NYC Health

Testimony

of

Deborah Kaplan, DrPH, MPH, R-PA
Assistant Commissioner, Bureau of Maternal, Infant and Reproductive Health
Division of Family and Child Health
New York City Department of Health and Mental Hygiene

before the

New York City Council Committee on Health

jointly with

New York City Council Committee on Women

on

Oversight: Maternal Mortality in New York City

and

Intros. 913 and 914

June 27, 2018
City Hall – Council Chambers
New York City

Good morning Chairpersons Rosenthal and Levine and members of the Committees. I am Dr. Deborah Kaplan, Assistant Commissioner of the Bureau of Maternal, Infant and Reproductive Health at the Department of Health and Mental Hygiene. I am joined by Dr. Torian Easterling, Assistant Commissioner of the Brooklyn Neighborhood Health Action Center. On behalf of Commissioner Bassett, I want to thank you for the opportunity to testify on the Department's work to reduce maternal mortality in New York City, and related pieces of legislation.

The mission of the Department is to improve the health of all New Yorkers and to eliminate health inequities, which are rooted in historical and contemporary injustices and discrimination, including structural racism. It is through this lens that we focus our work related to maternal, infant and reproductive health. The history of New York City includes the systematic segregation of people of color into neighborhoods that were deprived of resources for decades. To this day, these neighborhoods still carry the burden of underinvestment, including limited access to healthy food, safe places to walk and exercise and other resources necessary to be healthy and thrive. The Department recognizes that improving women's health before pregnancy is critical to reducing maternal and infant mortality and addressing the unacceptable racial disparities in birth outcomes.

To inform our work, we monitor and report on maternal mortality and severe maternal morbidity surveillance data. To date, the Department has issued two reports on enhanced surveillance of pregnancy-associated mortality, which are deaths during pregnancy or within one year of pregnancy from any cause, and pregnancy-related mortality, a subset of these deaths that are causally related to the pregnancy, based on data from 2001-2005 and 2006-2010. A similar analysis for 2011-2015 is currently underway and will be completed by the end of the year. The Department collects this information through death certificate data and additional surveillance of pregnancy-associated deaths, using the New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS) to analyze inpatient hospital discharge data.

In New York City, approximately 30 women die every year of pregnancy-related causes. And while the pregnancy-related mortality ratio decreased 48% in New York City between 2001 and 2010, it is consistently higher than the national average and the racial disparities in pregnancy-related mortality are unacceptable. From 2006-2010, Black women were twelve times more likely to die from a pregnancy-related cause than White women. Pregnancy-related mortality is associated with obesity, underlying chronic disease and poverty that also disproportionately affect New York City's Black population. The chronic stress of racism and social inequality contributes to pregnancy-related mortality, along with racial disparities in other health outcomes, including infant mortality, preterm birth and low birth weight.

In 2016, the Department released a report on our citywide severe maternal morbidity surveillance system, the first municipality in the United States to do so. Severe maternal morbidity is defined as a life-threatening complication during childbirth. Examples include heavy bleeding, kidney failure, stroke or heart attack during delivery. To put this in perspective, for every woman who dies of a pregnancy-related cause in New York City, approximately 100 women almost die. Our surveillance found that the rate of severe maternal morbidity in New York City was higher than the national severe maternal morbidity rate, and that it increased 28% from 2008 to 2012. Nearly 3,000 women experienced life threatening complications during pregnancy in 2012. As with maternal mortality, we found stark racial disparities. The severe maternal morbidity rate among Black women was three times that of White women. This holds true regardless of other socio-economic factors, such as education. In New York City, a Black woman with a college degree or higher is more likely to have serious complications during childbirth than a White woman with less than a high school education.

The Department has a number of groundbreaking programs focused on addressing systemic causes of maternal mortality and severe maternal morbidity through hospital and community-driven interventions.

The Department currently operates a Maternal Mortality and Morbidity Review Committee, known as M3RC, to review maternal deaths and make evidence-based recommendations at the community, health system, provider, patient and policy levels to prevent future deaths and life-threatening complications. Members of the M3RC include health providers from local hospitals and other health facilities, as well as representatives from community-based organizations, doulas, researchers, first responders and others to develop comprehensive recommendations that are meaningful from both a clinical and social perspective. There are similar committees in several other states across the country, though ours is the only committee focused on a city. The New York City M3RC is especially valuable because roughly half of the statewide maternal deaths in New York State occur in the five boroughs.

The Department is also focused on supporting women's health before and during pregnancy to ensure optimal outcomes. In May, the Department announced the Maternal Care Connection, a collaboration with SUNY Downstate Medical Center to improve obstetric care and chronic disease management, both of which contribute to racial disparities in birth outcomes. We look forward to updating you further on this work soon once details are finalized.

Related to this work is the Sexual and Reproductive Justice Community Engagement Group – or CEG, which is co-led by the Department and community partners including community leaders, activists and nonprofit organizations to guide and inform the implementation of the Department's Sexual and Reproductive Justice work. Through the CEG, a focus on birth justice has been adopted so that people know their rights during pregnancy, birth and immediate postpartum period in the healthcare setting. Key to the Birth Justice campaign are the Birth Justice Defenders and Birth Justice Champions. The Birth Justice Defenders are a group of community residents who have come together to educate others in their communities and advocate for safe and respectful maternity care for all individuals. The Birth Justice Champions are medical providers, including OBGYNs, midwives and doulas, who work to mobilize their communities around the principle that everyone giving birth deserves to be treated with respect and attention and have their needs met. This group promotes best practices for respectful care at birth within health care facilities. The Birth Justice Champions are conducting a series of Grand Rounds presentations on birth justice and respectful maternity care at hospitals around the city, and presentations have occurred at Elmhurst Hospital, Jamaica Hospital and Montefiore Medical Center, and more are planned this summer.

Intro 914

I would like now to turn to the bills being heard today. The Department supports the intent of Intro. 914, which would expand Local Law 55 of 2017 to require the Department to report additional data on maternal mortality and severe maternal morbidity and establish a maternal mortality review committee. As I mentioned, it is important to have a local Maternal Mortality and Morbidity Review Committee in New York City, and we thank the Council for recognizing the important work our committee is accomplishing.

The Department currently reports to the Council on maternal deaths, disaggregated by borough of residence and race/ethnicity. And we understand the importance of being able to track progress in order to understand the factors associated with these complications and develop policies and programs to move the needle in the right direction. Protecting the confidentiality of the women whose cases we study is of the utmost importance to the Department, and we are happy to work with Council to determine appropriate aggregate-level maternal mortality data to add to the report to provide a more comprehensive description of maternal mortality cases in New York City while protecting patient confidentiality.

Intro 913

Intro 913 would require the Department to assess the needs of pregnant people and the availability of free and low-cost doula services. We support the intent of this legislation and look forward to working with Council to provide meaningful data to inform this work.

The Department currently operates a number of programs supporting doula services, and growing the doula workforce in New York City. Through funding from Healthy Start, a federally funded program that aims to eliminate perinatal health disparities, we operate the By My Side Birth Support Program. By My Side provides free doula support to low-income women during their labor and delivery. Since its creation in March 2010, By My Side has served over 850 clients and their families, including labor support at more than 670 births. The Healthy Women, Healthy Futures initiative, funded by the City Council, offers doula services to low-income women throughout New York City. The initiative also trains and hires women from neighborhoods served by the program to serve as birth doulas. The majority of clients are referred through participating CBOs, which include Caribbean Women's Health Association, Brooklyn Perinatal Network and Community Health Center of Richmond.

The Department also collects data on the needs of pregnant women. Since 2001, we have collected these data through the Pregnancy Risk Assessment Monitoring System (PRAMS), a population-based survey of new mothers in New York City designed to monitor maternal experiences and behaviors before, during and after pregnancy. Findings from PRAMS are used to enhance our understanding of maternal behaviors, develop and evaluate programs to improve maternal and infant health, and inform policy development.

Doulas are an important part of a compendium of services to increase infant and maternal health outcomes, including midwifery and hospital and community-based interventions. We share the Council's goal of increasing access to doula services for pregnant individuals, and are currently working with the New York State Department of Health as they develop their pilot project to expand Medicaid coverage to include doula services.

Thank you again for the opportunity to testify. We are happy to answer any questions.

Ancient Song Doula Services
"Reclaiming the Ancient Principles

7 Marcus Garvey Avenue
Suite 436/437
Brooklyn, New York 11206
347-480-9504
chanel@ancientsongdoulaservices.com

June 27, 2018
Testimony presented by
Chanel Porchia- Albert
Executive Director Ancient Song Doula Services
Most Honorable New York City Council

Good Afternoon to all and give thanks for joining us here today to support the movement towards justice in maternal health.

Ancient Song Doula Services, a Brooklyn-based organization, has actively worked towards bridging racial disparities in maternal health through addressing racial and implicit bias since 2008. In training 300+ doulas both locally and nationally and serving over 250 individuals city-wide last year alone. Community-based and culturally- relevant organizations are crucial in spearheading the fight against the disparities in Black maternal mortality and morbidity in New York City were African -American women are twelve times more likely to die of a childbirth related complication or suffer a near miss.

Ancient Song Doula Services stands in favor of the bills being proposed today. We would, however, like to stress a couple of crucial areas that can assure an effective implementation of such reform. First, if these bills are to achieve the lasting change they seek, the inclusion of community-based maternal health experts in addressing implicit bias and racism within maternal health outcomes is imperative.

While often regarded as luxury items, doulas of color, particularly community-based doulas, address systematic racism, intergenerational trauma, and implicit bias in the birth room both during and before it happens. As we have seen in recent accounts published by ProPublica's Lost Mothers series and Serena Williams who recounts "while recovering in the hospital, Serena suddenly felt short of breath. Because of her history of blood clots, and because she was off her daily anticoagulant regimen due to the recent surgery, she immediately assumed she was having another pulmonary embolism. (Serena lives in fear of blood clots.) She walked out of the hospital room so her mother wouldn't worry and told the nearest nurse, between gasps, that she needed a CT scan with contrast and IV heparin (a blood thinner) right away. The nurse thought her pain medicine might be making her confused. But Serena insisted, and soon enough a doctor was performing an ultrasound of her legs. ***"I was like, a Doppler? I told you, I need a CT scan and a heparin drip," she remembers telling the team.*** The ultrasound revealed nothing, so they sent her for the CT, and sure enough, several small blood clots had settled in her lungs. Minutes later she was on the drip. ***"I was like, listen to Dr. Williams!"***

Ancient Song Doula Services
"Reclaiming the Ancient Principles

7 Marcus Garvey Avenue
Suite 436/437
Brooklyn, New York 11206
347-480-9504
chanel@ancientsongdoulaservices.com

Erica Garner a mother of an 8-year-old daughter and a 4-month-old son. Who was thrust into an activist role against police brutality following the death of her father Eric Garner while in police custody and who died four months postpartum and the countless other mothers here in the United States whose stories are never told.

Time and time again the voices of black women have been ignored within healthcare and continue to be dismissed as an afterthought, forced coercion into complying with medical procedures by threatening to call child protective services, the continued lack of access to equitable culturally relevant care, and compounded by the stress of racism and implicit bias continue to kill us on a daily basis and is showing up in the birth room and during the postpartum period.

Over time, organizations, such as Ancient Song Doula Services, have been providing community-based doula care to marginalized communities both on a local and national level to address these continued injustices. According to Choices in Childbirth, community-based doulas offer ample "culturally appropriate" support from "trained community health workers" and primarily serve under resourced communities with care, on a sliding scale, as they tailor "to the specific needs of the community" (Choices in Childbirth, 2016). Community health workers, such as doulas, are equipped to address discrimination and disparities through bridging barriers in language and gaps in culture (Choices in Childbirth, 2016). Given that payment for these community- based services are usually "out of pocket", the absence of any reimbursement makes doula care highly inaccessible, especially for families "with limited means" (Choices in Childbirth, 2016).

In addressing Maternal Mortality head on, first we must consider all of the factors that limit access to effective maternal health care and can result in such drastic disparities in outcomes. We have to think about food and housing insecurities , and access to cultural humility within the healthcare system . Given that systematic oppression is a social determinant of the high Black infant and maternal mortality rate, shifting tasks and responsibilities down the hierarchy of the healthcare system is both necessary and ideal for marginalized communities. For these reasons, the most crucial aspect is free/ low- cost doulas services. Prioritizing the reimbursement of community-based and culturally- relevant doula services through Medicaid is key, as its beneficiaries are often those who are affected the most in looking at such disparities within maternal health.

We, ultimately, stress that the implementation of Medicaid reimbursement be equitable, community-based, and provide access to a scope of services needed to be adequate to the needs of consumers. Reimbursement should be nothing less than a rate that is a living wage.

We urge that you use your voice to advocate for community-based doula programs being included in Governor Andrew Cuomo's proposed doula pilot program which seeks to address

Ancient Song Doula Services
"Reclaiming the Ancient Principles

7 Marcus Garvey Avenue
Suite 436/437
Brooklyn, New York 11206
347-480-9504
chanel@ancientsongdoulaservices.com

racial disparities in Maternal Health. Without comprehensive inclusion, moreover, community based stakeholders, who are doing the work within maternal healthcare, are doomed to fail before we even get started.

We recommend the following:

1. We call for institutional reform from administration to staffing that provides education to all on implicit bias, racial discrimination, and human rights in childbirth that addresses bodily autonomy, informed consent and shared decision making within their reproductive health choices.
2. Call for an accountability measures be implemented that tracks and monitors institutions and staffing that allows for consumers and staffing to report implicit bias and discrimination in care during prenatals, childbirth, and the postpartum period.
3. Community members are seen and incorporated within review of all proposed healthcare models and accountability measures.
4. A call for evidence based review of all systems of reproductive health care within New York City in particular all public and private hospital facilities within areas that exhibit high maternal mortality rates or near misses.
5. Midwifery care be incorporated as a viable system in addressing racial disparities and implicit bias and Medicaid reimbursement for those services be at a living wage regardless of where the patient decides to birth. In addition, Certified Professional Midwives be seen as an additional resource in addressing a shortage of midwives within New York City.

So I leave you all with the words of Audre Lorde, *"When we speak we are afraid our words will not be heard or welcomed. But when we are silent, we are still afraid. So it is better to speak."* and we will continue to do so until racial disparities within healthcare and implicit bias are addressed.

Thank you all for your time and energy and thank you, in advance, for supporting those looking to shift the narrative on pregnant and birthing people in New York City.

GIRLS FOR GENDER EQUITY

Girls for Gender Equity Testimony

The New York City Council's
Committee on Health

Int. 0913 and Int. 0914
Megan Jean Louis
06-27-2018

Good afternoon, My name is Megan Jean Louis, and I am a junior at the Macaulay Honors College at Brooklyn College, studying Biomedical Ethics and Cross-Cultural Psychology. I would also like to thank the Committee on Health and the Committee on Women for having this hearing on Access to Doula Services and Maternal Mortality. I am a member of Girls for Gender Equity (GGE)'s Young Women's Advisory Council. GGE is an intergenerational organization committed to the physical, psychological, social, and economic development of girls and women. Through education, organizing and physical fitness, GGE encourages communities to remove barriers and create opportunities for girls and women to live self-determined lives.

Doulas are committed to lowering the Infant Mortality and Maternal morbidity rate through collective action and offering resources to families so that they can make informed decisions about their care. Their purpose is to ensure a safe and empowering birthing experience. A recent Cochrane review found that "Continuous support during labour may improve outcomes for women and infants, including shorter duration of labor, decreased use of any analgesia and decreased negative feelings about childbirth experiences. We found no evidence of harm"[1] Doulas can become vital in the birthing process for pregnant people within New York City. If we put resources behind assessing the demand of these workers, we can reduce the Maternal Mortality rate. Signing Int 0913-2018 (Access to Doula Services) would be the first step in achieving this goal.

As a young person, I respectfully ask that Intro 0914 include reporting on the number of maternal mortalities, disaggregated by race or ethnicity, borough of residence, and age. In Intro 0913, it is also imperative that access to doulas include people across the age spectrum. In particular, I want to amplify the importance of young parent's timely and meaningful access to doula's as the Department of Mental Health and Hygiene as the agency expands this program and looks to the expertise of Ancient Song Doula Services as as this program is expanded.

Together we can work to reduce the Maternal Mortality rate by ensuring that we have data that

---

[1] Bohren MA, Hofmeyr G, Sakala C, Fukuzawa RK, Cuthbert A. Continuous support for women during childbirth. Cochrane Database of Systematic Reviews 2017, Issue 7. Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub6

GIRLS FOR GENDER EQUITY

provides full context to the issue. New York City's maternal mortality rate is slightly above average for the U.S, with 30 of the 700 to 900 deaths related to pregnancy and childbirth nationwide each year, New York City accounts for around 30.[2] Intro 0914 (Reporting on Maternal Mortality) would protect the Maternal Mortality and Morbidity Review Committee and allow for this work to continue for years to come. The annual report that we receive from its governing body, the Department of Health and Mental Hygiene also needs to include more disaggregated variables. Analyzing this data will better inform the decision making of Council members and City Agencies when tackling this issue and preclude the possibility of information falling through the cracks.

The collaboration of New York City and New York State in the pursuit of reducing Maternal Mortality will establish a precedent for other large states to follow The maternal mortality rate in the United States is simply unacceptable. In the United States, black women die of pregnancy-related causes at 4x (4 times) as often as white women.[3] I hope that with the data found in this report, we can continue to reduce the structural inequalities seen in New York City, whether it be access to healthy food, clean drinking water, good schools, or a safe neighborhood.

I ask that you support Int. 0913 and Int. 0914. Thank you for your time.

[2] https://www.propublica.org/article/new-york-city-launches-committee-to-review-maternal-deaths
[3]Pregnancy Mortality Surveillance System https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html

GIRLS FOR GENDER EQUITY

Girls for Gender Equity Testimony for the **New York City Council Committee on Women and Committee on Health**

Delivered by: Brittany Brathwaite, MPH, MSW
June 27, 2018

Good afternoon Chairperson Rosenthal, Chairperson Levine, and committee members. My name is Brittany Brathwaite and I am the Organizing and Innovation Manager at Girls for Gender Equity (GGE). GGE is a youth development and advocacy organization committed to the physical, psychological, social and economic development of girls and women. GGE challenges structural forces, including racism, sexism, transphobia, homophobia, and economic inequity, which constrict the freedom, full expression, and rights of transgender and cisgender girls and women of color, and gender non-conforming people of color.

Thank you for calling attention to the pertinent issue of maternal mortality and inequitable reproductive health outcomes especially among communities of color. GGE envisions a city where people of all ages and genders and their partners (if applicable) are empowered during pregnancy, labor, and postpartum to make healthy decisions for themselves, their children, their families, and their communities,

With regard to Council Member and Women's Issues Committee Chair Helen Rosenthal's bill Intro 0931, studies have shown that access to doula care improves maternal health outcomes by providing people-centered care and reduces the likelihood of surgical interventions such as cesarean deliveries. We recommend that the City Council require the DOHMH to include community-based and culturally relevant organizations such as Ancient Song Doula Services, an organization that has be actively spearheading the fight against disparities in maternal mortality and morbidity, particularly for Black women over the last decade. Ancient Song Doula Services has also trained over 300 doulas locally and nationally. Black women have led and continue to lead a movement to improve the maternal health and well being of their own children and families, and should be valued decision-makers in healthcare spaces.

Black women and TGNC people face discrimination in medical systems at different intersections of their identities. For example, Black women in the US are vulnerable to anti-Black racism and gender oppression. In April 2018, a New York Times exposé showed that even when we control for factors that might lead to lower quality healthcare such as income and health insurance, Black women still have disproportionately negative outcomes when it comes to childbirth and postpartum care. In fact, poor white women have better outcomes than educated, degreed Black women. Race is the only defining factor that

differentiates care received and health outcomes. We must ensure that all health providers receive training on implicit bias, class and gender bias, anti-racism and human rights in the practice of health care.

We also recommend that you support full spectrum doula work - which supports people during all phases of pregnancy, including abortion, miscarriage, birth and adoption --as well as a discussion on how issues like race, class, immigration, gender, age, and sexuality impact and affect doula care.

As you know, GGE's work focuses on young people. To that end, all people should receive safe, respectful, affordable, quality health care where they live, throughout the course of their lives - especially young people.

Access to full-spectrum doula care should be accessible to pregnant and parenting students. In 2016, GGE conducted a participatory action research project where we engaged over 100 young people attending New York City public schools to better understand the specific experiences that cis and trans girls of color and gender non-conforming students face. The product of this process resulted in a report with 45 recommendations for the city of New York entitled, *The School Girls Deserve.* As GGE has previously articulated in *The Schools Girls Deserve* report, pregnant and parenting young people experience particular obstacles that impact their ability to complete their education.

In addition to young people receiving access to full spectrum doula care, we recommend that each DOE school assign the role of a pregnant and parenting student liaison (PPSL) to a school staff person who embodies and upholds social justice, social work practice, and a human rights approach in advocating for the needs of pregnant and parenting students at their school. Access to more comprehensive support will give young pregnant and parenting students the choice and the resources they need to complete their education at their home school, and ensuring New York City school's compliance with federal law, specifically, Title IX. We know that positive pregnancy and birthing experiences can be beneficially transformative for young parents with long-lasting implications for their children.

We applaud the advancement of Intro 0914. Data is a crucial tool to understanding the problem. Many experts believe that maternal deaths, injuries, and illnesses are significantly underreported. In order to understand the true nature and magnitude of the maternal health disparities in New York City, we need to develop the ability to collect accurate, complete data on a range of relevant variables (many of which you have provided). We are particularly glad to see that this bill requires disaggregated data by race, gender, geography and other demographic factors that can help paint a better picture of needs in New York City. =Any data collection should include both quantitative and qualitative methods, including community-based participatory data, in order to understand the impact of race, gender, and socio-economic inequality on Black and TGNC people's health.

DOHMH might consider participatory research models which acknowledge community-based perspectives on care that can be used to set future research agendas. The city should engage reproductive justice organizations and other community-based groups and stakeholders to conduct this type of research.

Finally, the city should cross-reference the National Violent Death Reporting system (NVDRS) data maintained by the CDC with all maternal mortality and morbidity data collection. The NVDRS which contains information on violent deaths is important data tool for Black women in particular, because violence is a significant health risk for many Black women, in some states homicide is one of the leading causes of death among pregnant women. As one of the 32 states participating in the NVDRS, we have access to data that will help us identify maternal deaths that may be missed through other case identification methods.

We applaud the city on the bills being advanced today,we urge the city to take more responsibility to directly confront racial inequities in maternal health.Reporting bills and access to doula care cannot remedy this decades-old disparity as they solely focusing on medical interventions or individual behavior modification. Instead, we must acknowledge the root causes and social determinants of maternal health problems, proactively remove barriers that put Black women and TGNC people at risk, and prioritize policies that advance health equity overall. Policymakers have a great influence on the structural conditions in which women and GNC people live, work and grow -- and in turn, these conditions influence maternal health.

We must continue to make transformative investments in the health and well-being of Black women and girls and TGNC people throughout the life course, including in the areas of housing, nutrition, transportation, violence, environmental health, and economic justice.

Thank you for your work to advance the bills being heard today.

Sources:

Center for Reproductive Rights (2018). Black Mamas Matter - Advancing the human right to safe and respectful maternal health care. New York, NY: Center for Reproductive Rights.

Brathwaite, B., & Hudson, K. (2017). *The school girls deserve: Youth driven solutions for creating safe, holistic, and affirming New York City public schools.* New York, NY: Girls for Gender Equity.

Testimony of Dr. Sharon Griffith and Lindsay DuBois
Medical Director of Women's Health and Associate Director of Women's Health
Community Healthcare Network
Hearing before the New York City Council Committee on Health
RE: Int. No. 914: A Local Law to amend the administrative code of the city of New York, in relation to reporting on maternal mortality
Int. No. 913: A Local Law to amend the administrative code of the city of New York, in relation to access to doulas in New York City
New York City Council Chambers
Wednesday, June 27, 2018

Good morning and thank you for the opportunity to speak today. My name is Dr. Sharon Griffith, and I am the Director of Women's Health at Community Healthcare Network. CHN is a non-profit network of federally-qualified health centers, two school based health centers, and a fleet of mobile vans. We provide comprehensive services including primary care, prenatal care, behavioral health and social services, to over 85,000 New Yorkers.

30 years ago CHN was established as family planning clinic. Approximately 7 years ago we added to our network, two centers that were originally Maternal, Infant and Child centers. Comprehensive sexual and reproductive health and prenatal care has always been at the core of our mission. Today, we provide prenatal care to nearly 2,000 patients. The majority of our prenatal patients is of Hispanic or African – American ethnicity or race. Over 75% of our patients have Medicaid insurance. One quarter of our patient have a primary language other than English. Our patients give birth at partner hospitals throughout the city and are encouraged to return for postpartum care and well-baby visits. At CHN centers we care for patients with low obstetrical risk and collaborate with partner hospitals' maternal fetal units to refer patients with clinically recognized high obstetrical risk.

Maternal mortality in New York City represents approximately 4% of all maternal deaths in the United States per year. Additionally, black women in NYC are 12 times more likely to die from pregnancy-related causes than white women.

Because we care for the population of New Yorkers that is disproportionately represented in these statistics, we are here to demonstrate our support for the proposed bill to require DOHMH to report to the City Council on cases of maternal mortality and the proposal to codify the maternal mortality and morbidity review committee created last year. The City and State of New York are taking necessary steps to investigate cases of maternal mortality and design interventions that can improve health outcomes and reduce health disparities and we support those efforts.

It is important that the committee is comprised of various types of maternal health experts. Doctors and midwives are essential but the committee should also include representation from social workers, health educators, doulas, patient navigators and others with a nuanced understanding of social determinants of health.

The committee must ensure ongoing transparency in all activities. This is necessary to guarantee proper use of funds and efficiency of the review process.

We would like to advocate for the greater availability of disaggregated data. The fragmentation of EMR systems makes it difficult to track patients seen at different institutions and ensure continuity of care. The committee should consider sharing patient-level data with providers to help facilitate ongoing linkage to care.

Finally, the review committee should ensure proper dissemination of key findings to all relevant stakeholders and publish results for the general public. The review committee should also coordinate with members of the State appointed M3RC to better understand developments and trends in maternal health at the population level.

In conclusion, we applaud the City's efforts in dedicating vital resources to investigate devastating rates of maternal mortality. We are committed to any efforts to collaborate with the City and Administration to further these goals. Thank you for the opportunity to speak today.

Good morning, my name is Lindsay DuBois, and I am the Associate Director for Women's Health at Community Healthcare Network. I am also a doula with experience in private practice and community-based doula programs. Over the last few years, I've supported over 75 families through their birth experience. And I can tell you, doulas make an incredible difference.

We are here to show our support for this bill and the City's efforts to expand access to doula care. A doula's role providing physical, emotional, and informational support throughout pregnancy and birth is essential to improving birth outcomes for all New Yorkers. People who receive continuous support in labor are more likely to have spontaneous vaginal births and less likely to have pain medication, epidurals, negative feelings about childbirth, vacuum or forceps-assisted births, and Cesareans.

Despite these benefits, doulas attend only 5% of births in New York City. We have an important opportunity to expand access to doulas and create a lasting population impact.

Any plan developed by DOHMH must respond to the alarming health disparities we see in NYC. Black women in NYC are 12 times more likely to die from pregnancy-related causes than white women. With greater resources, community-based doula programs can help mitigate this devastating health crisis.

At the same time, public health researchers are deepening their understanding of the driving factors associated with maternal mortality and other health disparities. The "weathering theory" suggests that toxic racism sustained over a lifetime can cause premature deterioration of the body which can have a negative impact on birth. Doulas have an important role to play in understanding this process and the differential treatment experienced by certain groups.

Expanded access to doula support will require training and certification for a large cohort of new doulas. It is essential that training include cultural competency and a greater understanding of implicit bias. The plan must also dedicate adequate resources to ensure program sustainability and guarantee doulas are compensated with a living wage.

Community stakeholders and doula experts must be an integral part of the design, implementation, and monitoring of any plan created. The plan should consider new methods of tracking doula access over time, including birth certificate documentation or inclusion in the Pregnancy Risk Assessment Monitoring Systems (PRAMS) survey.

In my work as a doula, I've had the opportunity to support many women who have endured conditions of toxic stress. My clients have included people who were undocumented and people who did not speak English. I've supported women living in domestic violence shelters without any social support at the time they gave birth. In the face of these challenges, my experience has shown me that doulas help reduce fear, build confidence, improve communication, and simply humanize birth. As one client stated, "Having the help of a doula can be a blessing. It was for me. My doula listened to me and my body. She handled me with great care and concern. For me, labor wasn't like the horror stories I've heard. My doula made sure I was relaxed, safe and comfortable. She wasn't just another trained professional in the room. She felt like family. This is why we need our doulas."

CHN Centers

Open Weekday, Evening, Weekend, and Holiday Hours

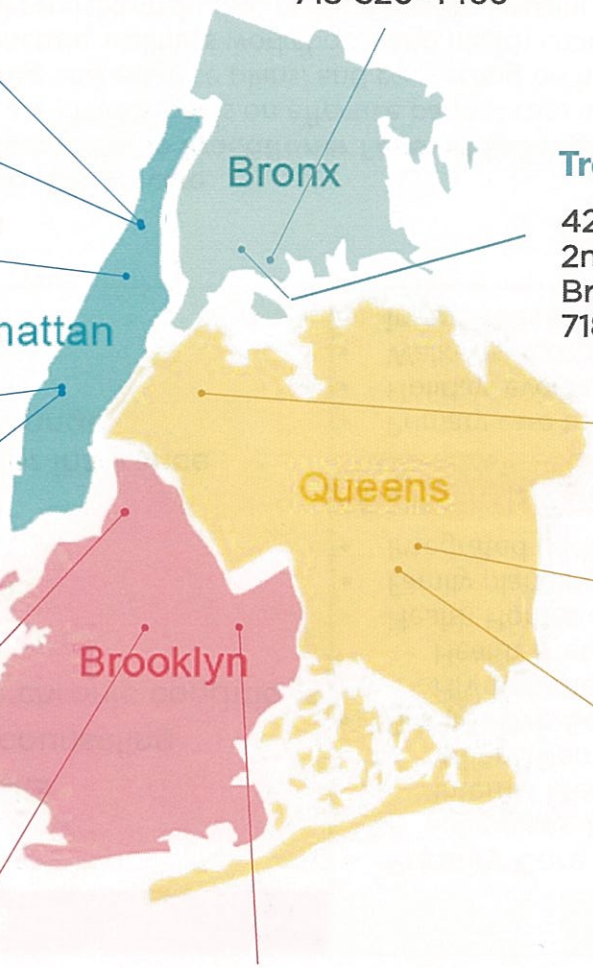
Washington Heights
511 West 157th Street
New York, NY 10032
212-781-7979

Phoenix School Based Health Center
511 West 157th Street
New York, NY 10032
917-521-3130

South Bronx
975 Westchester
Avenue Bronx, NY 10459
718-320-4466

Harlem
81 West 115th Street
New York, NY 10026
212-426-0088

Tremont
4215 Third Avenue
2nd Floor
Bronx, NY 10457
718-294-5891



Lower East
150 Essex Street
New York, NY 10002
212-477-1120

Long Island City
36-11 21st Street
Long Island City, NY
11106 718-482-7772

Sutphin Boulevard
97-04 Sutphin Boulevard
Jamaica, NY 11435
718-657-7088

Seward Park School Based Health Center
350 Grand Street
Room 240
New York, NY 10002
212-634-7550

Jamaica
90-04 161st Street
5th Floor
Jamaica, NY 11432
718-523-2123

Williamsburg
94-98 Manhattan Avenue
Brooklyn, NY 11206
718-388-0390

East New York
999 Blake Avenue
Brooklyn, NY 11208
718-277-8303

Crown Heights
1167 Nostrand
Avenue Brooklyn,
NY 11225
718-778-0198

Medical Mobile Vans
Offer primary care, and sexual health services, such as HIV testing, birth control, PrEP/PEP, Plan B, and low-cost STD testing. Call 212.545.2495 for more information, times and NYC locations.

Community Healthcare Network | Care you feel good about.

866.246.8259 **www.chnnyc.org**

CHN Fast Facts

Who We Are: We are a not-for-profit organization providing health care to underserved New Yorkers of all ages. We have 11 Health Centers, plus a fleet of Mobile Health Centers and 2 School Based Health Centers. We never turn anyone away from care, regardless of ability to pay.

We offer sliding scale fees based on income. We screen all our uninsured patients for insurance eligibility.

Annual Impact

- 85,000 patients
- 250,000 medical and ancillary visits
- 40,000 visits for STI testing and counseling
- 36,000 patients with one or more chronic conditions
- 34,000 HIV tests
- 3,700 smoking cessation visits
- 5,500 back-to-school physicals
- 11,200 mental health visits
- Helped 1,600 New Yorkers apply for insurance through the NY State of Health Exchange

Care Support Team

- **Primary Care**
  Physicians, NPs, and other providers in Family Practice, Internal Medicine, OB/GYN, Pediatrics, Med-Peds, Mid-Wifery, Dental, Psychiatry, Podiatry
- **Supportive Services**
  HIV treatment adherence counselors, Nutritionists, Mental Health Therapists, Social Workers, and Health Educators
- Health Homes care managers and patient navigators
- Family planning services for teens and adults
- Integrated addiction services for patients addicted to opioids

Comprehensive Centers

- Primary care teams at each site
- Holiday, evening and weekend hours
- Walk-ins Accepted
- Integrated use of electronic medical records

Unique Services and Programs

- **Transgender health services** integrated into primary care.
- First New York State primary care and psychiatric **Nurse Practitioner Fellowship Program.**
- **Health Literacy Department** trains healthcare professionals on effective patient care communication strategies.
- **Nutrition experts** create individualized eating and exercise plans, and counseling on health and wellness issues.
- Fitness classes, yoga and meditation, acupuncture, wellness workshops, and health coaching provided in the **wellness program.**
- **Health Homes** coordinate patient care and services, including public benefits, housing, mental health and substance abuse
- **Teens P.A.C.T.** program to empower teens to prevent unintended pregnancies and sexually-transmitted infections.

Patient Centered Medical Home: We provide each patient with a primary care provider and an expert team supporting his or her care

CITIZENS' COMMITTEE for CHILDREN
OF NEW YORK INC

Testimony of

Alice Bufkin
Director of Policy for Child and Adolescent Health
Citizens' Committee for Children

Before the

New York City Council
Committee on Women
Committee on Health

Oversight Hearing: Maternal Mortality in New York City

Int. Nos. 0913-2018 and 0914-2018

June 27, 2018

Good afternoon. My name is Alice Bufkin and I am the Director of Policy for Child and Adolescent Health at Citizens' Committee for Children of New York, Inc. (CCC). CCC is an independent, multi-issue child advocacy organization dedicated to ensuring every New York child is healthy, housed, educated and safe.

I would like to thank Chair Rosenthal and Chair Levine, as well as all the members of the Committee for Women and the Committee on Health, for holding today's hearing on how to improve maternal health outcomes in New York City. I would also like to thank Speaker Johnson and Majority Leader Cumbo for introducing the bills we are discussing today. Finally, I would like to thank the sponsors and co-sponsors of today's bills.

The introduction of the "Mother's Day Package" of bills underscores the City Council's ongoing commitment to improving supports for parents and caregivers, and for ensuring positive health outcomes for moms and babies. Attention to these issues could not come at a more critical time. The city's historically low infant mortality rate is a testament to the importance of investing in a targeted strategy to improve infant and maternal health outcomes. That said, racial/ethnic and geographic disparities in early prenatal care, infant mortality, preterm birth, and maternal mortality and morbidity remain stark.

In its 2016 report on maternal mortality rates, the Department of Health and Mental Hygiene (DOHMH) found that black, non-Hispanic women were 12 times more likely than white, non-Hispanic women to die from pregnancy-related causes. Asian/Pacific Islander women were more than four times as likely and Hispanic women were more than three times as likely as white, non-Hispanic women to die from pregnancy-related causes.[1]

As the Council is aware, maternal mortality is only the "tip of the iceberg" in terms of health outcomes for mothers. For every maternal death, it is estimated there are 100 instances of severe maternal morbidity (SMM), or life-threatening complications during delivery. In its report on SMM from 2008-2012, DOHMH found that the rate of SMM in New York City increased almost 30% from 2008 to 2012, and that its rate of SMM was 1.6 times the national rate from 2008 to 2009. Racial disparities persist in SMM, with Black non-Latina women facing a rate three times that of White non-Latina women. SMM rates were also highest within high-poverty neighborhoods.[2]

The causes underlying poor maternal health outcomes are many. Chronic stressors including poverty and structural racism contribute to poor outcomes among low-income mothers and women of color. Too few women have access to continuous healthcare coverage, from family planning and preconception care, to prenatal services and care during delivery, to postpartum and interconception care. Even when women in underserved communities do have access to healthcare services, they often face challenges finding care that matches the quality of providers who serve higher income or predominantly white populations.

Addressing major contributors to maternal mortality, such as hypertension and diabetes, is important for improving health outcomes for moms. So is increasing outreach and enrollment in health coverage, and ensuring stronger coordination among health providers serving women at different stages across their life course. Disparate quality of care and implicit racial biases in

---

[1] New York City Department of Health and Mental Hygiene. *Pregnancy-Associated Mortality: New York City, 2006-2010.* (2016). Available at: https://www1.nyc.gov/assets/doh/downloads/pdf/data/maternal-morbidity-report-08-12.pdf.
[2] New York City Department of Health and Mental Hygiene. *Severe Maternal Morbidity in New York City, 2008-2012.* (2016). Available at: https://www1.nyc.gov/assets/doh/downloads/pdf/data/maternal-morbidity-report-08-12.pdf.

healthcare system also deserve additional attention. Ultimately, addressing the social determinants of health (e.g., socioeconomic status, neighborhood and physical environment, access to healthcare, discrimination, education and other social influences on one's life) is key to improving overall health for moms, babies, and families.

CCC appreciates the work the DOHMH has done to improve infant and maternal health in the city. The department's Birth Equity Initiative, home visiting programs, Healthy Start Brooklyn, and expansion of maternal depression screenings are among the important initiatives the city has undertaken to address poor health outcomes among moms and babies. CCC appreciates the department's commitment to addressing health equity, and its investment in partnering with community stakeholders to continue working towards policy solutions.

As DOHMH and the City Council continue to consider strategies for addressing poor health outcomes, we urge increased attention to the impact federal immigration policies will have on maternal health. Anticipated changes to the public charge rule would force many New York immigrants to choose between accessing social service programs, and jeopardizing their immigration status.[3] We have already heard anecdotal evidence of federal policies impacting immigrants' decision to forego essential health services. Fear and uncertainty around federal immigration policies will lead many New Yorkers to avoid necessary care, including critical services for moms and children. We urge DOHMH, the City Council, and the Administration to invest in additional outreach and direct services to immigrant communities.

Again, CCC thanks the Committees for holding today's oversight hearing, and we support the intents and goals of both bills being introduced today. Below we address both bills individually.

Intro 914-2018: A Local Law to amend the administrative code of the city of New York, in relation to reporting on maternal mortality.

CCC supports the goals and intent of Intro 914-2018, which would expand upon the data required in DOHMH's annual report on maternal mortality, and would codify the maternal mortality and morbidity review committee created by DOHMH in December 2017. CCC thanks City Council Member Rosenthal for introducing this bill, and Council Members Cumbo, Rivera, Chin, Ampry-Samuel, Levine, and Ayala for co-sponsoring. However, we do have some concerns that the information required by the bill could jeopardize the privacy of the women in the study.

The establishment of the Maternal Mortality Review Board in 2017 was an important step towards addressing the city's high maternal mortality rate, and CCC lauds the City Council for continuing this work. We also appreciate the extensive work DOHMH has done to study and address disparities in maternal health outcomes, and we hope the review board will be provided with adequate resources to continue and intensify its efforts.

We support the bill's requirement that the report include recommendations for how to enhance cooperation between other city agencies that have a mandate related to maternal health. New York City has made substantial investments in infant/maternal health initiatives, and these efforts will be made stronger through improved coordination and collaboration.

---

[3] Henry J. Kaiser Family Foundation. "Proposed Changes to 'Public Charge" Policies for Immigrants: Implications for Health Coverage." (February 2018). Available at: https://www.kff.org/disparities-policy/fact-sheet/proposed-changes-to-public-charge-policies-for-immigrants-implications-for-health-coverage/

Though we support efforts to further study the contributors to poor maternal health outcomes, we have serious concerns about the level of detail required by the bill. Some of the new data required by § 17-199.3.b.1 could inadvertently reveal the identity of the women being studied. We therefore urge the City Council to work with the department to determine which data should be excluded to protect the confidentiality of the women who are part of the study.

Intro 913-2018: A Local Law to amend the administrative code of the city of New York, in relation to access to doulas in New York City.

Given the great need to address maternal health disparities, CCC is pleased that the City Council is examining how to expand doula services. CCC strongly supports Intro 913-2018, which would require DOHMH to develop a plan to provide access to doulas in the city, and complete an assessment of the needs of pregnant people and the availability of free and low-cost doulas to meet these needs. CCC thanks Council Member Rosenthal for introducing this legislation, and Council Members Ampry-Samuel, Cubmo, Rivera, Chin, Levin, Levine, and Ayala for co-sponsoring.

We also thank the City Council for restoring funding for the Maternal and Child Health Services Initiative for Fiscal Year 2019, and for adding an additional $500,000 to support additional doula services.

Doulas are an essential part of citywide strategies to improve maternal health outcomes. As the Council is aware, doulas offer non-clinical, hands-on physical, emotional, and information support before, during, and immediately after birth. They support clients in their decision-making during childbirth, and facilitate communications with maternity care providers to help ensure their clients' questions are answered and preferences are respected. They provide resources about labor and birth, and provide referrals when more extensive assistance is needed.

Community-based doula programs are a critical part of the doula landscape, offering a broad range of culturally appropriate supports to underserved communities. In addition to providing support during and after pregnancy, these no-cost services can include pre- and postpartum home visits and referrals for health and social services. Doulas may provide counseling and resources around issues including breastfeeding education, safe sleep habits, and attachment and responsive parenting. Programs may screen for indicators like depression, food insecurity, and intimate partner violence, and can help clients navigate the medical and social service systems. Community-based doulas often receive additional training, and are frequently part of the communities they serve, allowing them to better bridge language and cultural gaps.[4]

Evidence of the effectiveness of doulas is extensive. Continuous labor support from a trained individual outside the mother's family network leads to a host of positive outcomes for moms and infants. Continuous labor support during delivery increases the likelihood of shorter labor and spontaneous birth. Women are also less likely to have an epidural or give birth to a baby with a low APGAR score (a score used when baby's health and wellbeing are assessed at birth and shortly afterwards).[5] Women who use doulas specifically are more likely to have a spontaneous vaginal birth, are more likely to have lower maternal stress, and are more likely to rate their childbirth

[4] Nan Strauss, Katie Giessler, and Elan McAllister. *Doula Care in New York: Advancing the Goals of the Affordable Care* Act. Choices in Childbirth. (October 2014). Available at: https://choicesinchildbirth.org/wp-content/uploads/2014/10/Doula-Report-10.28.14.pdf.

[5] Meghan A. Mohren et al. "Continuous Support for Women During Childbirth (Review)." *Cochrane Database of Systematic Reviews.* (2017).

experience positively.[6] They are also more likely to initiate breastfeeding and substantially less likely to have a cesarean section.[7]

Though c-sections can be a life-saving surgery, unnecessary use of this medical procedure can lead to negative health complications for moms and babies. Reducing unnecessary c-section rates can also lead to substantial cost savings. One recent study in the United States found that women who received doula support had lower preterm and cesarean birth rates than Medicaid beneficiaries regionally. The study's authors estimate potential savings associated with doula support could lead to cost savings of approximately $1,000 per birth by reducing preterm and cesarean delivery rates.[8]

Research has also shown the effectiveness of doula programs within New York City. The By My Side (BMS) Birth Support Program serves pregnant women living in the neighborhoods of Brownsville, East New York, Bedford-Stuyvesant, and Bushwick. The project catchment area included areas with the highest preterm and low birthweight rates in the city, as well as an infant mortality rate as much as 76% higher than the NYC average. A recent study of BMS found that program participants had lower rates of preterm birth and low birthweight compared to the area overall. Feedback from the study also indicated doula support is highly valued and helps women have a voice in their perinatal health decisions.[9]

Increasing access to doulas has the potential to improve infant and maternal health outcomes, reduce unnecessary medical procedures, improve the childbirth experience, increase positive behaviors like breastfeeding, and help women navigate healthcare systems in the prenatal and postpartum periods. Despite these benefits, access to doulas remains out of reach for many of the most vulnerable women in the city, including low-income women and women of color.

Lack of diversity among doulas remains a concern: A national study found that most doulas are white, upper-middle class women.[10] Medicaid does not currently cover doula services, and the availability of community-based doula services remains severely limited. Governor Cuomo took important steps in April when he proposed expanding Medicaid coverage for doulas. However, it is still unclear how this policy will roll out in practice, and how readily it will support community-based models.

Recommendations

Studying the availability of and barriers to doula care is an important step towards improving access. CCC supports Intro 913, but offers the following recommendations:

- As the department undertakes this study, we urge continuous and committed collaboration with community stakeholders to help inform the Council's recommendations. This includes the

---

[6] Meghan A. Mohren et al. "Continuous Support for Women During Childbirth (Review)." *Cochrane Database of Systematic Reviews.* (2017).; Kenneth Gruber, Susan Cupito, Christina Dobson. "Impact of Doulas on Healthy Birth Outcomes." *Journal of Perinatal Education.* (2013).

[7] Meghan A. Mohren et al. "Continuous Support for Women During Childbirth (Review)." *Cochrane Database of Systematic Reviews.* (2017).; Kenneth Gruber, Susan Cupito, Christina Dobson. "Impact of Doulas on Healthy Birth Outcomes." *Journal of Perinatal Education.* (2013).

[8] Katy Kozhimannil et al. "Modeling the Cost-Effectiveness of Doula Care Associated with Reductions in Preterm Birth and Cesarean Delivery." *Birth Issues in Perinatal Care.* (January 2016).

[9] Mary-Powel Thomas et al. "Doula Services Within a Healthy Start Program: Increasing Access for an Underserved Population." *Maternal and Child Health Journal.* (2017).

[10] Paula Lantz et al. "Doulas as Childbirth Paraprofessionals: Results from a National Survey." *Women's Health Issues.* (2005).

voices of women who have benefited from the support of doulas, as well as women who have had negative childbirth experiences as a result of insufficient support surrounding the birth of her child. This also includes the voices of community-based doula providers who actively work within high-risk communities, and have close ties to the clients and communities they serve.

- One of the challenges many doulas face is distrust from some physicians, nurses, and other medical providers. This can create conflicts between the practices of medical professionals and the preferences of the client, as supported by her doula. As the department is undertaking its doula study, CCC recommends study of New York City hospital policies and the attitudes of health professionals towards doulas. The New York Coalition for Doula Access is already undertaking work to address barriers doulas face in hospitals. Incorporating this type of analysis into the DOHMH's study can help the department identify ways to foster better hospital policies and more collaborative relationships between doulas and nurses, midwives, and physicians.

- As the department undertakes data collection on doulas and examines available funding mechanisms, we urge the City Council and the department to ensure that any policy changes do not inadvertently restrict the ability of community-based providers to serve high-risk populations. Any move towards greater registration or credentialing of doulas must take into consideration the voices of community-based providers, and the potential impact on providers' ability to meet the needs of their community.

Conclusion

CCC is incredibly grateful that the City Council is initiating a discussion on how our city can improve health outcomes for moms and babies. We look forward to working with the City Council, DOHMH, and the Administration to promote the health and wellbeing of New York children and families.

Thank you for your time and consideration today.

New York City Council Hearing – June 27, 2019
Int. No. 914 In relation to reporting on maternal mortality
By Council Members Rosenthal, Cumbo, Rivera, Chin and Ampry-Samuel

Good Morning,
My name is Anne Gibeau, CNM, PhD and I have practiced as a midwife in the Bronx, NY for over 25 years. I currently am the Practice Director for the Midwifery Practice of the Department of Obstetrics, Gynecology and Women's Health at Jacobi Medical Center. I also am adjunct faculty at the Rory Meyers College of Nursing – Midwifery Education Program, and the Thomas Jefferson University Midwifery Education program. I am a Region Representative for the Downstate region for the New York State Association of Licensed Midwives, and past Region 1 representative for the American College of Nurse Midwives.

I am here today to address Int No. 914 to amend the administrative code of the city of New York, in relation to reporting on maternal mortality.

I am aware of the current maternal morbidity and mortality review committee of the New York City Department of Health and Mental Hygiene (NYCDHMH), and support the groundbreaking work of this important initiative that has been long overdue. I support measures that would secure the future of this endeavor. Careful review of the proposed structure prompted the following considerations:

Currently, both the New York State Department of Health, and the Center for Disease Control (CDC) have established a time frame of one year post-termination of pregnancy to define the time frame for maternal death, for reviews of maternal morbidity and mortality. In Int No. 914, there is a different time frame of 42 days. The NYCDHMH is already using a two-step process to identify maternal mortality: 1) maternal death within one year of giving birth; 2) autopsy results that indicate it was a death related to maternity causes. For there to be meaningful and comparative analysis of maternal mortality, definitions must be congruent. The CDC has set the standard for these types of reviews across the country. I would recommend that NYCDHMH adopt these definitions in policy for data to be comparable.

As elaborated in the proposed amendment, vital statistics data is to be disaggregated and examined 'on an individual-person level.' The focus of elements to be reviewed are limited to those related to the woman who died, and do not include specifics of the healthcare system that provided care. This focus does not allow for a comprehensive view of the tragic outcomes of severe morbidity and/or mortality, and prevents as full an understanding as possible. These "cases", these women, and their families, deserve no less.

To provide a broader understanding, the elements of care during the maternity cycle and the year beyond birth that women receive have to be examined. This review must include analysis

of severe morbidity that culminates in a mortality event, to define the entire continuum of the reality of maternal mortality.

Prenatal clinical care elements must include, at a minimum;

- Identification of providers of care, i.e., OB resident, MD, PA, LM, NP or other. Each of these providers is unique in their knowledge and skills, and philosophic and theoretical approach to perinatal care and pregnancy.
- Identification of clinical care practices to which the woman was subject that are not evidenced-based nor congruent with best practices of maternity care, including referral to a higher level of care if warranted.
- Presence of other support services, i.e., doula, WIC, referral for other health care needs, etc.
- Method of payment for care, i.e., Medicaid, private ins, self-pay, etc
- Place of prenatal care and place of birth; name and location – a woman may have received prenatal care at one site, and delivered at another site – sometimes across boroughs.

The inclusion of community members in this process is critical in order to include different views, approaches and questions to better understand the roots of this reality. People who are part of the community, know the community, and potentially share the concerns and values of the women who died as a result of a pregnancy-related cause, and may have different views of what pregnancy health care should include. Health care in New York City, as is true in most of the United States is dominated by a medical model of care. Additionally, since the 'modernization' of medicine resulting from the Flexner Report of 1910, the focus has been on "patients in the service of science rather than science in the service of patients." Historically, what has been lacking in the formulation and implementation of health care policy and programs, is the input of the women that specific health care policies or programs are meant to serve. Many women in New York City do not perceive that they have control over how their health care is provided. Add to that identified concerns regarding perceptions of disrespectful and discourteous care, i.e., care that is felt to be imposed, not offered in partnership with the patient. This deleterious approach to health care delivery has a strong and negative effect on the well-being of the women and families in our communities, and needs to be elucidated in order to obtain a comprehensive understanding of maternal mortality.

HIPAA requirements are stated in the amendment to protect the privacy of the woman, but there is no provision for confidentiality and non-discoverable protections for those who review cases. In New York City's litigious environment, this is essential for complete, unbiased and effective reviews on the part of members of the committee. The NYS legislature just ended its legislative session failing to pass their MMRB law due to strong disagreement between the houses on this issue.

Emerging issues in reviewing maternal morbidity and mortality include assessment of maternal mental health, suicide, and the presence of substance use disorder as contributing to maternal

death. The maternal mortality review committee that will produce the yearly report specified in Int. No. 914 would be encouraged to identify and assess emerging issues – either those identified on the national level, or as a result of their evaluation of the population here in New York City.

For any review process of maternal mortality to be effective and "life altering", there has to be coordination and effective communication between NYC and NYS MMRBs. The consistent isolation of the State from the City prevents meaningful and productive solutions that would correct this situation for both the state and the city.

I thank you for the opportunity to present to you today.

References:

Duffy, Thomas P. (2011) The Flexner Report – 100 Years Later. Yale Journal of Biology and Medicine. Sep: 84(3): 269-276.

Niedzwiadek, Nick. (2018). Maternal mortality legislation falls victim to confidentiality dispute. POLITICO. 6/26/18.

New York City Council Hearing - June 27, 2018
Int. 913 In Relation to access to Doulas in New York City

Greetings and Salutations Council Members Rosenthal, Ampry-Samuel, Cumbo, Rivera, Chin and Levin,

My name is Helena Grant and I am the Director of Midwifery at NYUSOM Woodhull Affiliate Division, NYC Health and Hospitals (Corp), a member of New York State Association of Licensed Midwives, the New York City Midwifery Chapter and a member of the American College of Nurse-Midwives.

I want to thank the City Council for the opportunity to discuss the offering of trained, qualified Doula care to ALL women in NYC and offer gratitude for your collective willingness to hear and meditate on this issue- one that can have so very much impact on the lives of women and families in the great City of NY.

As a Midwife that has served various communities of NYC, primarily and continuously in the Brooklyn area for 21 years, I am here to offer testimony in support of pregnant women in NYC having access to doulas as a complement to the clinical care of Midwives and other Obstetric providers and Specialists. Midwives and Doulas have long established relationships with one another that offer women pregnancy and after-birth care that synergizes their clinical and support care needs from a wholistic perspective. We share very similar philosophies and have long worked together as members of the same team.

In NYC especially, because evidence has conclusively demonstrated that women of color, especially Black Women, have a risk up to 12X of that of their white counterparts to suffer a Morbid event that sacrifices their Mortality, irrespective of socio-economic status, as a CITY, we need...the women NEED an ALL hands on Deck approach to ensuring that the maternity care experience becomes one where they are given every opportunity to access information and resources in the form of helping hearts and helping hands OUTSIDE of the hospital, clinic, and private office walls, that they can then bring INSIDE with them as well----to be received with respect and a willingness to listen, thus shifting the trajectory of these statistics.

Doula care, especially when the doulas represent the communities being served, become not only continual care support specialists, but an invaluable resource and insight to ALL things Non-clinical that the client may be experiencing that affect and effect her pregnancy and birth experience.

On assessment of Need- Although Doulas are not medically trained and therefore do not replace the clinical expertise of a licensed Midwife or a physician, they are invaluable as members of the birth team. Studies have shown that doulas decrease C/S rates by 50%, decrease the length of labor by 25%, use of oxytocin by 40% and use of epidural by 60%. Yet in a 2014 study, nationwide only 6% of women reported the use of doula care, while Midwifery care stands at approximately 10%. Many women are not aware of the benefits of doula

care...or of Midwifery care for that matter. With this in mind, I ask that the council not evaluate demand as a prelude to need. I instead ask that work be done to remove barriers to women being made aware of these evidence-based resources and statistics, so that they can be empowered to speak to their need and that Gov't agencies become information and care support conduits for families seeking parenthood, so that ALL women, especially those with additionally perceived risk statuses gain access to the benefits of plugging into a wholistic team care model that provides Midwifery, Obstetrical, Nursing and Doula care for ALL women.

One of the primary goals of doulas is to care for the woman's emotional health and enhance her ability to have positive birth memories through the establishment of an intimate relationship during the woman's season of pregnancy need and developing parenthood. This is achieved through home visits during pregnancy and postpartum, phone visits- and on-call access, continuous presence and reassurance during labor, and in-home breastfeeding support all of which is encompassed by respectful and dignity-laced care. This is a care bundle that those of us whether in the hospital or private sector, practicing Midwifery or Obstetrics, must admit, that we are not offering - especially to those women with perceived or unperceived risks that could garner the most benefit. To add to this, women that do desire such a care service may believe they cannot afford such a service and not be aware of Ancient Song Doula Services, Doula By-My Side, and Every Mother Counts as agencies dedicated to serving women that would otherwise not have access to the creation and benefit that doula care can garner.

On the issue of availability of free and low-cost doulas, I would submit to the Council that the words free and low-cost be removed from the bill, as doula work is a 24 hour a day laborious commitment. During my 21 years as a practicing Midwife, many times I have witnessed ONE doula hired by a woman come back and forth over the course of a three-day medical induction of labor and stay non-stop for 18 hours once the labor became established, the birth occurred, and there was at least a basic comfort and confidence the woman felt with lactation. As the Director of Midwifery at Woodhull, we refer many of our clientele to the agencies I previously mentioned. As the one of premiere Midwifery services in Brooklyn, we also collaborate with the Brooklyn Birthing Center as well as many homebirth Midwives that bring their clientele to the hospital for further labor management accompanied by private practice doulas. The work is NOT different, and in total transparency, in my experience the efforts by the agency doulas are more intensive because they are generally being offered to women who may be less educated, have less resources, be partner-less and/or completely alone without any support person at all and have familial and social issues to navigate. The compensation for Doulas hired and contracted by the City should be fair and equitable, based on usual and customary rates in NYC, level of experience and perhaps even hours worked both within the hospital and in the home. One such system of compensation is The NYC Doula collective, a private company which lists rates based on the number of births attended, for example, 1-10 births $400.00, 30-50 births $1200, over 100 births $2000-4000. Doulas committed to caring for the most vulnerable populations in NYC with the highest incidences of morbidity and mortality due to multifactorial systemic issues related to racialization and cultural insensitivity merit equitable compensation to their private practice counterparts.

Very much like Midwifery, women that have access to and choose doula care rate their childbirth experience positively. The doula care model increases and optimizes service, sustenance and support in real time through client advocacy, and a commitment to provide continual comfort and encouragement. Doulas as a collaborative part of the team, working with Midwives, Obstetricians and Nurses synergistically for ALL Women that are deciding to Mother in NYC will not only increase their respective information trajectories, but offers them individualized assurance that they will be advocated for, respected and heard even in the midst of this most unfathomable and abysmal Maternal Health care crisis in NYC.

Thank you again for listening and processing testimony that will serve as a bridge to your collective commitment to offering equitous and wholistic maternal care services to the women and families of NYC.

STATEN ISLAND UNIVERSITY HOSPITAL

ADMINISTRATIVE POLICIES AND PROCEDURES MANUAL

SUBJECT: Managing Maternal Refusals of Treatment Beneficial for the Fetus	**MANUAL CODE:** ADM III A 14.0
EFFECTIVE DATE: May 2008 Page 1 of 4	**SUPERSEDES:** NEW

GENERAL STATEMENT OF PURPOSE:

To provide guidelines for dealing with refusals by a pregnant woman (and/or her husband, the father of the child, or her legal surrogate) of medical treatment in the hospital judged to offer a reasonable possibility of significant benefit to her viable fetus.

GENERAL PRINCIPLES:

1. Both the fetus and the pregnant woman are patients of the Physicians and Staff; therefore, the best interests of both must be served to the fullest extent possible.

2. Every reasonable effort shall be made to respect the rights and wishes of the woman, but also to protect the welfare of the fetus.

3. Because of the physiologic dependence of the fetus on the pregnant woman, the burden of consequences of her actions on the fetus should be taken into account by her doctors and staff.

4. In some circumstances, the significance of the potential benefits to the fetus of medically indicated treatment may justify using the means necessary to override a maternal refusal of the treatment.

5. Every reasonable effort should be made to reduce any additional burdens or risks for the pregnant woman that may result from overriding her refusal of treatment beneficial to her fetus.

PROCEDURES:

1. If a pregnant patient refuses treatment in the hospital that is recommended by the Attending Physician(s) as medically indicated for her fetus, the Attending shall make the following evaluation of the situation:

   a. That there is reasonable certainty that the fetus is at risk of serious harm without the treatment.

   b. That the risks to the woman of the treatment are relatively small.

   c. That there is no viable alternative treatment which may reasonably be expected to protect the fetus from the risk.

STATEN ISLAND UNIVERSITY HOSPITAL

ADMINISTRATIVE POLICIES AND PROCEDURES MANUAL

SUBJECT: Managing Maternal Refusals of Treatment Beneficial for the Fetus	MANUAL CODE: ADM III A 14.0
EFFECTIVE DATE: May 2008 Page 2 of 4	SUPERSEDES: NEW

d. That there is a high probability that the intervention may prevent or substantially reduce the risk to the fetus.

e. That the fetus is reasonably judged to be viable based on gestational age of >23 weeks and absence of lethal untreatable anomalies.

f. That the probable benefits of the treatment to the fetus significantly outweigh the possible risks to the woman.

2. If the Attending Physician judges that all the conditions in #1 are met, he/she should proceed as follows:

a. The Attending Obstetrician and the Neonatalogist on-call must ensure that the patient is fully informed of the specific risks that her refusal may create for her fetus and for herself.

b. Arrangements must be made, if feasible, to provide her with counseling and other supportive services that may help her understand and cope with the situation.

c. The Attending Physician and other caregivers should make reasonable efforts to persuade the pregnant woman to change her mind and accept treatment that is beneficial for her fetus.

3. If the woman continues to refuse consent, the Attending Physician must determine whether the patient has the decisional capacity to refuse the treatment, and document his/her findings in the chart.

a. If the Attending Physician judges that the woman lacks capacity, he/she must arrange for a consult on the patient's capacity by an Attending Psychiatrist, as time permits.

b. If there is not enough time to arrange for the consult from the Attending Psychiatrist without significant additional risk to the fetus, the Attending Physician shall proceed to Step #7 Emergent Need (below).

c. If the woman is judged to lack decisional capacity, the Attending Physician shall seek informed consent from the woman's legal surrogate.

STATEN ISLAND UNIVERSITY HOSPITAL

ADMINISTRATIVE POLICIES AND PROCEDURES MANUAL

SUBJECT: Managing Maternal Refusals of Treatment Beneficial for the Fetus	MANUAL CODE: ADM III A 14.0
EFFECTIVE DATE: May 2008 Page 3 of 4	SUPERSEDES: NEW

4. If the woman with capacity or her legal surrogate continues to refuse the treatment, the Attending Physician shall notify the Director of Maternal Fetal Medicine or the Maternal Fetal Medicine Attending on-call.

5. If the Director of Maternal Fetal Medicine (or designee) agrees that all the conditions in # 1 are met, he/she *or* his/her designee shall notify the representative of the Office of Legal Affairs immediately.

6. The Director of Maternal Fetal Medicine and the representative of The Office of Legal Affairs and the Attending Physician may decide together what measures are appropriate and necessary to override the refusal and provide the treatment in order to protect the medical welfare of the fetus. When time permits, every effort should be made to obtain a court order.

7. EMERGENT NEED:

   If the Attending Physician judges that there is emergent need to treat the fetus, and reasonably determines that waiting for the consultation with the Director of Maternal Fetal Medicine and the Office of Legal Affairs could pose significant additional risk to the fetus, the Attending Physician may choose to take the measures necessary to override the refusal and protect the medical welfare of the fetus without further delay.

8. DOCUMENTATION:

   The attending should document the following in the maternal record:

   a. Fetal condition and risks/benefits of intervention for mother and fetus

   b. That counseling has been performed and by whom

   c. Whether mother has decisional capacity and if not, by whose determination

   d. Urgency of situation with emphasis on whether there is time to consult psychiatry and/or obtain court order

   e. Measures that will be taken

STATEN ISLAND UNIVERSITY HOSPITAL

ADMINISTRATIVE POLICIES AND PROCEDURES MANUAL

SUBJECT: Managing Maternal Refusals of Treatment Beneficial for the Fetus	MANUAL CODE: ADM III A 14.0
EFFECTIVE DATE: May 2008 Page 4 of 4	SUPERSEDES: NEW

9. If another Attending Physician, House Officer or Nurse believes that the conditions in #1 are met, he or she may notify the Director of Maternal Fetal Medicine, as per the SIUH Escalation Policy.

10. CONSCIENTIOUS EXEMPTION:

If an Attending Physician or House Officer or Nurse or other clinical staff has a strong moral or religious objection to administering non-consensual treatment to the woman in order to protect the welfare of the fetus in accordance with this policy, he or she may be excused from participating, provided that a medically appropriate transfer of care can be arranged.

POLICY REVIEW/HISTORY

Reviewed / Revised by: Staten Island University Hospital Administrative Control Person: 1/2008
Approved by Staten Island University Hospital Medical Executive Committee: Effective: 2/2008

SIGNATURES:

Reviewed by:	Title:	Date:
_____	President/CEO	_____ Month/Year
_____	Executive Vice President/COO and Chief Nurse Executive	_____ Month/Year
_____	Executive Vice-President	_____ Month/Year
_____	Chief Medical Officer	_____ Month/Year
_____	Sr. Vice President and General Counsel	_____ Month/Year
_____	Chairman, Obstetrics and Gynecology	_____ Month/Year
_____	Chairperson, Perinatal Bioethics Committee	_____ Month/Year

STATEN ISLAND UNIVERSITY HOSPITAL

475 Seaview Avenue
Staten Island, NY 10305-3498

DRAY, RINAT 032Y F
MR# 001826404 DOB: /1979
GORELIK, LEONID MD Adm: 7/26/11
(646) 675-7751
Acct# 012993020

PROGRESS NOTES

DATE	TIME	
7-26-1	2.30 PM	MFM Director Asked to speak to patient by Dr Gorelik at 1:30PM because she refused a C/Section. The fetus is at risks for serious harm with the C-section. The risk to the patient is small. There is no viable alternative to C-section. There is a high probability that c-section will prevent or substantially reduce the risk to the fetus. The fetus is >23 weeks gestation and does not have a lethal untreatable anomaly. The probable benefits of C-section significantly outweigh the possible risk to the woman. The woman has decisional capacity. I have advised to provide her refusal to have a C-section. Her physician Dr Gorelik and hospital attorney Ms Tracy are in agreement. PRINTED BY: CSANTELLO DATE 7/27/2011 THIS IS A COPY

36172 (04/04)

JotForm rev. (04/0

Debra Lesane, Director of Programs
Caribbean Women's Health Association, Inc.

Addressing Maternal Mortality and Severe Maternal Morbidity in NYC/
The Need for Additional Doula Support Services in NYC

City Council Testimony, June 27, 2018

Good Morning. My name is Debra Lesane and I am the Director of Programs at the Caribbean Women's Health Association, Inc., also known as CWHA. I am also a member of the New York City Maternal Mortality and Morbidity Review Committee, which was recently established by the New York City Department of Health and Mental Hygiene.

I am here today to express my support for both bills that are being considered today, 913-2018, the bill that would require the NYCDOHMH to assess the need and availability of doula services in NYC; and 914-2018, the bill that would require the NYCDOHMH to develop an annual report on maternal mortality and morbidity; including recommendations to address these issues.

CWHA is located in the Flatbush community of Brooklyn. CWHA has been providing support to pregnant and parenting women for more than 30 years. CWHA was established specifically to meet the needs of pregnant women from the Caribbean who did not have access to adequate prenatal care; and who were experiencing high rates of poor birth outcomes, including miscarriages, premature births and infant deaths. Over the years CWHA has developed an array of culturally appropriate initiatives to improve the health of immigrant women and their families, including breastfeeding education; safe sleep education, parenting workshops and women's fitness programs. CWHA also provides HIV Testing, Counseling and Prevention Education and Immigration Legal Assistance. CWHA's programs and services have also expanded beyond the boundaries of Flatbush. CWHA now provides health education and support services to

all; with a particular focus on the Central Brooklyn Communities of Bedford Stuyvesant, Brownsville and East New York. During the last two years, CWHA provided breastfeeding education and additional social support services to more than 250 pregnant women and their families.

In addition, CWHA coordinates Doula Support Services to the residents of Manhattan and the Bronx, as part of the Healthy Women's, Healthy Futures Initiative which is funded by the New York City Council. Healthy Women, Healthy Futures is a Citywide Initiative providing free doula support before, during and after birth; in the most high need areas in New York City.

Healthy Women, Healthy Futures also provides free doula training to low income women from the five boroughs. This is the fourth year that the HWHF Initiative has been funded and operational. Each year a new cohort of community based women, predominantly women of color, receive birth doula training, post-partum doula training; or both. To date the HWHF Initiative has been responsible for training more than 200 NYC resident doulas.

The Citywide Healthy Women, Healthy Futures Initiative is coordinated by CWHA, the Brooklyn Perinatal Network and the Community Health Center of Richmond.

I would like to take this opportunity to remind you of the benefits of doula support. Women who have doula support have fewer caesareans, shorter labors and fewer negative birth experiences. In addition, there are also health benefits for the newborn baby-including higher Apgar scores and increased rates of breastfeeding.

I would like to also highlight the following points:

1. The focus of your deliberations today should also include addressing severe maternal morbidity, which is a life threatening complication during delivery. According to a New York City Department of Health and Mental Hygiene Report,

2. the SMM rate in New York City increased 28.2% between 2008 and 2012.

3. Black and Non-Latina Women had the highest SMM rate, three times that of White and Non-Latina Women.

4. The SMM rates were higher among Women living in high-poverty neighborhoods

5. NYCDOHMH has also reported that other factors, such as racism, toxic stress and trauma also have a negative impact on overall birth outcomes and most likely contribute to the extremely high rates of SMM in NYC.

6. The community districts with the highest SMM rates (2008-2012) were all in Brooklyn- Brownsville, East Flatbush and East New York. Newly arrived women from the Caribbean, Central America and Africa had higher SMM rates than immigrant women who had been living in the US for more than a year.

7. Women with an underlying chronic condition such as hypertension, diabetes or heart disease were three times more likely to have SMM as women with no chronic conditions.

8. The same report indicates that factors associated with poverty such as inadequate housing and other social factors also increase the risk for SMM.

Recommendations

- Provide adequate and ongoing resources to **Increase the overall number of trained doula**s in New York City, with a particular focus on training doulas who can appropriately support the Caribbean, Central American and African immigrant communities. These resources should be made available to community

based organizations who have a track record of providing culturally sensitive support to these NYC residents and communities

- Provide adequate and ongoing resources to **increase the number of pregnant and post-partum women who receive no cost doula support in NYC**; especially women who reside in the most high need communities in NYC; with a particular focus on providing support to newly arrived pregnant and post-partum immigrant women from the Caribbean, Central America and Africa. These resources should be made available to community based organizations that have a track record of providing culturally sensitive support to these NYC residents and communities.

- Provide adequate and ongoing resources to also **meet the health education and social needs of newly arrived pregnant and post-partum immigrant women from the Caribbean, Central America and Africa.** These resources should be made available to community based organizations that have a track record of providing culturally sensitive support to these NYC residents and communities.

National Institute for Reproductive Health & NIRH Action Fund

FOR THE RECORD

Testimony of the National Institute for Reproductive Health
before
The New York City Council Committee on Health and Committee on Women
regarding
Int. No. 913: In relation to access to doulas in New York City and
Int. No. 914: In relation to reporting on maternal mortality.
June 27, 2018

Thank you to Councilmember Levine, Councilmember Rosenthal, the members of both committees, and all the bill sponsors for the opportunity to submit testimony today. My name is Danielle Castaldi-Micca and I am the director of political and government affairs at the National Institute for Reproductive Health and the NIRH Action Fund, reproductive rights organizations that build power at the state and local level to change public policy, galvanize public support, and normalize women's decisions about abortion and contraception.

Reproductive justice is a framework that establishes that everyone should have the power and resources to make healthy decisions about their bodies, sexuality, and reproduction. That includes the right of all people to choose to have or not have children, the right to choose the conditions under which to give birth or create a family, the right to care for their children with the necessary social support in a safe and healthy environment, and the right to control their own body and self-expression, free from any form of sexual or reproductive oppression. The term reproductive justice was first coined by black women in 1994, and the reproductive justice movement continues to be led by women of color.[1]

At NIRH, we stand with our sister organizations in the reproductive justice movement, and support policy efforts and culture change that improve the lives of pregnant New Yorkers and those who choose to become parents. We therefore applaud the bill sponsors for introducing the bills before you, which would increase reporting on maternal mortality, and assess the needs of pregnant people and the availability of free and low-cost doula services. Doula care reduces stress in a laboring woman. In a hospital environment that is often chaotic and impersonal, especially for women of low socioeconomic status, the continuous presence of a caring, supportive doula is often the only positive reinforcement that a laboring woman will experience. Having someone by your side who believes in you, trusts that you are capable of birthing your child, and stays with you for every step of your labor is often all a woman needs in order to find her strength and birth her child without the aid of costly medical interventions.

The positive health outcomes of doula care seem particularly relevant here. Not only is New York failing the women who have pregnancies and give birth here generally, but there are stark racial disparities as well. Black women are nearly four times more likely than white women to die of causes related to pregnancy or childbirth.[2] This is not an issue of money or financial privilege-- even black women of higher socio-economic status have a higher maternal mortality rate than white women of that same status; however, poor black women are at an even greater risk.

---

[1] For more information about reproductive justice, please visit https://www1.nyc.gov/site/doh/health/health-topics/sexual-reproductive-justice-nyc.page.
[2] *Pregnancy Mortality Surveillance System*, Centers for Disease Control and Prevention, *available at* https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html.

Among the primary factors that contribute to the high rate of maternal death is a poor understanding of the root causes and the most effective interventions. This information gap has prevented public health officials from taking effective measures to prevent maternal death, therefore additional information is vital. We do, however, urge policy makers and public health officials to take strict measures to ensure that confidentiality is not sacrificed in the name of data.

Reproductive freedom includes access to a range of reproductive health services, and we are proud to support these bills. We urge the Council to pass Int. 913 and 914.

NYU Langone Health

Lisa Nathan, MD, MPH
Assistant Professor
Department of Obstetrics and Gynecology

27 June 2018

Testimony before the New York City Council
Joint Hearing Committee on Health and Committee on Women
Oversight - Maternal Mortality in New York City

Good morning, my name is Lisa Nathan, MD, MPH. I am an Assistant Professor within the Department of Obstetrics and Gynecology specializing in Maternal Fetal Medicine at NYU Langone Health. I serve as the Site Director for Maternal Fetal Medicine at the Brooklyn Campus in Sunset Park. Thank you to both Chairman Levine and Chairwoman Rosenthal, members of the Committee on Health: Council Member Ampry-Samuel, Barron, Eugene and Powers and members of the Committee on Women: Council Member Kallos, Ayala, Cumbo and Lander for the opportunity to discuss this issue.

Today I am speaking on my own behalf, as well as on behalf of my Department and NYU Langone Health. Before I address the issues at hand, I would like to begin with a simple definition because it is important to understand what actually defines a maternal mortality when analyzing this complex problem. Maternal Mortality is defined by the World Health Organization as the death of a woman while pregnant or within 42 days of termination of pregnancy. This is irrespective of the duration and site of the pregnancy and it can be from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. The CDC uses a similar term, pregnancy associated death, which increases the period from 42 days to one year.

Globally, maternal mortality is falling. In 1990, there were an estimated 532,000 maternal deaths worldwide. In 2015 it was down to 303,000, representing a roughly 43% decline. This is in stark contrast to the U.S. As you are well aware, we have a crisis in this country. Women are dying at an alarming and increasing rate from pregnancy or childbirth-related complications. The maternal mortality rate has increased by nearly 27% from 2000 to 2014 and the most recent estimates show the maternal mortality rate has increased from approximately 7 deaths in the late '80s up to 17.3 deaths per 100,000 live-births. Canada, for comparison, has a rate of approximately 11 deaths per 100,000 live-births. What is equally alarming is that the U.S. has one of the highest rates of high-income countries and most others have been seeing a decrease in maternal mortality rates in recent years.

Some of these trends may be explained by the obvious changing demographic and clinical characteristics of American women who become pregnant. We have definitely witnessed a shift away from the typical young, healthy pregnant woman of the past. We are now seeing an increasing proportion of pregnant women being at least 35 years of age at the time of their child's birth and increasing rates of obesity, hypertension, and diabetes in these pregnant women. In addition, because of the older age and pre-existing chronic medical conditions, we are seeing cardiovascular disease now as the leading cause of maternal deaths in this country.

As concerning as the high rates and constant rise in maternal mortality in our country, are the huge disparities in maternal outcomes that exist in the United States. Poor pregnancy outcomes

NYU Langone Health

and maternal death disproportionately affect black women who are almost three times as likely to die from a maternal death as white women in this country (56.3 versus 20.3 deaths per 100,000 live births in one study).

These trends are seen here in New York State as well. The most recent data from 2013-2015 shows a maternal mortality rate of 55 for black women compared to 15 for white women and 10 for all other racial categories. Black women are 12 times as likely as white women to die from pregnancy related causes. The Bronx is the borough with the highest maternal mortality rate of 26 followed closely by Brooklyn, which has a rate of 25.7. This is in stark contrast to Manhattan, which is the borough with the lowest rate of 13.9. This, of course, is consistent with the demographics of these boroughs. The Bronx and Brooklyn have the greatest proportions of black women while Manhattan and Staten Island have the least.

These disparities are also seen when you look at rates of severe maternal morbidity, which is defined as an unexpected outcome during labor or delivery that result in short term and/or long term health consequences. For every maternal death, it is estimated that 100 women suffer a severe obstetric morbidity. New York City's rate of severe maternal morbidity has increased 28% from 2008-2012 and is higher than that national rate. Black women again, have the highest rates and are roughly three times that of white women. Similar to mortality rates, these rates remain highest among black women even after stratifying for other known risk factors. We are only just starting to explore the psychological impact these harrowing experiences have on these women and their families.

So, we ask why? Why are there such stark disparities that result in black women in this wealthy country having rates of maternal death that are seen in some developing countries around the world? I agree with others that the disparities come to exist due to a complex interplay of three main factors; patient, provider, and system level factors. Due to the complexity of the problem and the interplay between these factors, there will never be an easy solution nor will there be a single solution that in isolation will solve the problem. We need to address all of them simultaneously to see the change we are hoping to achieve.

If we start by looking at the system level factors, it is clear that there needs to be increased access to quality health insurance to provide a strong foundation for increased access to medical care. However, we know that increasing access to care does not translate into increased utilization of care. Utilization of care is a complicated issue as well with both social determinants and patient level factors at play. In addition, culturally competent, compassionate, un-biased, and patient-centered care is a provider factor that research has shown to be severely lacking and we know plays a role in a patient continuing care and adhering to a plan. Disturbingly, we are now seeing more and more evidence of overt and subconscious racism playing a factor in patient care and outcomes as well. That implicit bias exists amongst healthcare professionals is inescapable, but to think that it may compromise care being provided to the most vulnerable patients is truly unacceptable. Implicit bias awareness and training is essential and should be required semi-annually or annually.

NYU Langone Health

As a physician who has only practiced in the Bronx and Brooklyn and has served as a maternal death case abstractor for the city of New York, I can also attest to the fact that it is critical to improve the quality of the actual medical care provided to these women. All providers need to be trained in the importance of preconception care and need to look at any reproductive aged woman as someone who could become pregnant imminently. Chronic illnesses that are poorly managed or ignored for years prior to pregnancy can have devastating outcomes during pregnancy and/or in the postpartum period. Physicians also need regular structured training sessions in the major obstetric emergencies so that when the emergency happens, it is recognized quickly and managed efficiently. Research has shown that nearly half of all cases of severe maternal morbidity and maternal deaths are preventable. This exemplifies the fact that the quality of care provided is a critical piece to address.

With regards to the specific bills being put forth today, I would caution against disaggregating data. At a state and national level aggregate data is essential to report out on trends related to maternal death, while individual-level data is VERY concerning. Given the small number of maternal deaths, disaggregated information could easily lead to identifiable cases with obvious consequences. As a consultant maternal death abstractor for the New York City Department of Health and Mental Hygiene, I am very careful with how I present the cases to the Maternal Mortality Review Committee to preserve the privacy and anonymity of both the woman and the providers involved with her care.

I would like to conclude by telling you a bit about what we are doing in Brooklyn. NYU Langone Health Brooklyn, is a 450-bed teaching hospital in Sunset Park where almost 50% of residents are foreign-born and approximately 40% are best served in a language other than English. We anticipate 4500 women to deliver their babies with us this year. We have been actively working to address some of the issues discussed. We regularly provide simulation based training in obstetric emergencies for all our staff including nurses, physician assistants, residents, and attending physicians. These drills are typically unannounced and done on the floor in labor rooms to simulate the real emergency experience and allow the teams to practice management skills in a safe environment. In addition, we offer all staff online modules and instructor led training on implicit bias.

I thank you for this opportunity to speak. I would be glad to address any questions.

Testimony of Patricia James, RN

NYSNA Board Member of H&H Executive Council

Oversight – Maternal Mortality in NYC-

Council Chambers-City Hall

June 27, 2018

Good Afternoon. My name is Pat James. I am a registered nurse working at Health and Hospitals for ____ years, and a RN for ___ years. I am also on the NYSNA Executive Committee

representing over 9,000 nurses.

Thank you for allowing me to address you here today. Thank you to

the Chairs of these committees Mark Levine and Helen Rosenthal for

highlighting this very important issue.

I want you to know that the 9,000 nurses of Health & Hospitals

stand ready to work with you to do what we can to support the

expansion of Mid Wife services and improve reporting on maternal

mortality in our hospitals and facilities. That's why we support

Intro 914

Our goal is to help develop and implement strategies to reduce

maternal mortality and maternal health disparities in New York City.

Despite the recent trend of a global decline in maternal deaths, the U.S. maternal mortality ratio has increased.

The following was discussed at the 2018 NY Maternal Mortality

Summit. Although New York State's national ranking in maternal

mortality improved improved from 2010 to 2016, its maternal

mortality ratio remains high at 18.7 deaths per 100,000 live births.

New York women over 40 have a much higher pregnancy-related

mortality than younger women, with the lowest rates in women

aged 20 to 24. The Bronx has the highest rate, with Brooklyn

following behind, and the lowest rates are in Manhattan.

Significant racial disparities in maternal deaths persist in both New

York City and New York State.

According to the Centers for Disease Control and Prevention

Maternal death ratios among black women are three to four times

higher than among white women.

Race is not the cause of health inequities. When you see inequities in health, think about systems because systems create Inequities.

Access to safe affordable housing, a living wage, education, and

healthy food are social determinants that can lead to chronic stress.

Stress affects physical and emotional health and can foster unhealthy behaviors that produce health consequences.

To improve maternal health and the health of women of color it requires institutional transformation. The public hospital system leaders, families, and providers have the power to operationalize equity and decrease preventable maternal death, and improve the quality of health care.

Illinois Representative Robin Kelly announced a bill earlier this year that aims to save more women from dying during pregnancy or childbirth. The bill titled the Mothers and Offspring Maternal & Morbidity Awareness (MOMMA) Act addressing racism in the health care system.

Many midwives focus not only on maternity care, but also on the full range of health needs throughout life. Certified nurse-midwives (CNMs) provide care from your first period until after menopause, plus all the important health events in betweenBefore a woman can start a pregnancy that's healthy, she must be healthy herself.

Providers have to open a dialogue about health, about healthy lifestyles, about family planning, about pre-existing conditions, about concerns. For example comorbidity is the presence of one or more additional diseases or disorders co-occurring with a primary disease or disorder. The additional disorder may be a behavioral or mental disorder. Mental health conditions increase accidental deaths, suicide and homicide when untreated. These deaths may or

may not be included in current data for maternal mortality.

Pregnancy related deaths can be caused by hemorrhage,

cardiovascular and coronary conditions, cardiomyopathy, or

infections. Many pregnancy-related deaths are preventable. Opioid

use has been identified as having an impact on maternal mortality.

Mothers in jail do not have access to adequate health care.

Factors that contributed to the death included: lack of patient

knowledge on warning signs, provider misdiagnosis, and lack of

coordination between providers. In 2018 it is time to train health

care providers to properly listen and assess patient complaints in

order to effectively diagnose and treat appropriately.

Health challenges after giving birth include ~~postpartum~~ postpartum depression, diabetes,

hypertension, and thrombotic stroke.

Preeclampsia is a condition of pregnancy characterized by high

blood pressure and protein in the urine. Preeclampsia usually

occurs after the 34th week of gestation, but it can develop after the

infant is delivered. I believe access to Medicaid for a year following

giving birth would help mothers to remain healthy.

Midwives work with other members of the health care team, such as

physicians and nurses, which reduces fragmentation in care. They

work in a variety of settings, such as hospitals, medical offices,

clinics, birth centers, and homes. They provide general health care

services, gynecology care, and family planning, as well as maternity

care (before, during, and after childbirth). Health & Hospital has an

outstanding mid-wifery program at North Central Bronx Hospital.

We urge you to learn more about that program.

Significant strides in addressing maternal mortality in New York

have been made recently. However, significant deficits and inequities remain.

We must improve and standardize data collection by: incorporating

data on race and geography; conducting better analyses on

the stress responses toward racism; accepting Medicaid, in all hospitals; training and educating providers and, conducting research on pre-disease

pathways, and on connections between maternal and infant health.

Planned Parenthood
Care. No matter what.
Planned Parenthood of New York City
26 Bleecker Street
New York, NY 10012
p: 212.274.7200 · f: 212.274.7276
www.ppnyc.org

Testimony of Planned Parenthood of New York City
before
The New York City Council
Committee on Women and Committee on Health
regarding
Maternal Mortality in New York City

June 27, 2018

Good Morning. My name is Elizabeth Kahn, WHNP-BC, and I am the Associate Vice President of Clinical Services at Planned Parenthood of New York City. I am pleased to submit testimony for today's public hearing on maternal mortality in New York City. Thank you to Council Members Rosenthal and Levine, as well as the Committees on Women and Health, for convening this hearing, and to the Speaker and Council Member Rosenthal for introducing this important legislation.

Planned Parenthood of New York City has been a leading provider of reproductive and sexual health services in New York City for over 100 years, reaching approximately 85,000 New Yorkers annually through our clinical and education programs. As a health care provider, we know firsthand the importance of expanding access to maternal health care, and ensuring all people have access to services they need. Studies show major racial disparities in maternal mortality, with black women being four times as likely to die in childbirth than white women in New York State.[1] In New York City, the situation is far worse - black women are 12 times more likely to die from pregnancy-related causes than white women.[2] At PPNYC, we understand the importance of doulas in providing support and information to pregnant patients, and applaud legislation that increases access to doula services in the effort to prevent maternal mortality.

Planned Parenthood of New York City has partnered with The Doula Project for seven years, with volunteer doulas providing their support services at our Bronx, Brooklyn, and Queens health centers. These doulas seek to provide compassionate, non-judgmental emotional support, information, and pain management to pregnant people across the spectrum of pregnancy, without the burden of cost. The Doula Project has become part of the health center structure for both our patients and our staff, seamlessly integrating support into our patients' experiences. PPNYC supports Int. 0913-2018, which would require the DOHMH to assess the availability of doula

[1] Lazariu, Victoria and Marilyn Kacica. New York State Maternal Mortality Review Report: 2012-2013. New York State Department of Health. New York State Maternal Mortality Review Team Division of Family Health. August 2017.
https://www.health.ny.gov/community/adults/women/docs/maternal_mortality_review_2012-2013.pdf
[2] Pregnancy-Associated Mortality: New York City 2006-2010. New York City Department of Health and Mental Hygiene, Bureau of Maternal, Infant, and Reproductive Health.
https://www1.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report.pdf

26 Bleecker Street
New York, NY 10012
p: 212.274.7200 · f: 212.274.7276
www.ppnyc.org

services, because we know firsthand that access to doula services is a critical component of reproductive justice, bodily autonomy, and compassionate health care.

PPNYC also supports Int. 914-2018, which would require the DOHMH to report to the City Council on maternal mortality and codify the Maternal Mortality and Morbidity Review Committee (M3RC). This bill would make the data we collect on maternal mortality in New York City more expansive and comprehensive, and help sustain the work being done to address this issue. In addition to the M3RC, PPNYC supports the work of the Department of Health and Mental Hygiene's (DOHMH) Community Engagement Group (CEG) of Sexual and Reproductive Justice. As a member of the CEG, PPNYC works towards the group's goals to reduce maternal mortality, create more avenues for access to doula services, and address racial disparities across delivery rooms in New York City. The CEG brings together community members, providers, and city agencies to strategically realize these objectives.

The CEG's Birth Justice Champions and Birth Justice Providers work to expand access to doulas for low-income women of color, publishing the Standards of Care for Pregnant and Expecting Persons that will be distributed across health centers and hospitals. In the past four years, these birth justice groups have created hubs in the five boroughs for community members to access resources for pre- and post-natal care. In addition to these hubs, Birth Justice Providers are bringing a birth justice framework to hospitals by recruiting health care providers to create innovative ways to educate providers and institutions to implement just, respectful and dignified care during pregnancy. The CEG's campaigns are central to transforming practices rooted in institutional racism and discrimination that impact Medicaid recipients who are denied access to quality care, while creating community centered practices to eliminate barriers to access.

In addition to the DOHMH's Community Engagement Group and the M3RC, the city has taken important steps to reduce maternal mortality, including the Center for Health Equity's Healthy Start Brooklyn program and ThriveNYC and Health + Hospitals' work on maternal depression. We are also seeing action on the state level, and look forward to more information about the Governor's proposals to prevent maternal mortality, as well as the passage of A.10346A/S.8907, which would establish a Maternal Mortality Review Board on the state level. While these developments are encouraging, PPNYC stands with doulas, particularly those of color, who have concerns about the ways community-based doula services are left out of legislative proposals. We recommend that groups like the DOHMH's Community Engagement Group be centered and supported in the discourse on maternal mortality in New York City, and that more conversations are had with black-women led doula groups about Medicaid reimbursement and increased access to doula services. As maternal mortality disproportionately impacts black women, it is imperative that black women-led doula groups are centered, supported, and uplifted in proposed policy solutions.

26 Bleecker Street
New York, NY 10012
p: 212.274.7200 · f: 212.274.7276
www.ppnyc.org

PPNYC applauds legislation that meaningfully addresses the issue of maternal mortality in New York City, and all steps taken to improve the lives of mothers, their families, and their communities. We urge the City Council to pass Ints. 913 and 914 as we work to end maternal mortality. Thank you for the opportunity to submit testimony on this important issue.

###

Since 1916, Planned Parenthood of New York City (PPNYC) has been an advocate for and provider of sexual and reproductive health services and education for New Yorkers. Through a threefold mission of clinical services, education, and advocacy, PPNYC is bringing better health and more fulfilling lives to each new generation of New Yorkers. As a voice for sexual and reproductive health equity, PPNYC supports legislation and policies to ensure that all New Yorkers—and, in fact, people around the world—will have access to the full range of sexual reproductive health care services and information.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Kathryn McFadden

Address: 1325 St Marks Ave

I represent: Myself

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Michael M Bast

Address: 26 Court St Brooklyn 11242

I represent: Rinat Dray

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Chanel Porchia-Albert

Address: 7 Marcus Garvey Blvd BK

I represent: Ancient Song Doula Services

Address: 7 Marcus Garvey Blvd BK

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Nonkululeko Tyehemba CNM

Address: 118 W 117th St, Harlem NY

I represent: Harlem Birth Action Committee

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card 0913/14

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Brittany Brathwaite.

Address: _____

I represent: Girls for Gender Equity

Address: 25 Chapel st. Brooklyn, NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card 0913/14

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Kylynn Grier

Address: _____

I represent: Girls for Gender Equity

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Rinat Dray

Address: 1805 Coney island Ave

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 913 Res. No. _____

☐ in favor ☐ in opposition

Date: 6/27

(PLEASE PRINT)

Name: Dr. Lisa Nathan

Address: _____

I represent: NYU Langone Health

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Dr. Torian Easterling

Address: DOHMH

I represent: _____

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Dr. Deb Kaplan

Address: DOHMH

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Tonya Hardy

Address: 135-11-111th Ave

I represent: Ancient Song / Future Doula

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 913 Res. No. _____

☒ in favor ☐ in opposition

Date: 6/27/18

(PLEASE PRINT)

Name: Lindsay DuBois

Address: 1681e Dean Street #3 Brooklyn NY 11238

I represent: Community Healthcare Network

Address: 160 Madison Ave. 5th Fl NY NY 10010

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: 6/27

(PLEASE PRINT)

Name: Danielle Castaldi-Micca

Address: 227 Clermont Ave Bklyn

I represent: National Inst. For Reproductive Health

Address: 14 Wall st

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 0913/0914 Res. No. _____

☒ in favor ☐ in opposition

Date: 6-27-18

(PLEASE PRINT)

Name: Dr. Sharon Griffith

Address: 60 Madison Avenue, NY, NY 10010

I represent: Community Healthcare Network

Address: 60 Madison Avenue, NY, NY 10010

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 913, 914 Res. No. _____

☒ in favor ☐ in opposition

Date: 6/27/2018

(PLEASE PRINT)

Name: Alice Bufkin

Address: 14 Wall St Ste 4E

I represent: Citizens' Committee for Children of New York

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 914 Res. No. _____

☒ in favor ☐ in opposition

Date: 6/27/18

(PLEASE PRINT)

Name: Patricia James

Address: 931 East 82nd Street

I represent: New York State Nurses' Association

Address: 131 West 33rd Street NY NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 914 ~~1A~~ Res. No. _____

☒ in favor ☐ in opposition

Date: _____

Patricia James

(PLEASE PRINT)

Name: Alex Eaton, RCNM, PhD

Address: ~~[illegible]~~ 1st Floor Court Hospital NY

I represent: NYSNA Midwifery Institutional Center

Address: 1400 Pelham Pkwy South Bx NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 913 Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Helena A. Grant

Address: 137 Park Ave Mt Vernon NY 10550

I represent: NYS Assn Woodhull Hosp H&H

Address: NYSCAM ACNM

760 Bdway Bklyn NY 11206

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 913/914 Res. No. _____

☒ in favor ☐ in opposition

Date: 6.27.18

(PLEASE PRINT)

Name: Debra Lesane

Address: 3512 Church Ave. Brooklyn

I represent: Caribbean Women's Health Association

Address: 3512 Church Ave, Brooklyn 11203

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 913 Res. No. _____

☐ in favor ☐ in opposition

Date: 6/27/18

(PLEASE PRINT)

Name: Sevonna Brown

Address: 212 Kingston Avenue

I represent: Black Women's Blueprint and community based doulas

Address:

Please complete this card and return to the Sergeant-at-Arms