

# Rethinking maternal healthcare for the 21st century in the United States

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## Abstract

To date, the United States (U.S.) maternal mortality rate (MMR) is almost 30% higher than that of its global counterparts. With disproportionate maternal morbidities and mortalities across the U.S., the people look to governmental legislation to remedy the steadily rising cases of maternal and infant demise across various states. Health outcomes like postpartum hemorrhage, hypertension, and maternal infection during pregnancy are now important causes of maternal death across the U.S., conditions that were once sustainably treated and, therefore, preventable. Though maternal surveillance and legislation imparted by the Affordable Care Act (ACA) stipulated minor governance of maternal healthcare, indeed, rising maternal death tolls counter its effectiveness, showing disparate discrepancies across ethnicities. Comparative global country analysis reveals effective methods that need to be communicated in U.S. legislation for maternal care standardization and sustenance. States like California also offer tangible evidence of legislative change and maternal and infant outcome success. This paper provides an overview of the maternal and infant crisis in the U.S., provides insight into the current state of maternal surveillance and the ACA, compares the pros and cons of effective maternal healthcare in global countries, and offers a tangible solution to correct the maternal healthcare crisis in the United States of America.

**KEY WORDS:** America; care; crisis; healthcare, maternal healthcare; morbidity; mortality; United States; USA; maternal mortality rate.

## Riassunto

Ad oggi, il tasso di mortalità materna negli Stati Uniti d'America è di quasi il 30% più alto di quello degli altri Paesi del mondo. Con una morbilità ed una mortalità materna sproporzionata negli Stati Uniti d'America, le persone guardano agli interventi legislative presi dal governo per rimediare ai casi di morte di madri e di bambini che sono stabilmente crescenti tra i vari stati. Conseguenze negative per la salute come l'emorragia post-partum, l'ipertensione e l'infezione materna in gravidanza sono oggi importanti cause di morte materna negli Stati Uniti d'America, condizioni che una volta erano trattate in modo sostenibile e quindi prevenute. Sebbene la sorveglianza materna e la legislazione conferita dall'Affordable Care Act (ACA) abbiano determinato una minore governance della salute materna, l'aumento delle morti materne contrasta con la sua efficacia, evidenziando eterogenee discrepanze tra le etnie. Un'analisi comparativa a livello globale del Paese rivela che metodi efficaci necessitano di essere trasmessi nella legislazione statunitense per la standardizzazione della cura e del sostentamento materno. Stati come la California offrono un'evidenza concreta di cambiamento normativo e di outcome di successo a livello materno-infantile. Questo paper fornisce un quadro generale della crisi materno-infantile negli USA, fornisce conoscenza sullo stato attuale della sorveglianza materna e dell'ACA, confronta vantaggi e svantaggi dell'assistenza sanitaria materna di tutti i Paesi ed offre una soluzione tangibile per correggere la crisi dell'assistenza sanitaria materna negli USA.

### TAKE-HOME MESSAGE

*The lives of mothers and infants are invaluable. Without effective and thorough maternal healthcare policies in place in 21st century United States of America, more innocent lives will continue to perish across ethnicities with disparate discrepancies among racial minority mothers and children. The time to act is now; be the change you want to see in society.*

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## INTRODUCTION

To date, one of the recurrent health policy topics omnipresent in the American Presidential debates of 2020 is that of the state of maternal healthcare. While it is true that the United States of America allots a greater monetary denomination towards healthcare compared to other countries globally, many Americans still do not reap its benefits as a result of high costs and the greater likelihood of chronic disease [1]. Unfortunately, the acquisition and retention of maternal healthcare is no different. Yearly, about 1,200 American women undergo pregnancy or childbirth-related complications with fatal outcomes; 60,000 endure near-fatal outcomes despite the fact that maternity care surpassed 60 billion USD in 2012 [2]. Fatal maternal outcomes are also attributed to conditions such as postpartum hemorrhage, hypertension, and infection, among others [3].

Despite heightened awareness, ongoing research, and the plight to find a proactive solution to the maternal health crisis over the years, America has not done enough to change ominous mother-infant mortality statistics. Compared to the rest of the world, the United States (U.S.) now boasts a steadily increasing MMR of 26.4% per 100,000 births, a statistic that grimly contrasts the steadily decreasing MMRs worldwide [4]. Studies have shown that increased rates of cesarean sections, the absence of prenatal care, and heightened rates of obesity, diabetes, and heart disease are likely contributing factors that lead to higher American MMRs, factors that are manageable, highly treatable, and can likely improve overall patient health outcomes [1].

The purpose of this paper is to bring about change and draw attention to the absolute need for sustainable, effective, and financially responsible maternal and child healthcare in 21<sup>st</sup> century America. The paper will examine a brief overview of current literature including the pros and cons of maternal healthcare implementation worldwide, a summary of potential solutions, and a recapitulation of key points that emphasize the need for maternal healthcare in the U.S. today.

## DISCUSSION

### *Maternal surveillance, the Affordable Care Act, and global maternal care in the United States*

In general, maternal surveillance has occurred for centuries; since 1915 in the U.S., maternal death was monitored via the National Center for Health Statistics (NCHS) by means of state death certificates and reporting statistics such as MMRs, or maternal deaths per 100,000 live births [3]. Health policies have also targeted expanded insurance coverage objectives for maternal care since the Pregnancy Discrimination Act of 1978 and the 1980s pregnant women federal expansion eligibility for Medicaid, which included maternal care as a health benefit of the Affordable Care Act (ACA) [5]. The now enacted ACA enables more American women guaranteed access to health care, where over seven million working-age women have acquired health insurance since [1]. According to Simmons et al. [6] under the ACA, the majority of private insurances and Marketplace plans must offer a set of Essential Health Benefits which include newborn and maternity care, preventative benefits, and others like ambulatory patient and emergency services as well as hospitalization coverage. As a result, the U.S saw an increase of 8.7 million women who gained maternity coverage in 2015 [6].

While many women are insured through employer-based insurance or the healthcare marketplace coverage with acquired health benefits and cost protection via the ACA reform, recent changes made by Congress and the Trump administration may prove otherwise [1]. Changes like the repeal of the ACA's individual mandate penalty, plan expansion that does not comply with the ACA's consumer protections and benefit requirements like the requirement to provide maternity care, pressures to eliminate guaranteed coverage of preexisting conditions, and planned changes to Title X funding may change the benefits the American maternal population receives in terms of care [1].

The ACA regulations mandate that large group employer-based plans cap maternity out-of-pocket spending (OPS), however, plans are still entitled to enforce cost sharing like copayments or deductibles prior to plan coverage commencement [5]. From 2008 to 2015, the average total maternity OPS for all delivery forms rose from \$3,069 to \$4,569 USD; similarly, the average total OPS for vaginal delivery increased from \$2,910 to \$4,314 and from \$3,364 to \$5,161 for cesarean delivery within the same timeframe [5]. According to Moniz et al. [5], such trends were a direct result of an increase in deductible payments from 2008 to 2015, where the proportion of American women with any form of childbirth-related OPS augmented from 93.7 percent in 2008 to 98.2 percent in 2015. If such financial patterns continue over time coupled with the changes proposed by the government, the outcomes may yield an increase in maternal healthcare costs and limited access to health insurance and its benefits for individuals who do not qualify for subsidized care or have pre-existing conditions [1].

Global maternal health care around the world enables the vision of enacted health policies that aid countries to fund and support maternal and childcare efficiently. There are many countries around the world that contrastingly differ in their approaches to maternal and child health care compared to the U.S. Specifically, such comparative examples can serve as learning tools to aid in the development of adequate maternal healthcare for the women of America.

#### *Pros: Global countries with maternal healthcare vs effective states in the USA*

There are many advantageous aspects of global awareness and health policy implementation with regard to the maternal health care crisis. As stated by Kasthurirathne et al. [7], the primary cause of maternal mortality with the exception of malaria and HIV in developing, middle income countries around the world can be attributed to three aspects of individual and localized decision-making, na-

mely (i) the decision to seek care, (ii) reaching care, and (iii) receiving adequate care within a given country. From 1990 to 2013, middle income countries like Bangladesh, Ethiopia, India, Timor Leste, and Uruguay have indicated a reduction of maternal mortality by a whopping 65 to 78 percent; the U.S. mortality rates increased by 136% [7].

Documentation provided by the U.S. Health Resources & Services Administration (U.S. HRSA) exemplifies various global maternal health care models that have implemented successful change to overcome the maternal healthcare crisis. Countries like Uganda and Zambia implemented the 2012 Saving Mothers Giving Life (SMGL) initiative to decrease MMRs, with the focus on critical period of labor, delivery, and 48 hours post-delivery, a time period identified to incur the majority of maternal and 50% of newborn deaths [8]. Specifically, the implementation of SMGL decreased maternal mortality by 50% in the given regions and provided women and children with additional essential medical services like HIV prevention, care, and treatment [8]. High-income countries like Finland, Canada, and the United Kingdom (UK) have established publicly funded health care systems and found ways to provide reproductive-aged women with healthcare minus the barriers of out of pocket payments; universal coverage for counseling and care, home visits support, and family education/training in the post-delivery period also contributed to an increase in mortality rates in the given countries, where paid maternal and paternal leave were noted as key approaches to augment care [8]. Brazil focused their national strategies on improving prenatal care, delivery, and postpartum care networks via the National Caesarean and Normal Birth Guidelines and policies for vulnerable populations, where less emphasis was placed on medicalization and included the Obstetric Nurses and Obstetricians in low-risk childbirth care [8]. Additionally, a safe, efficient, private, and comfortable place for birth was guaranteed through Normal Delivery centers, Pregnant, Baby, and Puerperal Homes,

and 'Maternal Ambience' for the Brazilian population [8]. Canada implemented the Canadian Perinatal Surveillance System, which facilitates guidance and tracks maternal, childcare, and newborn indicators to monitor and guide policy development; this increased detail attention and perinatal death review [8]. Finally, the UK found that National confidential enquiries improved maternal mortality, where a review of women's care with morbidity post-pregnancy in addition to deaths was well noted [8]. Specifically, an elevation in awareness of sepsis in Ireland and the UK resulted in decreased maternal mortality from sepsis; the implementation of Certified Nurse Midwives and the need to implement the recommended midwifery ratio of 1 midwife to 27 perinatal women also proved to increase health outcomes, where continuity of midwifery-provided care improved vulnerable women outcomes, with a 24% decrease in premature births, and a 19% decrease in fetal mortality [8]. In the U.S., few states have a manageable plan enacted to battle the maternal health crisis.

There are two predominant states in the U.S. that have implemented proper health care policies to make significant maternal mortality ratio augmentation, namely California and New York. Black women of New York City (NYC) deal with increased rates of harm compared to their Caucasian contemporaries despite their college education, normal body mass indices, and affluence; Black women from wealthier NY demographics suffer poorer maternal outcomes than Caucasians, Asians, and Hispanic mothers of NYC's poorest region [4]. To correct this issue, NYC has allocated \$12.8 million to underwrite an initiative aimed to mitigate Black -Caucasian MMRs [4]. Funds will be directed to augment pregnancy and childbirth-related mortality data collection, fund implicit bias training for private and public institution medical staff, and underwrite a city-based public awareness campaign [4]. Additionally, training for identification and treatment of hemorrhage and blood clots are also being funded, two key areas associated with mater-

nal demise; other programs will function to implement the use of maternal care coordinators in an effort to aid high-risk mothers-to-be maneuver pregnancy [4]. The state of California has enacted many Alliance for Innovation in Maternal Health Program (AIM) gold standard practices and received recognition as being the only U.S. state that has seen a decrease in maternal mortality over the years [4]. It is this national evidence-based safety and quality improvement program that enabled California to drastically reduce their maternal complication rates by 21% in a 24-month period, with specific attention to kidney failure, blood clots, and heart attack during childbirth [4].

#### *Cons: Global countries without maternal healthcare vs the worst States in the USA*

According to Koblinsky et al. [9] from a global standpoint, while the MMR decreased by about 50% from 1990 to 2015, there are only 9 countries on a global platform with a primary maternal mortality ratio larger than 100 obtaining a Millennium Development Goal (MGD) 5 decrease of 75%, 26 countries that made no progress, and in 12 countries, the maternal mortality ratio increased, including United States of America. As of 2016, a woman's lifetime risk of dying as a result of pregnancy and childbirth still resides at more than 100 times greater in sub-Saharan Africa versus countries marked by higher income [9]. A gap among countries with the highest and lowest mortality rates rose, despite augmented use of maternity care; this reflects the deficit in care quality in terms of delayed, inadequate, unnecessary, and potentially harmful services, which decreases the prospect for mother and baby health gains [9]. A key ability to sustain global maternal care across various countries would be increased pressure on national and regional government systems to provide universal health care even in the poorest countries [9]. While these realities project a slow transition for some countries to date, the general trend in 2020 does reflect one of a global decrease in MMRs; however, for America, this is far from current practice.

According to Carroll [10] in 2000 to 2014, the U.S. MMR rose over 25%. Yearly, 50,000 American women endure life-threatening maternal complications, where 700 women die from childbirth; greater than half of such deaths are preventable [4]. American women state the least optimistic experiences compared to high-income countries like Canada, the UK, Netherlands, France, Germany, Norway, Switzerland, Sweden, Australia, and New Zealand; they demonstrate the highest burden of chronic disease, greatest rates of opting out of needed healthcare due to cost, exhibit difficulty affording health care, and are the least satisfied with their quality of care [1]. Over 25% of American women and those in Switzerland confirm spending  $\geq$  \$2,000 out of pocket for medical costs for either themselves or their family within the past year, versus 5% or less in other countries [1, 5].

Texas maternal rates are the worst in America; MMRs more than doubled from 2011 to 2014 [10]. While there is scanty literature that justifies exactly why the MMRs in states like Texas are ever increasing, the surmised cause can be attributed to legislative change. Specifically, Texan legislative public funding cuts to Planned Parenthood among other clinics correlated with an increase in the number of Texas births post the Planned Parenthood shutdown [11]. Additionally, rural Texan hospitals observed difficulty in recordkeeping requirements implemented by the ACA; 15 rural hospitals have closed over the last 4 year, those that are currently open lack adequate resources that would foster successful maternal outcomes [11]. It is also likely that a portion of the maternal death increase across the U.S. is attributed to chronic conditions like obesity, diabetes, and heart disease seen in women that are having children later in life [10]. Greater incidences of caesarian births and the opioid epidemic may also attribute to the disparity of maternal mortality in America [10]. Racially, there is an existing increase in Black maternal deaths in recent years, where Black and American Indian/Alaskan Native women experience 3 times more deaths per 100,000 in childbirth ver-

sus Caucasian women; [4, 10–12]. Even the number of Caucasian women who die in childbirth in the U.S. is greater than comparative developing countries globally [10].

### *Potential solutions: The future of maternal healthcare lies with strong legislative leadership and mirroring Californian health policies*

Now the question is: how do we make American Maternal Health Care great again? How do we prevent the thousands of maternal-related deaths yearly in the U.S. to drive our national maternal mortality statistics down? How do we save the lives that will build our future as a nation? The answer lies in the leadership, legislature, and adequate regulation of health policy implementation. According to Lu [13], the future of maternal healthcare depends on a clear delineated health policy platform and political strategy, electing efficient political candidates at the local, state, and federal levels, and placing maternal health leaders in positions of power where their voice on maternal healthcare subjects resonate with purpose and action to implement positive change.

### *Moving towards strong legislative leadership?*

Currently, maternal mortality in the U.S is assessed by maternal mortality review committees (MMRCs), care bundles, and standardized care also known as safety initiatives; MMRCs are defined as expert boards who review circumstances leading to death likely due to childbirth [14]. In 2018, 35 states have been identified to carry MMRCs; an alternate to the fee-for-service model is care bundling, which incentivizes efficient care coordination through the care regime by a combination of services rendered from prenatal to postpartum all for a single fixed rate [14]. Standardized care and safety initiatives function on an equivalent clinical basis, promoting quality improvement in individual birthing institutions or via states by setting up best practices and training providers to render a higher level

of maternity care [14]. As of 2019, four American democratic presidential candidates have verbalized detailed maternal health care proposals [12]. All democratic proposals target various attributes of maternal morbidity and mortality such as financially incentivizing quality of care improvement in hospitals, facilitating implicit-bias training and innovation in prenatal care to augment birth equity, improving the quality of maternal care and state infrastructure, and using Medicaid policy to augment access, new care model creation, and improved quality [12]. As the electoral debates progress, the sole 2020 candidate that has a foothold on maternal healthcare that has not dropped out from the race is Senator Warren; the maternal healthcare proposal focuses on ‘paying well for what matters’, offering hospital rewards for improving MMRs, and using bundled payments for healthcare improvement [12]. Proposed bundled payment maternity models impart a single global fee for all services for a given condition; payments can be bundled across providers which would incentivize collaboration, bundled across inpatient/outpatient settings which would incentivize coordination, and would facilitate shared savings providers and facilities that provide better care at a lower cost [12]. Unfortunately, proposed bundled maternal care may result in ‘cherry picking’ low-risk patients and the use of resource-deficient hospitals that fail to meet patient needs; this may also place poorer patients at high maternal morbidity risk in greater medical jeopardy [12]. For effective and statistically significant methods with positive, evidence-based outcomes, America needs to look to the states like California that prove decreased maternal mortality and morbidity (MMM) statistics that are both achievable and sustained across multiple ethnicities and socio-economical classes.

### *Mirroring Californian maternal health care policy*

The Californian government is the sole state in the U.S. that has single handedly reversed their negative maternal mortality statisti-

cs across ethnicities to date, 2020. In 2006, the California Department of Public Health (CDPH) began a maternal mortality investigation after observing an increase in the state’s maternal death and complication statistics; the California Maternal Quality Care Collaborative (CMQCC) was also formed at that time to bolster maternal quality improvement via public-private partnership [15]. Over the next ten years, California enacted key markers to ensure the decline of rising MMRs via actions to link public health surveillance, wide-range public and private partner mobilization, forming a rapid-cycle Maternal Data Center that supported and sustained quality improvement initiatives, and instilling a succession of data-supported broad-scoped improvement projects for quality [15]. In 2013, California’s MMR was halved to a 3-year average of 7.0 maternal deaths per 100,000 live births, statistics comparable to European standards, 7.2 deaths per 100,000 births, while the rest of the U.S experienced a rise in overall maternal mortality [15]. In 2018, Maine et al. [15] identified four key methods defined by the Californian government to change and reverse rising MMRs: (i) link actions to public health surveillance, (ii) wide-range private and public partner mobilization, (iii) promote a low-burden rapid-cycle data system, and (iv) focused public health and clinical intervention project implementation.

First, California linked actions with public health surveillance after noting a surge in maternal mortality via the surveillance of death certificates [15]. To do this, the government allocated Title V Maternal and Child Health Services Block Grant Program funds to start the California Pregnancy Associated Mortality Review project for detailed revision [15]. Since 2006, the Collaborative and the CDPH conglomerated an interdisciplinary committee of maternal, perinatal, and public health clinical experts to review maternal deaths, purveying cause of death, maternal demographics, contributing factors of death, and potential improvements [15]. These epidemiology statistics are then linked to actions such as communicating observa-

tions and recommendations to a variety of public and clinical stakeholders, developing quality improvement toolkits, and designing and implementing large-scale quality improvement initiatives directed to resolving review-obtained issues [15]. The identification of obstetric hemorrhage and preeclampsia was founded in the first two years of death reviews, marking the two most prevalent and preventable MMM causes [15]. Recent interdisciplinary works established toolkit task forces for the most common cause of maternal mortality: cardiovascular disease, the most preventable cause: Venous thromboembolism, and supporting vaginal birth and the reduction of primary cesarean deliveries [15]. After the CMQCC identified the need to eliminate early elective deliveries (EED), they coupled with March of Dimes and California's Department of Public Health, and included professional organizations, hospital association, health plans, and purchasers to collaborate and facilitate the action; the quality improvement toolkits were supported by the American College of Obstetricians and Gynecologists (ACOG) and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), and eventually, the Joint Commission of Centers for Medicare and Medicaid Services to urge changes in clinical practice [16]. After 8 years, there were less than > 200,000 births between 35 to  $\geq$  38 weeks gestations compared to 2008 California births if no intervention was implemented [16].

Second, California implemented wide-range private and public mobilization via the CDPH and the California Pregnancy-Associated Mortality Review Committee Collaborative [15]. The collaboration was instilled as a pivot for organizing stakeholders like state agencies, payers, purchasers, professional societies, hospital systems, key clinical leaders, and patient and public groups to formulate ideas and command reroutes to address the increasing MMM rate via steady communication, data sharing, and quality improvement practices [15]. For example, the Collaboration garnered support from ACOG and

AWHONN by facilitating a speaker network for hospital physicians and nurses outreach statewide, the Hospital Quality Institute and the California Hospital Association affianced hospital administration through newsletters, regional conferences and quality improvement collaborative co-sponsorships, and finally Medicaid programs, health plans, purchasers, and employers were involved in providing efficient maternal care in California [15]. The end and continuous result of private and public mobilization was increase and diversification of funding and the development of comprehensive data centers that collect data from a variety of resources in under 45-days, formed linkages, and re-reporting data to all hospitals to ensure quality improvement [15].

Third, California established low-burden rapid cycle systems after noting the insufficiency in data acquisition from the California Pregnancy-Associated Mortality Review Collaborative in terms of timeliness. To resolve this issue, California employed rapid-cycle data processing linkage of birth certificates and hospital discharge diagnosis files in a secure web portal that enabled supplemental data from electronic health records to be reviewed; this system is low-cost, flexible, supports rapid turnaround, supports benchmarking to compare data amongst hospitals with similar care levels, and is user-friendly to promote fluid use [15, 17]. The system was approved by the state Institutional Review Board and is continually monitored by the CDPH and provides monthly release of demographic information reports from the Center for Health Statistics and Informatics to the CMQCC in the Stanford University School of Medicine Information Resources and Technology Secure Server Program [17]. Monthly, CMQCC obtains mother and child discharge files from 202 of 242 maternity institutions in California, which are then linked via an algorithm that combines deterministic and probabilistic assessment;  $\geq$  50 mother-child performance measures and detailed analysis tools enable hospital benchmarking with progressive real-time tracking [17]. The



mutually beneficial partnership between the CDPH and CMQCC enables collected data to be directed to outreach activities, clinician practice correction, and overall efficient data monitoring and resolution implementation [17].

Finally, California's focus on public health and clinical intervention project implementation ensured that positive maternal outcomes were re-established following the implementation of a solid foundation, steps (i) to (iii). As of 2008, California implemented comprehensive Quality Improvement Toolkits (QITs) to tackle the top clinical problems identified by the California Pregnancy-Associated Mortality Review committee, initially aimed towards the resolution of obstetric hemorrhage and preeclampsia;  $\geq 10,000$  downloads have been obtained from the Collaborative website with 92% of hospital implementation for the Obstetric Hemorrhage Toolkit, and 72% implementation of the Preeclampsia Toolkit by 2016 [15]. Additionally, 180 out of 240 Californian hospitals participated in  $\geq 1$  quality improvement learning collaboration in 2009, where the Collaborative's Maternal Data Center facilitates obtaining real-time data and quality improvement support [16]. Currently, the present-day hemorrhage collaborative consists of  $\geq 130$  hospitals; the Supporting Vaginal Birth and Reducing Primary Cesarean Delivery Taskforce involves 160 hospitals [16]. Finally, to ensure that more institutions are involved in this change, the Collaborative instilled the Institute for Healthcare Improvement's Breakthrough Series Model, which utilizes nurse-physician mentorship teams for personalized group attention to 8-10 hospitals within a larger collaborative [15].

## CONCLUSION

As America draws closer to one of the most pivotal elections in U.S. history, we must ask ourselves what is important to the future of our country? With the unwavering burden of evidence pointing towards an abominable track record for ever increasing maternal mortality and morbidity, it is imperative that

we act now to change the story of our future, for our children, and for their children for years to come. America needs to enact sustainable, effective, and financially responsible maternal healthcare now in the 21<sup>st</sup> century; the alternative would be too grim to speak of, a reality that may render a dismal future for our progeny. It is our responsibility to appoint strong leadership that imparts knowledge and ability to get the job done, especially where our country's mothers and babies are concerned.

Countries around the world, some even deemed as third-world countries can boast greater MMM rates that have significantly dropped over the course of time; countries like Bangladesh, Ethiopia, India, Timor Leste, and Uruguay have seen a drastic decrease in maternal mortality after the implementation of demographic-specific intervention, whereas that of the U.S. continues to rise. Brazil, Finland, Canada, and the UK all have found ways to establish publicly funded health care systems to provide reproductive-aged women with healthcare while minimizing to nearly eliminating the burden of out of pocket spending, why can't America? While global countries like sub-Saharan Africa and Switzerland still experience higher maternal mortalities and greater out of pocket-spending respectively, we as Americans can still learn from them. The number of Caucasian American women who die in childbirth is higher than comparative Caucasian maternal death rates worldwide. In 2020, the American state of Texas is stamped globally as having disparately high Black and American Indian/Alaskan Native MMRs compared to the rest of the nation. The question is how do we fix this? How do we reverse maternal mortality and morbidity in the U.S? The answer lies in strong leadership and evidence-based practice; fortunately, we need not look too far for resolve.

The current status of U.S. maternal mortality is assessment via MMRCs, care bundles, and safety initiatives. In the 2020 presidential election, Senator Warren (D-MA) is the only remaining electoral candidate to acknowl-

ged the increase in “black and brown bodies that have disparately perished in their own homes and are then blamed for their own health problems and are presumed to feel less pain than white people, and are actually proposed to do something about it” [14]. If the U.S. fails to elect a candidate that has sufficient knowledge and leadership ability to instill tangible change, then the peril continues. America should look to the North; California is the only state in the U.S. that has successfully reduced their maternal mortality and morbidity rates across all ethnicities. Though the state’s transition to reverse high mortality rates did not come without hitch, California’s statistical reports serve as a guide to providing tangible and attainable evidence-based practice guidelines to rid America of the horrors that reproductive women of all

ages face when contemplating maternal transition. Through the initiation of a 4-step health policy reform, California has effectively reversed their maternal mortality and morbidity rates comparable to that of Western Europe in the 21<sup>st</sup> century. America as a whole should mirror Californian health policies by (i) linking actions to public health surveillance, (ii) implementing wide-range private and public partner mobilization, (iii) promoting a low-burden rapid-cycle data system, and (iv) focusing on public health and clinical intervention project implementation to create tangible change. This is a viable, economic, and nationally sustainable proposal for every state in America; with it, America can be proud to boast ever decreasing, low-burden maternal mortality and morbidity rates like the top contending countries of the world.

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