



January 20, 2022

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Written-only testimony in support of SB 42
Senate Committee on Public Health and Welfare

Chairman Hilderbrand and members of the Committee:

Thank you for the opportunity to provide testimony in support of SB 42, **which improves systems already in place for the study and investigation of maternal deaths in Kansas.** Kansas Action for Children is a nonprofit advocacy organization working to make Kansas a place where every child has the opportunity to grow up healthy and thrive. We work across the political spectrum to improve the lives of Kansas children through bipartisan advocacy, partnership, and information-sharing on key issues, including early learning and education, health, and economic security for families.

Pregnancy and the postpartum year following should be a safe and happy time for growing families. But for too many – and even one death is too many – it is a time of unexpected grief and loss. The Kansas Maternal Mortality Review (KMMR) Committee has started investigations into why pregnancy-associated deaths are occurring in Kansas. But we need to know much more about why these happen – and begin the systems work needed to address these deaths. SB 42 takes another step on that road.

Kansas released its first maternal mortality report in December 2020¹, which revealed that mothers during pregnancy, during birth, and up to a year after birth (postpartum) experience mortality (death) or severe maternal morbidity (serious complications that could lead to death). Between 2016–2018, 57 Kansas women died due to pregnancy-associated reasons². Between 2016–2019, 767 women experienced one or more severe maternal morbidities in connection with pregnancy, birth, or postpartum³.

As a state, we must be asking why these deaths and severe maternal morbidity issues connected to pregnancy occur, and how we can make changes to decrease these deaths and pregnancy complications.

¹ Kansas Maternal Mortality Review (2020). Kansas Maternal Mortality Report 2016–2018 Including Severe Maternal Morbidity, 2016–2019. https://kmmrc.org/wp-content/uploads/2021/02/KS-Maternal-Morbidity-Mortality-Report_Dec-2020_FINAL2-21.pdf

² Ibid.

³ Ibid.



SB 42 begins to codify some of these changes. The bill mandates that an external subcommittee be formed that includes stakeholders of color to review cases in which Black moms have died around childbirth. The 2020 KMMR report states, “The severe maternal morbidity rate for non-Hispanic Blacks was significantly higher than any other race and ethnicity” (p. 10)⁴. Of the deaths determined to be pregnancy-related, “racial and ethnic minorities were disproportionately affected. About two-thirds (8 deaths, 61.5%) were racial and ethnic minorities” (p.12)⁵. **Representation matters: those with lived experiences have insight that others may not have as to why some of these deaths may be occurring.**

SB 42 also adds a social determinants of health review form to the full committee’s review process. What are social determinants of health (SDH)? According to a brief from the Kaiser Family Foundation, SDH are “the conditions in which people are born, grow, live, work and age that shape health”⁶. Factors include transportation access, food access, home conditions and/or stability, job status, education, support networks, physical environments, treatment in society, and more. What do some of these factors look like?

- Did a new mother who died experience travel issues getting to her doctor’s appointments?
- Did she live far away from her doctor because she was in a rural area?
- Could she not afford or get access to healthier food choices?
- Did she have child care issues for other children in the house and couldn’t make appointments?
- Could she not take time off work to attend appointments?
- Was she supposed to be on bedrest for the last two months of pregnancy, but no one could help her out, and she had no time off from her job?
- Did she have to go back to work two weeks after her delivery to get a paycheck again despite wanting to follow doctor’s orders?

In order to determine why these deaths associated with pregnancy occur, we must learn much more about the conditions of the mom’s life prior to death or severe maternal morbidity. Knowing which social determinants of health factors could be contributing to these situations will help drive health care system changes and could lead to additional policy changes (such as connecting a pregnant mother with reliable transportation during and after her pregnancy if transportation access is an ongoing issue).

⁴ Kansas Maternal Mortality Review (2020). Kansas Maternal Mortality Report 2016-2018 Including Severe Maternal Morbidity, 2016-2019. https://kmmrc.org/wp-content/uploads/2021/02/KS-Maternal-Morbidity-Mortality-Report_Dec-2020_FINAL2-21.pdf

⁵ Ibid.

⁶ Artiga, S., & Hinton, E. (2018). Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. <https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>



Finally, SB 42 increases the ability to understand the data that is coming through maternal health care performance measures and requires the state to work with health care providers to improve the continuity of care during and after pregnancy. We ask you to favorably pass this bill from your committee.

Thank you for the opportunity to voice our support for SB 42, and please do not hesitate to contact me at heather@kac.org if you have any questions.