panel, please.

THE CLERK: Marianne Fray, Takara Gainey, LaQuesha Garland?

COUNCILMAN GREENLEE: Thank you. Good afternoon. Please whoever would like to start. Ms. Fray, I think you called first. If you have written testimony, that will all be made part of the record. Again, we're running behind schedule here so if you summarize any statement, we'd appreciate it and your written testimony would be made

part of the record. Thank you.

MS. FRAY: You're welcome. So good afternoon and thank you to the Public Health and Human Services Committee, Councilwoman Bass and Representative Cephas for inviting me, Marianne Fray, CEO for Maternity Care Coalition to testify on the maternal mortality epidemic.

I'm going to skip much of this and just go to the salient points that I think highlight what's really important. MCC has found that among our clients, largely low-income and women of color, the leading factors contributing to poor health outcomes are, and have been spoken about a lot earlier, institutional racism, chronic illnesses, effectively navigating the healthcare system and lack of sufficient paid leave.

I'd like to focus my remaining comments on solutions. So last year or earlier Dr. Joia Crear-Perry, founder of the National Birth Equity Collaborative, provided some testimony to the U.S. House of Representatives Sub-Committee on health in

support of H.R.1318, and that was preventing Maternal Mortality Act of 2017 and she said, "The legacy of hierarchy of human value based on the color of our skin continues to cause differences in health outcomes including maternal mortality racism is the factor, not black skin."

So what can we do about it? There have -- previous testimony has been focused on some work that's been done at the City and state level, Maternity -- excuse me, the Maternal Mortality Review Committee and Aasta spoke about that earlier. And there's some findings that have helped inform a design that MCC has in a program that's called Safe Start, and that's what I'd like to talk about.

This is a program that was founded from support from Merck for Mothers initiative, and it works to address what I think Councilwoman Blondell spoke about, Helen spoke about -- excuse me, Councilwoman Gym, about coordination. That seems to be part of the issue.

This particular program finds

support and coordinates between healthcare providers, insurers and reduces maternal mortality and we, in fact, have had some positive results. About 366 women have been involved in that and we've seen a -- they're more likely to receive adequate prenatal care, they're attending their prenatal visits more and there's been less inpatient admissions and emergency room visits.

And we think it's because of the coordination and because we recognize that the women that are working with them, the community health workers look like them and there's a high level of trust. So I'd like to turn it over because a lot of what we also talk about is solutions around doula care, which we have one of our doulas here. So I'm going to defer to let them speak about that and I think that will be helpful.

COUNCILMAN GREENLEE: Okay. Great. Please identify yourself and proceed. And again, we have your written testimony.

MS. GAINEY: Hi, I'm Takara Gainey. Good afternoon and thank you to the Public Health and Human Services Committee,

Councilwoman Bass and Representative Cephas for having me to share information about the role of doulas in addressing Philadelphia's maternal health crisis.

I am the Program Associate for the Breastfeeding Community Doula Program at Maternity Care Coalition and I'm also one of their community doulas. In communities of color where discrimination in the healthcare system is prevalent and people often feel disempowered, doula care can make a big impact.

There are so many things designed to take our power away in these situations, including the unknowns we have around our bodies and in birth, in particular. And then you have the vulnerability of labor and birth, but doula care can help shift the power during that moment and provide mothers with information, tools and confidence to speak up and advocate for the care, time or attention that they need.

Doulas are not superheroes. I hear a lot of the conversation today deferring to, well, get a doula, have doulas, fund

doulas. We are not the solve-all problem, solve-all solution to this problem. But doulas are trained birth companions that provide informational, emotional and nonmedical support to women before, during and after childbirth. The care is individualized and extensive research has correlated doula care with higher breastfeeding initiation rates, fewer caesarean sections, fewer low birth weight babies, lower risk for postpartum depression and improved satisfaction with the overall childbirth experience.

Disappointingly however, it is mostly people who can afford to hire a doula who benefits from having this care. Community-based doula programs have emerged around the country in recent years to help fill that gap to address the needs of communities of color and other communities in the margins who experience poor health outcomes.

The community-based doula program at Maternity Care Coalition is one of these innovative models. It has been a catalyst

for ongoing shift in the birth-worker community and for birthing families in Philadelphia. Currently in partnership with Temple University, we are now gearing up to expand our community-based doula program for a new perinatal community health worker training which will prepare women in the North Philadelphia community to serve pregnant people as both birth and postpartum doulas as well as breastfeeding counselors, so this new perinatal health worker model aligns with Pennsylvania's proposed standards for community health worker certification.

Our program to date has trained more than 170 community doulas and breastfeeding counselors, predominantly people of color and we have matched them with over 1500 pregnant people who request our services or were referred for doula breastfeeding support by their insurance provider, care coordinators or self-select in.

Community-based doulas help women find their voice and their confidence and

walk with them with respect. Community-based doula programs also promote economic and professional growth and sufficiency. Many of the people who had the support of one of our doula networks later became trained doulas themselves. Many of our trained birth workers have formed their own groups and projects and have gone on to nursing or midwifery school or have now jobs in maternal and infant health arena.

Now, I just want to speak to some of the key points to note and some things that the City of Philadelphia and Pennsylvania can implement. One of those being reimbursement must allow for increase accessibility of doulas. Currently, doula care is an out-of-pocket expense for most families unless they connect with a doula program through an organization such as Maternity Care Coalition.

Reimbursement rates must allow for doulas to earn a living wage. And I repeat that, reimbursement rates must allow for doulas to earn a living wage. This is hard work. It's invested work and a lot of

doulas who are employed as community doulas experience burn-out very early while doing this work.

Another suggestion is to invest in community-based models to ensure that doulas are enrolled in Medicaid reimbursement programs, are trained and supported to serve communities of color and provide funding to train a diverse community of doulas and breastfeeding counselors from communities of color, immigrant communities and other spaces with poor access to care. Thank you.

COUNCILMAN GREENLEE: Thank you very much. Thank you. Ms. Garland?

MS. GARLAND: Good afternoon. My name is LaQuesha Garland. I am representing Family Practice and Counseling Network. I am the Center Director for the impending Family Health and Birth Center Project. I'm extending gratitude to Councilwoman Cindy Bass and the Public Health and Human Services Committee for allowing us to be here today to give testimony.

When you think of countless women, Shalan Irving, Kara Johnson, Erica Garner,

Crystal Galloway, Lashanda Hazard, Tameisha Dickey, YoLanda Mention, Lashana Gilmore -- my condolences, family, these are just a few of the names of women, Black women who have died prematurely from pregnancy or birth-related causes in this country and I too understand this oh so well.

When I was presented with the opportunity to be a part of the Family Health and Birth Center Project, I bring my own lived experience while pregnant with my son. My birth plan was very simple. I was going to have a natural birth and I was going to breastfeed. I had a happy, healthy pregnancy. I prepared and I was looking forward to motherhood.

Going two weeks past my due date, I needed to be induced and despite my preparation and positive attitude, things did not go my way. I nearly died. Countless hours of painful induced labor, stress when my doctor shift ended and my care was transferred to strangers and what I felt was the violation at hands of what seemed to be the entire hospital staff led

to my dysfunctional labor.

I was told that they would need to go and grab my son via C-section. My blood pressure spiked. What was supposed to be the happiest moment of my life was clouded by sadness. In short, violation, trauma and failure. These were words that defined my birth story. And unfortunately, the birth stories of all too many Black women here in this City and this country. And here I thought I was the exception.

Statistics prove that Black women are twice as likely to suffer from severe complications during pregnancy and childbirth and we are hearing more and more of these instances through personal stories. Black women need to be validated. Knowing this, I'm convicted and I'm inspired to help to make a difference. Women need to be respected and engaged in their own experiences of pregnancy and in childbirth. And this is an issue that is affecting our City, our communities and our families.

As we are all aware, Philadelphia has some of the worst maternal and infant

mortality rates among major U.S. cities. Here in Philadelphia, Black women account for 45 percent of annual birthing population, but they account for 75 percent of pregnancy-related maternal deaths. Black women facing discrimination internalize stress leading to poor health outcomes over time. This condition of the weathering effect contributes vastly to maternal mortality and morbidity.

While socio-economic status may seem to be a contributing factor, to the contrary highly-educated Black women are still three and four times more likely to die giving birth than poor White women. So as part of a community solution, Family Practice Counseling Network plans to open a birth center in 2020 to provide women and families the opportunities that they need, a sense of ownership, respect and highest quality of care to address maternal mortality.

A birth center is a home-like setting where midwives provide care to women with low-risk pregnancies. A recent study

done by CMS, the Strong Start study, within Medicaid populations concluded that birth centers have healthier outcomes at a lower cost when compared to birth center hospital settings improving patient experience. This model will help save lives, reduce healthcare cost tremendously and improve community health and well-being.

So Family Practice and Counseling is a network of community centers across Philadelphia. We are a program of resources for human development. We have a strong track record of providing integrated healthcare services in vulnerable communities. We have five health centers. Over the 27 year -- over the past 27 years we've grown from one to five. And we know how to establish new initiatives and to grow new ideas. We reach about 25,000 patients annually inclusive of prenatal care services.

The birth center plans to include and provide integrated behavioral health care for all patients, health education and home visitation by dually-trained community

doulas, culturally proficient care. All health center staff receives ongoing racial bias training, rich data tracking systems to monitor outcomes over time, primary care and dental care services for the entire family.

We have strong alignment with organizations like New Voices For Reproductive Health, Black Mamas Matter, Maternity Care Coalition and others. We have a partnership with hospitals for high-risk deliveries and we're committed to this mission and we look forward to joining in a much-needed collective work to make an impact here. We believe that maternal mortality is not just her issue, but it is our issue. Thank you.

COUNCILMAN GREENLEE: Thank you, and thank you all for the work you all do. It's very important. Thank you.

(Applause.)

COUNCILMAN GREENLEE: Hold on one second. Councilwoman Gym?

COUNCILWOMAN GYM: I just wanted to add my voice to thank you very much for all the work that you've been doing and

especially appreciate all your testimony because I thought it was very direct and clear. But I was curious about who you think ought to be coordinating some of the recommendations that you made, particularly -- I mean, there's recommendations that you made that have to do with reimbursements. That sounds like it might be more at the state level than it could be at the local level.

But in terms of the other recommendations that you may have in terms of investing in community-based models, provide funding for training of doulas and other areas, do you see that as being a locally-driven initiative that could happen at the municipal level or is that something that you would feel you would want to see led by the City? Would you want it to be led by the Coalition of NGOs or CBOs at the local level in coordination with hospitals? Like how do you see --

MS. FRAY: All of the above. I mean really --

COUNCILWOMAN GYM: But someone's

got to pull it together. So who do you think really pulls all of this together?

MR. FRAY: It probably is going to be at the state level because I really think that there has to be this -- it's a combination of like legislation as well as -- the MCOs, really. The pressure from the states on the MCOs to make sure that they are going to meet their HEDIS measures, that's what's going to probably help because the MCOs have the money.

COUNCILWOMAN GYM: Okay.

MS. FRAY: So I really think it's going to have to start -- but it really does have to be thread together from the state and on multiple levels. So any one piece that is not included is not going to give us desired impact.

COUNCILWOMAN GYM: And what do you think the most important role the City can play or the City of Philadelphia can play in this area?

MS. FRAY: I think it's continuing to do the work that you do now. Putting pressure on every single one of the --

asking the questions of the departments that you did earlier, I think that's a big start because there is influence that the Council have that we and community organizations don't have to rely on these bodies to keep us all accountable, so I think it is making sure you ask those tough questions and expect us to be accountable to answer them. To not only answer them but to actually be doing something, yeah.

COUNCILWOMAN GYM: Yeah, thank you much.

COUNCILMAN GREENLEE: Thank you. Thank you, Councilwoman. Thank you all. Christian, our next panel, please.

THE CLERK: Saleemah McNeil, Mari-Carmen Farmer, Theresa Pettaway, Jovida Hill?

COUNCILMAN GREENLEE: Okay. This is the last panel I have on record. Is there anyone else here that wanted to testify? Seeing none, okay.

THE CLERK: She --

COUNCILMAN GREENLEE: All right. Come on up. You can come up too. We have

your written testimony, all three of you. So again, if you could -- that will be made totally part of the record. If you could summarize that, we'd appreciate it. Whoever would like to go first, please identify yourself and proceed.

MS. McNEIL: Hi, my name is Saleemah McNeil. Thank you for having me today. I am a reproductive therapist serving the Philadelphia and the surrounding counties. I come with experience on multiple levels. I used to be a doula. I am the founder and CEO of Oshun Family Center and curator of the Maternal Wellness Village, in addition, a survivor of birth trauma.

I delivered my son in 2006 and the a title of mother made me a statistic. My pregnancy went well until I went to deliver and my blood pressure was 202/153. I was in stroke range and I did not understand what was happening to my body at the point. I spent nine days in the hospital and weeks later, my postpartum mood fluctuation started to begin and I did not feel I could

tell anyone.

I didn't tell anybody because I did not trust that the providers who were caring for me would understand that I was emotionally depleted and not anything less than a mother. In my work I come across mothers that are looking for information about the adjustments occurring throughout their bodies, in support in recovering giving birth. Parents are struggling due to the risk factors associated with one of the most joyous times in their life, childbirth.

When my husband and I decide to expand our family, I have discussed the risk factors and blatantly stated please don't let me die. Those chilling words are terrifying and a tall order to fill, but it is our reality. Black families are deciding to have children despite the risk factors and it is undoubtedly a time for systemic change.

California is making strides in shifting the narrative and holding providers responsible for the care of gestational parents by addressing their biases. We have

to ask ourselves, am I worth saving? Is Pennsylvania progressive enough to change the narrative from Black and Brown people as implicit bias and racism is killing our bodies?

After working at Riverside Correctional Facility for a few years with the pregnant and parented population, I thought that I would never hear a story that made me cry because of the level of abuse, neglect and trauma some of the participants discussed but things have changed.

I have received an influx of clients dealing with suicidal ideations, attempts on their lives and self-harming actions. These women are pregnant, may have newborn babies and are in crisis. I will tell you about Rhonda. She's an educated woman of color, working in one of the top companies in the City. She is currently on maternity leave and dreads the moment she has to return to work.

During the intake appointment, she was asked about suicide ideations and denied such actions and thoughts. Three sessions

later she disclosed, I tried to take my life during my pregnancy. She proceeded to discuss the details which I will spare you of hearing today. Her affect was flat. Her words were cold and she appeared disassociated from the story in which is how she survived telling me.

I felt an overwhelming sense of sadness for her. I had a knot in my chest and tears that I had to hold back. At the conclusion of our session, I immediately sat and processed what I had heard. I took a moment to release all that I was feeling for this woman and every gestational parent that has experienced such hopelessness. As a clinician, I felt defeated. As our work continues together, Rhonda is better now but is still diligently working to live every day.

It is my life's mission to collaboratively work together to change this narrative. I do not want another parent to go months without care because of the fear, shame and guilt associated with a broken system, a system not constructed for us to

thrive.

For this, I have founded Oshun Family Center and launched a City-wide initiative to assist in reducing Black maternal mortality with the Maternal Wellness Village. This village is comprised of birth workers of color that includes therapists, doulas, lactation consultants, holistic healers, infertility warriors and nurses. Combined we have levels of education, 35 years of parenting, 25 years of labor support and a host of other things. We are a grass roots in working without funding to meet the needs of our community. We do it from a place of survival and sheer passion.

We have trained professionals doing screenings and an internal referral system. This creates a continuum of care and provides a better glimpse into the gestational parents' world, a factor that may impact the outcome of their delivery.

The opioid epidemic has greatly impacted families just as the crack epidemic did when it hit the Black community in the

'80s, and we are still recovering. Studies have shown that there is a physiological response to trauma and addiction is one of them. We need the support of our City officials, hospitals, insurance companies and community members to collectively combat this issue. We need you. Thank you.

COUNCILMAN GREENLEE: Thank you very much.

(Applause.)

COUNCILMAN GREENLEE: Who would like to go next?

MS. FARMER: I will go next. Good afternoon. My name is Mari-Carmen Farmer and I'm a certified nurse midwife. I've lived in West Philly for 25 years, have been a doula, childbirth educator and midwife for the last 18 years. I'm also the current president of a Philadelphia chapter of the Pennsylvania affiliate of the American College of Nurse Midwives, the Philly Metro Midwives. Thank you for having me today.

This opportunity to testify could not be more timely given the series of events that folded in our City this summer.

Since graduating from the University of Pennsylvania Midwifery Program, I had been practicing in Philadelphia's largest hospital-based midwifery practice at the recently shuttered Hahnemann University Hospital.

In the events that transpired there, over the last few months have been as difficult as you all might imagine for our patients and the communities we serve, for our former colleagues and of course for our practice. The loss of this safety-net institution created increased risk of poor outcomes for the families we served who were already at the margins of society. And although our practice has recently found a new home and the opportunity to establish an inaugural midwifery practice at Thomas Jefferson University Hospital, it will take quite a while to rebuild the highly collaborative team-based practice that existed at Hahnemann.

The fact remains that this closing marks an important moment in our City's history; one that demands that we focus our

attention on the inequities that exist within the larger healthcare system, on the implications of our failure as a nation to figure out a way to sustainably care for all people and on the essential contributions of midwives in providing quality affordable and culturally relevant care.

I'm honored to be here today to amplify the voices of the people being most affected by this closure and to advocate for equity and policy and practice, so I'm going to focus specifically on the midwifery model of care and how that can perhaps change the situation that we're in.

Nationally, 80 percent of maternal deaths are happening outside of hospitals and 60 percent occur more than a week after birth. Several people have mentioned this already. Research also shows that 80 percent of the factors that create health happen outside of providers' offices and hospitals.

While we can still improve care in our hospitals, deaths due to acute pregnancy conditions have been declining while deaths

due to chronic conditions especially mental health and substance use disorder has been rising. Much of the attention paid to the maternal mortality crisis has focused on sentinel events, but the increase in maternal deaths gives the impression that birth is inherently more risky than it used to be. This is simply not the case.

The increase is taking place because we aren't supporting childbearing families in critical ways that place them at risk for poor outcomes. Mothers are dying because our social safety net isn't strong enough because of the insidious history and current manifestations of racism and white supremacy in health care and because of our failure to directly address social and structural determinants of health in childhood and beyond.

In order to be truly effective, proposed solutions must be responsive to the full context of the lives of childbearing people. So what does community-based investments look like? And these are some solutions, some of them which have already

been proposed: Expansion of home visiting programs like Nurse Family Partnership and Visiting Nurse Association, Medicaid coverage for doula care and support for community-based training for doulas and perinatal community health workers, postnatal care as a continuum focused on diet care with multiple points of contact with health care and social service systems which also includes screening for postnatal complications, breastfeeding support, mental health assessment and treatment, and integration with primary and pediatric providers, support for seamless transitions between our Philadelphia health centers, hospitals and provider offices. This is a huge problem our midwifery practice faces on a regular basis.

How can we best integrate our patients who get care in the City's many health centers when they need specialty care in provider offices or inpatient care of one of our City's large tertiary-care hospitals. We need more investment in public health infrastructure. Ongoing well-integrated

implicit bias training for healthcare administrators, medical and midwifery students, providers and staff. This is work I am particularly passionate about and one that can be addressed decisively and quickly and was recently implemented in California.

And finally, investment in community-based midwifery-led birth centers like the one that was just mentioned by Ms. Garland. They are well-integrated in our City's health ecosystem. These types of birth centers offer a model of care that have demonstrated promising results, and she already referenced a strong start initiative which was what I was going to do.

Now, more specifically about midwifery. Midwifery integration and expansion of the perinatal workforce, particularly providing funding to make midwifery education accessible to individuals of color who come from impacted communities. There's good evidence to suggest that race concordant care improves care outcomes, and we know that drawing from these communities will help raise healthcare

leaders that understand both the most urgent needs and the most viable solutions. Dr. Jaspan already mentioned that for medical students, medical schools and I would echo the same for midwifery education.

Global payment reform is an area that also offers much promise. Linking payment to the quality of care, incentivizing care coordination across systems and encouraging a greater focus on preventive care and mental health care are some of the goals of progressive reform being explored around the country. The Pennsylvania Department of Human Services is already behind value-based payment approaches and is leading the way in this regard.

Then finally, Medicaid expansion to a full year after childbirth, which many people have already mentioned. Forty percent of births in Pennsylvania are covered by Medicaid which provides an opportunity to open access to mental and behavioral health services, care for substance use disorder, lactation services,

community-based home visiting and primary care.

I'll just skip to the end. Here is an example of how our current regulations prevent me as a midwife from providing optimal life-saving care in pregnancy. As we all know, the country and the state are in the midst of an epidemic of opioid addiction which has a significant impact on childbearing families.

As a midwife at Jefferson, I work with providers on the front line of caring for this population and can attest to the dire nature of this crisis. The Pa Perinatal Quality Collaborative reports that opioid use rate per 1,000 maternal hospital stays has increased from 3 per 1,000 maternal stays in 2000 and 2001 to a rate of 19.6 per 100 hospital stays in 2016 and '17. Pregnancy-associated deaths related to substance use disorder has risen accordingly.

Medication-assisted therapy is the recommended treatment of opioid use disorder in pregnancy and offers the best option for

protecting moms and babies from overdose deaths in pregnancy. Although federal law allows certified nurse midwives to prescribe medication-assisted therapy after completing 24 additional hours of training, state law in Pennsylvania prevents CNMs from appropriately prescribing this therapy. Meaning, I cannot provide the optimal evidence-based care to childbearing people with opioid use disorder.

Midwives are safety-net providers in many counties in this state and limiting our ability to practice to the full extent of our education and training is causing harm to childbearing families. I think Dr. Mehta mentioned that our practice takes care of five of the health centers in the City, so if you just go on that, that's the majority of women receiving prenatal care in Philadelphia at the health center. That's just one example.

Our current reimbursement system reflects a value society places on the lives of mothers and babies. Maternity care is a low-margin specialty, considered a lost

leader in something that health systems offer as a service to the community or as part of a strategy to build consumer loyalty for more lucrative medical services. This does not have to be the case. Let's imagine a bundled payment that includes comprehensive mental health services, access to providers of choice, a doula for every childbearing person, community-based postpartum home visiting, nutrition, lactation, childbirth and parenting classes and a blended case rate for cesareans and and vaginal births.

Let's imagine multi-disciplinary prenatal care teams so that families receive the level of care needed by the provider trained to provide quality care at the best value. And let's imagine a system that is designed to not just provide safe care and better outcome, but also optimal, empowering and life-affirming care.

The Philadelphia midwifery community is ready to partner with all of you to help create the reforms we know will make a difference for childbearing families,

and we offer our hope and trust in all of you as our elected officials to lead the way into a better future for maternal child health in Philly. Thank you.

COUNCILMAN GREENLEE: Thank you. Thank you very much. Ma'am, if I can ask you to move up to the front. Ms. Pettaway, if you could -- thank you. Ms. Pettaway, please identify yourself and proceed.

MS. PETTAWAY: Good morning. My name is Theresa Pettaway, founder and Executive Director of Pettaway Pursuit Foundation and this is my story. First, thank you for having me. Growing up, my family moved around lot from one place to another and to another.

But finally, at the age of 14 we bought a house in an area called The Bottom of West Philadelphia. I grew up as a tomboy and was always around a lot of boys. With this, my mother thought that it would benefit me to be medically examined by a gynecologist and possibly introduced to some form of birth control. So we decided to bring me to the first female exam at the age

of 15.

During this examination, the doctors discovered that not only was I 26 weeks pregnant, but I also was in labor and 4 cm dilated probably from playing football with the boys the night before. I was shocked by the news. My mind was racing. My heart was beating so fast. The doctors and my mother decided the best course of action was to give me some medicine to stop the labor.

They admitted me to the hospital to be monitored closely overnight. My mother left for the evening and promised that she would return first thing in the morning. I was alone. I was scared and I was very confuse -- very confused because not only did I not know that I was pregnant, I also did not feel the pain that most described as contractions and I was now being left in a strange place overnight without my mother.

At 5:30 in the morning and before my mother could even return, a nurse came in the room and looked at my monitors and stated that the contractions are increasing

instead of stopping. She called the doctor so that I could be examined again. During this check the doctor said, we are going to have to deliver this baby now. I did not feel any pain but I was still so frightened. I did not know what to do. In my mind I cried for my mother.

I would also -- I was told to push so I did. But when nothing happened, the nurses began to stimulate my breasts. Everything was so unclear to me. I asked myself, why is all of this happening to me. Finally at 8:30 a.m., I delivered a 1 pound, 9 ounce baby girl. She was whisked away in an incubator due to severe prematurity and to the NICU. My baby girl named Wavayna Miracle remained in the hospital for four months, hooked up to heart monitors, feeding tubes and various medical devices.

I was 15 years old. As a teen mom, I had to learn how to care for my tiny baby, what each piece of equipment attached to her was used for and to attend high school, maintain grades all while visiting my fragile baby in the NICU daily. The

hospital helped me, but they were not focused on having me learn all the -- the hospital helped me, but they were more so focused on having me learn the medical practice, that they did not look at my social needs.

I needed a social worker and I needed lactation support. After four months of struggling, my baby was sent home. Yes, it had -- it has been four months since I had delivered her, but I was a new mom, a teen mom to be exact. I felt like I was left alone to care for my child all by myself.

I had to quickly to put -- I had to quickly put everything I learned into use and at times, she stopped breathing. I had to learn to do CPR and to revive her. While my baby was battling to stay alive so was I. I attempted suicide due to the trauma and the stresses of being a new mom on top of my child's life being at risk.

Today I still feel the imprint of the marks of my experiences -- of the experiences it has left on my life. In 1994

I was in my late 20s when I got pregnant with my second baby. I was high risk due to my prior pregnancy. I had to wear a belt monitor twice daily for 15 to 20 minutes so they could transmit information to the doctors to make sure that the baby was okay. Having to do that did not reassure me and it caused me even more stress.

One morning I felt my baby kick my sac and had a slow leak of fluid. I feared I was going into labor. And that morning I had reservations about going to work, but the doctor reassured me that everything was okay. And as I was commuting to work, I felt the slow leak down my legs. I was thinking I will check it when I get to work.

I worked at an architect and engineering firm and it was a 10-floor building. While riding up the elevator, my water broke and gushed down my legs. I was in distress. The lady that was with me tried to help me. However, she did not know that I was pregnant since I barely had a stomach. I was only 28 weeks pregnant at the time.

When we reached to the reception area, the receptionist who happened to be my mother-in-law rushed and helped me and said, your water broke, so she hurriedly -- hurriedly got her car and we drove to the hospital. I was admitted, placed on observation once again.

As we were waiting for the doctor, the nurse alarmed me by telling me my baby's heart rate began to drop. That made me so worried. They started preparing me for emergency C-section. Everyone rushed out of the room. All was disheartened by what they had heard and seen.

At 6:30 in the evening, I delivered a 3 pound, 2 ounce baby girl. After three days, I was sent home but not with my baby. She had to stay in the NICU. I was so angry because I was not -- I was not allowed to leave with my baby. It was only my husband who was visiting her who bonded with her. Despite those circumstances, I was eager to breastfeed. The hospital staff gave me a hospital-grade pump to help pump my breast milk.

I was pumping multiple times a day to ensure my newborn was well-fed. With no assistance or a prior knowledge of breastfeeding, I accumulated whatever milk I had into a gallon container of which my husband would take to the hospital. However, when my hos -- when my husband gave the gallon of milk to the nurses, the nurses stated that the milk was contaminated due to improper storage. They said that there was no way that I could have accumulated that much milk with one pump session. They poured my hard work down the drain. They threw away my liquid gold.

At that moment I felt that society had failed me once again. And that was not the last time. In 1999 in my early 30s, I got pregnant with my third child. I was at risk due to my pregnant history, due to my age. At 20 weeks I had a procedure done to my cervix called a cerclage. It was a procedure to stitch up a women's cervix in an effort to maintain a full-term pregnancy.

After that, I was placed on bedrest for the remainder of my pregnancy. My

husband was working. My kids were at school. So most of the day I felt so lonely. I had no activity or work to do. I became depressed. One night during my 32nd week, I was awakened by feeling something wet on the bed. My water had broken. So my husband immediately went with me to the hospital where we -- where I was quickly provided with medicine to slow down my labor and placed on monitors for observation again.

My doctors immediately called, however -- my doctor was immediately called. However, he was on vacation so I was provided with a doctor on call. That doctor knew nothing about my case or history. After several hours of monitoring, the baby's heart rate began to drop so the decision was made to do emergency C-section. I was devastated. At 6:27 a 4 pound, 2 ounce baby boy was delivered and rushed to the NICU. My baby boy was fine despite early arrival.

These experiences show me that there's a clear lack of support for women,

especially women of color during their pregnancy and throughout their maternal health experience. I was a mother in three different social statuses. On welfare as a teenager, in my 20s of working class and married, and then median income in my 30s and married. In each of these varying statuses, I still received a lack of service.

The lack of service I received in the overall understanding of what I needed to care for myself and these tiny children wasn't communicated or understood. There was times where I couldn't even verbalize exactly what I needed because I was unclear myself. It was my faith in God and the strength that he gave me during these traumatic circumstances surrounding my childbirth and beyond, that I was allowed to be where I am today.

Having dealt with these life-altering births in both my teen and adult years led me to believe that there are some instances where maternal mortality can be prevented in mothers in the -- if mothers

were properly cared for during their process. For this reason, I founded the Pettaway Pursuit Foundation which promotes awareness in education to inform affected families about high-risk pregnancies and how to care for premature infants.

We recognize that this is an ongoing issue and has -- and we have rewritten this narrative by becoming the first organization to collaborate with insurance companies to offer doula support throughout the entire prenatal experience up to two months postpartum. So we've been doing the work since 2006.

Today we have helped save -- helped serve 2026 mothers in Pennsylvania, 276 mothers in Massachusetts and we are also serving Rhode Island as well. We will continue to journey wherever this pursuit will lead us and we are happy to help in any way we can.

COUNCILMAN GREENLEE: Thank you. Thank you for all the work you do. It's tremendous. Ma'am, please identify yourself and proceed.

MS. FIELDS: Latifah K. Fields, president of the National Coalition of 100 Black Women, Inc., Pennsylvania Chapter. I thank you today, Councilman Greenlee as well as Councilman Green for the opportunity to testify before you.

As we come off the heels of our National 19th Biennial Conference held October 9th through the 13th in Atlanta, Georgia where over 650 African-American women representing 63 chapters convened for leadership development, advocacy training, organizational awards, leadership elections and ultimately adopting over 14 resolutions, one of which is today's topic, I'd like to now read the National Coalition of 100 Black Women, Inc. 2019 Resolution on Maternal Mortality in African-American women adopted on October 12, 2019, whereas the National Coalition of 100 Black Women, Inc. here and known also as the Coalition is aware of and disturbed by the incidences of maternal mortality in African-Americans in the United States and whereas maternal mortality is defined as the death of a woman during

pregnancy, childbirth or within six weeks after birth and whereas recent statistics indicate an overwhelmingly disparity and incidences of maternal mortality among African-American women in the United States as compared to other developed countries and whereas Black expectant and new mothers in the U.S. die at about the same rate as women in countries such as Mexico and Uzbekistan according to the World Health Organization estimates, and whereas the 2019 National Public Radio series on Lost Mothers, maternal mortality in the U.S. includes information that there is racial disparity across income.

In recent years as high rates of maternal mortality in the U.S. have alarmed researchers, one statistic has been specially concerting -- concerning. According to the CDC, Black mothers in the U.S. die at three to four times the rate of White mothers; 243 percent more likely to die from pregnancy or childbirth-related causes. In the National Study of Five Medical Complications, there are common

causes of maternal death and injury, Black women were two to three times more likely to die than White women who had the same condition. And furthermore what's even more relatively well off, Black women die and nearly die at higher rates than Whites.

New York City offers a startling example. A 2016 analysis of five years of data found that Black college-educated mothers who gave birth in local hospitals were more likely to suffer severe complications of pregnancy or childbirth than White women who never graduated from high school, and whereas the Coalition finds these disparities and risk factors to be reprehensible in our well-developed country.

And furthermore, African-American women everywhere are to be given the same respect and level of care as other women throughout and after pregnancy process and whereas the Coalition finds that it appears that this is an intrinsic and systematic problem within our nation's health system where African-American women are at an extraordinarily higher risk death during and

after childbirth at rates exceptionally higher than White women across income levels, education and access to health care.

Therefore be it resolved, that the National Coalition of 100 Black Women, Inc. is charging our United States legislative body to prioritize research and preventative methodology to correct and eradicate the reprehensible practices and attitudes in our healthcare system that allows these disparities that result in the death of African-American women. Access without equality is inequality and inequity in health care, is not acceptable at any level.

I wrap up by asking that the National Coalition of 100 Black Women, Inc., Pennsylvania Chapter, the premiere health education, economic empowerment and public policy advocate for Black women and girls here in Pennsylvania be invited to the table for all legislation going forward as nationally mandated. I thank you for the opportunity to testify today and look forward to partnering together to support Resolution 190040. Thank you.

COUNCILMAN GREENLEE: Thank you very much. I think I can speak for the whole Committee, certainly Chairwoman Bass and the whole Committee, that there was some very good testimony here today. This won't be the end. I know that the Committee is going to address this issue. But again, we thank everybody for taking the time, I know it was a long day, taking the time and hanging in there and giving us your viewpoints. So again, thank you all very much and with that, the hearing on Resolution No. 190040, it will be held to the call of the Chair.

Thank you all very much.

MS. FIELDS: Thank you.

(At this time, the Public Hearing adjourned at 4:36 p.m.)

C E R T I F I C A T I O N

I, hereby certify that the proceedings and evidence noted are contained fully and accurately in the stenographic notes taken by me in the foregoing matter, and this is a correct transcript of the same.

_____
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