

117TH CONGRESS
1ST SESSION

H. R. 925

To amend the Public Health Service Act (42 U.S.C. 201 et seq.) to authorize funding for maternal mortality review committees to promote representative community engagement, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 8, 2021

Ms. DAVIDS of Kansas (for herself, Ms. UNDERWOOD, Ms. ADAMS, Mr. KHANNA, Ms. VELÁZQUEZ, Mrs. MCBATH, Mr. SMITH of Washington, Ms. SCANLON, Mr. LAWSON of Florida, Mrs. HAYES, Mr. BUTTERFIELD, Ms. MOORE of Wisconsin, Ms. STRICKLAND, Mr. RYAN, Mr. SCHIFF, Mr. JOHNSON of Georgia, Mr. HORSFORD, Ms. WASSERMAN SCHULTZ, Ms. BARRAGÁN, Mr. DEUTCH, Mr. PAYNE, Mr. BLUMENAUER, Mr. MOULTON, Mr. SOTO, Mr. NADLER, Mr. TRONE, Ms. CLARKE of New York, Ms. SCHAKOWSKY, Ms. BASS, Ms. PRESSLEY, Mr. EVANS, Ms. BLUNT ROCHESTER, Ms. CASTOR of Florida, Ms. SEWELL, and Ms. WILLIAMS of Georgia) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Natural Resources, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Public Health Service Act (42 U.S.C. 201 et seq.) to authorize funding for maternal mortality review committees to promote representative community engagement, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Data to Save Moms
3 Act”.

4 **SEC. 2. FUNDING FOR MATERNAL MORTALITY REVIEW**
5 **COMMITTEES TO PROMOTE REPRESENTA-**
6 **TIVE COMMUNITY ENGAGEMENT.**

7 (a) IN GENERAL.—Section 317K(d) of the Public
8 Health Service Act (42 U.S.C. 247b–12(d)) is amended
9 by adding at the end the following:

10 “(9) GRANTS TO PROMOTE REPRESENTATIVE
11 COMMUNITY ENGAGEMENT IN MATERNAL MOR-
12 TALITY REVIEW COMMITTEES.—

13 “(A) IN GENERAL.—The Secretary may,
14 using funds made available pursuant to sub-
15 paragraph (C), provide assistance to an applica-
16 ble maternal mortality review committee of a
17 State, Indian tribe, tribal organization, or
18 urban Indian organization (as such term is de-
19 fined in section 4 of the Indian Health Care
20 Improvement Act (25 U.S.C. 1603))—

21 “(i) to select for inclusion in the mem-
22 bership of such a committee community
23 members from the State, Indian tribe, trib-
24 al organization, or urban Indian organiza-
25 tion by—

1 “(I) prioritizing community mem-
2 bers who can increase the diversity of
3 the committee’s membership with re-
4 spect to race and ethnicity, location,
5 and professional background, includ-
6 ing members with non-clinical experi-
7 ences; and

8 “(II) to the extent applicable,
9 using funds reserved under subsection
10 (f), to address barriers to maternal
11 mortality review committee participa-
12 tion for community members, includ-
13 ing required training, transportation
14 barriers, compensation, and other sup-
15 ports as may be necessary;

16 “(ii) to establish initiatives to conduct
17 outreach and community engagement ef-
18 forts within communities throughout the
19 State or Tribe to seek input from commu-
20 nity members on the work of such mater-
21 nal mortality review committee, with a par-
22 ticular focus on outreach to minority
23 women; and

24 “(iii) to release public reports assess-
25 ing—

1 “(I) the pregnancy-related death
2 and pregnancy-associated death review
3 processes of the maternal mortality
4 review committee, with a particular
5 focus on the maternal mortality re-
6 view committee’s sensitivity to the
7 unique circumstances of pregnant and
8 postpartum individuals from racial
9 and ethnic minority groups (as such
10 term is defined in section 1707(g)(1))
11 who have suffered pregnancy-related
12 deaths; and

13 “(II) the impact of the use of
14 funds made available pursuant to
15 paragraph (C) on increasing the diver-
16 sity of the maternal mortality review
17 committee membership and promoting
18 community engagement efforts
19 throughout the State or Tribe.

20 “(B) TECHNICAL ASSISTANCE.—The Sec-
21 retary shall provide (either directly through the
22 Department of Health and Human Services or
23 by contract) technical assistance to any mater-
24 nal mortality review committee receiving a
25 grant under this paragraph on best practices

1 for increasing the diversity of the maternal
2 mortality review committee’s membership and
3 for conducting effective community engagement
4 throughout the State or Tribe.

5 “(C) AUTHORIZATION OF APPROPRIA-
6 TIONS.—In addition to any funds made avail-
7 able under subsection (f), there are authorized
8 to be appropriated to carry out this paragraph
9 \$10,000,000 for each of fiscal years 2022
10 through 2026.”.

11 (b) RESERVATION OF FUNDS.—Section 317K(f) of
12 the Public Health Service Act (42 U.S.C. 247b–12(f)) is
13 amended by adding at the end the following: “Of the
14 amount made available under the preceding sentence for
15 a fiscal year, not less than \$1,500,000 shall be reserved
16 for grants to Indian tribes, tribal organizations, or urban
17 Indian organizations (as those terms are defined in section
18 4 of the Indian Health Care Improvement Act (25 U.S.C.
19 1603))”.

20 **SEC. 3. DATA COLLECTION AND REVIEW.**

21 Section 317K(d)(3)(A)(i) of the Public Health Serv-
22 ice Act (42 U.S.C. 247b–12(d)(3)(A)(i)) is amended—

23 (1) by redesignating subclauses (II) and (III)
24 as subclauses (V) and (VI), respectively; and

1 (2) by inserting after subclause (I) the fol-
2 lowing:

3 “(II) to the extent practicable,
4 reviewing cases of severe maternal
5 morbidity, according to the most up-
6 to-date indicators;

7 “(III) to the extent practicable,
8 reviewing deaths during pregnancy or
9 up to 1 year after the end of a preg-
10 nancy from suicide, overdose, or other
11 death from a mental health condition
12 or substance use disorder attributed
13 to or aggravated by pregnancy or
14 childbirth complications;

15 “(IV) to the extent practicable,
16 consulting with local community-based
17 organizations representing pregnant
18 and postpartum individuals from de-
19 mographic groups disproportionately
20 impacted by poor maternal health out-
21 comes to ensure that, in addition to
22 clinical factors, non-clinical factors
23 that might have contributed to a preg-
24 nancy-related death are appropriately
25 considered;”.

1 **SEC. 4. REVIEW OF MATERNAL HEALTH DATA COLLECTION**
2 **PROCESSES AND QUALITY MEASURES.**

3 (a) IN GENERAL.—The Secretary of Health and
4 Human Services, acting through the Administrator for
5 Centers for Medicare & Medicaid Services and the Director
6 of the Agency for Healthcare Research and Quality, shall
7 consult with relevant stakeholders—

8 (1) to review existing maternal health data col-
9 lection processes and quality measures; and

10 (2) make recommendations to improve such
11 processes and measures, including topics described
12 under subsection (c).

13 (b) COLLABORATION.—In carrying out this section,
14 the Secretary shall consult with a diverse group of mater-
15 nal health stakeholders, which may include—

16 (1) pregnant and postpartum individuals and
17 their family members, and non-profit organizations
18 representing such individuals, with a particular focus
19 on patients from racial and ethnic minority groups;

20 (2) community-based organizations that provide
21 support for pregnant and postpartum individuals,
22 with a particular focus on patients from racial and
23 ethnic minority groups;

24 (3) membership organizations for maternity
25 care providers;

1 (4) organizations representing perinatal health
2 workers;

3 (5) organizations that focus on maternal mental
4 or behavioral health;

5 (6) organizations that focus on intimate partner
6 violence;

7 (7) institutions of higher education, with a par-
8 ticular focus on minority-serving institutions;

9 (8) licensed and accredited hospitals, birth cen-
10 ters, midwifery practices, or other medical practices
11 that provide maternal health care services to preg-
12 nant and postpartum patients;

13 (9) relevant State and local public agencies, in-
14 cluding State maternal mortality review committees;
15 and

16 (10) the National Quality Forum, or such other
17 standard-setting organizations specified by the Sec-
18 retary.

19 (c) TOPICS.—The review of maternal health data col-
20 lection processes and recommendations to improve such
21 processes and measures required under subsection (a)
22 shall assess all available relevant information, including
23 information from State-level sources, and shall consider at
24 least the following:

1 (1) Current State and Tribal practices for ma-
2 ternal health, maternal mortality, and severe mater-
3 nal morbidity data collection and dissemination, in-
4 cluding consideration of—

5 (A) the timeliness of processes for amend-
6 ing a death certificate when new information
7 pertaining to the death becomes available to re-
8 flect whether the death was a pregnancy-related
9 death;

10 (B) relevant data collected with electronic
11 health records, including data on race, eth-
12 nicity, socioeconomic status, insurance type,
13 and other relevant demographic information;

14 (C) maternal health data collected and
15 publicly reported by hospitals, health systems,
16 midwifery practices, and birth centers;

17 (D) the barriers preventing States from
18 correlating maternal outcome data with race
19 and ethnicity data;

20 (E) processes for determining the cause of
21 a pregnancy-associated death in States that do
22 not have a maternal mortality review com-
23 mittee;

24 (F) whether maternal mortality review
25 committees include multidisciplinary and di-

verse membership (as described in section 317K(d)(1)(A) of the Public Health Service Act (42 U.S.C. 247b–12(d)(1)(A)));

(G) whether members of maternal mortality review committees participate in trainings on bias, racism, or discrimination, and the quality of such trainings;

(H) the extent to which States have implemented systematic processes of listening to the stories of pregnant and postpartum individuals and their family members, with a particular focus on pregnant and postpartum individuals from racial and ethnic minority groups (as such term is defined in section 1707(g)(1) of the Public Health Service Act (42 U.S.C. 300u–6(g)(1))) and their family members, to fully understand the causes of, and inform potential solutions to, the maternal mortality and severe maternal morbidity crisis within their respective States;

(I) the extent to which maternal mortality review committees are considering social determinants of maternal health when examining the causes of pregnancy-associated and pregnancy-related deaths;

1 (J) the extent to which maternal mortality
2 review committees are making actionable rec-
3 ommendations based on their reviews of adverse
4 maternal health outcomes and the extent to
5 which such recommendations are being imple-
6 mented by appropriate stakeholders;

7 (K) the legal and administrative barriers
8 preventing the collection, collation, and dissemi-
9 nation of State maternity care data;

10 (L) the effectiveness of data collection and
11 reporting processes in separating pregnancy-as-
12 sociated deaths from pregnancy-related deaths;

13 (M) the current Federal, State, local, and
14 Tribal funding support for the activities re-
15 ferred to in subparagraphs (A) through (L).

16 (2) Whether the funding support referred to in
17 paragraph (1)(M) is adequate for States to carry out
18 optimal data collection and dissemination processes
19 with respect to maternal health, maternal mortality,
20 and severe maternal morbidity.

21 (3) Current quality measures for maternity
22 care, including prenatal measures, labor and delivery
23 measures, and postpartum measures, including top-
24 ics such as—

1 (A) effective quality measures for mater-
2 nity care used by hospitals, health systems,
3 midwifery practices, birth centers, health plans,
4 and other relevant entities;

5 (B) the sufficiency of current outcome
6 measures used to evaluate maternity care for
7 driving improved care, experiences, and out-
8 comes in maternity care payment and delivery
9 system models;

10 (C) maternal health quality measures that
11 other countries effectively use;

12 (D) validated measures that have been
13 used for research purposes that could be tested,
14 refined, and submitted for national endorse-
15 ment;

16 (E) barriers preventing maternity care pro-
17 viders and insurers from implementing quality
18 measures that are aligned with best practices;

19 (F) the frequency with which maternity
20 care quality measures are reviewed and revised;

21 (G) the strengths and weaknesses of the
22 Prenatal and Postpartum Care measures of the
23 Health Plan Employer Data and Information
24 Set measures established by the National Com-
25 mittee for Quality Assurance;

1 (H) the strengths and weaknesses of ma-
2 ternity care quality measures under the Med-
3 icaid program under title XIX of the Social Se-
4 curity Act (42 U.S.C. 1396 et seq.) and the
5 Children’s Health Insurance Program under
6 title XXI of such Act (42 U.S.C. 1397 et seq.),
7 including the extent to which States voluntarily
8 report relevant measures;

9 (I) the extent to which maternity care
10 quality measures are informed by patient expe-
11 riences that include measures of patient-re-
12 ported experience of care;

13 (J) the current processes for collecting
14 stratified data on the race and ethnicity of
15 pregnant and postpartum individuals in hos-
16 pitals, health systems, midwifery practices, and
17 birth centers, and for incorporating such ra-
18 cially and ethnically stratified data in maternity
19 care quality measures;

20 (K) the extent to which maternity care
21 quality measures account for the unique experi-
22 ences of pregnant and postpartum individuals
23 from racial and ethnic minority groups (as such
24 term is defined in section 1707(g)(1) of the

1 Public Health Service Act (42 U.S.C. 300u–
2 6(g)(1))); and

3 (L) the extent to which hospitals, health
4 systems, midwifery practices, and birth centers
5 are implementing existing maternity care qual-
6 ity measures.

7 (4) Recommendations on authorizing additional
8 funds and providing additional technical assistance
9 to improve maternal mortality review committees
10 and State and Tribal maternal health data collection
11 and reporting processes.

12 (5) Recommendations for new authorities that
13 may be granted to maternal mortality review com-
14 mittees to be able to—

15 (A) access records from other Federal and
16 State agencies and departments that may be
17 necessary to identify causes of pregnancy-asso-
18 ciated and pregnancy-related deaths that are
19 unique to pregnant and postpartum individuals
20 from specific populations, such as veterans and
21 individuals who are incarcerated; and

22 (B) work with relevant experts who are not
23 members of the maternal mortality review com-
24 mittee to assist in the review of pregnancy-asso-
25 ciated deaths of pregnant and postpartum indi-

1 viduals from specific populations, such as vet-
2 erans and individuals who are incarcerated.

3 (6) Recommendations to improve and stand-
4 ardize current quality measures for maternity care,
5 with a particular focus on racial and ethnic dispari-
6 ties in maternal health outcomes.

7 (7) Recommendations to improve the coordina-
8 tion by the Department of Health and Human Serv-
9 ices of the efforts undertaken by the agencies and
10 organizations within the Department related to ma-
11 ternal health data and quality measures.

12 (d) REPORT.—Not later than 1 year after the enact-
13 ment of this Act, the Secretary shall submit to the Con-
14 gress and make publicly available a report on the results
15 of the review of maternal health data collection processes
16 and quality measures and recommendations to improve
17 such processes and measures required under subsection
18 (a).

19 (e) DEFINITIONS.—In this section:

20 (1) MATERNAL MORTALITY REVIEW COM-
21 MITTEE.—The term “maternal mortality review
22 committee” means a maternal mortality review com-
23 mittee duly authorized by a State and receiving
24 funding under section 317k(a)(2)(D) of the Public
25 Health Service Act (42 U.S.C. 247b–12(a)(2)(D)).

1 (2) PREGNANCY-ASSOCIATED DEATH.—The
 2 term “pregnancy-associated”, with respect to a
 3 death, means a death of a pregnant or postpartum
 4 individual, by any cause, that occurs during, or with-
 5 in 1 year following, the individual’s pregnancy, re-
 6 gardless of the outcome, duration, or site of the
 7 pregnancy.

8 (3) PREGNANCY-RELATED DEATH.—The term
 9 “pregnancy-related”, with respect to a death, means
 10 a death of a pregnant or postpartum individual that
 11 occurs during, or within 1 year following, the indi-
 12 vidual’s pregnancy, from a pregnancy complication,
 13 a chain of events initiated by pregnancy, or the ag-
 14 gravation of an unrelated condition by the physio-
 15 logic effects of pregnancy.

16 (f) AUTHORIZATION OF APPROPRIATIONS.—There
 17 are authorized to be appropriated such sums as may be
 18 necessary to carry out this section for fiscal years 2022
 19 through 2025.

20 **SEC. 5. INDIAN HEALTH SERVICE STUDY ON MATERNAL**
 21 **MORTALITY AND SEVERE MATERNAL MOR-**
 22 **BIDITY.**

23 (a) IN GENERAL.—The Director of the Indian Health
 24 Service (referred to in this section as the “Director”)

1 shall, in coordination with entities described in subsection
2 (b)—

3 (1) not later than 90 days after the enactment
4 of this Act, enter into a contract with an inde-
5 pendent research organization or Tribal Epidemi-
6 ology Center to conduct a comprehensive study on
7 maternal mortality and severe maternal morbidity in
8 the populations of American Indian and Alaska Na-
9 tive individuals; and

10 (2) not later than 3 years after the date of the
11 enactment of this Act, submit to Congress a report
12 on such study that contains recommendations for
13 policies and practices that can be adopted to im-
14 prove maternal health outcomes for pregnant and
15 postpartum American Indian and Alaska Native in-
16 dividuals.

17 (b) PARTICIPATING ENTITIES.—The entities de-
18 scribed in this subsection shall consist of 12 members, se-
19 lected by the Director from among individuals nominated
20 by Indian tribes and tribal organizations (as such terms
21 are defined in section 4 of the Indian Self-Determination
22 and Education Assistance Act (25 U.S.C. 5304)), and
23 urban Indian organizations (as such term is defined in
24 section 4 of the Indian Health Care Improvement Act (25
25 U.S.C. 1603)). In selecting such members, the Director

1 shall ensure that each of the 12 service areas of the Indian
2 Health Service is represented.

3 (c) CONTENTS OF STUDY.—The study conducted
4 pursuant to subsection (a) shall—

5 (1) examine the causes of maternal mortality
6 and severe maternal morbidity that are unique to
7 American Indian and Alaska Native individuals;

8 (2) include a systematic process of listening to
9 the stories of American Indian and Alaska Native
10 pregnant and postpartum individuals to fully under-
11 stand the causes of, and inform potential solutions
12 to, the maternal mortality and severe maternal mor-
13 bidity crisis within their respective communities;

14 (3) distinguish between the causes of, landscape
15 of maternity care at, and recommendations to im-
16 prove maternal health outcomes within, the different
17 settings in which American Indian and Alaska Na-
18 tive pregnant and postpartum individuals receive
19 maternity care, such as—

20 (A) facilities operated by the Indian
21 Health Service;

22 (B) an Indian health program operated by
23 an Indian tribe or tribal organization pursuant
24 to a contract, grant, cooperative agreement, or

1 compact with the Indian Health Service pursu-
2 ant to the Indian Self-Determination Act; and

3 (C) an urban Indian health program oper-
4 ated by an urban Indian organization pursuant
5 to a grant or contract with the Indian Health
6 Service pursuant to title V of the Indian Health
7 Care Improvement Act;

8 (4) review processes for coordinating programs
9 of the Indian Health Service with social services pro-
10 vided through other programs administered by the
11 Secretary of Health and Human Services (other
12 than the Medicare program under title XVIII of the
13 Social Security Act, the Medicaid program under
14 title XIX of such Act, and the Children's Health In-
15 surance Program under title XXI of such Act);

16 (5) review current data collection and quality
17 measurement processes and practices;

18 (6) assess causes and frequency of maternal
19 mental health conditions and substance use dis-
20 orders;

21 (7) consider social determinants of health, in-
22 cluding poverty, lack of health insurance, unemploy-
23 ment, sexual violence, and environmental conditions
24 in Tribal areas;

1 (8) consider the role that historical mistreat-
2 ment of American Indian and Alaska Native women
3 has played in causing currently high rates of mater-
4 nal mortality and severe maternal morbidity;

5 (9) consider how current funding of the Indian
6 Health Service affects the ability of the Service to
7 deliver quality maternity care;

8 (10) consider the extent to which the delivery of
9 maternity care services is culturally appropriate for
10 American Indian and Alaska Native pregnant and
11 postpartum individuals;

12 (11) make recommendations to reduce misclass-
13 ification of American Indian and Alaska Native
14 pregnant and postpartum individuals, including con-
15 sideration of best practices in training for maternal
16 mortality review committee members to be able to
17 correctly classify American Indian and Alaska Na-
18 tive individuals; and

19 (12) make recommendations informed by the
20 stories shared by American Indian and Alaska Na-
21 tive pregnant and postpartum individuals in para-
22 graph (2) to improve maternal health outcomes for
23 such individuals.

24 (d) REPORT.—The agreement entered into under
25 subsection (a) with an independent research organization

1 or Tribal Epidemiology Center shall require that the orga-
2 nization or center transmit to Congress a report on the
3 results of the study conducted pursuant to that agreement
4 not later than 36 months after the date of the enactment
5 of this Act.

6 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
7 authorized to be appropriated to carry out this section
8 \$2,000,000 for each of fiscal years 2022 through 2024.

9 **SEC. 6. GRANTS TO MINORITY-SERVING INSTITUTIONS TO**
10 **STUDY MATERNAL MORTALITY, SEVERE MA-**
11 **TERNAL MORBIDITY, AND OTHER ADVERSE**
12 **MATERNAL HEALTH OUTCOMES.**

13 (a) IN GENERAL.—The Secretary of Health and
14 Human Services shall establish a program under which
15 the Secretary shall award grants to research centers,
16 health professions schools and programs, and other enti-
17 ties at minority-serving institutions to study specific as-
18 pects of the maternal health crisis among pregnant and
19 postpartum individuals from racial and ethnic minority
20 groups. Such research may—

21 (1) include the development and implementation
22 of systematic processes of listening to the stories of
23 pregnant and postpartum individuals from racial
24 and ethnic minority groups, and perinatal health
25 workers supporting such individuals, to fully under-

1 stand the causes of, and inform potential solutions
2 to, the maternal mortality and severe maternal mor-
3 bidity crisis within their respective communities;

4 (2) assess the potential causes of relatively low
5 rates of maternal mortality among Hispanic individ-
6 uals, including potential racial misclassification and
7 other data collection and reporting issues that might
8 be misrepresenting maternal mortality rates among
9 Hispanic individuals in the United States; and

10 (3) assess differences in rates of adverse mater-
11 nal health outcomes among subgroups identifying as
12 Hispanic.

13 (b) APPLICATION.—To be eligible to receive a grant
14 under subsection (a), an entity described in such sub-
15 section shall submit to the Secretary an application at
16 such time, in such manner, and containing such informa-
17 tion as the Secretary may require.

18 (c) TECHNICAL ASSISTANCE.—The Secretary may
19 use not more than 10 percent of the funds made available
20 under subsection (f)—

21 (1) to conduct outreach to Minority-Serving In-
22 stitutions to raise awareness of the availability of
23 grants under this subsection (a);

24 (2) to provide technical assistance in the appli-
25 cation process for such a grant; and

1 (3) to promote capacity building as needed to
2 enable entities described in such subsection to sub-
3 mit such an application.

4 (d) REPORTING REQUIREMENT.—Each entity award-
5 ed a grant under this section shall periodically submit to
6 the Secretary a report on the status of activities conducted
7 using the grant.

8 (e) EVALUATION.—Beginning one year after the date
9 on which the first grant is awarded under this section,
10 the Secretary shall submit to Congress an annual report
11 summarizing the findings of research conducted using
12 funds made available under this section.

13 (f) MINORITY-SERVING INSTITUTIONS DEFINED.—In
14 this section, the term “minority-serving institution” has
15 the meaning given the term in section 371(a) of the High-
16 er Education Act of 1965 (20 U.S.C. 1067q(a)).

17 (g) AUTHORIZATION OF APPROPRIATIONS.—There
18 are authorized to be appropriated to carry out this section
19 \$10,000,000 for each of fiscal years 2022 through 2026.

20 **SEC. 7. DEFINITIONS.**

21 In this Act:

22 (1) CULTURALLY CONGRUENT.—The term “cul-
23 turally congruent”, with respect to care or maternity
24 care, means care that is in agreement with the pre-
25 ferred cultural values, beliefs, worldview, language,

1 and practices of the health care consumer and other
2 stakeholders.

3 (2) MATERNITY CARE PROVIDER.—The term
4 “maternity care provider” means a health care pro-
5 vider who—

6 (A) is a physician, physician assistant,
7 midwife who meets at a minimum the inter-
8 national definition of the midwife and global
9 standards for midwifery education as estab-
10 lished by the International Confederation of
11 Midwives, nurse practitioner, or clinical nurse
12 specialist; and

13 (B) has a focus on maternal or perinatal
14 health.

15 (3) MATERNAL MORTALITY.—The term “mater-
16 nal mortality” means a death occurring during or
17 within a one-year period after pregnancy, caused by
18 pregnancy-related or childbirth complications, in-
19 cluding a suicide, overdose, or other death resulting
20 from a mental health or substance use disorder at-
21 tributed to or aggravated by pregnancy-related or
22 childbirth complications.

23 (4) PERINATAL HEALTH WORKER.—The term
24 “perinatal health worker” means a doula, commu-
25 nity health worker, peer supporter, breastfeeding

1 and lactation educator or counselor, nutritionist or
2 dietitian, childbirth educator, social worker, home
3 visitor, language interpreter, or navigator.

4 (5) POSTPARTUM AND POSTPARTUM PERIOD.—

5 The terms “postpartum” and “postpartum period”
6 refer to the 1-year period beginning on the last day
7 of the pregnancy of an individual.

8 (6) PREGNANCY-ASSOCIATED DEATH.—The

9 term “pregnancy-associated death” means a death of
10 a pregnant or postpartum individual, by any cause,
11 that occurs during, or within 1 year following, the
12 individual’s pregnancy, regardless of the outcome,
13 duration, or site of the pregnancy.

14 (7) PREGNANCY-RELATED DEATH.—The term

15 “pregnancy-related death” means a death of a preg-
16 nant or postpartum individual that occurs during, or
17 within 1 year following, the individual’s pregnancy,
18 from a pregnancy complication, a chain of events
19 initiated by pregnancy, or the aggravation of an un-
20 related condition by the physiologic effects of preg-
21 nancy.

22 (8) RACIAL AND ETHNIC MINORITY GROUP.—

23 The term “racial and ethnic minority group” has the
24 meaning given such term in section 1707(g)(1) of

1 the Public Health Service Act (42 U.S.C. 300u–
2 6(g)(1)).

3 (9) SEVERE MATERNAL MORBIDITY.—The term
4 “severe maternal morbidity” means a health condi-
5 tion, including mental health conditions and sub-
6 stance use disorders, attributed to or aggravated by
7 pregnancy or childbirth that results in significant
8 short-term or long-term consequences to the health
9 of the individual who was pregnant.

10 (10) SOCIAL DETERMINANTS OF MATERNAL
11 HEALTH DEFINED.—The term “social determinants
12 of maternal health” means non-clinical factors that
13 impact maternal health outcomes, including—

14 (A) economic factors, which may include
15 poverty, employment, food security, support for
16 and access to lactation and other infant feeding
17 options, housing stability, and related factors;

18 (B) neighborhood factors, which may in-
19 clude quality of housing, access to transpor-
20 tation, access to child care, availability of
21 healthy foods and nutrition counseling, avail-
22 ability of clean water, air and water quality,
23 ambient temperatures, neighborhood crime and
24 violence, access to broadband, and related fac-
25 tors;

1 (C) social and community factors, which
2 may include systemic racism, gender discrimi-
3 nation or discrimination based on other pro-
4 tected classes, workplace conditions, incarcer-
5 ation, and related factors;

6 (D) household factors, which may include
7 ability to conduct lead testing and abatement,
8 car seat installation, indoor air temperatures,
9 and related factors;

10 (E) education access and quality factors,
11 which may include educational attainment, lan-
12 guage and literacy, and related factors; and

13 (F) health care access factors, including
14 health insurance coverage, access to culturally
15 congruent health care services, providers, and
16 non-clinical support, access to home visiting
17 services, access to wellness and stress manage-
18 ment programs, health literacy, access to tele-
19 health and items required to receive telehealth
20 services, and related factors.

○