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 21, 2016

TO: The Honorable Jill Tokuda, Chair
Senate Committee on Ways and Means

FROM: Rachael Wong, DrPH, Director

SUBJECT: **SB 2317 SD1 - Relating to Health**

Hearing: Tuesday, February 23, 2016 at 9:50 a.m.
Conference Room 211, State Capitol

DEPARTMENT'S POSITION: The Department of Human Services (DHS) supports the bill provided that its passage does not replace or adversely impact priorities indicated in the Executive Budget.

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.

HAWAII
STATE
COMMISSION
ON THE
STATUS
OF
WOMEN

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Catherine.a.betts@hawaii.gov
Visit us at:
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235 S. Beretania #407
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February 22, 2016

Testimony in Support, SB 2317, SD1, Relating to Health

To: Senator Jill N. Tokuda, Chair
Senator Donovan M. Dela Cruz, Vice Chair
Members of the Senate Committee on Ways and Means

From: Cathy Betts, Executive Director
Hawaii State Commission on the Status of Women

Re: Testimony in Support, SB 2317, SD1, Relating to Health

On behalf of the Hawaii State Commission on the Status of Women, I would like to express my support for SB 2317, SD1, which would establish a maternal mortality review panel to review maternal deaths in Hawaii as well as reinstate child death reviews.

The Centers for Disease Control (CDC), the American Congress of Obstetricians and Gynecologists, the World Health Organization, and the Association of Maternal & Child Health Programs, among many other organizations, strongly recommend that all states have a formal review process of maternal deaths to decrease maternal mortality and morbidity. Hawaii does not review maternal deaths, despite having a maternal mortality ratio of anywhere between 9-14 deaths per 100,000 live births.

According to the World Health Organization, 47 countries had lower maternal mortality ratios than the U.S. Nationally, women of color have a higher maternal mortality ratio than white women (CDC, NCHS). Yet, no similar data is currently publicly available or analyzed for Hawaii's multiethnic population.

Maternal mortality reviews highlight possible areas for system improvements and changes that can lead to better pregnancy care for all women and have been proven to work in other states and countries. Establishing a maternal mortality review panel will undoubtedly save lives. The Commission supports this measure and respectfully requests that you pass this bill with the appropriation of funds. Thank you for hearing this important measure.

DAVID Y. IGE
GOVERNOR OF HAWAII

VIRGINIA PRESSLER, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
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doh.testimony@doh.hawaii.gov

Testimony COMMENTING on S.B. 2317, S.D. 1
Relating to Health

SENATOR JILL N. TOKUDA, CHAIR
SENATE COMMITTEE ON WAYS AND MEANS

Hearing Date: February 23, 2016 Room Number: 211

Fiscal Implications: SB 2317, S.D. 1 appropriates $150,000 to the Department of Health (DOH) for fiscal year 2016-2017 to conduct child death reviews and implement a program for the performance of maternal death reviews. 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. 2317, S.D. 1, will provide the foundation for a coordinated approach to address local systems and policies to improve maternal and child health.

Areas within this measure or related to this measure needed to ensure implementation of bill requirements include having authorization to establish and fill a position; having a mechanism in place to identify and obtain the number of deaths of children in state custody (and causes of those deaths) during the calendar year prior to the year of submission of the annual report; and, having a system in place for obtaining timely data allowing for reporting the number of deaths of women while pregnant or within one year after a pregnancy, within twelve months prior to the submission of the annual report.

Thank you for this opportunity to testify.

Offered Amendments: None

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55 Merchant St., 22nd Floor
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KAPI'OLANI
CHILD PROTECTION
CENTER
An Affiliate of Hawai'i Pacific Health

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www.kapiolani.org/child-protection -center

DATE: February 23, 2016

TO: The Honorable Jill Tokuda, Chair
The Honorable Donavan Dela Cruz, Vice Chair
Senate Committee on Ways and Means

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. 2317 S.D. 1
Relating to Health

Good morning Chair Tokuda, Vice Chair Dela Cruz, and members of the Senate Committee on Ways and Means.

The Kapiolani Child Protection Center (KCPC) strongly supports S.B. 2317 S.D. 1, which 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; and requires that health care providers release information for the Department of Health or others to conduct studies to reduce maternal morbidity or mortality.

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

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

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

This represents a significant deficit in Hawaii's understanding of what has been killing and injuring our children and young people for the past decade, and lost opportunities to design programs to prevent deaths and serious harm from a range of sources, including but not limited to child abuse, unsafe sleep practices, drowning, and other emerging health and safety issues.

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

S.B. 2317 S.D. 1 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. 2317 S.D. 1 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. 2317 S.D. 1.

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 22, 2016

To: Senator Jill Tokuda, Chair
Senator Donovan Dela Cruz, Vice Chair

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

Re: In support of
SB 2317 SD1
Hearing: Tuesday, February 23, 2016
Conference Room 211, State Capitol

Chair Tokuda, Vice Chair Dela Cruz, Members of the Committees:

I am writing to express strong support for SB 2317 SD1: Child and Maternal Death Reviews

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 2317 SD1 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 2317 SD1 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.

55 Merchant Street
Honolulu, Hawai'i 96813-4333

www.hawaiipacifichealth.org

February 23, 2016 at 9:50 AM
Conference Room 211

Senate Committee on Ways and Means

To: Senator Jill Tokuda, Chair
Senator Donovan Dela Cruz, Vice Chair

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

Re: SB 2317, SD1 - 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 2317, SD1 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 objective 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.

American Congress of Obstetricians and Gynecologists
District VIII, Hawaii (Guam & American Samoa) Section
Greigh Hirata, MD, FACOG, Chair
94-235 Hanawai Circle, #1B
Waipahu, Hawaii 96797

THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

To: COMMITTEE ON WAYS AND MEANS
Senator Jill N. Tokuda, Chair
Senator Donovan M. Dela Cruz, Vice Chair

DATE: Tuesday, February 23, 2016
TIME: 9:50 a.m.
PLACE: Conference Room 211

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

Re: SB 2317, SD1 Relating to Health

Position: Strongly Support

Establishing the Maternal Mortality Review Panel

Dear Senator Tokuda, Senator Dela Cruz, and committee members:

The American Congress of Obstetricians and Gynecologists, Hawaii Section (Hawaii ACOG) strongly supports the establishment of a Hawaii Maternal Mortality Review Panel as well as the reinstatement of Child Death Review to conduct comprehensive, multidisciplinary reviews of maternal and child deaths towards improving maternal-child health in our state. Deaths of children and pregnant women 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 is logical to combine resources for theses reviews. The Hawaii State Department of Health (DOH) is supportive of this legislation.**

Field Code Changed

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 Women's Health.

February 22, 2016 TESTIMONY: Written only

To: The Honorable Jill N. Tokuda, Chair
The Honorable Donovan M. Dela Cruz, Vice Chair
Members of the Senate Committee on Ways and Means

From: **Hawaii Public Health Association**

Subject: **SUPPORT – SB2317 SD1** RELATING TO HEALTH: CHILD DEATH AND MATERNAL MORTALITY REVIEWS

Hearing: February 23, 2016 at 9:50am at State Capitol Room 211

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 SB2317 SD1** which appropriates funds to the Department of Health to conduct child death reviews and implement a program to perform maternal death reviews.

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

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

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

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

Thank you for the opportunity to testify in support of **SB2317 SD1**, which would allow funding to 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

1319 Punahou Street
Honolulu, Hawai'i 96826-1001

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

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www.kapiolani.org

February 23, 2016 at 9:50 AM
Conference Room 211

Senate Committee on Ways and Means

To: Senator Jill Tokuda, Chair
Senator Donovan Dela Cruz, Vice Chair

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

Re: SB 2317, SD1 - Testimony in 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 **supports** SB 2317, SD1 which appropriates funds to the Department of Health to conduct comprehensive reviews of child and maternal deaths that have occurred in the State and report findings to the legislature**.** We support the objective 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.

Program sustainability

I have some concern about the sustainability of a one-year appropriation and support all efforts to reinstate the maternal mortality review in a resource-conscientious, endurable manner.

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

Tuesday, February 23, 2016
9:50 AM
Conference Room 211

TO: Senate Committee on Ways and Means
Senator Senator Jill N. Tokuda, Chair
Senator Donovan M. Dela Cruz, Vice Chair

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

RE: SB2317 SD1 - RELATING TO CHILD AND MATERNAL DEATH REVIEWS

POSITION: Strongly Support

Dear Chair Tokuda, Vice Chair Dela Cruz, and Committee Members:

As the leader of a maternal health organization that cares and advocates for pregnant women and new mothers, **I strongly support SB2317 SD1**, establishing a Hawaii Maternal Mortality Review Panel and an appropriation to perform comprehensive reviews of Hawaii maternal deaths, as well as reinstate the Child Death Reviews.

Whereas the Centers for Disease Control, American Congress of Obstetricians and Gynecologists, World Health Organization, Association of Maternal & Child Health Programs, and many other organizations strongly recommend that all states have a formal review process to decrease maternal mortality and morbidity, Hawaii does not review maternal deaths.

A woman should not have to fear for her life in the event of childbirth. Maternal mortality reviews highlight possible areas for system improvements and changes that can lead to better pregnancy care for all women and have been proven to work in other states and countries. Hawaii's maternal death rate is comparable to the overall U.S. rate, however, we are the only developed country with an increasing maternal death rate and Hawaii is one out of only 13 states in the nation that does not conduct maternal mortality reviews.

It has also been found that 75% of child deaths in Hawaii were preventable, however, Hawaii is one of only two states in the nation not conducting child death reviews. We need to be able to evaluate and work to improve our rates of maternal and infant deaths, as states and countries with an established mortality review panels have been able to make a sizable impact on standards of care and prevention efforts.

Many factors responsible for infant mortality coincide with maternal mortality. Deaths of a child or a pregnant woman are vital events that should be required by law to be investigated to find the primary causes and ensure the greatest opportunity for education and prevention for the future. Taking steps to evaluate the causes and implement steps to prevent maternal and infant mortality is vital to our health system of care.

Please support Hawaii's women and keiki with this bill. Thank you for the opportunity to submit testimony on this important women's health issue.

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(808) 737-5805 lisak@hmhb-hawaii.org www.hmhb-hawaii.org

From: mailinglist@capitol.hawaii.gov
To: WAM Testimony
Cc: laurie.field@ppvnh.org
Subject: *Submitted testimony for SB2317 on Feb 23, 2016 09:50AM*
Date: Friday, February 19, 2016 4:12:00 PM

SB2317
Submitted on: 2/19/2016
Testimony for WAM on Feb 23, 2016 09:50AM in Conference Room 211

Submitted By	Organization	Testifier Position	Present at Hearing
Laurie Field	Planned Parenthood Votes Northwest and Hawaii	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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Date: February 19, 2016

To: Senator Tokuda, Chair
Senator Dela Cruz, Vice Chair

From: JoAnn Farnsworth
Farnsworth Consulting

Re: In support of **SB 2317SD 1**
Hearing: February 23, 2016

Chair Tokuda, Vice Chair Dela Cruz, 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 2317SD1: 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 2317SD1 with an appropriation of $150,000. 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