SB2234

Measure Title:	RELATING TO CHILD AND MATERNAL DEATH REVIEWS.
Report Title:	Child and Maternal Death Reviews; Department of Health; Reporting; Appropriation ($)
Description:	Appropriates funds to the department of health to conduct child death reviews and implement a program to perform maternal death reviews. Requires the department of health to submit an annual report to the legislature relating to child and maternal deaths and death reviews in the State.
Companion:	HB1788
Package:	Keiki Caucus
Current Referral:	CPH, WAM
Introducer(s):	CHUN OAKLAND, HARIMOTO, RUDERMAN, SHIMABUKURO, Galuteria, Keith-Agaran, Kim, L. Thielen

DAVID Y. IGE
GOVERNOR OF HAWAII

VIRGINIA PRESSLER, M.D.
DIRECTOR OF HEALTH

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

Testimony COMMENTING on S.B. 2234
Relating to Child and Maternal Death Reviews

SENATOR ROSALYN BAKER, CHAIR
SENATE COMMITTEES ON COMMERCE, CONSUMER PROTECTION, AND HEALTH
Hearing Date: February 9, 2016 Room Number: 229

Fiscal Implications: SB 2234 appropriates $150,000 to the Departmet of Health (DOH) for fiscal year 2016-2017 to conduct child death reviews and implement a program for the performance of maternal death reivews. DOH defers to the Governor's Supplemental Budget Request for its fiscal priorities regarding the general fund appropriation.

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

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

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

Both maternal mortality reviews and child death reviews, as a combined maternal and child mortality framework described in S.B. 2234, will provide the foundation for a coordinated approach to address local systems and policies to improve maternal and child health.

Thank you for this opportunity to testify.

Offered Amendments: None

DAVID Y. IGE
GOVERNOR

RACHAEL WONG, DrPH
DIRECTOR

PANKAJ BHANOT
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809-0339

February 8, 2016

TO: The Honorable Rosalyn H. Baker, Chair
Senate Committee on Commerce, Consumer Protection, and Health

FROM: Rachael Wong, DrPH, Director

SUBJECT: SB 2234, Relating to Child and Maternal Death Reviews

Hearing: Tuesday, February 9, 2016 at 9:00 a.m.
Conference Room 229, State Capitol

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

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

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

Thank you for the opportunity to testify.

March of Dimes Foundation

Hawaii Chapter
1580 Makaloa Street, Suite 1200
Honolulu, HI 96814
Telephone (808) 973-2155
Inter-island 1-800-272-5240
Fax (808) 973-2160

marchofdimes.org/hawaii

Date: February 8, 2016

To: Senator Rosalyn Baker, Chair
Senator Michelle Kidani, Vice Chair

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

Re: In support of
SB 2234
Hearing: Tuesday, February 9, 2016
Conference Room 229, State Capitol

Chair Baker, Vice Chair Kidani, Members of the Committees:

I am writing to express strong support for SB 2234: Child and Maternal Death Review

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

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

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

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

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

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

Senate Bill SB 2234 provides for the Department of Health to begin again to conduct child death reviews and to implement maternal death reviews in Hawaii.

The March of Dimes supports SB 2234 for its potential public health surveillance to improve monitoring of maternal and child health and better inform prevention and intervention strategies. Mahalo for your support.

1319 Punahou Street
Honolulu, Hawai'i 96826-1001

KAPI'OLANI
MEDICAL CENTER
FOR WOMEN & CHILDREN
An Affiliate of Hawai'i Pacific Health

808-983-6000
www.kapiolani.org

February 9, 2016 at 9:00 AM
Conference Room 229

Senate Committee on Commerce, Consumer Protection, and Health

To: Sen Rosalyn H. Baker, Chair
Sen Michelle N. Kidani, Vice Chair

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

Re: SB 2234 - Testimony in Strong Support

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

Kapi'olani **strongly supports** SB 2234 which makes an appropriation to the Department of Health to conduct child death reviews and implement a program to perform maternal death reviews**.**

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

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

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

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

Thank you very much for the opportunity to testify on this measure. I ask that you pass this very important measure.
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KAPIOLANI CHILD PROTECTION CENTER
55 Merchant St., 22nd Floor
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KAPI'OLANI
CHILD PROTECTION
CENTER
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www.kapiolani.org/child-protection -center

DATE: February 9, 2016

TO: The Honorable Rosalyn Baker, Chair
The Honorable Michelle Kidani, Vice Chair
Senate Committee on Commerce, Consumer Protection, and Health

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

RE: Testimony in Strong Support of S.B. 2234
Relating to Child and Maternal Death Reviews

Good morning Chair Baker, Vice Chair Kidani, and members of the Senate Committee on Commerce, Consumer Protection, and Health.

The Kapiolani Child Protection Center (KCPC) strongly supports S.B. 2234, which appropriates funds to the Department of Health to conduct child death reviews and implement a program to perform maternal death reviews, and further requires the Department of Health to submit an annual report to the legislature relating to child and maternal deaths and death reviews in the State.

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

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

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

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

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

Likewise, Hawaii is one of only 13 states that are not currently conducting Maternal Death Reviews (MDR) for women who pass away during pregnancy or in the year following pregnancy, even though such maternal mortality is increasing nationwide and it is recognized that up to 50% of maternal deaths are preventable. In Hawaii, approximately 9 maternal deaths are identified each year, corresponding to an average of 19,000 births per year. Unfortunately, it is our understanding that although Hawaii law authorizes the performance of MDRs and Hawaii once possessed a program to conduct such reviews, that program has also been defunct since the early 2000s.

S.B. 2234 would allow the Department of Health to establish a funded unit with its Maternal and Child Health Branch to ensure the ongoing performance of maternal and child death reviews through a sustainable program, while keeping the Legislature and the public reasonably informed of the unit's activities and the progress of the review processes.

Moreover, it is our understanding, based on ongoing discussions with Department of Health personnel and other agency and community stakeholders, that the combined child and maternal death review unit envisioned by S.B. 2234 makes sense for several important reasons. Many factors responsible for infant death and serious injury are shared with maternal mortality, and so there is subject matter overlap between the two review processes. Moreover, coordination and medical abstracting skills and knowledge can be cross applied to both types of death review; there is overlap between the internal Department of Health and other state agency resources which would likely be called upon for consultation and assistance in both processes; and the number of maternal deaths (about 9 per year) relative to child deaths (about 170 per year) supports establishing and sustaining a shared unit that is empowered to organize the performance of both review processes.

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

Therefore, we respectfully urge you to join us in strongly supporting S.B. 2234.

February 8, 2016 TESTIMONY: Written only

To: The Honorable Rosalyn H. Baker, Chair
The Honorable Michelle N. Kidani, Vice Chair
Members of the Senate Committee on Commerce, Consumer Protection, and Health

From: **Hawaii Public Health Association**

Subject: **SUPPORT – SB 2234** RELATING TO CHILD AND MATERNAL DEATH REVIEWS

Hearing: February 9, 2016 at 9:00 am at State Capitol Room 229

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

HPHA **supports the passage of SB 2234** which appropriates funds to the Department of Health to conduct child death reviews and implement a program to perform maternal death reviews.

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

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

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

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

Thank you for the opportunity to testify in support of **SB 2234**, which would resume child death reviews and implement a program to conduct maternal death reviews.

Respectfully submitted,

Hoce Kalkas, MPH
HPHA Legislative and Government Relations Committee Chair

55 Merchant Street
Honolulu, Hawai'i 96813-4333

www.hawaiipacifichealth.org

February 9, 2016 at 9:00 AM
Conference Room 229

Senate Committee on Commerce, Consumer Protection, and Health

To: Sen Rosalyn H. Baker, Chair
Sen Michelle N. Kidani, Vice Chair

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

Re: SB 2234 - Testimony in Strong Support

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

HPH **strongly supports** SB 2234 which makes an appropriation to the Department of Health to conduct child death reviews and implement a program to perform maternal death reviews**.**

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

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

SB 2234 also provides a more adequate level of resources to ensure its goals are met.

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

From: mailinglist@capitol.hawaii.gov
To: CPH Testimony
Cc: gbreakey@gmail.com
Subject: Submitted testimony for SB2234 on Feb 9, 2016 09:00AM
Date: Friday, February 05, 2016 5:19:55 PM
Attachments: SB2234_DOC.htm

SB2234
Submitted on: 2/5/2016
Testimony for CPH on Feb 9, 2016 09:00AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Gail F Breakey	Hawaii Association for Infant Mental Health.	Support	No

Comments:

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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From: mailinglist@capitol.hawaii.gov
To: CPH Testimony
Cc: mrocca@hscadv.org
Subject: *Submitted testimony for SB2234 on Feb 9, 2016 09:00AM*
Date: Friday, February 05, 2016 3:54:59 PM

SB2234
Submitted on: 2/5/2016
Testimony for CPH on Feb 9, 2016 09:00AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Michelle Rocca	Hawaii State Coalition Against Domestic Violence	Support	No

Comments:

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From: mailinglist@capitol.hawaii.gov
To: CPH Testimony
Cc: lea.tiare@gmail.com
Subject: Submitted testimony for SB2234 on Feb 9, 2016 09:00AM
Date: Saturday, February 06, 2016 5:06:00 PM

SB2234
Submitted on: 2/6/2016
Testimony for CPH on Feb 9, 2016 09:00AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Lea Minton	Individual	Support	No

Comments: I support SB2234 in appropriating funds for the child death review, and I understand the need to combine a maternal mortality review under this act as well. I read the Department of Health's testimony regarding SB2317 (Maternal Mortality Review Panel) and agree with their financial concerns. However, my concern with SB2234 is that it does not specifically include a panel of members to conduct the review, instead laying the review solely on the Department of Health. This gives me pause as the purpose of having a representative panel, both for child and maternal mortality review panels, is to ensure that we are learning from the mortalities and making appropriate health care practice changes. Thank you for your time and consideration on this important matter.

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

To: Senate Committee on Commerce, Consumer Protection, and Health
Senator Rosalyn Baker, Chair
Senator Michelle Kidani, Vice Chair

DATE: Tuesday, February 9, 2016
TIME: 9:00 A.M.
PLACE: Conference Room 229

FROM: Autumn Broady, MD, MPH

Re: SB2234 Relating to Child and Maternal Death Reviews

Position: Strongly Support

Dear Senators Baker, Kidani and Committee Members:

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

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

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

work: unlike overall United States data with rising maternal death rates, the United Kingdom and the state of California have decreased their maternal mortality by instituting programs aimed at preventable causes of death. Findings from review panels guide the creation of treatment protocols, education campaigns and standardization of pregnancy care.

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

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

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

Kelly Yamasato, MD
740 Sunset Avenue
Honolulu, HI 96816

To: Senate Committee on Commerce, Consumer Protection, and Health
Senator Rosalyn Baker, Chair
Senator Michelle Kidani, Vice Chair

DATE: Tuesday, February 9, 2016
TIME: 9:00 A.M.
PLACE: Conference Room 229

FROM: Kelly Yamasato, MD

Re: SB2234 Relating to Child and Maternal Death Reviews

Position: Strongly Support

Dear Senators Baker, Kidani and Committee Members:

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

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

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

work: unlike overall United States data with rising maternal death rates, the United Kingdom and the state of California have decreased their maternal mortality by instituting programs aimed at preventable causes of death. Findings from review panels guide the creation of treatment protocols, education campaigns and standardization of pregnancy care.

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

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

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

Date: February 6, 2016

To: Senator Rosalyn Baker, Chair
Senator Michelle Kidani, Vice Chair

From: JoAnn Farnsworth
Farnsworth Consulting

Re: In support of **SB 2234**
Hearing: Tuesday, February 9, 2016

Chair Baker, Vice Chair Kidani, Members of the Committees:

My name is JoAnn Farnsworth and I have worked in the field of child and maternal health for thirty years here in Hawaii and I am writing to express strong support for SB 2234: Child and Maternal Death Review. Child and maternal death reviews should be part of every state's core public health function of assessment and improving health care access and quality. The purpose of reviewing pregnancy-related and child deaths is to gain insight into the medical and social factors that lead to these events in order to decrease such deaths in the future.

Passage of SB 2234 is critical for the following reasons:

- Deaths of a child or a pregnant woman are sentinel events that require proper investigations to understand the underlying causes and opportunities for prevention.

- Mortality reviews identify **missed opportunities** and **remediable factors** in cases of child and maternal deaths

- There is **no allocation of resources** to ensure the ongoing conduct of maternal and child death reviews. Establishment of a **permanently funded** unit within MCH, DOH to conduct regular reviews of all child and maternal deaths addresses sustainability.

- Many factors responsible for infant mortality are shared with maternal mortality. **It just makes sense to combine resources** for these reviews.

- Findings from review panels guide the creation of treatment protocols, education campaigns and standardization of care and will **reduce child and maternal deaths**.

- **Hawaii is one of only 13 states not conducting** maternal mortality reviews
    - Maternal mortality is **increasing**
    - Up to **50% of maternal mortality is preventable**
- There are approximately 10 maternal deaths/year in Hawaii; our state maternal death rate mirrors national rates

- **Hawaii**, as of 2013, is **one of only two states not conducting** Child Death Reviews
    - **75% of child deaths in Hawaii** were found to be **preventable**
    - There are approximately 170 child deaths/year in Hawaii

From: mailinglist@capitol.hawaii.gov
To: CPH Testimony
Cc: joyamarshall0416@gmail.com
Subject: *Submitted testimony for SB2234 on Feb 9, 2016 09:00AM*
Date: Thursday, February 04, 2016 7:58:50 PM

SB2234
Submitted on: 2/4/2016
Testimony for CPH on Feb 9, 2016 09:00AM in Conference Room 229

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

Comments:

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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