

Committee on Public Health and Human Services
October 15, 2019

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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2 COUNCILWOMAN BASS: Good afternoon.

3 Good afternoon. This hearing is called to
4 order. This is the Public Hearing of the
5 City Council Committee on Public Health and
6 Human Services. The purpose of this meeting
7 is to hear testimony on Resolution No.
8 190040. The Members of the Committee in
9 attendance are myself and Councilman Bill
10 Greenlee and we expect others to be joining
11 us throughout the course of this hearing.
12 And now if we could have the Clerk read the
13 title of Resolution No. 190040.

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

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

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

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

7 COUNCILWOMAN BASS: Right.

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

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

17 THE CLERK: State Rep. Morgan
18 Cephas.

19 COUNCILWOMAN BASS: Good afternoon,
20 Representative.

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

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

25 MS. CEPHAS: I'm well.

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

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

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

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

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

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

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

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

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

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

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

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

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

25 Over the past several months in

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

17 Alongside the many stakeholders,
18 these efforts have led to securing millions
19 of dollars in grants at both the local and
20 state level. Just last month Governor Tom
21 Wolf announced a CDC grant funding award for
22 the Pennsylvania Maternal Mortality Review
23 Committee which supports the Philadelphia
24 Review Committee, and we were able to secure
25 \$2.25 million.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 So I again thank you for having

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

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

14 MS. CEPHAS: Yes, Lashana.

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

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

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

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

1 anyone else have questions?

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

5 THE CLERK: Edward Gilmore?

6 (No response.)

7 COUNCILWOMAN BASS: Okay.

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

10 (Panel approaches Witness Table.)

11 COUNCILWOMAN BASS: Good afternoon.

12 MS. MULLA: Good afternoon.

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

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

17 COUNCILWOMAN BASS: Please begin
18 your testimony.

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

25 I am an obstetrician and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Public Health and a practicing OB/GYN in
2 Philadelphia.

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

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

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

1 States in 2010.

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

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

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

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

3 Over the course of over 30
4 meetings, the Philadelphia Maternal
5 Mortality Review Team has gained knowledge
6 and insight about maternal morbidity and
7 mortality by reviewing over 200
8 pregnancy-associated deaths of Philadelphia
9 residents. Based on aggravated surveillance
10 data from deaths that occurred from 2010 to
11 2018, and all of these are preliminary
12 numbers, 30 percent of these deaths were
13 categorized as pregnancy-related.

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

1 non-Hispanic women have accounted for 15
2 percent.

3 The Philadelphia maternal mortality
4 data set has thus far revealed that 40
5 percent of all reviewed deaths had a
6 diagnosis of mental health history and 60
7 percent have had a previous and/or current
8 substance use disorder. Overdose-related
9 deaths, which have risen dramatically in
10 Philadelphia's general population, has
11 likewise risen rapidly among pregnancy and
12 postpartum women, whereas 25 percent of
13 reviewed maternal deaths between 2010 and
14 2016 were due to accidental drug
15 intoxications. That percentage has
16 increased to 38 percent of reviewed maternal
17 deaths from 2017 and '18.

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

1 While there is no formal system in
2 place to move these recommendations forward,
3 the Maternal Mortality Review Team, the
4 Maternal Health Partners develop
5 collaborative teams to begin addressing
6 recommendations. Successes include the
7 creation of a centralized referral system
8 for home visiting services which is
9 currently in its implementation phase, a
10 prenatal lab-sharing agreement to facilitate
11 health information exchange among all
12 delivery hospitals, Medicaid reimbursement
13 for immediate postpartum long-acting
14 reversible contraception and a City-wide
15 educational program focused on screening,
16 brief intervention and referral to treatment
17 for substance use disorder in pregnancy.

18 Though progress has been made, more
19 investment is needed to scale up and develop
20 innovative interventions to improve the way
21 in which women are cared for during
22 pregnancy and after they give birth.

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

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

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

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

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

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

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

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

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

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

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

7 The problem that we have is when we
8 find the solutions, the opportunities for
9 intervention for intimate partner violence
10 are limited at best and certainly not
11 reimbursed. So we must rely on grants,
12 philanthropy or just doing the right thing
13 to help patients. We at Einstein deliver
14 3,000 babies a year.

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

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

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

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

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

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

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

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

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

1 behalf, and we are their advocates.

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

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

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

13 Councilwoman Sanchez?

14 COUNCILWOMAN QUINONES-SANCHEZ:

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

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

1 (Panel member raised hand.)

2 COUNCILWOMAN QUINONES-SANCHEZ: Can
3 you speak to its diversity on some of the
4 issues that are being highlighted here?

5 MS. MEHTA: Sure. So it's a
6 multi-diversity team. Dr. Mulla actually
7 sits on it. It's a number of different
8 stakeholders from community-based
9 organizations as well as representatives
10 from different areas of the -- both Health
11 Department, we have people from insurance
12 companies that are represented there, we
13 have doctors, midwives and not just OB/GYNs,
14 but we have cardiologists on the team,
15 critical care physicians so mostly
16 concerning the medical community as well
17 as --

18 COUNCILWOMAN QUINONES-SANCHEZ: Is
19 it diverse? One of the issues we're talking
20 about --

21 MS. MEHTA: Oh, yes.

22 COUNCILWOMAN QUINONES-SANCHEZ: --
23 is people of color.

24 MS. MEHTA: It is diverse, yes.

25 COUNCILWOMAN QUINONES-SANCHEZ: Are

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

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

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

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

25 MS. MEHTA: Yeah, that's already

1 being considered and we'll be honoring that
2 definitely.

3 COUNCILWOMAN QUINONES-SANCHEZ:

4 Okay. So operationalize for me what this
5 Community Action Team will be doing.

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

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

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

25 COUNCILWOMAN QUINONES-SANCHEZ: So

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

4 MS. MEHTA: So this Action Team is
5 really the action arm of the Review Team.

6 So let's say the Review Team reviews cases
7 that come up with recommendations. In the
8 past, these recommendations were hoping that
9 an advocate or somebody that's already

10 working in the community will take that up
11 and do that. So this will more

12 structuralize it. So we'll say, okay, these
13 are the things that are going on right now.

14 How can we move forward these

15 recommendations in a more streamlined

16 fashion. So people on this Action Team will

17 be already members, community members that

18 are working, you know, in these different

19 aspects.

20 So if we're thinking about prenatal

21 care, we already have a collaborative of all

22 of the labor and delivery hospitals that

23 meet monthly, as the leadership -- the

24 nursing leadership as well as the physician

25 leadership of each of the hospitals, so

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

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

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

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

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

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

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

24 COUNCILWOMAN QUINONES-SANCHEZ:
25 Okay.

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

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

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

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

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

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

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

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

19 MS. MEHTA: Five.

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

25 MS. MEHTA: Yeah. So I trained at

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

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

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

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

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

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

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

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

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

25 COUNCILWOMAN QUINONES-SANCHEZ: No,

1 it doesn't.

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

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

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

1 these specific circumstances.

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

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

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

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

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

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

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

1 hopefully make it beyond their first
2 birthday.

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

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

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

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

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

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

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

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

3 COUNCILWOMAN REYNOLDS BROWN: Okay.

4 So that goes to Councilwoman Sanchez's
5 remarks and/or concerns. How do you
6 operationalize what that looks like?

7 MS. MEHTA: What what looks like
8 exactly?

9 COUNCILWOMAN REYNOLDS BROWN: The
10 coordination piece.

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

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

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

1 getting access to records.

2 COUNCILWOMAN REYNOLDS BROWN: I
3 see.

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

13 COUNCILWOMAN REYNOLDS BROWN: I
14 see.

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

17 COUNCILWOMAN REYNOLDS BROWN:
18 Achievements.

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

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

7 COUNCILWOMAN REYNOLDS BROWN: I
8 see.

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

17 COUNCILWOMAN REYNOLDS BROWN:
18 Terrific.

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

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

1 Thank you for lifting this issue
2 back on the radar screen. When I came here
3 20 years ago, we were discussing this issue.
4 So I see that --

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

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

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

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

1 just established ours in I want to say in
2 2017 or -- yes, in 2017 of --

3 MS. MEHTA: 2018.

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

8 COUNCILWOMAN REYNOLDS BROWN:
9 Across the Commonwealth.

10 MS. CEPHAS: Across the
11 Commonwealth.

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

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

25 I believe there was one -- I don't

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

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

24 COUNCILWOMAN REYNOLDS BROWN: Wow.

25 MS. CEPHAS: -- because again,

1 majority of the deaths are happening during

2 I feel like we call it the fourth period?

3 MS. MEHTA: The fourth trimester.

4 MS. CEPHAS: The fourth trimester.

5 I'm trying to get the lingo myself. So
6 that's one of the areas of interest. Some
7 other states have passed legislation to
8 certify doula care, require insurance
9 companies to reimburse doulas. California
10 naturally is always leading the way on all
11 of these things. They are requiring their
12 medical institutions, providers,
13 practitioners to take on implicit bias
14 training to address some of the racial
15 disparities that we have within this space.

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

21 COUNCILWOMAN REYNOLDS BROWN:

22 Really such a waste of time and waste of
23 money.

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

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

7 COUNCILWOMAN REYNOLDS BROWN: Wow.

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

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

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

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

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

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

25 The opioid issue has been something

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

3 COUNCILWOMAN REYNOLDS BROWN:

4 Agreed. Thank you very, very much on your
5 leadership on this issue.

6 MS. CEPHAS: Thank you.

7 COUNCILWOMAN REYNOLDS BROWN: Thank
8 you, Madam Chairwoman.

9 COUNCILWOMAN BASS: Thank you,
10 Councilwoman. Councilwoman Gym?

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

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

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

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

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

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

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

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

1 of their deliveries came from the
2 Philadelphia Health Center in conjunction
3 with their Women's Care Center, so the
4 Philadelphia Health Center which was about
5 800 deliveries in that time period, they
6 were warmly handed off to the same providers
7 but at Jefferson, so there was sort of the
8 same -- it would have been the same way that
9 they would have gone to Hahnemann, they went
10 to Jefferson with the same midwives and
11 everyone caring for them and the midwives
12 still continued to care for them in the
13 health centers.

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

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

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

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

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

25 MS. MEHTA: No. So --

1 COUNCILWOMAN GYM: -- anything like
2 that so --

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

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

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

4 MS. MULLA: Right.

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

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

15 MS. MEHTA: To Jefferson.

16 COUNCILWOMAN GYM: To Jefferson.
17 Forever?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 MS. MEHTA: Yes.

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

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

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

1 on that.

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

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

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

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

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

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

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

15 COUNCILWOMAN BASS: Thank you,
16 Council lady. Councilman Green?

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

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

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

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

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

12 MS. CEPHAS: Yes.

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

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

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

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

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

1 with funding.

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

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

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

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

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

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

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

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

25 COUNCILMAN GREEN: Thank you, Madam

1 Chair.

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

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

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

22 (Panel approaches Witness Table.)

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

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

3 COUNCILWOMAN BASS: Please begin
4 your testimony.

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

7 COUNCILWOMAN BASS: Okay.

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

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

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

1 more than 160 pregnancy-associated deaths in
2 Philadelphia residents between 2010 and
3 2018.

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

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

25 But today what I'd like to talk to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 When it comes time for her next

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

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

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

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

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

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

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

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

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

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

5 MS. REEVES: Thank you.

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

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

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

20 COUNCILWOMAN BASS: Okay.

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

23 COUNCILWOMAN BASS: All right.

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

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

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

13 COUNCILWOMAN BASS: Okay.

14 MR. GILMORE: I'm a Vietnam
15 veteran. I worked for the U.S. Postal
16 Service 37 years, retired as a high-level
17 manager. So when it comes to health care,
18 my kids got the best health care. Yet and
19 still my daughter died at childbirth July
20 26th. I saw my daughter the day before.
21 She was in perfect health.

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

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

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

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

1 total shock.

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

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

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

1 testimony. Thank you very much.

2 COUNCILWOMAN BASS: Well, I thank
3 you.

4 (Applause.)

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

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

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

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

10 MR. GILMORE: I want to add to
11 that.

12 COUNCILWOMAN BASS: Yes.

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

18 COUNCILWOMAN BASS: Yes.

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

22 COUNCILWOMAN BASS: That's right.

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

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

3 COUNCILWOMAN BASS: Absolutely.

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

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

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

16 MR. GILMORE: Thank you.

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

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

24 MR. GILMORE: Thank you.

25 MS. AHMAD: We must do better.

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

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

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

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

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

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

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

7 We need immediate measures such as
8 ongoing implicit bias training and strong
9 consequences when such bias is detected.

10 Another effective measure that can
11 immediately reduce the number of Black
12 mothers dying is the use of doulas, has been
13 mentioned already, trained birth coaches who
14 provide women with physical and emotional
15 support during pregnancy, preparing them
16 with what to expect and amplifying their
17 voice at childbirth and the postpartum
18 period.

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

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

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

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

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

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

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

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

22 (Applause.)

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

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

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

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

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

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

1 part of the record. Thank you.

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

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

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

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

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

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

25 This particular program finds

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 walk with them with respect.

2 Community-based doula programs also promote
3 economic and professional growth and
4 sufficiency. Many of the people who had the
5 support of one of our doula networks later
6 became trained doulas themselves. Many of
7 our trained birth workers have formed their
8 own groups and projects and have gone on to
9 nursing or midwifery school or have now jobs
10 in maternal and infant health arena.

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

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

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

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

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

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

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

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

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

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

1 to my dysfunctional labor.

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

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

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

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

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

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

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

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

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

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

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

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

20 (Applause.)

21 COUNCILMAN GREENLEE: Hold on one
22 second. Councilwoman Gym?

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

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

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

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

25 COUNCILWOMAN GYM: But someone's

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

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

12 COUNCILWOMAN GYM: Okay.

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

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

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

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

11 COUNCILWOMAN GYM: Yeah, thank you
12 much.

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

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

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

23 THE CLERK: She --

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

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

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

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

1 tell anyone.

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

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

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

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

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

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

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

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

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

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

1 thrive.

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

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

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

1 '80s, and we are still recovering. Studies
2 have shown that there is a physiological
3 response to trauma and addiction is one of
4 them. We need the support of our City
5 officials, hospitals, insurance companies
6 and community members to collectively combat
7 this issue. We need you. Thank you.

8 COUNCILMAN GREENLEE: Thank you
9 very much.

10 (Applause.)

11 COUNCILMAN GREENLEE: Who would
12 like to go next?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 leaders that understand both the most urgent
2 needs and the most viable solutions.

3 Dr. Jaspan already mentioned that for
4 medical students, medical schools and I
5 would echo the same for midwifery education.

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

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

1 community-based home visiting and primary
2 care.

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

11 As a midwife at Jefferson, I work
12 with providers on the front line of caring
13 for this population and can attest to the
14 dire nature of this crisis. The Pa
15 Perinatal Quality Collaborative reports that
16 opioid use rate per 1,000 maternal hospital
17 stays has increased from 3 per 1,000
18 maternal stays in 2000 and 2001 to a rate of
19 19.6 per 100 hospital stays in 2016 and '17.
20 Pregnancy-associated deaths related to
21 substance use disorder has risen
22 accordingly.

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

1 protecting moms and babies from overdose
2 deaths in pregnancy. Although federal law
3 allows certified nurse midwives to prescribe
4 medication-assisted therapy after completing
5 24 additional hours of training, state law
6 in Pennsylvania prevents CNMs from
7 appropriately prescribing this therapy.
8 Meaning, I cannot provide the optimal
9 evidence-based care to childbearing people
10 with opioid use disorder.

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

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

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

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

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

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

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

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

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

1 of 15.

2 During this examination, the
3 doctors discovered that not only was I 26
4 weeks pregnant, but I also was in labor and
5 4 cm dilated probably from playing football
6 with the boys the night before. I was
7 shocked by the news. My mind was racing.
8 My heart was beating so fast. The doctors
9 and my mother decided the best course of
10 action was to give me some medicine to stop
11 the labor.

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

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

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

8 I would also -- I was told to push
9 so I did. But when nothing happened, the
10 nurses began to stimulate my breasts.
11 Everything was so unclear to me. I asked
12 myself, why is all of this happening to me.
13 Finally at 8:30 a.m., I delivered a 1 pound,
14 9 ounce baby girl. She was whisked away in
15 an incubator due to severe prematurity and
16 to the NICU. My baby girl named Wavayna
17 Miracle remained in the hospital for four
18 months, hooked up to heart monitors, feeding
19 tubes and various medical devices.

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

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

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

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

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

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

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

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

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

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

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

1 I was pumping multiple times a day
2 to ensure my newborn was well-fed. With no
3 assistance or a prior knowledge of
4 breastfeeding, I accumulated whatever milk I
5 had into a gallon container of which my
6 husband would take to the hospital.

7 However, when my hos -- when my husband gave
8 the gallon of milk to the nurses, the nurses
9 stated that the milk was contaminated due to
10 improper storage. They said that there was
11 no way that I could have accumulated that
12 much milk with one pump session. They
13 poured my hard work down the drain. They
14 threw away my liquid gold.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 Thank you all very much.

16 MS. FIELDS: Thank you.

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

Court Reporter - Notary Public

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this transcript does not apply to any
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