Testimony

of

Jacqueline M. Ebanks
Executive Director, Commission on Gender Equity

before the

New York City Council

Committee on Health, Committee on Women and Gender Equity, and Committee on Hospitals

on

Maternal Mortality and Morbidity in New York City

and

Intro 2017, Intro 2042, Resolution 1239, Resolution 1408

December 7, 2020
Virtually
New York, NY

Good morning Chairs Levine, Rosenthal, and Rivera, and members of the committees. I am Jacqueline Ebanks, Executive Director of New York City's Commission on Gender Equity (CGE). In this role I also serve as an advisor to the Mayor and First Lady on policies and issues impacting gender equity in New York City for all girls, women, transgender, and gender non-binary New Yorkers regardless of their ability, age, ethnicity/race, faith, gender expression, immigrant status, sexual orientation, and socioeconomic status.

CGE works to create a deep and lasting institutional commitment to tearing down equity barriers across New York City and carries out its activities across three areas of focus within a human rights framework and using an intersectional lens. These areas of focus are:

1. **Economic Mobility and Opportunity**. The goal is to create a City where people of all gender identities and gender expressions live economically secure lives and have access to opportunities to thrive.
2. **Health and Reproductive Justice**. The goal is to foster a City free from gender- and race-based health disparities.
3. **Safety**. The goal is to foster a City free from gender- and race-based violence.

To address gender- and race-based health disparities in NYC, CGE recognizes the importance of ensuring access to and affordability of comprehensive, culturally competent sexual and reproductive health care services for all New Yorkers regardless of gender identity and gender expression. With this in mind, CGE identified reducing infant and maternal mortality in Black and Latinx communities as one of our lead initiatives, since 2018.

Consequently, CGE maintains key partnerships with health advocates and colleagues at the Department of Health and Mental Hygiene (DOHMH) and Health and Hospitals (H+H) to ensure responsiveness to the needs of pregnant and child-bearing women and gender non-conforming, non-binary New Yorkers. We are pleased to count several health advocates as members of the Commission. With their involvement, we have numerous direct opportunities to learn about issues of sexual and reproductive health that face New Yorkers where they live and work.

Our partnership with our colleagues at DOHMH included serving, from 2017 – 2019, as a member of DOHMH's Maternal Morbidity and Mortality Steering Committee. As members of the steering committee, we worked with a multi-disciplinary team to:

- Explore policy and program recommendations to reduce maternal mortality and severe maternal morbidity in New York City with an equity focus.

- Advise and support DOHMH and its partners on ways to implement recommended strategies.

- Communicate findings and recommendations to key stakeholders and constituencies and advocate for their support.

In 2019, CGE was proud to feature H + H's comprehensive offering of blended training programs to build competency in providing affirming services for members of the LGBTQ community in our Annual Report. This work has significant positive implications for the provision of supportive sexual and reproductive health services for LGBTQ+ New Yorkers. In fact, in 2019, for the fourth year in a row, twenty-three patient care locations within the H+H network received the designation "Leader in LGBTQ Healthcare Equality" by the Human Rights Campaign.

Through these partnerships, CGE strives to develop and maintain a comprehensive, solution-oriented approach to NYC's high maternal mortality and morbidity rates in Black and Latinx communities. In so doing, we will be able to amplify and support the various programmatic, policy, and public education initiatives launched and managed by our colleagues at DOHMH and H+H. This will better connect pregnant and childbearing New Yorkers to critical and timely needed pregnancy-related medical care and support. We look forward to deepening our work with these partners in the next year.

Regarding the bills under consideration today, I will turn to my colleagues Estelle Raboni at DOHMH and Dr. Wendy Wilcox at H+H to provide comments. CGE stands in support of their recommendations.

Again, thank you for this opportunity to testify on this critical issue. I look forward to continuing to partnership.

Testimony

of

Estelle Raboni, M.P.H., M.C.H.E.S.
Acting Assistant Commissioner, Bureau of Maternal, Infant and Reproductive Health
New York City Department of Health and Mental Hygiene

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December 7, 2020
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Good morning Chairs Rosenthal, Rivera, and Levine, and members of the committees. I am Estelle Raboni, Acting Assistant Commissioner for the Bureau of Maternal, Infant and Reproductive Health at the New York City Department of Health and Mental Hygiene. I am joined by my colleagues Jacqueline Ebanks, Executive Director of the Commission for Gender Equity, and Dr. Wendy Wilcox, Chairperson of Obstetrics and Gynecology from NYC Health + Hospitals (H+H). On behalf of Commissioner Chokshi, I want to thank you for the opportunity to testify today on this important topic, and for your commitment to improving maternal health outcomes for New Yorkers.

I want to say loud and clear: racism is a public health crisis. And one of the most startling statistics we have in New York City to demonstrate this crisis pertains to maternal health and mortality. Black women in New York City are eight times more likely to die from pregnancy-related causes than White, non-Latina women. In fact, White, non-Latina women without a high school diploma have better maternal health outcomes than Black women with a college degree. This is the unacceptable and unjust reality in NYC. Decades of structural racism and pervasive historical disinvestment of Black and Brown communities have led to these avoidable disparities. Despite improvements in reducing deaths related to pregnancy and childbirth, more needs to be done. Reducing maternal deaths and life-threatening complications is a priority for this Administration. Access to quality family planning services, maternal health care, and sexual and reproductive health care services are foundational components of our work to eliminate disparities in Black and Brown communities. The Health Department's five-year plan has been pivotal in our efforts to change the narrative and achieve health equity and justice for Black New Yorkers.

In 2017, the Health Department established the New York City Maternal Mortality and Morbidity Review Committee, referred to as the M3RC. The goal of the M3RC is to reduce preventable maternal deaths by gaining a holistic understanding of each maternal death to determine cause, assess preventability, and identify contributory factors and actionable recommendations to prevent future tragedies. More recently in 2018, the Health Department in partnership with H+H worked together to bolster the City's efforts to reduce racial and ethnic disparities in maternal health. This work includes enhanced public health data surveillance through M3RC and deploying a three-pronged strategy to improve the quality of maternity care at hospitals. This strategy includes: (1) developing a pilot project with three hospitals to conduct in-hospital quality improvement reviews of Severe Maternal Morbidity (SMM) cases; - these are life-threatening events that occur after childbirth and can include heavy bleeding, blood clots, kidney failure, stroke and heart attack - (2) implementing a qualitative research study to explore the perceptions and experiences of pregnant and parenting people who experienced a severe maternal morbidity while giving birth, and the consequences of the severe complication on their lives, and lastly; (3) informing and supporting mobilization around maternal health by sharing findings, engaging community stakeholders and hospital partners to change the systems and structures in which people give birth with a focus on SMM.

Additionally, the Health Department works directly with communities facing the most significant health, social and economic challenges by engaging Birth Justice Defenders (BJDs) to conduct community outreach and education about the New York City Standards for Respectful Care at Birth. These standards were created to inform, educate, and support people giving birth. These standards encourage pregnant people to know their basic human rights and be active decision-makers in their birthing experience, and are also helpful for providers to remind them to respect and be aware of their patients' human rights during pregnancy, labor and childbirth. We are currently implementing the New York City Standards for Respectful Care through virtual training with 14 maternity hospitals who serve the majority of pregnant black and brown people in the city. I will now share more detail on some of the work led by the Health Department, beginning with the M3RC.

The Health Department formed and convened its first-ever M3RC review committee in 2017 using methods, guidance and tools from the Centers for Disease Control's Maternal Mortality Review Information Application. The Health Department reviews all maternal deaths through this multidisciplinary, multi-ethnic and racially diverse M3RC. Membership of this committee is drawn from clinical and non-clinical providers across all specialties and includes law enforcement, community partners, the NYC Medical Examiner's Office and key leaders within American College of Nurse Midwives and New York Medical College. The M3RC contributes to the larger repository of data and literature in this field. Most recently, the M3RC made recommendations based on an in-depth review of all pregnancy-associated deaths that occurred in 2016 and 2017. These recommendations address improvements in systems and facilities in which pregnant people give birth, improving provider care and raising public awareness among community stakeholders and pregnant people of postpartum warning signs and their basic human right to respectful care.

Since the start of the COVID-19 pandemic, the committee has been meeting virtually and has continued this important work. The committee meets every two to three months to conduct a multidisciplinary expert review of each maternal death in New York City from both clinical and social determinants of health perspectives. At the end of every calendar year, the committee proposes key recommendations to improve the care of pregnant persons.

With respect to the Department's work on SMM, we are convening a virtual New York City Maternal Health Summit, "Improving Care and Supporting Healthy Childbirth Experiences", on Wednesday, December 8th. To date, there are over 350 people registered for this event, reflecting interest to hear from experts from clinical and community settings discuss findings from the Severe Maternal Morbidity Project. The virtual summit will include web-based panels that will explore the various components of the Project and offer participants an opportunity to learn about the SMM Project's efforts to address maternal health inequities.

Another significant component in our work to improve maternal outcomes is the Maternal Hospital Quality Improvement Network, or MHQIN. Spearheaded by the Health Department and in partnership with H+H, the MHQIN is a comprehensive strategy with New York City public and private maternity hospitals to address the root causes of persistent racial and ethnic disparities in maternal mortality and severe morbidity, with an emphasis on establishing an in-house quality improvement process. Specific efforts taken include implicit bias training for clinical and non-clinical staff at the city's maternity hospitals to improve equity in childbirth, and training on trauma-and-resilience-informed systems, which provides a shared language and understanding of how stress and trauma affect individuals, institutions and communities along with practical tools to address implicit bias in clinical decision-making. We have supported clinical training in medical simulation for leading causes of SMM, and improved hospital-doula collaboration by focusing on capacity-building.

At the start of the COVID-19 public health emergency, we faced some challenges in this work. For example, case abstractors were not allowed on site at hospital facilities due to infection control measures, and virtual meetings with hospitals were temporarily paused as staff were entirely dedicated to immediate COVID-19 response. Since May, we have reinstated monthly calls with most of the MHQIN hospitals and case abstraction has resumed at most sites. Both our doula capacity-building and implicit bias trainings have moved from in-person to virtual modalities. Furthermore, under MHQIN, the Birth Justice Defenders continued their engagement efforts in communities impacted by maternal health disparities and worse health outcomes. Virtual webinars were viewed 7,000 times by community members. In order to meet emerging health needs resulting from the public health emergency, we also developed tailored resources, including a specific webpage dedicated to addressing the needs of pregnant persons during the pandemic.

In addition to these resources, the Health Department has developed a series of public awareness campaigns to complement our community-based work. To gain community input on these campaigns, we conducted listening sessions with community members consisting of persons of reproductive and parenting age representing the five boroughs, as well as focus groups with healthcare providers. These campaigns include: Safe and Respectful Care, aimed at community residents and healthcare providers to educate New Yorkers about their rights and options before, during and after pregnancy, and to promote the Standards for Respectful Care; a Public Health Detailing Campaign for healthcare providers, centered on having a healthy pregnancy and educating patients on chronic disease prevention and management as well as providing tools and resources to support diabetes and hypertension self-management; and finally, the M3RC toolkit for healthcare providers, community organizations, and local health departments, summarizing our work on this topic and making the knowledge accessible for others.

We are fiercely committed to changing the culture around birthing care in New York City, and are proud of the work this Administration has led to take significant steps towards reducing disparities in care.

I will now speak to the bills being heard today before handing it over to my colleague Dr. Wilcox from H+H.

Intro 2017-2020

Intro 2017 would require the Health Department to develop voluntary guidelines for hospital visitation policies in the event of a public health emergency, and to distribute such guidelines to every hospital in New York City, post such guidelines on the agency's website, and submit such guidelines to the Mayor and Speaker of the Council. The Health Department understands Council's interest in ensuring there is clear guidance during an emergency and that public health considerations are incorporated into any emergency measures taken by a healthcare facility. However, the Health Department does not have regulatory authority over hospitals – that authority sits with the State Health Department. As such, we are concerned that issuing voluntary guidance potentially conflicting with State guidance or regulations would cause confusion for patients and their loved ones.

Intro 2042-2020

Intro 2042 would require the Health Department to post information about midwives, including the services they offer and how to find them, on our website in English and in each of the citywide designated languages. We support this legislation and Council's interest in making more information on midwives available and accessible to New Yorkers. We are open to discussing what would be most useful to share on our webpages.

I want to thank the Council for their dedication to this topic and for holding this hearing today. We are proud to be partners in this work, and I am happy to answer any questions.

Dear Council Members,

Since 2018, California has a partnership with Yelp, the online review website, to publish maternal health data for each hospital in the state. Some of the data points included are rate of cesarean sections, episiotimies and successful VBACs. This transparency in information regarding maternity care in hospitals not only has empowered pregnant individuals throughout California to make decisions regarding their care but has helped hold hospitals accountable for their maternal health outcomes.

In fact, in the last 20 years, California has effectively reduced their maternal mortality by half (from 14 deaths per 100,000 in 2008 to 7.5 deaths per 100,000 in 2013) while the rest of the United States, including New York, have had a continuous rise in maternal deaths.

In 2016, *New York State Law § 2803-J Information for Maternity Patients* was passed, mandating that New York hospitals annually publish their data on birth related events and procedures such as number of vaginal or Cesarean births, use of forceps or vacuum, inductions, vaginal births after prior Cesareans, and other vital statistics. But this is not enough! Obtaining this information is challenging for patients,

In light of the ongoing Black maternal mortality crisis, I must insist this law be expanded to include reporting on maternal deaths, before, during and up to six weeks after childbirth; third trimester fetal losses and stillbirths; hemorrhage; and injuries related to childbirth including damage to tissue and organs during Cesarean birth, third and fourth degree tearing; with a racial break down on all data points.

In low income, predominantly Black or Hispanic neighborhoods physical proximity to a hospital is often a major deciding factor of where to receive prenatal and labor care. Recent studies show that the hospital at which pregnant people receive care is a primary determinant of Cesarean rates, morbidity and mortality. In absence of published hospital data regarding pregnancy outcomes, pregnant people and particularly Black women in New York State, cannot make informed decisions about where to receive their care or whether their local hospital is a safe place for them to birth their babies.

Transparency in racial disparities of pregnancy and birth outcomes is an essential step in ensuring better outcomes for all pregnant New Yorkers. New York's hospitals have been allowed to operate with impunity after deaths, loss or injury occur for too long. Requiring hospitals to publish maternal, fetal and infant morbidity and mortality data is essential in holding these institutions accountable for preventable injuries and deaths and improving pregnancy outcomes for patients.

I implore you to amend *New York State Law § 2803-J Information for Maternity Patients* to include statistics and racial data on maternal deaths, third trimester fetal losses and stillbirths, and birth related injuries. This information is critical in the fight against New York's maternal mortality crisis and vast racial disparities in maternal health. I also implore you to establish a similar partnership with Yelp as the State of California has to make this information easily accessible to the pregnant people of New York City.

Sincerely,

Jesse Pournaras, Birth Doula

New York City Council Hearing

Maternal Mortality and Morbidity in NYC

Committee on Hospitals

Committee on Health

&

Committee on Women and Gender Equity

Wendy C. Wilcox, MD, MBA, MPH, FACOG

Chair, Department of Obstetrics and Gynecology at NYC Health + Hospital/Kings County, and Clinical Service Line Lead for Maternal Mortality Reduction and Women's Health

NYC Health + Hospitals

December 07, 2020

Good morning Chairperson Rivera, Chairperson Rosenthal, Chairperson Levine and Members of the Committee on Hospitals, Women and Gender Equity and Health. I am Dr. Wendy Wilcox, Chair of the department of Obstetrics and Gynecology at NYC Health + Hospital/Kings County, and Clinical Service Line Lead for Maternal Mortality Reduction and Women's Health for NYC Health and Hospitals (H+H). I also served as Co-Chair for the New York State Taskforce on Maternal Mortality and Disparate Racial Outcomes. I have been a practicing clinician for over 20 years and I have worked for NYC Health and Hospitals since 2008. Thank you for the opportunity to testify before you to discuss Maternal Mortality and Morbidity in NYC.

New York City Health and Hospitals has a long history of working to improve the health of women and children in this city. As you are aware, our patients are often un- or under-insured and may come from under-served neighborhoods; thereby necessitating a more urgent need for attention.

For over 10 years Bellevue Hospital has served as the New York State Department of Health Regional Perinatal Center for Health +Hospitals. As a Regional Perinatal Center, Bellevue's responsibilities include monitoring quality metrics from across the system; holding educational events for H+H perinatal staff; accepting transfers

for complex and higher acuity patients from the other 10 Health + Hospital facilities and providing 24-hour specialty and sub-specialty consultation services as well as patient transport. The Regional Perinatal Center conducts on-site visits to the other facilities within H+H to review cases and conduct quality reviews.

In 2013, H+H joined the American College of Obstetrics and Gynecology's (ACOG) "Safe Motherhood Initiative" which implemented standardized interventions to reduce adverse events related to: severe hypertension in pregnancy; prevention of thromboembolic events of pregnancy (meaning prevention of life-threatening clots called pulmonary emboli); and managing severe, life-threatening maternal hemorrhage – the three leading causes of maternal mortality at the time. In fact, NYC Health +Hospitals was recognized by ACOG DII as the only health system in New York State which had every hospital in its system to participate in the "Safe Motherhood Initiative."

In 2014, NYC Health +Hospitals established the Institute for Medical Simulation and Learning (aka IMSAL), where we "prepare for real life-threatening events". We developed simulated scenarios in obstetrics and other clinical areas, so that our provider and nursing teams can practice the skills necessary to respond to those rare events—those rare events where a quick and correct response can make the

difference between life and death. For obstetrics, we have simulations in shoulder dystocia, a revised maternal hemorrhage simulation course, and one to respond to cardiac arrest in pregnancy. Our simulation course to manage severe hypertension in pregnancy will begin once our hemorrhage simulation has been completed (late 2021 or early 2022). Since implementing obstetric simulations, we have seen an improved response in these occurrences but also a reduction in medical malpractice indemnities paid.

In 2015, all 11 hospitals in the H+H system, joined the Greater New York Hospital Association (GNYHA) Depression Collaborative (which was part of NYCThrive) and implemented perinatal depression screening as part of the prenatal, postpartum and newborn visit. 85% of people who were screened through this program positive were connected to care.

In 2018, NYC H+H invested in **Relias**, an online educational course that provides assessment based personalized learning accepted by the American Board of Obstetrics and Gynecology for Maintenance of Certification. Health + Hospitals invested in Relias to increase the clinical knowledge and judgement of our provider teams, engage in best practices, improve teamwork and communication, decrease variation among clinicians, and reduce clinical errors, thereby reducing the number

of obstetrical adverse events. Relias is now required for attaining and maintaining privileges in our perinatal services.

Also in 2018, Health + Hospitals partnered with the City Hall and DOHMH to begin implementing a comprehensive quality improvement program to improve the care of pregnant persons and focus reducing pregnancy-related morbidity and mortality for women of color.

In our **Maternal Medical Home (MMH)**, care coordinators and social workers provide enhanced support and wrap-around services for pregnant persons who are at-risk for undesired pregnancy outcomes due to medical, behavioral health, or social determinants of health (SDOH) factors. The maternal medical home embodies two models of care:

Socio-Ecological Model

- Providing health education and encouraging self-efficacy.
- Building trusting and lasting relationships between patients and MMH team, and between facilities and community-based organizations (CBOs)
- Standardizing obstetric screening and assessment across the NYC Health + Hospitals system

Sociocultural Environment Model

- Connecting patients with needed resources and services.
- Encouragement and facilitation of patient autonomy in their prenatal care and birthing experiences.

The Simulation Program trains the OB healthcare team to manage the top 3 causes of maternal mortality:

- Cardiovascular collapse
- Acute life-threatening blood loss
- Severe hypertension

The **interval pregnancy optimization program** helps to improve maternal health by training primary care providers to ask patients specifically about pregnancy intention. The patient is asked whether they are planning to become pregnant in the next year. If yes, they are referred for pre-conception counseling. If not, they are referred for effective contraception of their choice.

Our **mother-baby coordinated visit program** aims to increase adherence to the postpartum visit by having the patient post-partum visit scheduled with the baby's pediatric visit.

Addressing **implicit bias** is a priority at Health + Hospitals. H+H has conducted an implicit bias training for our Board of Directors and for the medical and operational leaders i our eleven facilities (+ Gotham) with Perceptions Institute.

We are also working hand in hand with DOHMH to provide training sessions to the **Maternal Hospital Quality Improvement Network (MHQIN)**. The MHQIN is a comprehensive strategy with 14 NYC maternity hospitals to address the root causes of persistent racial/ethnic disparities in maternal mortality and severe maternal morbidity with emphasis on the importance and the "how to" of setting up a quality improvement process in their departments. With DOHMH support, the MHQIN integrates reviews of all cases of obstetrical hemorrhages and ICU admissions into OB department quality improvement processes. MHQIN hospitals provide data back to DOHMH to inform future population-based strategies to address these conditions. I will let my colleague from DOHMH further describe the MHQIN.

NYC Health + Hospitals' **Community Care program** ensures that pregnant women have access to the highest quality of care in a home setting. This includes (but is not exclusive for) antepartum assessment and instruction, teaching and support for breastfeeding, supportive care for infants who are at risk for neonatal morbidity or mortality.

As part of the New York City's Birth Equity Initiative, H+H partnered with DOHMH and the Centering Healthcare Institute to launch CenteringPregnancy, an evidence-based group prenatal program, at NYC Health + Hospitals/Elmhurst Hospital. Although further research is needed, there is some evidence that CenteringPregnancy can improve maternal and infant health outcomes, including preterm birth reduction in certain populations. Centering encourages greater patient engagement during the prenatal experience. The program features group pregnancy visits with a provider, networking with other pregnant women, group discussions, and prenatal wellness and education classes on nutrition, stress management, and breast feeding. All pregnant women are eligible to participate in the group care sessions and are asked to join the group during their initial prenatal visit, unless their pregnancy shows signs of being or becoming very high-risk. The sessions begin at about 16-20 weeks gestation, and occur with the same frequency and routine pregnant care visits.

Midwifery services are also offered throughout Health + Hospitals to improve patients' experiences. NYC H+H employs over 70 midwives across the system and thus is the largest employer of midwives in New York City. Patients may access doula services through our relationship with community-based organizations. Patients who request doula services are referred to community providers including:

Brooklyn Perinatal Network; By My Side; Caribbean Women's Health Association; Bronx ReBirth, and Ancient Song. Over the last three years, we have made many referrals for doula support for patients and are looking to expand these referral services.

In conclusion, we would like to thank the Council for its support of Health + Hospitals to improve the care and outcomes for the women we serve. I am happy to answer any questions.

Testimony to the New York City Council Committee on Health, Committee on Hospitals, and Committee on Women and Gender Equity

Oversight Hearing on Maternal Mortality and Morbidity in New York City
Monday, December 7, 2020

December 9, 2020

Distinguished Members of the Committee on Health, Committee on Hospitals, and Committee on Women and Gender Equity:

The New York State Health Foundation (NYSHealth) appreciates the opportunity to submit written testimony on the status of maternal health in New York City. We offer information from our recent research report on severe maternal morbidity in New York to add to the evidence base of racial and ethnic disparities in maternal health outcomes. In addition, we identify policy approaches for consideration to support and encourage the use of midwives and community-based health workers to reduce incidence of severe maternal morbidity, close disparities by race and ethnicity, and accommodate patient choice.

The Status of Maternal Health in New York City

The United States has a higher maternal mortality rate compared to other peer developed nations.[1,2] Unfortunately, maternal death is considered the "tip of the iceberg" of an even larger body of adverse maternal events impacting women.[3,4] Prior research has found that for every maternal death, there are up to 100 occurrences of severe maternal morbidity (SMM).[5] SMM refers to outcomes during labor and delivery that result in adverse short- or long-term consequences to a woman's health.[6] These outcomes may be life-threatening and require the need for lifesaving procedures, such as a blood transfusion or ventilation.[7]

New York State has historically had higher rates of SMM than the rest of the nation. The most recent years of nationwide data show that New York State ranked in highest quartile of state SMM rates.[8] Prior research has documented the high rates of SMM and racial and ethnic

[1] World Health Organization, "Trends in Maternal Mortality 2000 to 2017: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division," 2019, https://www.who.int/reproductivehealth/publications/maternal-mortality-2000-2017/en/.
[2] Munira Gunja et al., "What Is the Status of Women's Health and Health Care in the U.S. Compared to Ten Other Countries?" (The Commonwealth Fund, December 2018), https://www.commonwealthfund.org/publications/issue-briefs/2018/dec/womens-health-us-compared-ten-other-countries.
[3] It is important to note that not all people facing these issues identify as women.
[4] William M. Callaghan, Andreea A. Creanga, and Elena V. Kuklina, "Severe Maternal Morbidity among Delivery and Postpartum Hospitalizations in the United States," *Obstetrics and Gynecology* 120, no. 5 (November 2012): 1029–36, https://doi.org/10.1097/aog.0b013e31826d60c5.
[5] Callaghan, Creanga, and Kuklina.
[6] Centers for Disease Control and Prevention, "Severe Maternal Morbidity in the United States," January 31, 2020, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html.
[7] American College of Obstetricians and Gynecologists and the Society for Maternal–Fetal Medicine, Sarah K. Kilpatrick, and Jeffrey L. Ecker, "Severe Maternal Morbidity: Screening and Review," *American Journal of Obstetrics and Gynecology* 215, no. 3 (2016): B17-22, https://doi.org/10.1016/j.ajog.2016.07.050.
[8] See attachment "ALL FAD – June 8 2020.xlsx" contained within: HRSA Maternal and Child Health, "Federally Available Data" (U.S. Department of Health and Human Services, July 2, 2020), https://mchb.tvisdata.hrsa.gov/uploadedfiles/TvisWebReports/Documents/FADResourceDocument.pdf.

disparities in New York City specifically.[9,10,11] This is particularly concerning given that, in 2018, New York City accounted for approximately half (49%) of all deliveries in the State, including more than half of all Black and Hispanic deliveries. There are significant disparities in SMM by race and ethnicity in New York City, even after controlling for differences in health status, insurance type, sociodemographic characteristics, education, prenatal care, and socioeconomic status.[12,13]

NYSHealth's Work to Improve Maternal Health

NYSHealth is a private, independent foundation that works to improve the health of all New Yorkers, especially the most vulnerable. Our grantmaking and research has provided us with experience in and knowledge of the disparities in maternal health across New York State. In particular, through our *Empowering Health Care Consumers* program, we have supported work to expand access to transparent information about maternal health care quality and outcomes.[14]

NYSHealth has recently funded multiple projects to enable New Yorkers to make informed and higher-value decisions about maternity care. This includes the development of an online tool that allows expectant mothers to compare local providers in the New York City area based on quality measures and other factors that affect maternity and newborn care.[15] In addition, the Foundation is supporting an effort by one of the largest unions in the State to develop a high-value maternity care network for its expectant parents, who are predominantly lower-wage union workers and women of color.[16,17]

New Research on Severe Maternal Morbidity in New York City

At this critical juncture, NYSHealth would like to provide the Committees with new research that sheds light on the stark racial and ethnic disparities in severe maternal morbidity in New York City. This analysis can support the City in its continued efforts to design programs and target resources. Below are key findings from a 2020 NYSHealth analysis of SMM, using 2011–2018 inpatient hospital admissions associated with deliveries.

[9] New York City Department of Health and Mental Hygiene, "Severe Maternal Morbidity Surveillance," July 3, 2018, https://www1.nyc.gov/assets/doh/downloads/pdf/data/severe-maternal-morbidity-data.pdf.
[10] Elizabeth A. Howell et al., "Site of Delivery Contribution to Black-White Severe Maternal Morbidity Disparity," *American Journal of Obstetrics and Gynecology* 215, no. 2 (2016): 143–52, https://doi.org/10.1016/j.ajog.2016.05.007.
[11] Elizabeth A. Howell et al., "Race and Ethnicity, Medical Insurance, and Within-Hospital Severe Maternal Morbidity Disparities," *Obstetrics and Gynecology* 135, no. 2 (2020): 285–93, https://doi.org/10.1097/AOG.0000000000003667.
[12] Howell et al., "Site of Delivery Contribution to Black-White Severe Maternal Morbidity Disparity."
[13] Howell et al., "Race and Ethnicity, Medical Insurance, and Within-Hospital Severe Maternal Morbidity Disparities."
[14] New York State Health Foundation, "Empowering Health Care Consumers," accessed December 1, 2020, https://nyshealthfoundation.org/what-we-fund/empowering-health-care-consumers/.
[15] ExpectNY, "Information That Empowers," accessed December 1, 2020, https://expectny.com.
[16] "Building Service 32BJ Health Fund," New York State Health Foundation, accessed December 1, 2020, https://nyshealthfoundation.org/grantee/building-service-32bj-health-fund/.
[17] Melanie Grayce West, "New York City Union Uses Its Size to Leverage Improved Maternity Care," *The Wall Street Journal*, August 19, 2019, https://www.wsj.com/articles/new-york-city-union-uses-its-size-to-leverage-improved-maternity-care-11566256083.

- 3,311 deliveries in New York City in 2018 were associated with an SMM event, out of the 102,268 inpatient hospital admissions associated with deliveries analyzed.[18] This translates to an overall SMM rate of approximately 324 out of every 10,000 deliveries (or 3.2%) (see ***Figure 1***). This was higher than the overall New York State rate (2.7 %).

- In 2018, New York City had the highest rate of SMM in the State, with an SMM rate more than three-and-a-half times larger than the region with the lowest rate (324 per 10,000 deliveries in New York City, compared to 90 per 10,000 in the Finger Lakes) (see ***Figure 2***).

- Disparities in SMM by race and ethnicity persisted in New York City from 2011 through 2018 (see ***Figure 3***). In 2018, the SMM rate for Black women was 506 per 10,000 deliveries, amounting to 2.3x the rate for white women.[19] The rate for Hispanic women was approximately 1.7x the rate for white women; the rate for Asian women was approximately 1.3x the rate for white women (362 and 274 per 10,000, respectively, compared to 216 per 10,000). For Black and Hispanic women, these are similar disparities as in 2011 (2.6x for Black women and 1.7x for Hispanic women).

- Racial and ethnic disparities were present both for populations covered by Medicaid and those covered by private insurance plans. Substantial racial and ethnic disparities were also present across both vaginal and cesarean deliveries.

- The majority of SMM events were related to blood transfusions (see ***Figure 4***). Blood transfusions are a proxy for identifying hemorrhage, a form of SMM, but can be an imperfect indicator of SMM. The recent increase in blood transfusion may reflect increased quality improvement efforts in New York to mitigate maternal hemorrhage. However, there remain racial and ethnic disparities in SMM cases with and without blood transfusions.

For more details about this data, please see our full report, available here: https://nyshealthfoundation.org/wp-content/uploads/2020/08/severe-maternal-morbidity.pdf.

Expanding the Role of Midwives and Community-Based Health Workers

Several important provisions have been implemented to reduce SMM and address racial and ethnic disparities in recent years at both the City and State levels. Our full report discusses recent efforts to increase quality improvement, improve data collection and monitoring, combat implicit bias, and facilitate access to community-based health workers. Recognizing that some of the causes of SMM, such as implicit racial bias, have been ingrained into the societal and health care system culture for decades, solutions must draw from all these domains and work in tandem. For example, while the City's Maternal Mortality and Morbidity Review Committee identifies clinical trends by conducting case reviews of every maternal death in the City, the City's

[18] SMM is identified using a definition developed by the Centers for Disease Control and Prevention. See: Centers for Disease Control and Prevention, "How Does CDC Identify Severe Maternal Morbidity?," December 26, 2019, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/smm/severe-morbidity-ICD.htm.

[19] In this report, we categorize non-Hispanic Black women as Black, non-Hispanic Asian women as Asian, and non-Hispanic white women as white.

Maternal Hospital Quality Improvement Network can use these data to provide hospital-specific recommendations to reduce disparities in preventable SMM. A coordinated, sustained, and aggressive effort will be required to permanently reduce SMM in New York City.

Joint planning between the City and State is vital to complement efforts, build upon models that work, and avoid duplication. For example, City involvement will be valuable to the State's development of a data warehouse measuring hospital performance on perinatal quality measures.[20] The State's Perinatal Quality Collaborative is also currently developing an implicit racial bias curriculum for hospitals, which could build upon existing trainings conducted at NYC Health + Hospitals.[21]

Below, we provide input on the importance of midwives and community-based health workers in reducing incidence of SMM as one critical component of a multi-pronged solution. We then highlight key actions taken by the City and State to improve access to these services and advocate for these programs to be expanded and studied. Finally, we propose a bundled payment model as another pathway to increase access to midwifery and community-based health worker services at NYC Health + Hospitals.

The Benefit of Midwives and Community-Based Health Workers

Midwives and community-based health workers such as birth doulas and community health workers (CHWs) have been shown to play an important role in improving maternal health outcomes.[22,23,24] From 2013–2017, the Center for Medicare & Medicaid Innovation developed and tested delivery models that integrate these health workers as part of the Strong Start for Mothers and Newborns Initiative.[25] These models, which included a birth center model and a maternity care home model, had either equal or better outcomes than control models for the same or lower cost. The birth center model, led by midwives, was most consistently shown to result in comparatively better outcomes and lower costs.

Women of color may particularly benefit from midwifery and community-based health worker services. Research documents that women of color often experience disrespect—including racism and discrimination—during their pregnancy care, feel uninvolved in the clinical decision-making process, or do not feel that they have a voice in the delivery room.[26] In addition to contributing to low-quality care, these events can increase the risk of SMM. Doulas and CHWs can help advocate for respectful care at the time of birth and by educating women about their

[20] State of New York Office of the Budget, "Governor Andrew Cuomo Announces Highlights of the FY 2020 State Budget," April 1, 2019, https://www.budget.ny.gov/pubs/press/2019/pr-enactfy20.html.
[21] State of New York Office of the Budget.
[22] Vivienne Souter et al., "Comparison of Midwifery and Obstetric Care in Low-Risk Hospital Births," *Obstetrics and Gynecology* 134, no. 5 (2019): 1056–65, https://doi.org/10.1097/AOG.0000000000003521.
[23] Kenneth J. Gruber, Susan H. Cupito, and Christina F. Dobson, "Impact of Doulas on Healthy Birth Outcomes," *The Journal of Perinatal Education* 22, no. 1 (2013): 49–58, https://doi.org/10.1891/1058-1243.22.1.49.
[24] Centers for Disease Control and Prevention, "Policy Evidence Assessment Report: Community Health Worker Policy Components" (Atlanta, GA: Centers for Disease Control and Prevention, 2014), https://www.cdc.gov/dhdsp/pubs/docs/chw_evidence_assessment_report.pdf.
[25] Centers for Medicare and Medicaid Services, "Strong Start for Mothers and Newborns Initiative: Enhanced Prenatal Care Models," July 28, 2020, https://innovation.cms.gov/innovation-models/strong-start-strategy-2.
[26] Monica R. McLemore et al., "Health Care Experiences of Pregnant, Birthing and Postnatal Women of Color at Risk for Preterm Birth," *Social Science & Medicine* 201 (2018): 127–35, https://doi.org/10.1016/j.socscimed.2018.02.013.

rights during pregnancy. Providing access to midwifery services is also critical for respecting patient choice and reproductive autonomy.

Strategies to Increase Access to Midwives and Community-Based Health Workers

NYSHealth applauds the City for facilitating access to doula services through its Healthy Women, Healthy Futures doula initiative, which has provided culturally-appropriate doula support to more than 1,000 clients as of 2019.[27] The By My Side Birth Support Program (BMS), part of the federally-funded program Healthy Start Brooklyn, also offers free doula services to Medicaid-eligible clients in Brownsville and East New York.[28] Importantly, BMS also sponsors doula trainings to increase the size and diversity of the City's doula workforce. These programs are an important step toward guaranteeing access to doula care for all New Yorkers who want support in their pregnancy. However, the need for doula services is far greater than the capacity of these two programs and is not limited to the income groups and geographic areas currently served. The City should expand the capacity of these programs to serve more New Yorkers in all neighborhoods of New York City. The City should also consider supporting long-term assessments of these programs to provide evidence of the need for and effectiveness of such services.

The City should also build upon recent State initiatives to increase access to doulas and CHWs. The State launched a pilot program in 2019 to allow Medicaid reimbursement for doula services.[29] The pilot program is currently operating in Erie County and was scheduled to launch in Kings County, but has failed to recruit an adequate number of doulas because of low reimbursement rates.[30] Furthermore, the pilot excludes three ZIP codes in Brownsville and East New York, despite these areas having among the highest rates of poor birth outcomes in the City.[31] Consideration should be given to adapt the Medicaid pilot to better support access to doulas in New York City, including expanding the program to areas with the highest rates of SMM, as well as paying an adequate amount for doula services.

The State also funds the Department of Health's Maternal Infant Community Health Collaboratives (MICHC) to increase access to CHWs.[32] In New York City, six MICHC projects are collaborating with community partners and health workers to engage high-need women in health care and social services.[33] CHWs have played an important role during the COVID-19 pandemic in New York, working with pregnant women remotely to navigate the rapidly changing environment of maternity care and hospital delivery. For example, Public Health Solutions (PHS), which operates the Queens MICHC project, innovatively adapted its community health worker model in response to COVID-19 to continue supporting expectant and

[27] New York City Department of Health and Mental Hygiene, "The State of Doula Care in NYC 2019," 2019, https://www1.nyc.gov/assets/doh/downloads/pdf/csi/doula-report-2019.pdf.
[28] New York City Department of Health and Mental Hygiene.
[29] New York State Department of Health, "New York State Doula Pilot Program," November 2020, https://www.health.ny.gov/health_care/medicaid/redesign/doulapilot/index.htm.
[30] New York City Department of Health and Mental Hygiene, "The State of Doula Care in NYC 2019," accessed December 2020, https://www1.nyc.gov/assets/doh/downloads/pdf/csi/doula-report-2019.pdf.
[31] New York City Department of Health and Mental Hygiene.
[32] State of New York Office of the Budget, "Governor Andrew Cuomo Announces Highlights of the FY 2020 State Budget."
[33] New York State Department of Health, "Maternal and Infant Community Health Collaboratives Initiative," October 2020, https://www.health.ny.gov/community/adults/women/maternal_and_infant_comm_health_collaboratives.htm.

new parents via phone and video visit.[34] The City should build upon these existing CHW projects and consider conducting assessments to better understand how to maximize the effectiveness of such services.

Finally, the City should consider innovative payment models as a pathway to increase access to midwife, doula, and CHW services at the City's public hospital system. One such model is a bundled payment model for deliveries. In a bundled payment model, a payer pays a lump sum for all medical care associated with pregnancy. A bundled payment model supports a more holistic and coordinated approach to care, as one payment could cover the entire prenatal period, labor and delivery, and the postpartum time period for both mother and newborn. Providers are incentivized to work together and use higher-value and evidence-based models—such as those that use birth centers, midwives, CHWs and doulas—in order to manage costs below the lump sum. In this way, a bundled payment model for maternity care accommodates patient choice, as the health system would be better positioned to receive reimbursement for a wider variety of care models that can meet the unique preferences, beliefs, and needs of their patients.

Several commercial payers and state Medicaid programs are beginning to test bundled payment models for maternity care across the country.[35,36,37] Such models have also been widely tested for other types of services (e.g., hip and knee replacements), resulting in lower, more predictable costs, as well as higher quality care.[38] The City Council should consider how to use its oversight role over the NYC Health + Hospitals public health care system to encourage and support the use of bundled payment models. NYC Health + Hospitals accounts for a substantial proportion of births in the City, particularly in lower-income areas at higher risk for SMM. Matching the payment model with new, innovative delivery system models is critical to help ensure improved access to midwife, doula, and CHW services that can accommodate birthing choice and improve health outcomes.

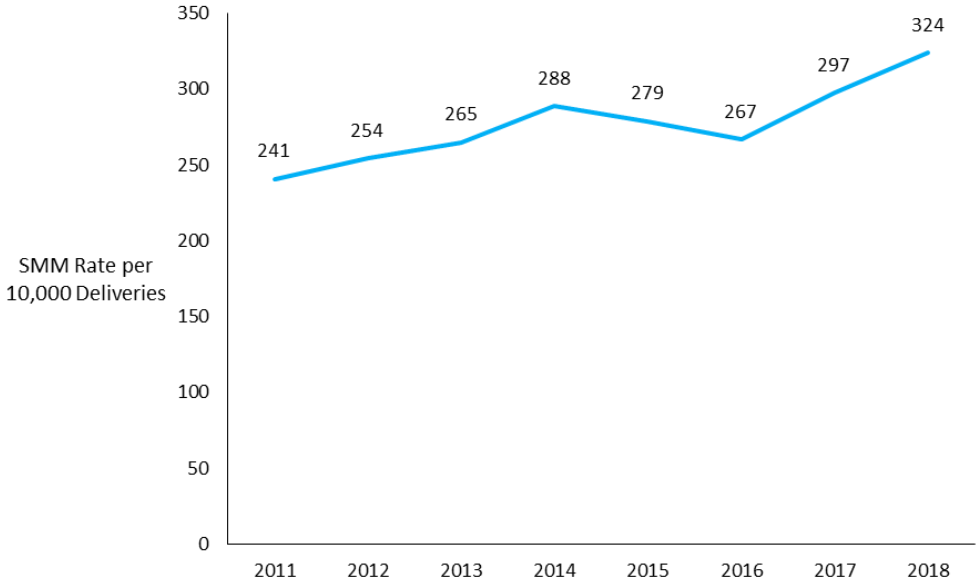
Conclusion

NYSHealth is grateful for the shared commitment among stakeholders to improve maternal health in New York City and close racial and ethnic disparities. While there is no one solution to combat SMM, a sustained and multi-pronged effort—one that includes expanded access to midwives and community-based health workers—will help improve health outcomes for pregnant New Yorkers. We look forward to continuing our partnerships with the City and other organizations to achieve this goal.

[34] Public Health Solutions, "Supporting Expectant and New Parents during COVID-19," https://nyshealthfoundation.org/event-recap/practically-speaking-supporting-expectant-and-new-parents-during-covid-19/.
[35] Clare Pierce-Wrobel and Katie Green, "To Help Fix The Maternal Health Crisis, Look To Value-Based Payment," *Health Affairs Blog* (blog), July 16, 2019, https://www.healthaffairs.org/do/10.1377/hblog20190711.816632/full/.
[36] Carmen Heredia Rodriguez, "Insurers Test New Way To Cut Maternity Care Costs: Bundling," Kaiser Health News, September 27, 2019, https://khn.org/news/maternity-care-bundling-payments-insurance-cesarean-sections/.
[37] Elizabeth Whitman, "Bundles of Joy? How New Payment Models for Maternal Care Could Deliver Lower Costs," Modern Healthcare, April 13, 2016, https://www.modernhealthcare.com/article/20160813/MAGAZINE/308139965/bundles-of-joy-how-new-payment-models-for-maternal-care-could-deliver-lower-costs.
[38] Centers for Medicare and Medicaid Services, "Comprehensive Care for Joint Replacement Model," November 24, 2020, https://innovation.cms.gov/innovation-models/cjr.

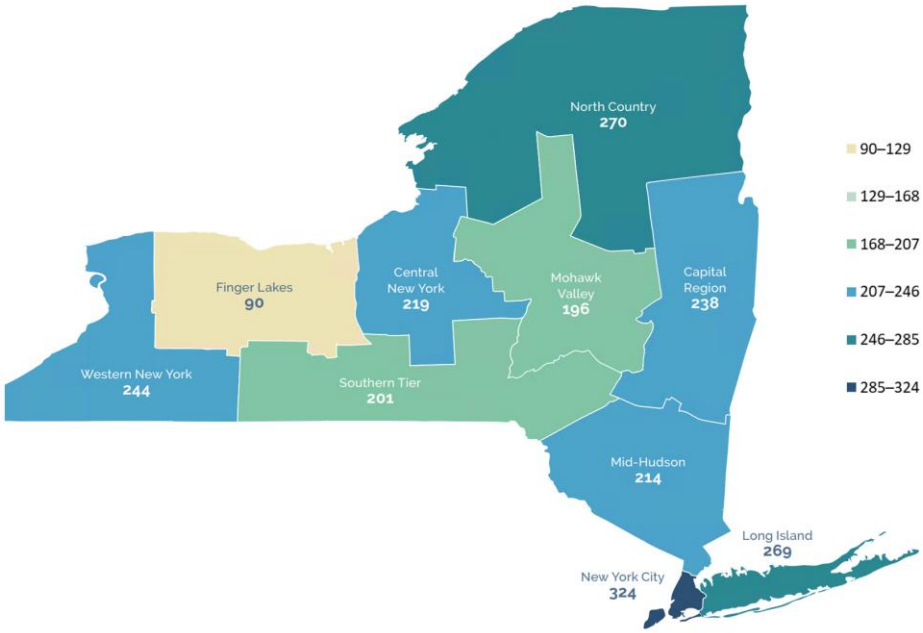
Appendix

Fig 1. Severe Maternal Morbidity Rates in New York City: 2011–2018



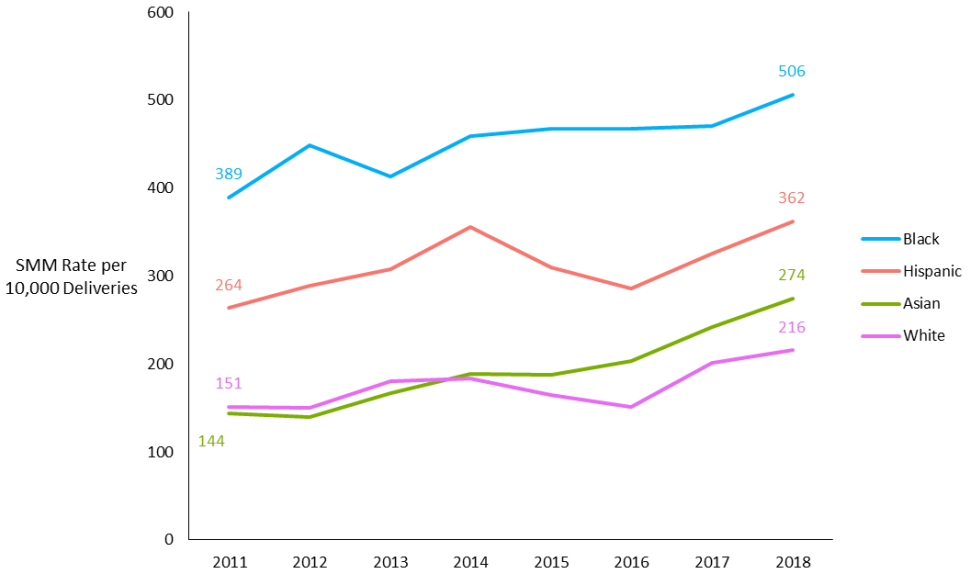
Source: New York State Health Foundation analysis of 2011–2018 New York State Statewide Planning and Research Cooperative System (SPARCS) data.
Notes: See full report for details on the data and SMM rate calculation, including the number of deliveries in total.

Fig 2. Severe Maternal Morbidity Rates by Region of New York State: 2018



Source: New York State Health Foundation analysis of 2011–2018 New York State Statewide Planning and Research Cooperative System (SPARCS) data.
Notes: See full report for details on the data and SMM rate calculation, including the total number of deliveries by region used in the analysis. New York's Empire State Development Corporation regions are used to identify regions: https://esd.ny.gov/regions.

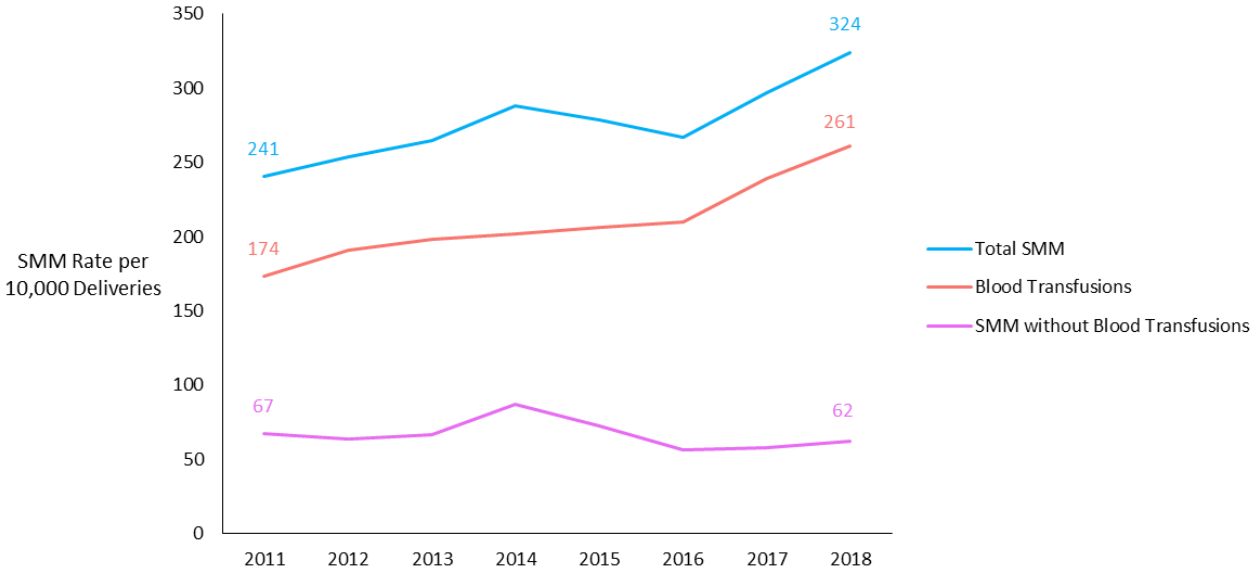
Fig 3. Severe Maternal Morbidity Rates by Race and Ethnicity in New York City: 2011–2018



Source: New York State Health Foundation analysis of 2011–2018 New York State Statewide Planning and Research Cooperative System (SPARCS) data.

Notes: Non-Hispanic Black women are categorized as Black, non-Hispanic Asian women are categorized as Asian, and non-Hispanic white women as categorized as white. See full report for details on the data and SMM rate calculation.

Fig 4. Severe Maternal Morbidity Rates with and without Blood Transfusions in New York City: 2011–2018



Source: New York State Health Foundation analysis of 2011–2018 New York State Statewide Planning and Research Cooperative System (SPARCS) data.

Notes: See full report for details on the data and SMM rate calculation. In this figure, the "SMM with Blood Transfusions" line includes deliveries where a blood transfusion was the only indicator of SMM, and deliveries where a blood transfusion was an indicator along with another, non-blood transfusion indicator of SMM.

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Chairperson: Bettie Mays

The Brooklyn Perinatal Network, Inc. (BPN)
And
The Leadership Team of the Brooklyn Coalition for Health Equity for Women and Families
(The Brooklyn Coalition)
to
The NYC City Council Joint Oversight Hearing
Committees on Health, Hospitals and Women & Gender Equity.
Monday, December 7, 2020 at 10:00 a.m. via Zoom

Maternal Mortality and Morbidity in NYC

Presented by Ngozi Moses
Executive Director, Brooklyn Perinatal Network, Inc.
Convener of The Brooklyn Coalition

BPN is 33 years old with a primary focus on collectively addressing Maternal and Child Health disparities in Brooklyn's communities with other partners. Our aim is to help mitigate risks for infant and maternal morbidity and mortality, thus improving maternal and child health outcomes (MCH). We believe birth equity is a human right and have been fighting this appalling injustice for over 3 decades.

Our prime strategies in this fight include the direct delivery of social health services and resources and leading and facilitating community collaborations and partnerships among human service community based organizations, clinical service providers and other stakeholders in area birthing hospitals and community clinics. This coalition building enables efforts to coordinate health promotion resources and advocacy aimed at maximizing access for those at high risk of poor outcomes, especially for those primarily residing in our underserved target communities in North and Central Brooklyn and neighboring communities (including Brownsville, East NY, Flatbush, Crown Heights, Canarsie). For almost 20 years, we have convened the Brooklyn Coalition for Health Equity for Women and Families. Members have received some funding for the City Council's Maternal Child Health Service Initiative (MCHSI) to support infant and maternal health focused work.

BPN and our coalition partners collaborate with areas birthing Hospitals, including those in the NYC Health and Hospitals (H+H) network, to provide Birth and Postpartum Doula Services and assist in the process of achieving designations as Doula Friendly Hospitals. Additionally, we help them to address the social determinants of health with their patients. BPN specifically participates

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in the NYC DOHMH Maternity Hospital Quality Improvement Initiative (MHQIN) in advising the utilization of Doula services and assisting the development of Doulas Friendly Hospitals. The specified MHQIN 6 goal is:

> Improving hospital relationships with doulas. This includes supporting hospital implementation of doula-friendly policies, providing technical assistance and training, and ensuring referral to doula program. Building out screening and referral pathways to action centers and CBOs using NowPow (to ensure they are addressing non-medical needs of pregnant clients). Kings County Hospital Center (KCHC) is the only Brooklyn participant in this H+H citywide quality care improvement project at this time.

The majority of our collaboration with the Hospitals is unfunded and poses a burden for CBOs with small budgets due to the significant challenges to our sustainability. These include extensive delayed contract execution and months of delays in payments to the Doula consultants for their services delivered. We appeal therefore to this Oversight Committee to add its influence to help find ways to expedite the contract processing and to release our funds much earlier.

This Testimony addresses the problem of the Black Maternal Morbidity and Mortality Crisis in Brooklyn, paying particular attention to how the COVID pandemic has affected our CBOs work and access to care for the community members we serve. Much of this Information has already been shared with some Council Members and Staff at earlier briefings.

Maternal Health Disparity Facts:

- Health inequities are killing Black and Brown people. Long before COVID 19's disproportionate infection, hospitalization and death rates starkly illustrated health inequities[1]
- ***Black Women in New York City were already <u>eight times</u>[2] more likely than their white peers to die of childbirth related causes.***

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7500250/
[2] https://www1.nyc.gov/office-of-the-mayor/news/365-18/de-blasio-administration-launches-comprehensive-plan-reduce-maternal-deaths-life-threatening

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- For every 1 maternal death about 100 women experience near misses, a life-threatening event during childbirth termed severe morbidity – i.e. more than 3,000 women experience these near misses.
- Much of the morbidity and mortality is preventable.

If women get timely access to the appropriate resources and good quality care that addresses their medical, behavioral and social health needs, maternal outcomes can be improved. The clinical service system alone cannot effectively address the behavioral and social health needs compared to the CBOS who excel at this task. Collaboration with the health and human services sector organizations is recognized as very helpful by our hospital partners. Below is a message from one of our hospital partners to BPN confirming the value of our partnership:

> *Thursday, January 16, 2020 4:24 PM*
> *To: Denise West*
> *Subject: doulas in L&D at SUNY downstate*
> *Hope this email finds you well and Happy, Blessed New Year*
> *It is my Pleasure to send you this email to inform you that I (am) getting an excellent feedback from doctors in L&D regarding some of the Doulas participated in Deliveries in our L&D. they have described as a pleasant experience. Let us keep the good work and will schedule a meeting with nurses as well to share our feedback.*
> *Thanks for your Help*

BPN is not directly funded for this collaboration or others that are required/occurring to help improve outcomes for clients.

BPN strives to make a difference every day by connecting experienced birth coaches and Doulas with pregnant women of color in our community. We advocate with and for them before, during, and after their delivery. Put simply, this work saves lives. However, funding and other needed resources for our vital services are inadequate. Appropriate funding and resources would extend BPN's ability to protect the next pregnant black woman fighting for her life on what should be her happiest day.

Our institutions and community services have been historically and chronically underfunded and lack adequate health facilitating resources. It is time for remediation. There are strategies that work, but we must undo the traditional distributions and put more resources into community-level prevention interventions that assist women and prevent crises in the hospital and poor clinical outcomes. **There is considerable evidence that community-based organizations can more**

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effectively address social factors and mitigate multiple risks when operating within a structured service network coordinated with clinical care providers.

The evidence-based Pathways Communities HUB Program Model[3] is one approach that BPN and our Coalition of local maternal health providers is promoting. This solution has been implemented in many states and cities where improved outcomes and health care savings has been demonstrated. The model has the endorsement of many health care authorities including the National Association of Maternal Child Health Programs (AMCHP) and the Center for Medicare and Medicaid Innovations (CMMI).

Our Proposed Solution and Request:
Support community-led, coordinated outreach and engagement with clinical care partners.
BPN and our Coalition partner seek funding to support a demonstration program of the evidence-supported Brooklyn Pathways HUB proposed for implementation in central Brooklyn communities that represent the hot spot experiencing the maternal morbidity and mortality crisis. The PHUB program model is applicable across the city. BPN proposes to integrate the current MCHSI funded work, building on it to increase the capacity to help achieve the goals and increase impact of the council's MCHSI work we engage with, by creating Perinatal Health Service Pathways – to engage prenatal and postpartum Doulas - assuring fidelity to certified PHUB program model that utilizes trained Community Health Workers (CHW) as the core service staff.

The COVID Pandemic and Accessing Hospital Services.

1. Visitation Rights:
Early in the pandemic, there were concerns about visitation rights, and some changes required by hospitals to their policies were made. However, there are still challenges with inconsistent applications that our Doula and clients report from hospital to hospital, despite the requirements of the State. Some concerns reported are :

- For example a frequent concern we have heard from clients is that they were only allowed one person with them in the hospital for delivery. This often meant having to choose between a trusted family member and a doula (if they had one).

[3] https://pchi-hub.com/

- The presence of a Doula and a family Member may be allowed in for birth but **not** allowed back in for postpartum period; thus the family/Doula can't leave hospital (as will not be allowed re-entry) during the birth.

- Even when visitation restrictions were relaxed some hospital staff would continue to mention to clients the previous restrictions, because they may not have been updated, or, inconsistent facility messaging occurred with the staff.

- Hospital staff may vary their entry process and requirements of the Doulas supporting the client at birthing, in some cases requesting additional certification paperwork that is not required.

Early in the pandemic the chaos, uncertainty about the illness itself and the high death toll was alarming. Even though some additional policies and procedures put into place to best protect the mother and baby from COVID, the new surge in COVID Infections has renewed concerns about quality, safe maternity care in the city. Patients would feel more secure knowing there is monitoring for facility compliance.

Solution

- Require Hospitals to publish their policies for patients Visitation Rights and have them readily available to clients with staff present to answer related questions.
- Some authority should monitor for compliance with the State's requirements. The Governor's Executive Order was not uniformly applied by hospitals and has resulted in variations where applied.

Birthing moms are getting care for prenatal appointments, though most of the care is tele-health. But Telehealth care is not suitable for everyone.

- Transportation is a barrier to care as people are hesitant to use public transportation and that may keep clients from seeking/showing up for in-person medical services – prenatal, postpartum, and pediatric care- until it is critically needed.

- Hospitals messaging regarding access to care may be insufficient. More effective methods of reaching clients are needed about available in-person and Telehealth services are available.

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Solutions

- Heath Plans can be required to advertise what transportation assistance they provide and have such information freely available everywhere especially at health care institutions.
- Make UBER/Lyft or some other free transportation more available.
    - Medicare Advantage plans pay for this service for members to make sure they get to and from their appointments, and it is helpful in keeping appointments for in-person blood work and exams that follow Telehealth visits.

2. Recommendations for Hospitals communication during this new surge**.**

- Hospitals should Provide Reminders.
    - Individuals should receive reminders from their providers/provider institutions about scheduling their routine appointments and the status of any related tests/procedures to maintain their health during periods when COVID restrictions are in place, as well as when they have been relaxed.
    - These entities should also provide information about preventive actions for self care and wellness including mental, physical, spiritual, and emotional health.
- Better Inform support persons who will attend birth:
    - To prepare early for the experience by sharing protocols and PPE.
    - Advise whether they can provide the tablet devices required for virtual support needed during birthing. Some hospitals do have electronic devices that can facilitate that but do not offer them to clients/Doula.

Improve Messaging around Care Policies to clients/Doulas

- Hospitals should also implement their policies via text alerts/social media/hospital portals/phone calls to their patients expecting to give birth at their hospital.
- Their policies should be displayed in an easy to understand format in multiple languages and include a responsive contact to assist with any questions or concerns.

3.Recommendations Council Policy Actions

- Make specific funding available for Hospital-CBO Collaboration.
- Many Hospitals want to work with CBOs but need to be funded for this. Much of the current collaborative CBO work is free with high demands for their time. Specific funding will allow CBOs to focus more effectively to coordinate with the clinical delivery system to address maternal health and COVID related needs.

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- Require hospitals to work with CBOs - Doulas, Midwives, etc. – for developing best practices for L&D patients who test positive for COVID?

BPN is a part of the NYCDOH-Maternity Hospital Quality Improvement Network, focusing on the Doula capacity component. We works with local hospitals in making their Labor & Delivery departments Doula Friendly. But, we are not engaged when they are developing best practices for Labor & Delivery for those who test positive for COVID. Engagement in this area is important to help CBOs to help best meet the needs of the patient in their outpatient environments.

Presented by
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Executive Director
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259 Bristol St., Suite 242, Brooklyn NY 11212

BPN's Public Statements were made at today's (Dec. 7, 2020) Press Conference by our Community Doula Mentor, Ms. Tia Dowling.

Hello all, my name is Neriah Jones and I am a student at CUNY school of public health. I offer this testimony on behalf of the approximately two million New York City residents now struggling against hunger.

During these unprecedented times of economic turmoil resulting from the COVID-19 pandemic, low-income New Yorkers are especially vulnerable to food insecurity. In April 2020, a study by Hungry Free America showed that 38 percent of parents in New York City reported cutting the size of meals or skipping meals for their children because they did not have enough money; this is double the previous rate from their previous study. The study also found that 34 percent of NYC adults skipped meals or cut portions because they lacked enough food or money; this is three and a half times the adult hunger rate from their previous study.

The need for federally funded Supplemental Nutrition Assistance Program (SNAP) has become even more pronounced as hunger begins to soar across New York City. The SNAP program allows 1.6 million low-income New Yorkers to put healthy food on their tables- this is nearly 20 percent of the City's population. However, the Trump Administration aims to change eligibility, in which would curb access to the low-income New Yorkers who depend on this food assistance. It's also important to note that many eligible non-citizens in New York City are either withdrawing from or not enrolling in SNAP.

First, this rule would cut SNAP benefits by restricting states from extending benefit time limits. This means individuals between the ages 18-49 without dependents and able body will lose SNAP benefits after 3 months. This rule does not consider folks who can't control their wages during this economic crisis.

Secondly, low-income families will no longer be automatically eligible for SNAP benefits if they already receive other public assistance. Additional critical expenses like childcare, will no longer support the need for SNAP benefits.

Lastly, the new rule will change the way a family's utility costs are calculated to lower SNAP monthly benefits for New Yorkers who are significantly vulnerable at this time.

New York City must do more to fight hunger; ensuring a federal nutrition assistance safety net like SNAP is adequately-funded and easy to-access is one of the ways to do it.
We must urge the House and Senate leadership to pass the Resolution No. 1043-2019, condemning the Trump Administration's plan to cut food stamps for 3 million People, to help protect the 20 percent of hungry New Yorkers.

Testimony of Emily Frankel, Government Affairs Manager
Nurse-Family Partnership

Before the New York City Council Committees on
Women and Gender Equality, Health, and Hospitals

December 7th, 2020

Thank you for the opportunity to present testimony as a part of today's hearing on "Maternal Mortality and Morbidity in New York City." I am Emily Frankel, the Government Affairs Manager for Nurse-Family Partnership. We applaud your work and interest in better understanding this important issue. Nurse-Family Partnership acknowledges that institutionalized racism and implicit bias exists in health care. This leads to gaps in health care that can have devastating consequences for women and leads to racial disparities in maternal mortality and morbidity. Our nurses are on the front lines of prevention efforts aimed at reducing maternal mortality and achieving better birth outcomes.

Nurse-Family Partnership is an evidence-based community health program that helps transform the lives of low-income mothers who are pregnant with their first child. Each first-time mother is partnered with a specially trained registered nurse early in her pregnancy and receives regular, ongoing nurse home visits that continue through her child's second birthday. The duration of the program is approximately two and a half years. Our nurses help clients achieve healthier pregnancies and births, stronger child development, and a path towards economic self-sufficiency. This is accomplished through the provision of health education and guidance, care coordination, and preventive services to NFP moms and their children.

NFP is a true and tested model with over 40 years of randomized controlled trial research and longitudinal follow-up studies. This research has found that families served by NFP experience the following improvements in maternal health:

- 35% fewer cases of pregnancy-induced hypertension[1]
- 18% fewer preterm births[2]
- 79% reduction in preterm delivery among women who smoke cigarettes[3]
- 31% reduction in very closely spaced (<6 months) subsequent pregnancies[4]

In New York City, the National Service Office of Nurse-Family Partnership works with a variety of community-based organizations and health care agencies to deliver the program. Since 2003, NFP has served over 16,400 families across all five boroughs through its 5 network partners: the New York City Department of Health and Mental Hygiene (DOHMH), Montefiore Home Care

[1] Kitzman H, et al. Effect of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing. A randomized controlled trial. JAMA. 199.
[2] Thorland, B., Currie, D. et al (2017). Status of Birth Outcomes in Clients of the Nurse-Family Partnership. Maternal Child Health. 21:439-445; DOI 10.1007/s10995-016-2231-6.
[3] Olds DL, Henderson CRJ, et al. Improving the delivery of prenatal care and outcomes of pregnancy: a randomized trial of nurse home visitation. Pediatrics. 1986
[4] Kitzman H, Olds DL, et al. Enduring effects of nurse home visitation on maternal life course: a 3-year follow-up of a randomized trial. JAMA. 2000.

(Bronx), Public Health Solutions (Queens and Staten Island), SCO Family of Services (Brooklyn), and the Visiting Nurse Service of New York (Bronx).

NYC NFP is currently funded to serve 2,985 families annually. A portion of this funding is baselined in the New York City Budget. We thank the City Council, the Office of the Mayor, and DOHMH for their support.

Maternal Mortality and the Role of NFP

In the United States, an estimated 700 women die each year during pregnancy, childbirth, or the first year following birth.[5] Approximately half of these maternal deaths are preventable.[6] Significant disparities exist in pregnancy and birth outcomes according to race, ethnicity, age, income, and health insurance status.[7] In New York State, which ranked 30th in the nation for its maternal mortality rate in 2016, black women are three times more likely to die than white women.[8] Black mothers living in New York City face even steeper odds- they are 12 times more likely to die from complications arising during or after childbirth.[9] A NYC DOHMH report on severe maternal morbidity (SMM) found that non-Hispanic black women had the highest SMM rate- a rate three times higher than non-Hispanic white women.[10] Evidence-based interventions like Nurse-Family Partnership play a vital role in identifying and mitigating the risk factors that can lead to maternal mortality and morbidity.

The NFP model, along with the trusted relationship between a nurse and mother, creates protective factors for mom and baby against the societal challenges that contribute to toxic stress, systemic racism, and adverse pregnancy outcomes. NFP nurses serve a specific population of first-time mothers who face inequities across this spectrum. Many of our mothers are young, living in poverty, and navigating several challenges, including social isolation, abuse, and mental illness. Our nurses are uniquely situated to reach underserved women and trained to help mothers at one of the most transformative parts of their lives -- the birth of a first child.

NFP nurses use their clinical expertise and assessment skills to understand the strengths and risks that mothers have experienced in their lifetime that may impact their health and their child's health. With a two generational approach, nurses identify early warning signs of health problems during pregnancy, post-partum, infancy, and early childhood that can lead to adverse outcomes—even death. For example, nurses can identify early signs of preeclampsia, high blood pressure and other cardiovascular risks, and educate the mom about the warning signs she needs to closely watch for and when she needs to seek emergency medical care. In addition to monitoring for risk factors, NFP nurses ensure that women and children experiencing signs of possible health complications are seen by the appropriate health care provider and that appropriate follow-up care is completed. They also connect moms with community resources and partners to provide ongoing support and care.

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[5] Centers for Disease Control and Prevention. Pregnancy-related deaths. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm (Updated May 9, 2018).
[6] Troiano N, Witcher P. Maternal Mortality and Morbidity in the United States. The Journal of Perinatal & Neonatal Nursing. 2018.
[7] Ibid.
[8] New York State Taskforce on Maternal Mortality and Disparate Racial Outcomes. Recommendations to the Governor to Reduce Maternal Mortality and Racial Disparities. https://health.ny.gov/community/adults/women/task_force_maternal_mortality/docs/maternal_mortality_report.pdf (March 2019).
[9] New York City Department of Health and Mental Hygiene Bureau of Maternal, Infant and Reproductive Health. Pregnancy Associated Mortality: New York City, 2006-2010. https://www1.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report.pdf.
[10] New York City Department of Health and Mental Hygiene Bureau of Maternal, Infant and Reproductive Health. Severe Maternal Morbidity in New York City, 2008-2012. https://www1.nyc.gov/assets/doh/downloads/pdf/data/maternal-morbidity-report-08-12.pdf (2016).

For example, during her last in-person home visit prior to the pandemic, a 17-year-old Bronx mom was complaining of some preeclamptic symptoms. The NFP nurse took her blood pressure and noted that it was in the severe range. The nurse spoke to the mom regarding the need to go to Labor and Delivery (L&D) to be evaluated. The nurse contacted her obstetrician who agreed. The mom went to the hospital and was found to be preeclamptic and her labor was induced. After the mom was discharged from the hospital, her NFP nurse contacted her to have a telehealth visit. While the nurse was conducting her assessment, the mom complained of symptoms consistent with postpartum preeclampsia. The nurse encouraged the client to contact her obstetrician, and as a result, she was able to get a blood pressure machine from her local pharmacy the same day. After the machine was delivered, the NFP nurse conducted a telehealth visit with the mom to teach her how to use the device and to educate her about the signs and symptoms associated with postpartum complications of elevated blood pressure. During this visit, the mom took her blood pressure, and it was still elevated. She was reluctant to return to the hospital to be treated due to fear of COVID-19 exposure. The NFP nurse encouraged the mom to see her primary care provider, which she did.

The life of this mom and her baby were saved because she had an NFP nurse with the experience, clinical reasoning skills, and specialized training to assist her at critical moments during her pregnancy and in the post-partum period. As demonstrated by this example, NFP nurses play a critical role in helping each mother develop a deep understanding of her health. Our nurses provide guidance and support to NFP moms as they learn how to navigate the health care system for themselves and their child. NFP nurses empower pregnant women and new mothers to advocate for themselves to be seen and heard by their health care providers and to have their health assessed when they know that something is not right with their body. If a mom believes something is wrong, the nurse encourages her to not take "NO" for an answer. If a medical provider dismisses her concerns, she knows to stand up for herself and insist that her concerns be addressed. This is especially important when identifying and addressing racism and implicit bias in health care.

The NFP model has demonstrated sizeable and sustained pregnancy outcomes amongst the high-risk population that we serve. A 20-year follow up study of the program shows that NFP is effective at reducing all-cause mortality among mothers and preventable-cause mortality in their first-born children living in highly disadvantaged settings. This study showed that mothers who did not receive nurse home-visits were nearly 3 times more likely to die from all causes of death than nurse-visited moms (3.7% versus 1.3%).[11]

When making investments, we believe that strong data with impactful outcomes is critical, but some of the best evidence that NFP can demonstrate is in the thriving, families that we see graduate from our program – mothers who are empowered to demand a better future for themselves and their children despite their individual challenges, and achieving goals that they may not have thought to be attainable. NFP believes that all mothers should be empowered in this way – and while NFP serves a distinct population, we are committed to better understanding and addressing who is "at-risk" for adverse pregnancy and birth outcomes. As a program that is rooted in delivering an evidence-based intervention that works for those who need it, we have been and always will be committed to targeted research and innovation of the model, education

[11] Olds, D., Kitzman, H., et al. Impact of Home Visiting by Nurses on Maternal and Child Mortality: Results of a Two-Decade Follow-Up of a Randomized, Clinical Trial. JAMA Pediatrics. 2014

of our nurses, and understanding the communities in which we operate. NFP's model requires understanding each client's lived experiences to identify strengths and challenges that foster resiliency and to mitigate nurses' biases or judgements about their clients' experiences.

We need our partners in government to invest in evidence-based programs like NFP, and also to invest in policies that address social determinants of health, such as food insecurity, lack of stable and affordable housing, and access to affordable and quality health care. These are structural issues that have contributed to racial disparities in maternal health and pregnancy outcomes.

Bringing Nurse-Family Partnership to scale in New York City could do a lot to prevent adverse pregnancy outcomes and maternal mortality. With existing state and city funding, NFP programs serve only 5 percent of the eligible families in the city. Every $1 invested in NFP saves New York City $8.30 in future costs for highest-risk families served.[12] We urge the New York City Council to expand funding for NFP in the city so we can reach more high-risk moms and help mitigate the risk factors associated with maternal mortality.

Nurse-Family Partnership thanks the chairs and members of the New York City Council Committees on Women and Gender Equality, Health, and Hospitals for starting this important conversation and for exploring how we as a city can address and overcome the racial disparities that greatly impact maternal mortality and morbidity. We hope to be a resource as you continue this work. Thank you again for the opportunity to present testimony.

[12] Ted Miller, Ph.D., Pacific Institute for Research and Evaluation, Return on Investment Calculator, 11/5/2016. The state-specific return on investment calculator modifies national estimates based on a published systematic review of more than 30 NFP evaluations (Miller, Prevention Science, 2015) to project state-specific outcomes and associated return on investment. The calculator is updated periodically to reflect major research updates. (Lateset Revision 3/27/2017).

Nurse-Family Partnership

OVERVIEW

FACT

GENERAL INFORMATION

Nurse-Family Partnership® is an evidence-based, community health program with over 40 years of evidence showing significant improvements in the health and lives of first-time moms and their children living in poverty.

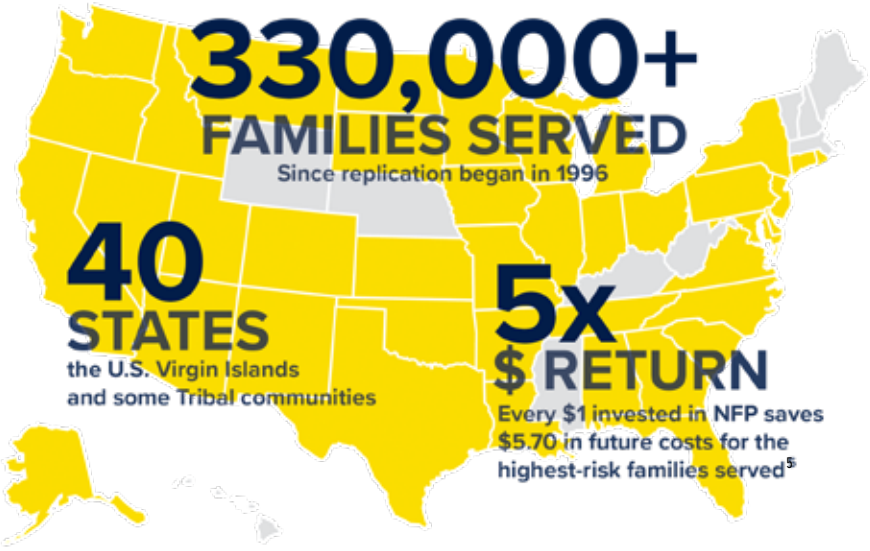
> CHILDREN'S PROGRAMS ARE SUCCESSFUL WHEN THEY LEVERAGE THE MOST DIFFICULT JOB IN THE WORLD: PARENTING
>
> NICHOLAS KRISTOF, NEW YORK TIMES COLUMNIST

Better Worlds Start with Great Mothers

Nurse-Family Partnership empowers vulnerable first-time moms to transform their lives and create better futures for themselves and their babies. Research consistently proves that Nurse-Family Partnership succeeds at its most important goals: keeping children healthy and safe and improving the lives of moms and babies.

Nurse-Family Partnership works by having specially trained nurses regularly visit young, first-time moms-to-be, starting early in the pregnancy, continuing through the child's second birthday.

The expectant moms benefit by getting the care and support they need in order to have a healthy pregnancy. At the same time, new moms develop a close relationship with a nurse who becomes a trusted resource they can rely on for advice on everything from safely caring for their child to taking steps to provide a stable, secure future for their new family. Throughout the partnership, the nurse provides new moms with the confidence and the tools they need not only to assure a healthy start for their babies, but to envision a life of stability and opportunities for success for both mom and child.



Great Nurses Strengthen Families

Our highly-trained nurses give expectant women valuable knowledge and support, enabling positive outcomes. Each Nurse-Family Partnership nurse is specially trained to deliver our unique program—the original model, developed by David Olds, Ph.D., remains at the core of the program today. The partnership between a nurse, a mom or family and the child is a winning combination, and this relationship of trust makes a measurable difference for the whole family across generations.

OVERVIEW

We Are The Gold Standard

More than 40 years of scientific studies have consistently proven that we succeed at our most important goals of keeping children healthy and safe, and improving the lives of moms and babies.

48% REDUCTION IN CHILD ABUSE AND NEGLECT [1]

67% LESS BEHAVIORAL AND INTELLECTUAL PROBLEMS IN CHILDREN AT AGE 6 [2]

72% FEWER CONVICTIONS OF MOTHERS (MEASURED WHEN CHILD IS 15) [1]

82% INCREASE IN MONTHS EMPLOYED [3]

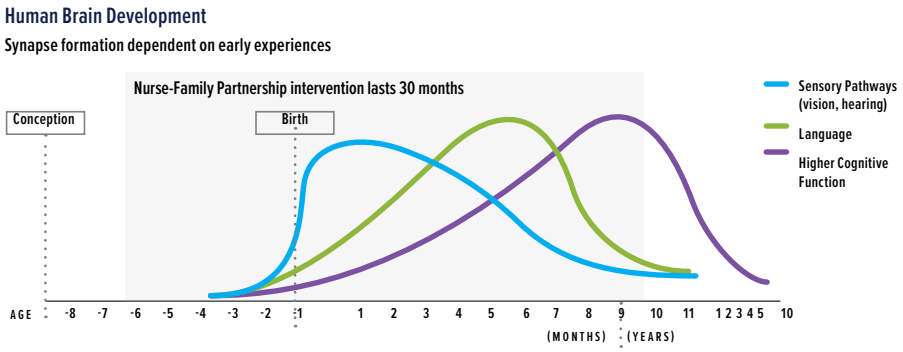
35% FEWER HYPERTENSIVE DISORDERS OF PREGNANCY [4]

Nurse-Family Partnership Goals

1. Improve pregnancy outcomes by helping women engage in good preventive health practices, including thorough prenatal care from their healthcare providers, improving their diets and reducing their use of cigarettes, alcohol and illegal substances;
2. Improve child health and development by helping parents provide responsible and competent care; and
3. Improve the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work.

Proven Results

The Nurse-Family Partnership program has been independently reviewed and evaluated, and is ranked as the Gold Standard of home visiting programs. A report from the Center on the Developing Child at Harvard University shows the extent to which very early childhood experiences influence later learning, behavior and health.



Source: Nelson, C.A., In Neurons to Neighborhoods (2000).

This Harvard report shows, during the first 30 months of a child's life, basic brain functions related to vision, hearing and language development. It is during this window of opportunity that the early and intensive support by a Nurse-Family Partnership nurse can have a huge impact on the future of both mother and child.

> "THERE IS A MAGIC WINDOW DURING PREGNANCY… A TIME WHEN THE DESIRE TO BE A GOOD MOTHER AND RAISE A HEALTHY, HAPPY CHILD CREATES MOTIVATION TO OVERCOME INCREDIBLE OBSTACLES INCLUDING POVERTY WITH THE HELP OF A WELL-TRAINED NURSE."
>
> **DAVID OLDS, PHD, FOUNDER OF NURSE-FAMILY PARTNERSHIP, PROFESSOR OF PEDIATRICS AT UNIVERSITY OF COLORADO**

Nurse-Family Partnership
Helping First-Time Parents Succeed®

1900 Grant Street, 4th Floor
Denver, Colorado 80203
NurseFamilyPartnership.org
866.864.5226

1. Olds, D.L., et al. (1997). Long-Term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect Fifteen-Year Follow-up of a Randomized Trial. JAMA 1997
2. Olds DL, et al. Effects of nurse home visiting on maternal life-course and child development: age-six follow-up of a randomized trial. Pediatrics 2004
3. Olds DL, Henderson CRJ, Tatelbaum R, Chamberlin R. Improving the life-course development of socially disadvantaged mothers: a randomized trial of nurse home visitation. American Journal of Public Health 1988
4. Kitzman H, et al. Effect of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing. A randomized controlled trial. Journal of the American Medical Association 1997
5. Karoly, L., Kilburn, M. R., Cannon, J. Proven results, future promise. RAND Corporation 2005.

NEW YORK CITY NFP FACT SHEET

What is Nurse-Family Partnership?

Nurse-Family Partnership® (NFP) is an evidence-based, community health program that helps transform the lives of low-income mothers pregnant with their first child. Each mother served by NFP is partnered with a registered nurse early in her pregnancy and receives ongoing nurse home visits that continue through her child's second birthday. NFP ensures the most vulnerable babies are given the best care at the most critical times in early development and empowers moms to transform their lives and create better futures for themselves and their babies.

The goals of Nurse-Family Partnership are to improve pregnancy outcomes by helping women engage in good preventive health practices, including thorough prenatal care from their healthcare providers, improving their diets, and reducing their use of cigarettes, alcohol and illegal substances; Improve child health and development by helping parents provide responsible and competent care; and to improve the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work.

Current Landscape

Since 2003, Nurse-Family Partnership has served over 16,400 families in New York City. The New York City Department of Health and Mental Hygiene (DOHMH) directly provides NFP in parts of Queens, Brooklyn, Manhattan and citywide through the Targeted Citywide Initiative (TCI). TCI is a specialized group of nurses that serve women and teens in shelters, teens in foster care and those involved in the juvenile justice system, and women who are currently or formerly incarcerated. TCI nurses can serve mothers from anywhere in the city and can follow these families, who are likely to be more transient, anywhere they relocate throughout the five boroughs.

NYC NFP Network Partners

NYC DOHMH Sites

- Harlem Hospital
- Jamaica
- Metropolitan Hospital
- Targeted Citywide Initiative
- Woodhull Hospital

DOHMH External Vendors

- Public Health Solutions (Western Queens & Staten Island)
- SCO Family of Services (Brooklyn)
- Visiting Nurse Service of New York (Bronx)

Montefiore Home Care (Bronx)

DOHMH also partners with external vendors to deliver NFP across the city. These organizations include, Public Health Solutions, SCO Family of Services and the Visiting Nurse Service of New York. In addition to these agencies, Montefiore Home Care operates an NFP program in the Bronx. Public funding for NFP, including city funds, is used to directly support 18 teams and 129 NFP nurses that can serve over 3,000 New York City families at any given time.

For more information about Nurse-Family Partnership, please contact:
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Emily.Frankel@nursefamilypartnership.org | (718) 736-4275

Nurse-Family Partnership

FACT

NEW YORK CITY NFP WORKS

NYC ROI: $8.30 per $1.00 spent[1]
NY State: $12.40 per $1.00 spent[1]

PROVEN OUTCOMES

NFP is a nationally proven prevention program that has demonstrated consistent success in several rigorously designed randomized controlled trials. It affects families for years after they participate – serving as a launch pad for future success and helping to break the cycle of poverty.

PROMOTES
School Readiness[1]

Reduces behavioral and emotional problems at Child age 6 by 67%

Reduces language delays among toddlers by 41%

IMPROVES
Long-term Outcomes[3]

85.6% of NYC mothers initiated breastfeeding compared to 81% nationally

Child immunizations up-to-date by 24 months postpartum is 85% in NYC compared to 70% nationally

Mothers employed full or part-time by 24 months postpartem 48%

BOOSTS
Healthy Child & Adolescent Development[1]

Reduces injuries treated in emergency departments by 34%, ages 0-2

56% drop in alcohol, tobacco and marijuana use, ages 12-15

Reduces child maltreatment through abe 15 by 33%

On average, enrolling 1,000 low-income New York City families in Nurse-Family Partnership will save $8.30 for every dollar invested.

Nurse-Family Partnership Produces Savings for New York City Taxpayers

On average, enrolling 1,000 low-income families in New York will prevent the following:

- **98 closely-spaced, high-risk pregnancies**
- **43 subsequent preterm births to young moms**
- **72 cases of preeclampsia**
- **63 child injuries treated in emergency departments.**
- **107 cases of verified child maltreatment**
- **1,302 violent crimes**
- **526 youth arrests**
- **3 infant deaths**

All Data in Box[1]

For more information about Nurse-Family Partnership, please contact:
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1 Unless noted, data in this document are attributed to Ted Miller, Ph.D., Pacific Institute for Research and Evaluation, Return on Investment Calculator, 11/5/2016. The state-specific return on investment calculator modifies national estimates based on a published systematic review of more than 30 NFP evaluations (Miller, Prevention Science, 2015) to project state-specific outcomes and associated return on investment. The calculator is updated periodically to reflect major research updates. (Lateset Revision 3/27/2017)

Original Investigation

Effect of Home Visiting by Nurses on Maternal and Child Mortality

Results of a 2-Decade Follow-up of a Randomized Clinical Trial

David L. Olds, PhD; Harriet Kitzman, RN, PhD; Michael D. Knudtson, MS; Elizabeth Anson, MS; Joyce A. Smith, PhD; Robert Cole, PhD

IMPORTANCE Mothers and children living in adverse contexts are at risk of premature death.

OBJECTIVE To determine the effect of prenatal and infant/toddler nurse home visiting on maternal and child mortality during a 2-decade period (1990-2011).

DESIGN, SETTING, AND PARTICIPANTS A randomized clinical trial was designed originally to assess the home visiting program's effect on pregnancy outcomes and maternal and child health through child age 2 years. The study was conducted in a public system of obstetric and pediatric care in Memphis, Tennessee. Participants included primarily African American women and their first live-born children living in highly disadvantaged urban neighborhoods, who were assigned to 1 of 4 treatment groups: treatment 1 (transportation for prenatal care [n = 166]), treatment 2 (transportation plus developmental screening for infants and toddlers [n = 514]), treatment 3 (transportation plus prenatal/postpartum home visiting [n = 230]), and treatment 4 (transportation, screening, and prenatal, postpartum, and infant/toddler home visiting [n = 228]). Treatments 1 and 3 were included originally to increase statistical power for testing pregnancy outcomes. For determining mortality, background information was available for all 1138 mothers assigned to all 4 treatments and all but 2 live-born children in treatments 2 and 4 (n = 704). Inclusion of children in treatments 1 and 3 was not possible because background information was missing on too many children.

INTERVENTIONS Nurses sought to improve the outcomes of pregnancy, children's health and development, and mothers' health and life-course with home visits beginning during pregnancy and continuing through child age 2 years.

MAIN OUTCOMES AND MEASURES All-cause mortality in mothers and preventable-cause mortality in children (sudden infant death syndrome, unintentional injury, and homicide) derived from the National Death Index.

RESULTS The mean (SE) 21-year maternal all-cause mortality rate was 3.7% (0.74%) in the combined control group (treatments 1 and 2), 0.4% (0.43%) in treatment 3, and 2.2% (0.97%) in treatment 4. The survival contrast of treatments 1 and 2 combined with treatment 3 was significant ($P = .007$); the contrast of treatments 1 and 2 combined with treatment 4 was not significant ($P = .19$), and the contrast of treatments 1 and 2 combined with treatments 3 and 4 combined was significant (post hoc $P = .008$). At child age 20 years, the preventable-cause child mortality rate was 1.6% (0.57%) in treatment 2 and 0.0% (SE not calculable) in treatment 4; the survival contrast was significant ($P = .04$).

CONCLUSIONS AND RELEVANCE Prenatal and infant/toddler home visitation by nurses is a promising means of reducing all-cause mortality among mothers and preventable-cause mortality in their first-born children living in highly disadvantaged settings.

TRIAL REGISTRATION clinicaltrials.gov Identifier: NCT00708695

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Racial and economic disparities in adult mortality are substantial[1-5] and increasing in the United States,[5] with the risk of death increasing in a nonlinear fashion as income declines.[2] In recent decades, the disproportionately high mortality associated with low income is applying to larger portions of the US population.[2] Between 1992 and 2006, female mortality increased in 43% of US counties[6]; variations in county-level female mortality changes over time were accounted for by the percentage of residents with a college degree, who were of Hispanic heritage, and who did not smoke but were not explained by medical care conditions, such as proportions of primary care providers or uninsured within counties.[6] Access to care is important,[7] but more fully reducing mortality associated with low income is likely to depend on improving damaging behaviors and toxic contexts.[8,9]

Mortality among US children and youth has declined significantly over many decades,[10,11] yet substantial disparities persist for children and youth living in poorer communities and for African Americans.[10-14] A large portion of these disparities is explained by higher rates of death due to sudden infant death syndrome,[14,15] unintentional injuries,[11,13] and homicide.[11,13] These causes of death are prime candidates for prevention because they are thought to be influenced by the degree to which the developing fetus is protected from adversity, the child is well cared for,[15-17] home environments are safe,[17] and children's and youths' behavior is well regulated.[18] As far as we know, there have been no randomized clinical trials of early interventions that have found reductions in mortality for these causes.

Since 1990, we have been conducting, in Memphis, Tennessee, a randomized clinical trial of a program of prenatal and infancy/toddler home visiting by nurses for very low-income mothers, primarily African American, bearing their first children. The program is known today as the Nurse-Family Partnership (NFP).[19-24] Nurses in the NFP are charged with improving maternal and child health during pregnancy and the first 2 years of the child's life.[25] The Memphis trial is the second in a series of 3 conducted with different populations.[25-33] The first trial of the NFP, begun in 1977, was conducted with a primarily white sample with mixed sociodemographic risk living in a semi-rural community in upstate New York (Elmira).[29-33] We focused the Memphis trial on women with higher concentrations of sociodemographic risk because the results of the Elmira trial indicated that the functional and economic benefits of the NFP were more pronounced in these higher risk segments of the sample.[29-33] Earlier findings from the Memphis trial included treatment-control differences in children's injuries revealed in the medical record,[19] problems with behavioral regulation at school entry,[21] and use of substances and internalizing disorders at age 12 years.[23] For mothers in the Memphis trial, enduring differences have been found in the timing of subsequent pregnancies; use of welfare, food stamps, and Medicaid; and behavioral impairment resulting from substance use.[19-24]

As part of an 18-year follow-up of the mothers and children in Memphis, we monitored the rates of maternal and child death as we traced the sample. We had not hypothesized program effects on maternal and child mortality because we assumed that rates among mothers and children in these age ranges would be too low to discern the effect of the program. We report here, nevertheless, treatment-control maternal and child mortality differences, given their public health importance. The current study was approved by the University of Rochester Institutional Review Board. Participants were provided financial compensation for completing assessments.

Methods

We conducted a randomized clinical trial of the NFP in a public system of obstetric and pediatric care in Memphis, Tennessee, designed originally to assess the program's effects on pregnancy outcomes and maternal and child health through child age 2 years.[19]

Participants

A total of 1138 of 1289 eligible women (88.3%) completed written informed consent and were randomized from June 1, 1990, through August 31, 1991. We primarily enrolled African American women at less than 29 weeks of gestation, with no previous live births, and with at least 2 of the following sociodemographic risk characteristics: unmarried, having less than 12 years of education, and unemployed. Of the women enrolled, 92.1% were African American, 98.1% were unmarried, 64.1% were 18 years or younger at registration, and 85.1% came from households with annual incomes below the US federal poverty guidelines. After completing informed consent and baseline interviews, women were randomly assigned to 1 of 4 treatment conditions described below.[19]

Treatment Conditions

As shown in eTable 1 in the Supplement, women in treatment 1 (n = 166) were provided free transportation for prenatal care appointments. Women in treatment 2 (n = 514) were provided the transportation for prenatal care and developmental screening and referral services for their children at ages 6, 12, and 24 months. Those in treatment 3 (n = 230) were provided the free transportation and nurse home visits during pregnancy plus 2 postpartum visits. Women in treatment 4 (n = 228) were provided the same services as those in treatment 3, plus home visits through child age 2 years as well as developmental screening and referrals for their children. To maximize statistical power and minimize costs, participants were disproportionally assigned among treatments. Treatments 1 and 2 were combined to form a control group, and treatments 3 and 4 were combined to form a group visited during pregnancy for assessment of the program's effect on pregnancy outcomes. To reduce research costs, participants in treatments 1 and 3 were not monitored originally for postnatal assessments.[19]

Randomization

Random assignment was conducted by means of a computer program based on methods that are extensions of those of Soares and Wu.[34] This procedure concealed randomization from data gatherers directly involved with participants in Memphis. We used slightly different assignment ratios and treat-

ment allocation schemes during 3 time frames in the 15-month sample recruitment period.[19] This procedure was used to accommodate shifting expectations about completed sample size (because of competition with other studies that sampled the same population) and to manage a relatively large number of women enrolled during the first 2 months of recruitment when only 10 of the 12 project nurses had been hired. Treatment 1 was added to the design during the second and third allocation periods to reduce the number of families assigned to the 2 nurse-visited conditions.

Home Visiting Intervention

Women in treatments 3 and 4 received a mean of 7 prenatal visits, and those in treatment 4 received a mean of 26 visits after delivery. The NFP nurses are charged with (1) improving the outcomes of pregnancy by helping women improve their prenatal health, (2) improving children's subsequent health and development by helping mothers provide more competent care of their babies, and (3) improving women's health and development by helping them develop self-care practices, plan subsequent pregnancies, complete their educations, and find employment. The program guidelines include specific activities to support women's protection of their health including eating balanced diets; avoiding substance use, unsafe sexual practices, and risky social relationships; engaging in exercise and hygiene; and advocating for themselves with providers of office-based care.[25,35,36] The program guidelines provide extensive support to caregivers in their efforts to care well for their children, including promoting safe sleep practices (eg, placing babies on their backs during nap time and at night), ensuring safe sleep environments, reducing hazards in the home, and supporting regulated, responsive care of the child.[25,35,36]

Mortality Outcomes

For the analysis of maternal mortality, we matched all women randomized in each of the 4 treatment conditions with National Death Index (NDI) records using the mothers' names, birthdates, sex, and Social Security Numbers. The NDI is the criterion standard for ascertainment of mortality and cause of death in the United States.[37] For the study of child mortality, we had identifying information for all but 2 live-born children in treatments 2 and 4. Inclusion of children in treatments 1 and 3 was not possible because background information was missing on too many children. The NDI records were available through December 31, 2011.

We categorized causes of maternal deaths into natural and external categories using standard cause-of-death categories from the *International Classification of Diseases, Ninth Revision (ICD-9)* and *International Statistical Classification of Diseases, 10th Revision (ICD-10)* (*ICD-9* for deaths before 1999 and *ICD-10* for deaths 1999-2011).[38,39] Natural causes in this sample included neoplasms, human immunodeficiency virus infection, sickle cell anemia, diabetes mellitus, endocarditis, stroke, renal disease, acidosis, aortic dissection, and pulmonary embolism. External causes included drug overdose, suicide, unintentional injuries, and homicide.

We classified the following causes of children's deaths as preventable: sudden infant death syndrome, unintentional injuries, and homicide. There were no suicides. Natural causes of child death in this sample included multiple congenital malformations, conditions due to an anomaly of an unspecified chromosome, malignant neoplasms of the brain, extreme immaturity, chronic respiratory disease developing during the perinatal period, and infectious colitis, enteritis, and gastroenteritis.

Table 1 reports the number of mothers randomized to treatment conditions, the number of mothers in each condition interviewed after December 31, 2011, the number of cases sent to NDI for abstraction of mortality data, and the number of maternal and child cases for which we were able to ascertain survival status. We determined maternal survival status for all 1138 women randomized and child survival status for 706 of the 708 children in treatment groups 2 and 4 born alive. Across treatment groups, participants studied for mortality status were essentially equivalent on background characteristics at the time of randomization (eTable 2 in the Supplement for mothers and eTable 3 in the Supplement for children).[19]

Mothers who had not died had a mean (SD) duration of follow-up of 20.9 (0.4) years and a mean age of 39.4 (3.1) years at this follow-up (range, 33.4-54.8 years). Children who had not died had a mean age (follow-up time) of 20.6 (0.4) years (range of 19.7-22.1 years).

Statistical Analysis

The Kaplan-Meier method was used to estimate survival functions for all-cause mortality outcomes.[40] The log-rank test was used for comparing differences in survival functions. For external-cause mortality (for mothers) and preventable-cause mortality (for children) we used competing risk analysis to estimate cumulative probabilities of failure.[41] The Gray test was used to compare differences in cumulative probability functions.[42] For mothers, survival was assessed from their date

Table 1. Sample Composition Through Birth by Treatment

	Treatment			
Participant Status, No.	1	2	3	4
Mothers allocated to each treatment	166	514[a]	230	228
Mothers interviewed after December 31, 2011		19		10
Data on mother sent to NDI	166	495	230	218
Mothers included in mortality analyses	166	514	230	228
Miscarriages		19		8
Stillbirths		5		2
Children born alive		490		218
Missing identifiers		1		1
Children interviewed after December 31, 2011		21		9
Child identifier data sent to NDI		468		208
Children included in mortality analyses		489		217

Abbreviation: NDI, National Death Index.

[a] One person was randomized a second time following a miscarriage and was subsequently excluded. Earlier reports[20] of sample size showed 1139 participants and noted the exclusion of this case.

Table 2. Deaths and Cause-of-Death Categories by Treatment Condition

Cause of Death	Treatment 1	2	3	4
Maternal deaths, No.				
Natural (disease related)	5	11	1	4
External (unintentional injuries, suicide, drug overdose, homicide)	0	11	0	1
Total				
Deaths	5	22	1	5
Sample size[a]	166	514	230	228
Child deaths, No.				
Natural (disease related)		5		2
Preventable (SIDS, unintentional injuries, homicide)		9		0
Total				
Deaths[b]		14		2
Sample size[c]		489		217

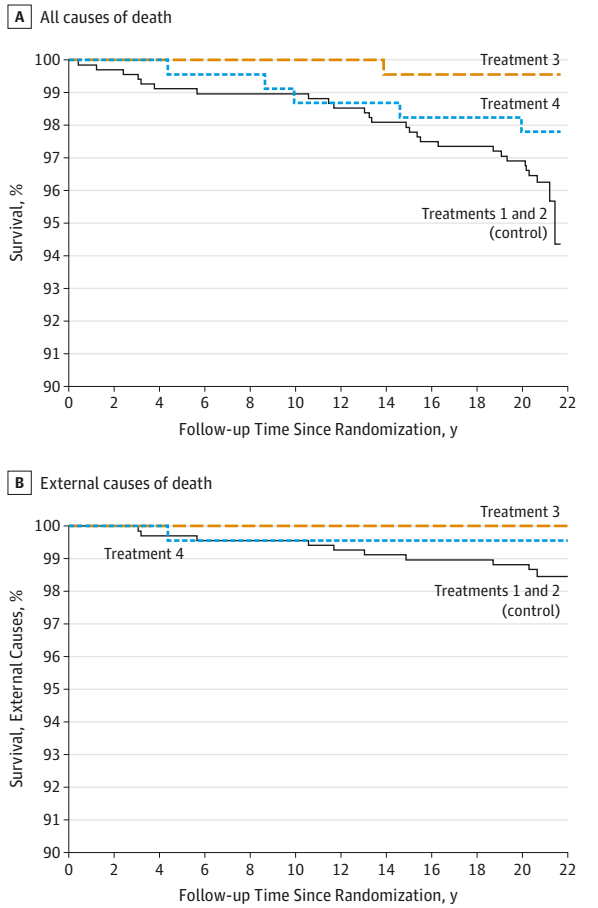
Abbreviation: SIDS, sudden infant death syndrome.

[a] Includes all cases randomized to all 4 treatment groups.

[b] We did not assess child deaths in treatments 1 and 3 because we had unacceptably high rates of missing data for purposes of matching children in these two conditions. We had not conducted prior postnatal assessments of women and children in these groups.

[c] Includes all but 2 cases born alive in treatments 2 and 4.

Figure 1. Survival Curves for Mothers in the Nurse-Family Partnership Trial



A, All causes of death. B, External causes of death. All 1105 mothers who survived had at least 20.2 years of follow-up after randomization. The numbers at risk of dying at 20.5, 21.0, 21.5, and 22.0 years after randomization were 898, 437, 65, and 1, respectively.

of randomization until the date of death or, if alive, until December 31, 2011, or the last time that we interviewed them. For live-born children, survival started from their date of birth until the date of death or, if alive, until December 31, 2011, or the last time we interviewed them.

For the analysis of maternal mortality, we conducted 3 treatment contrasts: control (treatments 1 and 2 combined) vs (1) prenatal and postpartum home visiting (treatment 3); (2) prenatal, postpartum, and infant/toddler home visiting (treatment 4); and (3) the combination of treatments 3 plus 4 (a post hoc test). For the assessment of child mortality, we contrasted treatment 2 with treatment 4. We made no adjustments for multiple comparisons.

Results

Maternal Mortality

Table 2 reports the number of maternal deaths from natural and external causes. There were 27 deaths for all causes in treatments 1 and 2 combined, 1 in treatment 3, and 5 in treatment 4. There were 11 deaths in treatments 1 and 2 combined due to external causes, none in treatment 3, and 1 in treatment 4.

Figure 1A shows the all-cause survival curves for mothers in the 3 treatment conditions, with treatments 1 and 2 combined as the control group. At 21 years following randomization, the mean (SE) all-cause mortality rate was 3.7% (0.74%) in treatments 1 and 2 combined, 0.4% (0.43%) in treatment 3, and 2.2% (0.97%) in treatment 4. The survival contrast of treatments 1 and 2 with treatment 3 was significant (P = .007), the contrast of treatments 1 and 2 combined with treatment 4 was not significant (P = .19), and the contrast of treatments 1 and 2 combined with treatments 3 and 4 combined was significant (post hoc P = .008).

Figure 1B shows the survival curves for external causes of mortality. At 21 years after randomization, the external-cause mortality rate was 1.7% (0.51%) in treatments 1 and 2 combined, 0.0% (SE not calculable) in treatment 3, and 0.4% (0.44%) in treatment 4. The external-cause survival analysis contrast of treatments 1 and 2 combined with treatment 3 was marginally significant (P = .053); with treatment 4 was not significant (P = .18); and with treatments 3 and 4 combined was significant (post hoc P = .02).

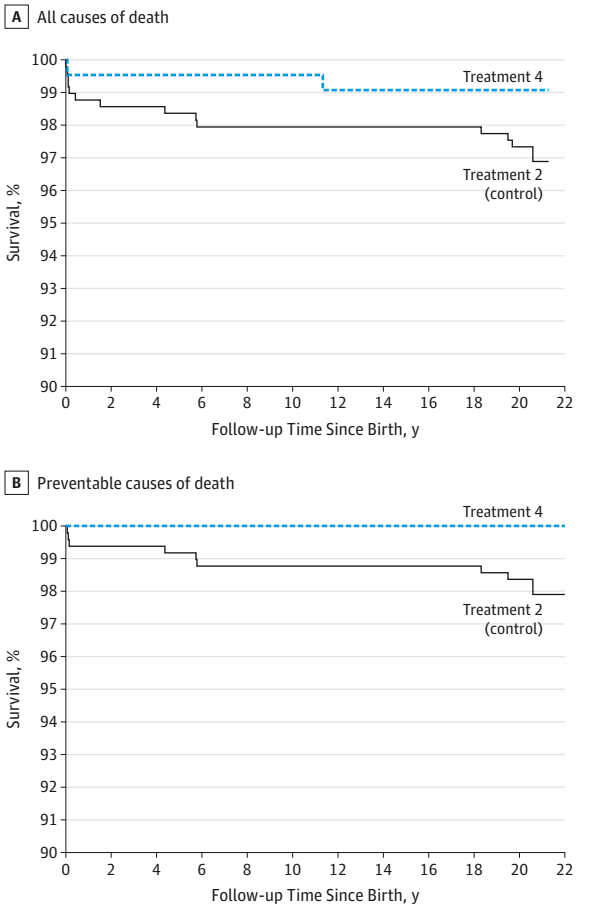
Child Mortality

Table 2 reports the number of child deaths for natural and preventable causes. There were 14 deaths for all causes in treatment 2 and 2 deaths in treatment 4. Five of the deaths in treatment 2 and 2 in treatment 4 were due to natural causes. Nine of the deaths in treatment 2 were due to preventable causes, whereas there were no deaths associated with preventable causes in treatment 4.

Figure 2A shows the survival curves for children in treatments 2 and 4, examining all causes of mortality. At child age 20 years, the all-cause mortality rate was 2.7% (0.73%) in treatment 2 and 0.9% (0.65%) in treatment 4. The nurse-control survival contrast was not significant (P = .11).

At child age 20 years, the preventable-cause mortality death rate was 1.6% (0.57%) in treatment 2 and 0.0% (SE not calculable) in treatment 4. The preventable-cause survival contrast of treatment 2 with treatment 4, shown in Figure 2B, was significant (P = .04).

Figure 2. Survival Curves for Children in the Nurse-Family Partnership Trial



A, All causes of death. B, Preventable causes of death. All 690 children who survived had at least 19.7 years of follow-up after birth. The numbers at risk of dying at 20.0, 20.5, 21.0, 21.5, and 22.0 years after randomization were 620, 369, 132, 4, and 1, respectively.

Discussion

During the 2-decade period following registration in this trial, women enrolled in the 2 nurse-visited groups were less likely to have died than women assigned to the control group, and by age 20 years, children whose mothers received home visits during pregnancy and through child age 2 years were less likely to have died from preventable causes compared with their counterparts in the control group.

Although highly promising, these findings need to be understood in light of their limitations. First, the effect of the program on mortality was not hypothesized because of the infrequency of death among most groups in this age range.[1] Second, the sparseness of the data and limited sample size for a study of mortality mean that the findings are sensitive to relatively small changes in the numbers of deaths in the intervention and control conditions. Third, had we formulated hypotheses at the start of this trial, we would have expected a linear ordering of home-visiting effects on maternal mortality, with the strongest effect being present for treatment 4, the group that received home visits through child age 2 years. Apparent differences between treatments 3 and 4 in maternal mortality are likely sampling artifacts.

Notwithstanding these limitations, the findings are noteworthy because mortality is an unequivocal outcome and its prevention aligns with the goals of the program and earlier program effects. Nurses are charged with improving maternal and child health by helping activate and support women's motivations to protect their children and themselves.[25,35,36] The program's effect on maternal mortality from prenatal and postpartum visitation alone is plausible because pregnancy and the birth of first children activate mothers' highly conserved brain-based systems needed for children's protection and development.[43-45] Nurses' support of mothers' efforts to protect themselves and their offspring[46] is likely to buffer the damaging effects of toxic stress on mothers' rapidly changing neural circuitry and behavior during pregnancy and the puerperium.[43-48]

The reduction in external-cause maternal mortality in the 2 visited groups is thus noteworthy. A significant portion of the variance in these causes of maternal mortality is likely explained by maternal behaviors that require anticipation of risk and regulated behavior (eg, wearing seat belts and avoiding criminally involved individuals). Research[47] with nulliparous pregnant rats emphasizes that gestation is a period of particular vulnerability for the developing fetus and mother, with mild stress affecting both maternal behavior and microRNA expression in the frontal cortex, a region involved in decision-making and maternal care. Moreover, structural changes in human brain regions involved in maternal motivation and behavior occur immediately following delivery.[49]

Given that the NFP is designed to help mothers anticipate risks and build skills to accomplish their goals,[25,35,36] it is important that nurse-visited mothers in the Memphis trial reported a greater sense of mastery after randomization than did their counterparts in the control group[19,23] and that self-efficacy and uplifting experiences in other studies have been found to attenuate pregnant women's stress responses.[50] Moreover, prenatal visitation produced positive changes before birth: women visited during pregnancy were more likely to use other community services and to have lower rates of yeast infection and pregnancy-induced hypertension than were women in the control group.[19] Although the earlier Elmira trial found that the full program usually produced larger effects on maternal and child health than did prenatal visitation,[29-33] adolescents whose mothers were visited during pregnancy alone, like those who

underwent the entire program, had fewer arrests and convictions compared with adolescents in the control group.[33]

The reduction in child mortality due to preventable causes is consistent with earlier program effects on children's duration of hospitalization for injuries,[19] home environments,[19] mothers' beliefs associated with child abuse,[19] mothers' behavioral impairments resulting from substance use,[24] children's behavioral dysregulation,[21] and children's depression, anxiety, and use of substances.[23] Moreover, we chose not to classify the following causes of infant mortality originating during pregnancy and the newborn period as preventable: extreme immaturity, chronic respiratory disease arising in the perinatal period, and infectious colitis, enteritis, and gastroenteritis. These causes of mortality were present only in the control group, so treating them as preventable would have increased the significance of differences.

Five features of these findings make them noteworthy. First, the findings are based on a randomized clinical trial with more than 2 decades of follow-up. Second, unlike many other outcomes, death is an unequivocal outcome measured validly. Third, survival was measured for all women randomized and all but 2 of the children born alive, nearly eliminating possible attrition bias. Fourth, this study is close to a population-based effectiveness trial because it enrolled a very large portion (88%) of the population invited to participate through a public system of care, and the program was delivered through the Memphis/Shelby County Health Department, where it was buffeted by many of the challenges found in public health delivery settings. Fifth, the effects of the program on both maternal and child mortality and their consistency with the program's goals, objectives, and earlier effects increase the validity of each outcome. These findings should be replicated in well-powered trials with populations at very high levels of familial and neighborhood risk.

Conclusions

The relatively lower rates of death found among nurse-visited mothers and children compared with those in the control group are consistent with the effect of the program on earlier aspects of maternal and child health. These findings suggest that this intervention may have longer-term effects on health and mortality as the mothers and their children grow older.

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Study concept and design: Olds, Kitzman, Cole.
Acquisition, analysis, or interpretation of data: Kitzman, Knudtson, Anson, Smith, Cole.
Drafting of the manuscript: Olds, Kitzman.
Critical revision of the manuscript for important intellectual content: All authors.
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TESTIMONY/PRESENTATION TO THE NEW YORK CITY COUNCIL

COMMITTEES ON HEALTH/HOSPITALS/ WOMEN AND GENDER EQUITY

DEBRA LESANE

DIRECTOR OF PROGRAMS
CARIBBEAN WOMEN'S HEALTH ASSOCIATION, INC.

DECEMBER 7, 2020

Good Day

My name is Debra Lesane and I am the Director of Programs for the Caribbean Women's Health Association. Caribbean Women's Health Association was established 37 years ago to provide Maternal and Child Health Support services, because immigrant women in East Flatbush, predominantly from the Caribbean, were not receiving adequate prenatal and post-partum health care support, so the pregnancy and birth outcomes for this population were poor. Over the years, the CWHA programs have expanded to meet the needs of the community. Currently, CWHA still has a particular focus on meeting the needs of pregnant and post- partum women,

and we also provide HIV testing and prevention education and immigration legal services.

Although maternal and child outcomes have improved overall in NYC in the last 37 years, there are still glaring maternal and child health disparities across the neighborhoods and communities of NYC.

I live and work in East Flatbush, where 37 years later, we are still working very hard to improve the maternal and child health outcomes for mothers and babies in NYC.

Unfortunately, today, the rates for maternal mortality in New York City are unacceptably high; and disproportionately impact women of color, specifically Black, Non-Latina women. Black, non-Latina women in NYC are 12 times more likely to die during pregnancy and childbirth. In addition, the rates for severe maternal

morbidity in certain NYC communities are also high and most often impact women of color. Severe maternal morbidity includes life threatening complications during pregnancy and childbirth. The most recent data is for 2014, when 3,138 women in NYC experienced life- threatening complications during pregnancy and/or childbirth. Unfortunately, the rates for severe maternal morbidity have been increasing in NYC. The SMM rates are measured per 10,000 deliveries. Immigrant women are particularly at risk for SMM. For 2013-2014 the SMM rate for East Flatbush was 567.7 cases per 10,000 deliveries, compared to a rate of 270.2 for NYC overall. Also, for East Flatbush, the rates of expectant mothers receiving late or no prenatal care is higher than the citywide rate (15.6% compared to 6.7% for NYC overall). In addition, one in eight births to East Flatbush

residents is preterm, (baby is born three or more weeks before the due date), which is higher than the citywide rate. In addition, East Flatbush still has consistently high rates of infant mortality and neonatal mortality between 2013 and 2017.

There are many factors that contribute to these striking disparities, including preconception health status, poverty, racism and overall access to quality and respectful health care. However, the social determinants of health also play a major role in women's overall physical and emotional health, including housing, access to healthy food, etc. CWHA currently provides Breastfeeding workshops, parenting classes and other supportive services to more than 600 pregnant and/or post-partum women per year. In addition, since the start of the COVID-19 pandemic, CWHA has also

been providing financial and other assistance to hundreds of pregnant and post-partum women, including food, diapers, baby clothes and other necessary supplies. Most of these women are referred to CWHA from local hospital prenatal care clinics and other community service providers. Considering the maternal health issues that continue to exist in our communities, our hospitals and community-based partners need adequate and secure staffing and funding to be able to provide a high level of care and service coordination to all, regardless of insurance or immigration status. This is especially important for pregnant and post-partum women of color who are high risk and who should be receiving care in a comfortable, culturally sensitive and stress- free environment.

Recommendations

1. The NYC Council should identify additional resources for improved coordination between hospital-based services and community based supportive services for pregnant women; especially for communities like East Flatbush in Brooklyn where the health status indicators for pregnant women are still unacceptable. A higher level of coordination would improve communication between hospitals and community, and insure that information is better disseminated to women.
2. The NYC Council should provide additional resources for the highest need areas in NYC (areas with the highest rates of Maternal Mortality and SMM); for culturally sensitive and evidenced based interventions that will improve the quality of prenatal care and post-

partum services for high-risk women, such as perinatal case management services, comprehensive doula support programs and centering pregnancy programs.

3. Considering the increased needs due to CIVID-19; NYC agencies should develop systems that prioritize the needs of pregnant and post-partum women, including the NYC Department of Homeless Services, NYC Dept of Social Services (Food Stamps/Public Assistance), Domestic Violence Shelters, Food Pantry Services, etc.
4. Provide additional community based mental health services for pregnant and post-partum women.

New York City Council

Committee on Hospitals
Committee on Health
Committee on Women and Gender Equity

Hearing Testimony:
"Maternal Mortality and Morbidity"

Lorraine Ryan, Senior Vice President, Legal, Regulatory and Professional Affairs

GREATER NEW YORK HOSPITAL ASSOCIATION

Chairs Rivera, Levine, and Rosenthal and members of the Committee on Hospitals, the Committee on Health, and the Committee on Women and Gender Equity, my name is Lorraine Ryan, Senior Vice President for Legal, Regulatory, and Professional Affairs at Greater New York Hospital Association (GNYHA). GNYHA proudly represents all hospitals in New York City, both not-for-profit and public, and hospitals throughout New York State, New Jersey, Connecticut, and Rhode Island.

Thank you for the opportunity to speak with you today about the extremely important issue of maternal mortality and morbidity. I have worked on clinical care improvement initiatives as a nurse and for over a decade as GNYHA's director of quality improvement (QI) and patient safety programs. I currently serve as a member of Governor Andrew Cuomo's Taskforce on Maternal Mortality and Disparate Racial Outcomes and his COVID-19 Maternity Task Force, and the New York City Department of Health and Mental Hygiene's (DOHMH) Maternal Mortality Steering Committee. I am also currently helping plan a Maternal Child Health Equity summit to be held next month sponsored by the New York Academy of Medicine and participating in the development of the New York State Department of Health (DOH) health equity improvement collaborative.

GNYHA and our member hospitals believe health care is a human right and work toward ensuring universal coverage and the highest quality of patient care. While for-profit hospitals are becoming the norm in other states, New York's not-for-profit and public hospitals continue their mission to care for the most vulnerable. Addressing racial disparities in maternal mortality and morbidity is a key element of that mission.

There are clear racial disparities in maternal mortality and morbidity. Black and Latina women die or experience severe complications at higher rates than white women during and after pregnancy. A recent study (based on data from 2010–2014) found that severe maternal morbidity among black and Latina women was higher than among white women—even when they delivered at the same New York City hospital—regardless of socioeconomic or insurance status.[1] In 2019, New York State ranked 23rd in the nation with 25.5 pregnancy-related deaths per 100,000 live births.[2] This has since improved to 20.8 pregnancy-related deaths per 100,000 live births.[3]

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1 Howell, Elizabeth A., MD, MPP; Egorova, Natalia N., PhD, MPH; Janevic, Teresa, PhD, MPH; Brodman, Michael, MD; Balbierz, Amy, MPH; Zeitlin, Jennifer, DSc, MA; Hebert, Paul L., PhD, "Race and Ethnicity, Medical Insurance, and Within-Hospital Severe Maternal Morbidity Disparities," *Obstetrics and Gynecology* (February 2020).

2 United Health Foundation, America's Health Rankings, "Maternal Mortality." Available at https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality_a/state/NY.

3 *ibid*

However, the status quo remains unacceptable and New York's hospitals are committed to addressing it, as well as the root causes of these disparities: poverty, discrimination, and systemic and structural racism.

Today I will address maternal health within the context of the ongoing COVID-19 pandemic and broader efforts to address maternal mortality and morbidity.

Maternal Health during the COVID-19 Pandemic

The COVID-19 pandemic has shone a light on racial disparities in health care. Black and brown communities have been disproportionately impacted by the virus.

COVID-19 potentially increases the risk of severe maternal illness and pre-term birth. During the early stages of the pandemic, New York State took steps to protect maternal health by expanding access to telehealth visits and midwives, authorizing out-of-state obstetrician-gynecologists to practice in New York to improve surge capacity, and identifying sexual and reproductive health services as essential, meaning they were not subject to the ban on elective surgeries.

Soon after the initial patient surge in the spring, the Governor convened a COVID-19 Maternity Task Force, upon which I serve. Secretary to the Governor Melissa DeRosa issued the Task Force's initial recommendations to the Governor on April 29, 2020, who accepted them in full. Some of the Task Force's recommendations[4] include:

- diversifying birthing site options to support patient choice
- authorizing support persons to accompany a pregnant individual for the duration of their hospital stay, and a doula as an additional support person, as medically appropriate
- universal testing of pregnant patients, and testing of the support person as testing becomes available
- ensuring equity by engaging community-based organizations and community members involved in maternal health
- enhancing messaging and education to rebuild confidence in maternity care, explain infection control practices, and for patient maternal health literacy
- collaboration on reviewing the impact of COVID-19 on pregnancy and newborns

Throughout the pandemic, DOH has issued new and updated guidance for health care providers related to pregnancy and COVID-19, including the following:

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[4] See COVID-19 Maternity Task Force, "Recommendations to the Governor to Promote Increased Choice and Access to Safe Maternity Care During the COVID-19 Pandemic," April 29, 2020. https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/042920_CMTF_Recommendations.pdf.

- Pregnancy and COVID-19 Resources for Health Care Providers
- Health Advisory: COVID-19 and Provision of Prenatal and Postpartum Care
- Initial Care of Newborns Born to Pregnant Persons with Suspected or Confirmed COVID-19
- Protocol for COVID-19 Testing Applicable for Pregnant People and Support Persons

Additionally, DOH has developed patient education materials that can be used with patients in an inpatient or outpatient setting as appropriate. These include:

- Pregnancy and COVID-19 resources for pregnant people and their families
- COVID-19 breastfeeding guidance
- Information for patients after giving birth

Even as a second wave is bearing down on New York City, hospitals continue to provide the same level of maternal care services they offered before the pandemic. We cannot stress enough how important it is for pregnant persons not to delay their care. Hospitals have implemented robust infection control measures and other strategies to ensure the safety of patients and hospital workers alike. These include:

- Strict adherence to Centers for Disease Control and Prevent infection control guidelines
- Separating known COVID-19 patients as much as possible from non-COVID-19 patients, including in emergency rooms, waiting rooms, and obstetrical units
- Aggressively screening for the virus at all points of entry
- Ensuring adequate testing capabilities for staff and patients
- Innovative protocols for maintaining social distancing
- Appropriate communications with patients to pre-screen for COVID-19 and to ensure personal protective equipment (PPE) is in place prior to anyone entering hospital facilities
- Engineering controls, including adequate air exchanges
- Requiring patients to wear masks and providing them with one if necessary
- Offering patients telehealth visits when appropriate
- Prioritizing scheduled and medically necessary surgeries and services
- Implementing alternative scheduling strategies, like reserving early morning appointments for the most vulnerable patients

State DOH Guidance for COVID-19 Testing of All Pregnant Individuals

DOH continues to expand COVID-19 diagnostic and serologic testing for New Yorkers and recently issued the following guidance to implement the testing recommendations of the Governor's COVID-19 Maternity Task Force:

- Universal COVID-19 testing of all pregnant individuals during pregnancy and within one week prior to their estimated due date or upon admission if second test is not conducted one week prior to delivery;
- As testing becomes increasingly available, support persons may also be tested, either at the hospital or birthing center upon admission for delivery or prior to accompanying the pregnant patient to the hospital or birth center. Hospitals and birth centers may develop their own policies about support person testing, based on capacity of the facility and testing capabilities.

Hospital Visitation

The birth of a child is an extremely special life event, and we understand the desire of pregnant people to have loved ones by their side. Unfortunately, the reality of the pandemic has forced hospitals to adopt more restrictive visitation polices—based on DOH guidance—to protect patients and hospital workers and preserve hospital capacity.

During the initial patient surge in the spring, hospitals implemented a DOH directive to suspend all visitation to slow and control the spread of the virus. In late March, DOH made exceptions and expanded visitation for four categories of patients, including pediatrics, cognitively impaired, immediate end of life, and labor, delivery and post-partum (which permitted a "support person" to attend the delivery). In April, the Governor's Maternity Task Force recommended that a doula be permitted to attend the labor, delivery, and post-partum phase of hospital care at the request of the patient, in addition to the support person.

During the summer, as cases fell and hospital capacity grew, GNYHA helped develop a pilot program to expand hospital visitation for all patients. Visits were time limited, and visitors were required to wear PPE and were subject to symptom and temperature checks. DOH developed and disseminated new visitation guidance based on the success of the pilot program, resulting in more expansive, but well-controlled visitation restrictions for all patients. Currently, most hospitals limit visitation to one individual at a time—except for obstetrics. Due to recent high rates of COVID-19 infectivity, several hospitals across the State have shut down visitation to all but obstetrics and the other three aforementioned categories of patients.

Efforts to Address Maternal Mortality and Morbidity

Below is a general overview of efforts to address maternal mortality and morbidity and associated racial disparities.

Legislation and Government Policy

US Department of Health and Human Services

Last week, the US Department of Health and Human Services issued an action plan aimed at reducing maternal deaths and disparities that put women at risk before, during, and following pregnancy. Many of the recommended approaches and targeted initiatives in the report to reduce mortality and morbidity in pregnancy are priorities for GNYHA, our clinicians, and hospitals and will guide our ongoing efforts.

Taskforce on Maternal Mortality and Disparate Racial Outcomes. In 2018, Governor Cuomo created a multidisciplinary group of clinical experts, medical practitioners, policymakers, and community members to inform State policy on maternal mortality and morbidity. Its co-chairs are DOH Commissioner Howard Zucker, New York State Association of Licensed Midwives President Sascha James Conterelli, former SUNY Upstate President Danielle Laraque-Arena, and Wendy Wilcox, chair of the Department of Obstetrics and Gynecology at NYC Health + Hospitals/Kings County. The Taskforce released a report in 2019 recommending 10 steps to address maternal mortality and continues to advise policymakers.[5]

Maternal Mortality Review Boards (MMRB). Examining cases of maternal mortality and morbidity is key to improving patient care and birth outcomes and reducing racial disparities. In 2019, Governor Cuomo signed legislation (A.2376/S.1819) to create a group of experts for this purpose. Its multidisciplinary team is tasked with reviewing maternal death data, identifying the causes of the poor outcomes, and disseminating evidence-based best practices to prevent them in the future. The board focuses on QI, reviewing outcomes of care, conducting peer reviews, and collaborating on process improvements.

New York City has its own MMRB, a right that is specified in State law. DOHMH also operates the aforementioned Maternal Mortality and Morbidity Steering Committee, which focuses on addressing the root causes of death and morbidity in pregnancy. GNYHA supported the State legislation, advocated for its passage in Albany, and coordinates with DOH and DOHMH on these efforts.

2019-20 State Budget Initiatives. The fiscal year 2019-20 New York State budget allocated $8 million over two years to fund initiatives addressing maternal mortality, including the MMRB. Components of the plan include:

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5 See Taskforce on Maternal Mortality, "Recommendations to the Governor," March 2019, pp. 6-7. The recommendations are as follows: 1) establish a statewide MMRB, 2) design and implement a training program for hospitals on implicit racial bias, 3) establish a perinatal data warehouse, 4) provide equitable reimbursement to midwives, 5) expand and enhance community health worker services, 6) create a SUNY scholarship for midwives to promote diversity, 7) create competency-based curricula for providers and medical and nursing schools, 8) establish a loan forgiveness program for underrepresented providers that intend to practice women's health care services, 9) convene a statewide work group to improve postpartum care, and 10) promote universal birth preparedness and postpartum continuity of care.

- more community health workers
- implicit bias training and post-birth training for medical professionals
- building a perinatal data warehouse to shape QI efforts and State policy
- a program to increase the ratio of minority perinatal health care providers
- pilots in Erie County and Brooklyn to increase the use of doulas

Quality Improvement Programs

DOHMH, DOH, the American College of Obstetricians and Gynecologists (ACOG), and hospitals are working together to implement clinical and community health interventions to reduce maternal mortality and associated racial disparities. GNYHA is an active participant in all of these initiatives and supports member hospitals on the initiatives outlined below:

Promoting Health Equity

DOH is developing the New York State Birth Equity Improvement Project that will address clinical and communication strategies to ensure equity in the delivery of prenatal, intrapartum, post-partum, and newborn care. GNYHA is on the advisory group to develop this initiative and will support implementation by helping members of the birthing team, including physicians, midwives, nurses, and doulas understand their patients' unique circumstances and use that knowledge to deliver equitable, culturally competent care to all pregnant persons.

GNYHA will provide online training resources to supplement our member hospitals' own initiatives that address implicit bias.

Prenatal QI Programs

- Led by DOHMH, New York City implemented a **maternal depression screening program** as part of the wider Thrive NYC initiative. GNYHA helped implement the program, which screens pregnant persons for depression before delivery and post-partum and connects them to proper services if necessary.
- New York State leads a statewide improvement collaborative to reduce **opioid use disorder (OUD) in pregnancy and neonatal abstinence syndrome**. This effort (the Opioid Use Disorder in Pregnancy & Neonatal Abstinence Syndrome Project) trains maternal care providers to screen pregnant persons for OUD and refers them to appropriate services, including substance use counselors and treatment. It also includes training emergency department and labor and delivery staff to destigmatize the use of these services. The effort's goal is to teach practitioners to ask questions in nonjudgmental ways and screen all patients—not just a subset of people. GNYHA, our member hospitals, the Healthcare Association of New York State (HANYS), and ACOG all collaborate on this project. Process measures show

an increase in screening for OUD in pregnancy and earlier intervention in newborns that have been exposed to substance use in pregnancy.

Perinatal QI Programs

Through the DOH-led **New York State Perinatal Quality Collaborative (NYSPQC)**,[6] hospitals work with government, maternal care providers, and others to improve care for women and babies by promoting evidence-based care. Some NYSPQC projects are detailed below:

- The **Obstetric Hemorrhage Project** aims to implement obstetric hemorrhage protocols in hospitals and reduce mortality and morbidity from hemorrhage. GNYHA, our member hospitals, HANYS, and ACOG are working on a voluntary basis to actively engage all birthing hospitals across the State in implementing ACOG's Safe Motherhood Initiative bundle of best practices. To date, 100% of the regional perinatal centers and over 70% of all other birthing hospitals across the State have been actively engaged in bundle implementation.
- The aforementioned **Opioid Use Disorder in Pregnancy & Neonatal Abstinence Syndrome Project** is also part of the NYSPQC
- New York State hospitals are working with maternal health providers, DOH, and DOHMH to promote **safe sleep practices** to reduce infant mortality

Through past DOH-led collaborative initiatives supported by GNYHA, ACOG, and HANYS, hospitals and maternal care providers have implemented best practices to manage **hypertension** (high blood pressure) and **venous thromboembolism** (blood clots) throughout pregnancy to reduce related complications, which are associated with maternal mortality and morbidity.

Postpartum Care Expert Workgroup

Early this year, DOH convened the first meeting of its Postpartum Care Expert Workgroup, which will identify and address barriers and challenges to providing comprehensive post-partum care to women across New York State. GNYHA is an active participant.

We Can and Must Do More

GNYHA and our member hospitals are collaborating with government, community-based organizations, and other health care stakeholders to address maternal mortality and morbidity and associated disparities. Even amid the pandemic, hospitals deliver high-quality care to every patient, run programs to combat bias and promote culturally

6 SUNY University at Albany, School of Public Health, "New York State Perinatal Quality Collaborative." Available at https://www.albany.edu/cphce/mch_nyspqc.shtml.

competent and equitable care,[7] support legislative efforts to improve birth outcomes, collaborate with community-based organizations, and participate in robust clinical QI programs. Hospitals are working to implement recommendations made by the Governor's taskforce and are constantly looking for ways to improve maternal care.

However, there is still work to be done. We must place a greater emphasis on addressing the social determinants of health that contribute to disparities in maternal mortality and morbidity—structural racism, food and housing insecurity, language barriers, lack of access to primary care, education, and emotional support, poor health literacy and transportation options, and much more. While hospitals constantly strive to improve maternal care, they can ultimately only control what happens inside their four walls. That is why we must all continue to collaborate to better address the issues that underlie and can lead to maternal mortality and morbidity.

GNYHA and our members support bolstering the fraying social safety net that has been further imperiled by the pandemic-induced recession. GNYHA is fighting in Washington for a substantial relief package, without which New York State may be forced to slash the Medicaid budget by 20-30%. This would wreak havoc on the State's health care system and exacerbate maternal mortality and morbidity issues among Black and Latina women, who rely more heavily on the Medicaid program than white women. We must continue to protect and further invest in programs that strengthen marginalized communities. Social justice must be our guiding principle.

Conclusion

Thank you for the opportunity to testify before the City Council on this critically important issue. GNYHA and our member hospitals are committed to working with the City Council to address maternal mortality and morbidity issues. I am happy to answer any questions you may have.

7 GNYHA continues to support hospitals as they seek to improve the cultural competence of the care they deliver. Efforts include cultural competence training provided to almost 2,000 frontline staff (mostly from New York City hospitals) under a DOH grant, sharing best practices and challenges on language access, and helping hospitals to identify and share best practices in LGBTQ+ care. See GNYHA testimony on "The Delivery of Culturally Competent & Equitable Health Care Services in New York City Hospitals," submitted for the Hospitals Committee hearing on September 18, 2019, for more information.

Planned Parenthood
Care. No matter what.
Planned Parenthood of Greater New York

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Testimony of Planned Parenthood of Greater New York Before the New York City Council Committees on Women and Gender Equity, Health, and Hospitals on Addressing Maternal Mortality and Morbidity in New York City

December 7th, 2020

Good Morning. My name is Maryam Mohammed-Miller and I am the Manager of Government Relations at Planned Parenthood of Greater New York. Thank you to the Committee Chairs, Council Members Rosenthal, Rivera, and Levine, for holding this important hearing to explore how the city can address the alarming rates of maternal mortality and morbidity, especially amongst Black women. We also thank the bill sponsors for introducing legislation that moves us closer to achieving reproductive justice for the most marginalized in our communities.

PPGNY has proudly provided the full range of sexual and reproductive health care services and quality education programs to all New Yorkers for over 100 years. Last year, our New York City health centers conducted over 104,000 patient visits, providing care regardless of patients' immigration status, identity or ability to pay . Our education programs also engaged over 19,000 people—including 1,800 youth. Our Project Street Beat program, through their offices and mobile health center, conducted over 20,000 encounters throughout the city. In 2019, we enrolled over 6,300 people in health insurance programs. In response to the COVID-19 pandemic, we have continued to provide vital healthcare through in person visits and telehealth appointments, as well as educational programming. We transformed our care delivery model to ensure individuals could safely access our services while adhering to government guidelines to decrease the spread of the virus.

What the COVID-19 pandemic revealed to many New Yorkers is that there are inequities in our public health system that leave the most vulnerable without adequate access to care. However, this has been the reality marginalized communities have continued to face. As a sexual and reproductive healthcare provider, we are committed to working to expand maternal healthcare and recognize the barriers many individuals face when attempting to seek care. For several years, we have partnered with volunteer doulas at the Doula Project to provide their support services at our Bronx, Brooklyn, and Queens health centers. These doulas provide compassionate, non-judgmental emotional support, information, and pain management to pregnant people across the spectrum of pregnancy, without the burden of cost. However, we know that due to cost and

limited availability, doula access is often limited to more affluent individuals who can afford doula service fees or have insurance that can cover the cost.

For Black people, specifically Black women, the compounded identities of race, gender, and often economic status makes seeking reproductive health care increasingly difficult. 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] These outcomes are a result of institutionalized medical racism and implicit bias within our healthcare systems that lead to the unique needs of Black women being ignored and a lack of cultural competency to effectively provide care to this community. Studies suggest that Black women are more likely to have their health issues ignored by their doctor than their white counterparts and are treated differently than white patients when they present the same symptoms.[3]

Studies also indicate that the presence of support individuals, including doulas, when Black women are giving birth led to positive health outcomes for both mother and baby.[4] Birth doulas are trained individuals who work with their clients to provide continuous emotional and physical support throughout the pregnancy and during birth. Doulas also provide advocacy and inform their clients about what is happening during their labor and ensure that their clients can make informed decisions in their birth experience.[5] The impact of doula care is especially pronounced amongst individuals who are low income, socially disadvantaged, are giving birth in a hospital alone, and have language and cultural barriers. Studies suggest that doula support reduces the need for medical interventions, leads to fewer complications, and a more satisfying birth

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[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

[3] Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care." Edited by Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson. National Academies Press (US), 2003. https://www.ncbi.nlm.nih.gov/pubmed/25032386.

[4] Gruber, Kenneth J, Susan H Cupito, and Christina F Dobson. "Impact of Doulas on Healthy Birth Outcomes." The Journal of perinatal education. Springer Publishing Company, 2013. find.https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/.

[5] University of New Mexico. "Doulas: An Alternative Yet Complementary Addition to Care... : Clinical Obstetrics and Gynecology." LWW. Accessed December 3rd, 2020. https://journals.lww.com/clinicalobgyn/Citation/2001/12000/Doulas__An_Alternative_Yet_Complementary_Addition.9.aspx.

experience.[6] A study of the By My Side Birth Support Program, a Brooklyn based initiative that connected Black and Latinx individuals from high poverty areas to doulas for free, found that program participants had better birth outcomes when compared to individuals of similar backgrounds who were not connected to doula care.[7]

In recent years, doula care and other birth support services, often provided by Black and Brown women-led organizations, have become increasingly available to women who could not otherwise pay for free or very low-cost. However, there are structural barriers including cost and low reimbursement rates for doula care that still do not allow many in need to access these vital services. We ask that the city do more to ensure all pregnant people, but especially Black women, have access to the information and services they need to have healthy births. PPGNY supports the committee's efforts to make pregnancy and birth safer for all.

We support Resolution 1408, sponsored by Council Member Rosenthal, that calls on the New York State legislature to pass and the Governor to sign A10440(Gottfried)/S8307(Rivera) relating to the accreditation, approval, and operation of midwifery birth centers. The bill would clarify certification standards and require the state to recognize midwifery-led birth centers that are licensed by a national accrediting body. In 2016, the state made progress by passing legislation aimed at removing barriers to establish more birth centers.[8] However, the state did not release guidance on the creation of these centers until 2019; and in 2020, the Department of Health released a Certification of Need Process that is unfortunately delaying the process to open more centers. The number of birthing centers in New York City has steadily decreased in the last decade[9]. As the call for safe places to give birth outside of the hospital setting grows, it is important that New York step up and meet this need. During the pandemic, many pregnant people shifted their birth plans and opted to give birth at home or at available birth centers, only to realize that there was a small number of these resources available.[10] As the pandemic continues and cases begin to spike in the city, it is more important than ever to provide safe, alternative spaces for pregnant people to give birth.

PPGNY also supports Introduction 2017, sponsored by Council Member Rivera, that would direct the NYC Department of Health and Hygiene to produce guidance on hospital visitation policy during a public health crisis, such as the COVID-19 pandemic. At the height of the

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[6] Gruber, Kenneth J, Susan H Cupito, and Christina F Dobson. “Impact of Doulas on Healthy Birth Outcomes.” The Journal of perinatal education. Springer Publishing Company, 2013. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/.

[7] Thomas, Mary-Powel, Gabriela Ammann, Ellen Brazier, Philip Noyes, and Aletha Maybank. “Doula Services Within a Healthy Start Program: Increasing Access for an Underserved Population.” Maternal and child health journal. Springer US, December 2017. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5736765/.

[8] NY State Senate Bill S4325. (2017, November 08). Retrieved December 05, 2020, from https://www.nysenate.gov/legislation/bills/2015/s4325

[9] New York midwives lose the right to deliver babies at home. (2010, May 14). Retrieved December 05, 2020, from https://www.theguardian.com/lifeandstyle/2010/may/14/home-births-new-york-midwives

[10] Freytas-tamura, K. (2020, April 21). Pregnant and Scared of 'Covid Hospitals,' They're Giving Birth at Home. Retrieved December 05, 2020, from https://www.nytimes.com/2020/04/21/nyregion/coronavirus-home-births.html

pandemic, many NYC hospitals moved to restrict visitor access in an effort to decrease transmission of the virus. However, inconsistent visitor policies throughout the different hospital systems led to much confusion for patients giving birth, leaving many to do so alone. Additionally, doulas and other birth support workers were not allowed to access their patients. For Black women, the absence of a doula could potentially lead to a situation with a disastrous outcome. In response to this, Governor Cuomo released guidance overruling hospital restrictions and released guidance that allowed people giving birth to have at least one person accompanying them[11]. Introduction 2017 further clarifies policies that ensure people giving birth have the support they need.

We are also in support of legislative measures that grow accessibility to doula care. As previously mentioned, we recognize the important role doulas play in ensuring people giving birth, especially those most vulnerable to negative health outcomes, can do so safely. The cost of doula services, again, is a significant barrier. We urge New York City and the state to explore effective ways that allow low-income individuals to afford doula services. Additionally, find ways to adequately reimburse doulas for the services through public health insurance programs. While the relative high cost of doula care is an issue, the complexities around reimbursements also serves as a barrier for doulas' ability to provide services.[12] PPGNY looks forward to working with the Council to effectively address this issue.

PPGNY 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 thank the City Council for creating this opportunity to explore this important topic. Too often, we hear the stories of Black mothers needlessly losing their lives during or shortly after birth to preventable issues. We can work together to make maternal mortality a thing of the past. We look forward to working with the Council to strengthen our public health system and growing healthcare access for all.

Thank you.

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Planned Parenthood of Greater New York (PPGNY) is a leading provider, educator, and advocate of sexual and reproductive health care in New York State. PPGNY offers a wide range of services across 65% of NYS - including gynecological care; birth control; cancer screenings; pregnancy testing; STI testing and treatment; HIV prevention, testing, and counseling; transgender hormone therapy; and vasectomy. PPGNY is also proud to provide abortion services to anyone who needs compassionate, non-judgmental care. PPGNY is a trusted source

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[11] Yan, H. (2020, March 30). New York state overrules a hospital policy saying mothers must give birth without their partners. Retrieved December 05, 2020, from https://www.cnn.com/2020/03/29/health/new-york-hospital-childbirth-policy-overturned/index.html

[12] Lantz, Paula M, Lisa Kane Low, Sanjani Varkey, and Robyn L Watson. "Doulas as Childbirth Paraprofessionals: Results from a National Survey." Women's health issues: official publication of the Jacobs Institute of Women's Health. U.S. National Library of Medicine, 2005. https://www.ncbi.nlm.nih.gov/pubmed/15894196?log$=activity.

of medically accurate, evidence-based information that allows people to make informed decisions about their health and future. As a voice for reproductive freedom, PPGNY supports legislation and policies that ensure all New Yorkers have access to the full range of reproductive health services and education.

Official Testimony for the Women's Community Justice Association
Committee on Women Gender Equity Jointly with the Committee on Health and the Committee on Hospitals
December 7th, 2020 at 10AM EST

Good morning, my name is Jordyn Rosenthal and I am the Director of Community of the Women's Community Justice Association (WCJA). I want to thank the committee chairs for holding this oversight hearing today concerning maternal mortality and morbidity in New York City.

The Women's Community Justice Association is a nonprofit organization dedicated to reducing mass incarceration in New York State and advocates for policies that ensure the long term stability of vulnerable female and gender non conforming populations currently or previously involved with the criminal justice system. As part of our work we lead the Beyond Rosie's 2020 campaign which is dedicated to decarcertaing the Rose M. Singer Center on Rikers Island. Our sister organization, Housing Plus Solutions is a member of an alternative to incarceration demonstration project--the Women's Community Justice Project. Since July 1st, 2018 WCJP has served 171 women and 35 or about 20% were pregnant.

Information concerning pregnant women on Rikers Island is extremely limited. For instance in the beginning of the COVID-19 pandemic the Board of Corrections began to publish it's daily covid report which originally included the number of pregnant women in Department of Corrections custody. Without any notice in May the Board stopped reporting this line of data. Upon investigation BOC felt the information they were receiving from DOCS was inaccurate and they did not feel comfortable publishing it. It boggles me that we can't accurately say how many pregnant women are in the city's care or that we even subject pregnant women to the horrors of pretrial detainment. After reaching out to the Board last week, I found out that as of the last week of November there were four pregnant women on Rikers Island, that is four too many.

We have also found through our work with the Women's Community Justice Project that there are major deficits in communication post release. They have found that the pregnant women released into their care consistently have no health insurance nor is there a plan for a continuum of care once they are in the community. They are basically left to fend for themselves. Even further, the Department of Corrections does not give women information related to their medical history or care while in custody.

Maternal health and morbidity are extremely important topics that need to be discussed and we cannot forget about the pregnant women society hides from us behind bars. We need better systems in place to ensure they have the highest quality of care and ultimately create diversion programs so no pregnant women ever have to suffer the horrors of Rikers Island. Before I finish I ask the council to implore the Board of Corrections and Department of Corrections to create a system of transparency and accountability for the people in their custody. Thank you for your time today, I appreciate the chance to testify.

Submitted to NYC City Council
Submitted by: Nzingha Tyehemba
Date of Submission: 12/10/20

Below Resources Found Here: https://www.thetaskforce.org/reproductive-justice.html

QUEERING REPRODUCTIVE HEALTH, RIGHTS & JUSTICE

The National LGBTQ Task Force recognizes that everyone has a fundamental right to sexual and bodily autonomy, which includes the right to decide whether or when to become a parent, parent the children we have, and to do so with dignity and free from violence and discrimination. We support the reproductive health, rights, and justice ("repro*") movements because LGBTQ people need access to reproductive healthcare and services, but we continue to face pervasive discrimination designed to block recognition of our identities and relationships and to hinder our ability to access the healthcare we need, including gender-affirming care and sexual and reproductive healthcare.

LGBTQ people need access to reproductive health care, including contraception, abortion, assisted reproductive services, HIV care, pregnancy care, parenting resources, and more. Although many people talk about reproductive health as a "women's issue," many LGBTQ people—including lesbian and bisexual women, transgender men, two-spirit, intersex, nonbinary and gender non-conforming individuals—can get pregnant, use birth control, have abortions, carry pregnancies, and become parents.

Further, our hard won legal rights as LGBTQ and reproductive rights movements have long been intertwined through Supreme Court decisions dating back over 40 years. From Roe v. Wade to the Supreme Court's 2015 marriage decision, our ability to live our lives fully and to not be discriminated against are dependent on each other's mutual progress.

We also have the same opposition. Controlling sexuality and gender expression usually share an agenda with controlling reproductive choices. Most recently, our opponents have been using religion and "conscience" as a guise for discrimination against LGBTQ people and people seeking access to reproductive health services.

RESOURCES

- **Final Healthcare Conscience Rule FAQ**
- **Reproductive Justice Glossary of Terms**
- **Queer- and Trans-Inclusive Sex Education [PDF]**
- **Queering Reproductive Justice Toolkit [PDF]**
- **Queering Reproductive Justice – A Mini Toolkit [PDF]**

Testimony in Support of T2020-6888 Oversight-Maternal Mortality and Morbidity in NYC

Submitted By: Patricia Davis, MSN, RN, AGACNP-BC

December 9, 2020

Greetings Chair Rosenthal, Chair Rivera, Chair Levine and Council Members. My name is Patricia Davis, I am a Bronx Resident, and an Acute Care Nurse Practitioner working in Pulmonary Medicine at Montefiore Medical Center in the Bronx.

It is my pleasure to share testimony to the NYC Council Committees on Health, Hospitals and Women & Gender Equity in support of Maternal Mortality and Morbidity in NYC.

I don't work in maternity or pediatrics but as a Nurse Practitioner I provide care for Black and Brown pregnant women who have expressed real concern regarding their health and the quality of care that they are receiving during their pregnancy and delivery. These women are often marginalized and made to feel that they don't have a voice when it comes to their own health. The health disparities that exist among pregnant women of color and whites is a leading cause of poor outcomes, morbidity and mortality.

The harsh reality of this issue came to me firsthand when a close friend called me frantic and crying as she shared that her brother's wife had died shortly after giving birth. Her sister-in-law knew something was wrong and tried to inform the providers, but they dismissed her complaints as normal post-labor pains and bleeding. This was her fourth child, so she knew what was normal and she and her husband desperately pleaded with them to do something. Within a few hours the bleeding progressed and could not be controlled and just a few hours after giving birth she died. Her husband was left to care for his first child and her remaining three children on his own. Their nightmare still lives on.

I was so moved by this story that when I was given the opportunity to write about health disparities through an assignment in my Doctoral program at Duke University School of Nursing I immediately chose to write about Black maternal health. The Op-ed essay was recently published in the Bronx Times and since that time so many women have reached out to me showing such strength while they shared their stories. I've heard stories of improper treatment and care during and after pregnancy, disrespectful providers who have belittled women during visits and even during delivery, lack of access to good competent providers, and lack of access to doulas and midwives due to insurance or lack of knowledge on how to obtain these services. According to the Centers for Disease Control and Prevention (CDC) the majority of maternal deaths are preventable, meaning if there was some change made relating to the provider, facility, or health care system the deaths could have been averted. As I mentioned in my Op-ed essay, Black women are three to four times more likely to die from pregnancy-related causes than white women. These numbers are alarming especially for the women who live in underserved communities in NYC who have limited access to quality healthcare.

I support Int 2042-2020 as it is important for pregnant women to have the ability to choose and make informed decisions about the provider they want to entrust with the care and delivery of their child. Information on how to access midwives need to be posted online.

I support Res 1239-2020 making doulas accessible to all individuals but especially those women with Medicaid or lack health insurance because they deserve the same birthing options.

I support Res 1408-2020 because it is pertinent to the health of women of color to have midwifery birth centers that are in their communities that provide support and person-centered care. Particularly during this pandemic it is even more important to have birth workers like midwives who can provide prenatal, birth, and postpartum care for women who may be too afraid to be in a hospital.

I urge you to recognize that Black maternal mortality and morbidity is a public health crisis created from years of structural and systematic racism in our health care system. It is time to change the system and create a system that is equitable for all.

I thank you for allowing me the opportunity to submit my testimony.

I would like to thank Council Member Vanessa L. Gibson's office for reading my article and inviting me to the hearing.

Thank you,

Patricia Davis, MSN, RN, AGACNP-BC

My spouse & mother of my son Amber Rose Isaac passed April 21st at 12:36 am at montefiore einstein in the Bronx.

Amber and I found out that we were having a baby on Septemer 27th 2019, we were excited and ready to become a family and had planned this pregnancy months in advance.

Our first appointment visit with Amber's OB/GYN at Montefiore Moses was an unsettling one and drained the excitement out of the pregnancy. I remember feeling judged after leaving the appointment whenever the Dr found out that we were unmarried and having a child. Amber had known her OB/GYN since she felt she was going to be in safe hands especially being a first time mother. In due time we found that Ambers OB/GYN's prenatal care was not the best standard of care and even received mistreatment from other staff members around Montefiore

Amber complained of lack of communication from the Doctors office from the beginning of her pregnancy. Amber had to get her mother involved on numerous occasions, her mother being a long term colleague of Montefior's for 25 years. Amber's mother called the doctor's office twice to speak to the manager for her daughter having to take time from work to go to a scheduled appointment and when she gets there they tell Amber she doesn't have an appointment scheduled. The second time Amber's mother called to inquire about changing Amber's doctor because we didn't like the things she said to Amber or her bedside manner. It was difficult to get someone else due to COVID and schedules were changing and telephonic appointments were being implemented.

As covid started to peek at the beginning of february Amber's conditioning had gotten worse and her health was starting to deteriorate as she was starting to feel pain in her buttocks and thighs as well as shortness of breath. Amber wanted to go on maternity leave a month earlier because of the strain on her body and her breathing, she was due May 30th and wanted to leave in April. Amber was an Early Life head teacher and could not leave until the school officially shut down. Parents were sending their sick children to school without a doctors note and the school would allow this because they were losing out on money. Amber had sick toddlers coughing on her, sneezing on her, rub saliva on her. With her breathing conditions she still had to pick children up and sometimes have to carry them upstairs in between shifts which the children would kick her in her stomach as she is pregnant & having troubles breathing. She voiced her concerns to her OBGYN on why she should leave in April instead of May when her OB tells her that she has pregnant assistants in the office working so what's the difference with them coming to work and her going to work. (totally inappropriate physicians should check why patients have symptoms not give their personal opinion on someones workload) Amber was working and was in school for her Masters during her pregnancy). Meanwhile there are white counterparts whom are on early medical leave & are due after Amber.

The OBGYN filled out the FMLA papers but Amber job rejected the early leave because there was not medical or clinical issue described on why the early leave was necessary and stated that Amber wanted to leave for personal reasons. Amber went back to the OBGYN for a re-submit. The OBGYN told Amber that she would need to go see a high risk doctor to fill out the FMLA papers if she wanted to leave early. We were only appointed to a high risk Doctor for that reason (not due to her platelets nor health deterioration).

Amber went back in March and was seen by a different OBGYN. The doctor noticed that Ambers iron was low and prescribed iron pills 2 times a day and also prescribed a blood pressure monitor and a thermometer for the upcoming telephonic or zoom appointments.

After facing so much neglect from the Doctors & the telehealth program we decided that we wanted to hire Midwives and Doulas instead, people that were going to be more attentive to Ambers needs. On April 3rd our Midwife had viewed Amber's medical records from the previous visits with her OBGYN that Amber's platelets were dropping without her knowledge since December 2019. The Midwife was confused as to why Amber was not being seen which then Amber was denied access to a homebirth & birthing center due to Amber becoming High Risk.

Then we had to find another High Risk Doctor so we went to her mothers job switching over to Montefiore Einstein where they said we would be taken care of.

Amber did not get to see the High Risk OBGYN due to the first appointment being canceled by the Dr. There was a subsequent appointment by phone but not orders for blood given until April 10th, 2020. After receiving those results the Dr. calls Amber and tells her that her platelets are still dropping and that she was concerned about her liver enzymes as well. The Dr. told Amber to go the following on April 17 to take blood work. We went to the lab to take blood on April 17 and the orders were not in the system. Amber

called the Doctors office to let them know, The staff tried to locate the OBGYN or another physician to call or input the order. Amber waited 2 hours and nothing was done. She went back home. I was indignant and called someone higher up to complain about The OBGYB's neglect as well as the High Risk Doctor. A few minutes after the call, Amber received a call from the High Risk Doctor apologizing and said she doesn't know why it wasn't in the system and doesn't know why the lab staff didn't call her,. She gave Amber her personal cell and instructed her to go back to the lab that early evening. Very early on Saturday, April 18, 2020, Amber received a call from The High Risk Doctor telling her to go the Einstein, 6South for treatment of her platelets. We did not know if this would be a short visit or an overnight. It turned out to be an extended stay until the day she died on April 21, @ 12:34AM.

She was being treated with Prednisone on that Saturday and Sunday along with Fetal Monitoring. The baby was doing well at 34 weeks. Amber was not feeling sickly. Amber was test twice for COVID during her stay and both results were negative, The director, Dr. Peter Bernstein told staff that she should be treated as if she has COVID. (I don't know if that was a precaution to make sure everyone had PPE, however, it was traumatic to Amber). She felt alone and scared.

Monday, April 20, we received a call from another Doctor who was at the bedside of Amber. Amber wanted the doctor to include Amber's mother on their plan of action. The Doctors stated that the treatment for the last 2 days was not working and that they were planning to induce her. She said that they expected it to be a day long of inducement since the baby is premature. I asked why is Ambers platelets dropping is it ITP. She said no its not Thrombopytocenia, she checked Amber blood history from early childhood to now and not record of that. She said it was HELLP Syndrome and the lowering stops once the baby is delivered.

They didn't know that Amber had Hellp Syndrome this whole time & they had plenty of time to treat her condition which they did not. They wanted to perform an emergency C-Section although the baby was not in distress. Amber's heart had stopped as soon as they cut her open and she died with no family around. Now my son has to grow up without his mother for the rest of his life because people wanted to sign off on her paperwork as her health deteriorated & they didn't want to do their jobs.

12/7/20

I am Nonkululeko Tyehemba, a certified nurse midwife and I am one of the founders of the Harlem Birth Action Committee.

In 1989, our organization was founded because of our concern with the high infant mortality rates that existed in our community as well as the high rates of late or no prenatal care for expectant parents. In the 1990s, we became an intimate part of the perinatal networks that led to the Healthy Start program, which vigorously fought to reduce this health crisis to some success. In the last twenty years though, the rate of maternal mortality--mothers dying--has reached pronounced and egregious levels in our community and in our city.

This year alone, for in NYC, at least four to five known healthy black mothers have died before birth or shortly after birth of pregnancy/childbirth related complications. We can only guess about the number of unknown mothers who have died or developed some preventable complication. Despite education or socioeconomic status, black parents are dying during childbirth. When tennis champion Serena Williams spoke out about the medical emergency she endured after the birth of her child in 2017 (which could have led to her death) she sparked a long overdue debate about the dismal rate of maternal death and injury in the United States as well as the way Black women and people of color bear the brunt of subpar care. We know that institutional and structural racism are largely responsible for this state of affairs.

Studies have indicated that over sixty percent of these tragedies did not have to occur. Many investigators are stating that some of these extremely harmful results happen because birthing mothers and their families are not being heard. Black women are the least listened to and it is costing them their lives in an unprecedented fashion. Dr. Teleki, in a 2018 article in the New York Times, states that "the problem is not that pregnant people are uneducated or uninformed, the problem is that those in charge are not listening to them."

At the same time the rates of defensive obstetrical interventions that lead to a cascade of operative events has increased astronomically. For example, one out of every three women are having unnecessary c-sections despite guidelines by the World Health Organizations that the rate should be no more than fifteen percent--nationwide we're at thirty-five percent. Over 90% of first-time mothers have episiotomies that a large number do not need. Let's not mention the extraordinary number of women having epidurals that could have been managed differently.

We have proposed a BETTER BIRTHS BLOCK X BLOCK | B5 ReproJustice Health Model to directly reach our community district block by block. In collaboration with other reproductive & reprojustice health organizations, the B5 Health Model will benefit black parents in Community District 10 by ensuring their:

- **understanding of all aspects of the childbirth experience**
- **familiarizing themselves with the danger signs of pregnancy;**
- **increasing their access to maternal healthcare;**

- **reclaiming their humanity, dignity, self-empowerment, self-advocacy, self-determination during the entire childbirth experience; and utilizing tools to monitor, manage, and stabilize stress and anxiety**

Moreover, we need a new paradigm of reproductive, justice based healthcare. We need to increase the number of midwives attending low-risk mothers. We need to demand more midwives in our hospitals. Some hospitals do not have any in midwives, i.e Harlem Hospital, Lincoln Hospital et al. We need to emphasize, prioritize, and educate more Black midwives to care for low-risk birthing mothers particularly in midwifery deserts. Midwives are educated to focus on the physiological management of birthing; in general doctors are trained in defensive management We need to adopt a model of care where midwives are prioritized for low-risk mothers and parents. Despite the New York State Governor's Task Force on Maternal Morbidity and Mortality;the tragedies of mothers dying of pregnancy-related complications in the richest country in the industrialized world continue. If midwives are good for the Royal family of England, they should be good enough for the families in the United States!

New York City Council Hospitals Committee Hearing on Maternal Mortality

Testimony of Patricia O. Loftman, CNM, LM, MS, FACNM
cnm788@msn.com
December 7, 2020

Greetings,

Thank you for this opportunity to provide testimony before the Hospitals Committee on Maternal Morbidity and Mortality.

My name is Patricia Loftman. I am a Certified Nurse Midwife, Fellow of the American College of Nurse Midwives and former Harlem Hospital Center Midwifery Service Director from 1984-1999. I graduated from Columbia University Graduate School of Nursing with a specialty in midwifery in 1981. I practiced full scope midwifery caring for women for three decades. I retired from clinical midwifery in 2010.

The American Public Health Association (APHA) identified racism as a Public Health Issue and described how racism affected public health and health disparities. Racism is the power to control the distribution of money, power and resources and the differential access to goods, services, and opportunities based on race at the global, national, and local levels. [1] Structural, institutional racism is the foundation from which social determinants of health emanates and accounts for persistent health inequities. Social determinants of health are "the condition in which people are born, grow, work, live, age, and the wider set of forces and systems shaping the conditions of their daily life." [2]

Maternal mortality is a consequence of social determinants of health more than health behaviors and clinical care. [3] Historically, women at risk for a poor pregnancy outcome were characterized as those with no prenatal care, low income, low literacy, engaging in unhealthy behaviors such as tobacco, alcohol and/or illegal drug use, exposed to intimate partner violence and having mental health challenges. Although socioeconomic factors and individual behaviors contribute to negative birth outcomes, evidence supports that when controlling for these factors, racism and personal experiences of discriminatory events play an even greater role in poor birth outcomes including maternal mortality. [1] The 1992 sentinel study by Schoendorf, Hogue, Kleinman, and Rowley (1992) published in the New England Journal of Medicine demonstrated that being a college educated, middle class African American woman was not protective against poor birth outcomes (Schoendorf et al, 1992). [1] This disparity was reaffirmed in 2019. [4]

What is important for this committee to understand is that maternal mortality is a process that begins long before a woman becomes pregnant. The vascular changes that contribute to maternal mortality begins in utero traveling a life course that builds and accumulates with each experience and stress of daily living of being Black, Latinx and Indigenous. Invisible, yet present, these life experiences and stressors create cellular DNA changes that results in the vascular changes that predisposes Black women to poor pregnancy outcomes including maternal mortality. Black women in the United States are three to four times more likely and Indigenous women are more than twice as likely to die from a pregnancy-related complication as white women. [4] The COVID-19 pandemic only exacerbated these inequities. [5]

Strategies to address maternal mortality for Black and Indigenous women requires a systems-wide approach that addresses factors related to access to care and the quality of that care. [6] For example,

evidence documents that Black and Latinx women, in New York City, experienced a higher risk for severe maternal morbidity compared with white women within the same hospital even after controlling for patient, insurance and hospital characteristics. [7] One strategy to promote access to care is supporting increased racial and ethnic diversity in the maternity health workforce. Delivering health care encompasses two elements. The first element centers on the relationship between the provider and the woman. The second element centers on the provider quality. Does the provider possess the most current medical information and technical skill to render high quality, evidence-based health care? While both elements are critical, the more important of the two is the provider-woman relationship. Women must be motivated to enter and remain in the health care system to avail herself of the available medical services. Race concordant care has been associated with strengthened patient-provider relationship. Further, a growing body of evidence suggests better outcomes for individuals cared for by race concordant providers. [1] [8] [9] [10]

What is the value and significance of race concordant care?

- Individuals report a preference for race concordant providers.
- Race concordant providers usually reside in the community and possess shared experiences of daily life, language, values, customs and cultural norms.
- Individuals report feeling more connected and comfortable, respect and trust, satisfaction and confidence with race concordant providers.
- As a result, individuals demonstrate increased adherence with appointments and treatment plans and increased retention in the health care system.
- Individuals report negative attitudes about providers from other racial/ethnic groups reflecting internalization of broader issues around societal racism. [1] [10] [11]

Evidence based, outcomes data is lacking about race concordant care provided by Black, Latinx and Indigenous midwives to Black, Latinx and Indigenous women. The sparse evidence that does exist documented that 13 percent of Black women reported that they were treated poorly, in hospitals, during their last childbirth because of race, ethnicity, language, or cultural background. [12] As a result, 25 percent of Black women reported that they would be willing to consider a home birth for their next pregnancy. [13] According to The American College of Nurse Midwives (ACNM), there are approximately 12,907 Certified Nurse-Midwives and 117 Certified Midwives as of August 2020. Black, Latinx and Indigenous midwives represent 13 percent for a national total of 1660. [14] There are approximately 1000 Licensed Midwives in New York State the bulk of whom are in New York City and who are not Black, Latinx or Indigenous. This statistic precludes most Black, Latinx and Indigenous women, including pregnant and childbearing women, from ever being cared for by a race concordant midwife.

I was privileged, during my thirty (30) years practicing midwifery at Harlem Hospital Center, to participate in two clinical projects rendering women's health care. One was in Harlem Hospital focusing on pregnant drug using women. The second was located outside of Harlem Hospital in a community-based health center focused on women's health care across the life span. However, the unique characteristic of both clinical sites was that they were completely staffed by Black providers in all disciplines represented- Internal Medicine, OB/GYN and Pediatrics. Both sites experienced high attendance rates with low no show rates demonstrating high patient satisfaction as a recurring theme verbalized by Black, Latinx and Indigenous patients is receiving disrespectful, unsatisfying care. [13]

In conclusion, the conventional strategy to address maternal mortality has been to focus on the maternity cycle from preconception care to one-year post-partum. However, the most effective strategy would be to focus on rendering preventive women's health care long before pregnancy. Ideally, women

should enter the maternity cycle healthy. This results from health promotion and maintenance activities that begins in adolescence and continues through the reproductive years. Healthy women have healthy babies. Post pregnancy, women should return to their health promotion and maintenance providers. Focusing solely on the maternity cycle precludes the opportunity to stabilize and control chronic conditions that are associated with poor outcomes. In the end, however, only by intentionally addressing structural and institutional racism can health equity be achieved and maternal mortality be eliminated. [15] [16]

Black, Latinx and Indigenous women should not die just because they want to experience motherhood.

Thank You.

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LaShanda Dandrich, IBCLC

Uptown Village Cooperative

December 8, 2020

To Whom It May Concern,

My name is LaShanda Dandrich. I am a postpartum doula and IBCLC, International Board Certified Lactation Consultant. I work in many different community settings in NYC providing education and support to new families prenatally and postpartum.

I also volunteer on the Chocolate Milk Café National Board as the Director of Facilitators. Chocolate Milk Café offers peer to peer support and guidance to families that identify of the African Diaspora. The organization promotes the education of providing human milk to infants and children. We encourage both pregnant and postpartum individuals to attend. Our groups offer support and guidance on not only infant feeding but all things that support a healthy pregnancy and early postpartum.

The groups are free and accessible to many families that are not able to afford doula care prenatally or postpartum. As well as not having access to lactation education and support. As a lactation consultant I work closely with my doula colleagues to help families get the best continuity of care and follow up postpartum. I also teach many doulas how to help families get breast/chest feeding off to a good start, as the doula is the first in the home in the first few days, sometimes weeks in the postpartum period.

Having access to doula care prenatally and postpartum has been proven to positively effect the birth and postpartum outcomes not only for the birthing person but also for infants.

I urge the committee to support R1239-2020 and grant Doula Access for Medicaid and those uninsured.

Thank You,

LaShanda Dandrich, IBCLC

Testimony on Res. No. 1239

I submit this testimony as a birth, postpartum, and full spectrum doula who serves the New York City area, a city where only 6% of births are attended by doulas. The need to make doulas accessible has always been of utmost importance but in the face of the COVID-19 pandemic, it is shown that doulas have become essential to birthing people and their families. With nursing staffs overworked due to the pandemic, doulas are able to provide continuous physical support throughout labor that nurses may be unable to provide. Doula care must be covered under private insurance and Medicaid policies as a necessary measure to reduce the rates of maternal mortality, infant mortality, unplanned c-sections, and medically unnecessary inductions which often lead to c-sections, which disproportionately affect Black birthing people and other birthing people of color.

This policy must be crafted realistically with the needs of the doula in mind as well as the needs of the patients. Doulas do not simply show up for birth. We build a relationship with our clients over time, helping them prepare for labor through education, referrals, and other resources. A doula's fee normally includes: two prenatal visits, unlimited virtual support throughout pregnancy, 24/7 on-call support starting weeks before the client's due date, an average of 12-18 hours of labor support, and one postpartum visit, with many doulas offering even more services and support that is within their professional scope. The average price of an experienced doula in New York City is $1,550 so I implore that this resolution specify that insurance companies and Medicaid reimburse doulas up to $1,550 as this will cover a wide range of experience levels. Doulas are highly-skilled, trained professionals who provide an essential service and we must be compensated accordingly.

It is also important that this resolution does not exclude doulas who are not certified because the standard of certification is not universal nor equivalent to licensing. When hospitals require that doulas must be "certified" they exclude even the most experienced doulas without certification and professionally trained doulas who chose not to certify or who have yet to certify. This further excludes lower-income clients from receiving doula care in the hospital system because lower-income clients are more likely to hire a trained doula who is working to certify who will often work pro bono or with lower rates. If this language requires certification, we will eventually see a complete decline in the number of certified doulas since most certification programs require trained doulas to attend a minimum number of births to certify. That decline will eventually result in higher cesarean rates and higher maternal mortality. I'd like to propose that the language use the word "trained" when speaking about doulas who must be permitted to attend births in hospitals. It is also imperative that nursing staff be advised of these policies so trained doulas are no longer barred from providing an essential and sometimes life saving service to our clients.