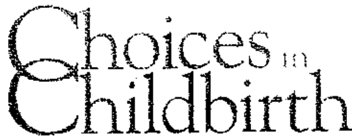


Statement by Elan McAllister, President of Choices in Childbirth
Maternal and Infant Health in New York City
Hearings by the New York City Council
Health and Women's Issues Committees
February 7, 2008

My name is Élan McAllister and I am a labor doula in New York City and the President and Co-Founder of Choices in Childbirth, a NYC-based consumer advocacy group that educates the public about birthing women's rights and options.

I'd like to start off by giving you some background on the journey that brought me here today because I think that it will shed some light on current issues in maternity care in New York City as well as stress the importance of Intro No. 575.

In the year 2000 I started working as a labor doula. For those of you who are not familiar with that term, a doula is someone who acts as a support person for a birthing woman and her family. In this capacity I provided my clients with evidence based information during the prenatal period as well as emotional and physical support during labor and birth. As a doula I never offered medical advice or acted as a patient advocate, both of these roles go beyond the scope of doula practice. I encouraged my clients to become educated so that they were aware of their options, confident in their choices and prepared to advocate for themselves if need be.

During my first four years as a labor doula from 2000 to 2004, I witnessed a major shift in maternity care. I saw the trend alter in favor of a more medical model of birth with marked increases in procedures and interventions. It became increasingly difficult for my clients to have the birth experiences that they wanted and expected. I have included a chart of Cesarean statistics during these years in my written testimony. You will see that from 2000-2005 Cesarean rates increased by 25% city wide. We currently have hospitals with cesarean section rates between 40 and 50%. This despite the fact that The World Health Organization recommends a safe Cesarean section rate of between 5 and 10%

with a ceiling of 15%. Currently, no hospital in New York City falls within that safe range.

In 2004 my colleagues and I founded Choices in Childbirth because we believed that women were not getting the information they needed to make fully informed maternity care decisions. We felt that the public had the right to know what to expect from the maternity care system and that making hospital intervention rates publicly accessible was an important step toward improving transparency in maternity care.

We were surprised to learn about The Maternity Information Act which had been passed 15 years earlier but had clearly been forgotten. It became our mission to make sure that the MIA was enforced. To that end we contacted the New York State Department of Health and requested obstetric intervention data for all hospitals in the state. It took some time and convincing but we eventually received data that was more than 2 years old but fairly complete. Until recently, our website was the only place that consumers could go to access this data. Next, Choices in Childbirth volunteers began touring hospitals and requesting a written copy of intervention rates at the end of the tour. Not only did all of the hospitals that we visited fail to produce the copy, many volunteers were told that they were not allowed access to that type of information because it violated patient privacy laws. Volunteers recorded these instances but we were unsure, as a group, how to best use this information until we were contacted by a member of the Public Advocate's office.

In 2005 and 2006 Choices in Childbirth worked with the Public Advocate for the City of New York to investigate the compliance rate of the hospitals in New York City with the Maternity Information Act. In both years we found a 0% compliance rate in all 44 hospitals. In 2007 The Public Advocates Office went on to launch a campaign geared towards educating hospital administration and staff about the Maternity Information Act and the need for all hospitals to provide the public with the relevant information. As a result of these efforts, by summer of 2007 all 44 hospitals could produce a pamphlet with the required information. We share the Public Advocates concern, however, that the pamphlets are only being disseminated upon request. The Maternity Information Act states that hospitals **must provide a copy to every prospective maternity care patient**. The vast majority of women do not even know that this information is available and therefore would never request it. This law was intended to bring about a greater

level of transparency in maternity care and it cannot achieve its objective if the people who need this information are unlikely to receive it.

And women do need this information. One of the most determinant factors in the outcome of a woman's birth experience is where she chooses to give birth. Hospital policies and protocols have a direct and dramatic effect on the course of labor and delivery. Labor that is heavily managed leads to higher cesarean section rates. If provided with information, a low-risk woman who wants to avoid unnecessary interventions may choose not to birth at a hospital like Columbia University Medical Center which has a Cesarean section rate of almost 40% or St. Vincent's Hospital on Staten Island with its rate of 45%. Those odds might not be good enough for her. A lack of access to information may lead her to a situation where she experiences care that is not in line with her expectations or wishes.

With the proposed bill, Intro No. 575, the Public Advocates office is once again working to ensure access to relevant hospital intervention data. While we fully support this effort we feel that there are two areas that need to be addressed in order for this bill to be more effective.

First, we would like to see language included in the bill that puts facility intervention rates, specifically cesarean section rates, into a proper context. While including data from all 44 hospitals in one pamphlet is extremely useful to a potential consumer, further comparisons can be drawn if state and national levels are also listed. Presenting these rates will better ensure that the consumer is able to make a more informed choice. Ideally, we would also like to see language included that highlights the WHO's recommended c-section levels. Our sky high rates are not in keeping with international standards or the best medical research available and the public, especially childbearing women, should know that.

Second, we need to make sure that these pamphlets are actually being disseminated to the public. Therefore, there needs to be a mechanism within the bill that clearly states that the pamphlets will be actively distributed and find their way into the hands of birthing women.

If the objectives outlined in Intro No. 575 and those stated above are achieved we will then have the unique ability in New York State to create a higher level of transparency in maternity care. This is a goal that we should all aspire to. In its 2001 report, the Institute of Medicine (IOM) identified transparency in our health

care system as one of the ten steps necessary to overall system improvement. It stated that:

> "Health systems must be accountable to the public; to do their work openly; to make their results known to the public and professionals alike; and to build trust through disclosure, even of the system's own problems. All information {should} flow freely so that anyone involved in the system, including patients and families, can make the most informed choices and know at any time whatever facts may be relevant to a patient's decision making."[1]

We have the opportunity, with Intro No. 575 to improve the quality of maternity care in New York City and to empower the public so that women can make informed choices regarding their own health care. We at Choices in Childbirth hope that you will recognize the importance of this opportunity and will endorse this bill.

[1] Crossing the Quality Chasm, 2001, Institute of Medicine

Choices in Childbirth

HELPING WOMEN MAKE INFORMED MATERNITY CARE DECISIONS

NEW YORK CITY HOSPITALS CESAREAN SECTION RATES 2000-2005

The World Health Organization recommends that the cesarean section rate for industrialized nations should not exceed 15%. A safe range, as determined by WHO experts, is ***10-15%.***

Borough	Hospital	2000	2001	2002	2003	2004	2005*
MANHATTAN	New York Downtown Hospital	11.1 %	13.5 %	13.3 %	14.2 %	18.4 %	18.8 %
	Women's Hospital	26.2 %	23.4 %	22.6 %	21.7 %	23.6 %	23.8 %
	Roosevelt Hospital	28.7 %	25.9 %	27.0 %	25.9 %	26.7 %	25.0 %
	Bellevue Hospital	18.4 %	18.5 %	19.8 %	20.9 %	22.6 %	25.2 %
	Harlem Hospital Center	23.0 %	19.5 %	24.9 %	22.0 %	23.1 %	26.1 %
	Beth Israel Hospital	24.0 %	24.3 %	22.4 %	23.4 %	26.1 %	27.7 %
	Lenox Hill Hospital	29.8 %	29.1 %	31.5 %	31.7 %	33.1 %	28.0 %
	Metropolitan Hospital	25.3 %	24.6 %	22.8 %	22.5 %	23.8 %	28.1 %
	St. Vincent's Hospital	24.9 %	25.3 %	26.1 %	25.6 %	29.3 %	28.3 %
	Mount Sinai Hospital	23.7 %	27.8 %	26.9 %	28.4 %	29.3 %	29.7 %
	New York Univ. Medical Center	25.6 %	25.9 %	26.4 %	28.3 %	29.9 %	32.0 %
	NY-Presbyterian Hosp./The Allen Pavilion	22.9 %	24.3 %	28.0 %	27.9 %	29.8 %	32.3 %
	NY-Presbyterian Hosp./Weill Cornell Med. Ctr.	29.2 %	32.0 %	35.7 %	37.3 %	39.6 %	37.8 %
	NY-Presbyterian Hosp./Columbia U. Med. Ctr.	28.3 %	31.9 %	33.8 %	34.8 %	37.1 %	38.9 %
QUEENS	City Hospital Center at Elmhurst	19.8 %	22.2 %	21.3 %	23.1 %	24.2 %	23.3 %
	Queens Center Hospital	18.5 %	19.9 %	20.0 %	22.1 %	24.7 %	23.4 %
	Jamaica Hospital	28.1 %	24.9 %	25.3 %	25.8 %	28.8 %	29.6 %
	LaGuardia Hospital	34.5 %	32.3 %	28.9 %	32.2 %	28.0 %	31.0 %
	New York Hosp./Med. Center of Queens	25.3 %	26.5 %	28.1 %	28.2 %	30.5 %	31.8 %
	St. John's Episcopal Hospital	25.2 %	28.6 %	24.8 %	31.9 %	31.4 %	34.3 %
	Long Island Jewish Medical Center	27.4 %	28.9 %	29.4 %	30.6 %	33.5 %	35.1 %
	St. John's Queens Hospital	23.4 %	28.8 %	31.7 %	32.0 %	34.5 %	37.1 %
	Flushing Hospital/Medical Center	30.7 %	32.9 %	33.4 %	35.6 %	37.0 %	38.8 %
BROOKLYN	Maimonides Medical Center	14.9 %	17.5 %	18.9 %	19.1 %	18.7 %	20.3 %
	Wyckoff Heights Hospital	24.2 %	21.3 %	28.1 %	25.7 %	27.6 %	25.8 %
	Kings County Hospital	21.2 %	20.5 %	23.0 %	23.1 %	27.5 %	27.0 %
	Coney Island Hospital	19.7 %	18.0 %	24.1 %	27.1 %	26.9 %	27.3 %
	Lutheran Medical Center	24.6 %	25.9 %	27.1 %	25.6 %	27.4 %	27.9 %
	Woodhull Hospital	24.2 %	25.0 %	27.9 %	29.5 %	31.5 %	29.7 %
	Brookdale Hospital Medical Center	24.1 %	24.2 %	26.4 %	25.8 %	26.4 %	30.2 %
	Victory Memorial Hospital	32.6 %	33.2 %	37.4 %	28.6 %	36.2 %	31.9 %
	University Hospital Of Brooklyn	26.4 %	24.8 %	26.2 %	29.2 %	32.6 %	33.5 %
	Long Island College Hospital	31.1 %	30.4 %	28.2 %	29.5 %	32.2 %	34.0 %
	Brooklyn Hospital	29.6 %	29.8 %	32.9 %	34.8 %	38.5 %	34.1 %
	Methodist Hospital	28.5 %	28.1 %	32.0 %	33.7 %	34.8 %	38.0 %
BRONX	North Central Bronx Hospital	17.4 %	17.3 %	16.3 %	21.4 %	18.3 %	17.3 %
	St. Barnabas Hospital	20.1 %	19.6 %	21.3 %	23.4 %	24.7 %	23.9 %
	Jacobi Hospital	14.1 %	16.4 %	18.1 %	19.4 %	21.6 %	25.4 %
	Lincoln Hospital	22.6 %	24.2 %	22.7 %	22.6 %	22.4 %	26.3 %
	Bronx Lebanon Hospital	23.8 %	25.1 %	26.8 %	28.2 %	28.0 %	28.3 %
	Our Lady of Mercy Medical Center	24.1 %	18.3 %	9.7 %	18.0 %	28.2 %	29.0 %
	Weiler Hospital	21.0 %	24.0 %	22.7 %	23.7 %	29.3 %	31.8 %
STATEN ISLAND	Staten Island University Hospital	22.3 %	22.3 %	22.0 %	22.0 %	23.0 %	22.8 %
	St. Vincent's Hospital	34.7 %	35.5 %	37.1 %	35.6 %	39.5 %	44.6 %

*Latest statistics available from the New York State Department of Health.

Maureen Corry
Executive Director
Childbirth Connection

Testimony at
The Council of the City of New York
Oversight Hearing: Maternal and Newborn Health in New York City

Int. No. 575- In relation to requiring the Department of Health and Mental Hygiene to post on its website in a user-friendly format and disseminate certain information mandated by the Maternity Information Act of 1989 (New York State Public Health Law §2803-j).

Thursday, February 7, 2008
10:00am, Committee Room, City Hall

Thank you. I am pleased to represent Childbirth Connection (formerly Maternity Center Association) at this important oversight hearing, to lend our support to this law that would require the Department of Health and Mental Hygiene to post, on its website, maternity information as mandated by the Maternity Information Act. Childbirth Connection is a 90 year-old national non-profit located in New York City. Our mission is to improve the quality of maternity care through research, education, advocacy and policy.

Leaders throughout the health care system recognize the importance of making performance transparent, so that consumers can make wise choices, purchasers can understand whether they are getting good value for their considerable investments, and facilities and caregivers can improve their performance. The proposed legislation would increase transparency for the large and vulnerable population of childbearing women and newborns.

A couple of years ago, I stood outside of Lenox Hill Hospital with the New York City Public Advocate, Betsy Gotbaum, participating in a news conference to call attention to New York City hospitals' noncompliance with the Maternity Information Act. It is important to note that, as a result of Ms.Gotbaum's investigation into this matter, all New

York City hospitals have produced a pamphlet containing the maternity information as required by law. However, we believe that this is not enough. If women do receive these pamphlets, it is usually after they have already chosen the hospital where they will give birth and have had little opportunity to compare that hospital's information with any other hospital. Moreover, the figures change annually, and pamphlets quickly become outdated. By posting this information on the DOH's website, women will have direct and easy access to the most recent hospital statistics and will be able to compare hospitals and make a much more informed decision about where to have their baby. While the New York State Department of Health has most, but not all, of this information on their website, the information is very difficult to obtain, as it is not posted clearly on the site and one must click on several pages to find it. Additionally, when we called the State DOH last week and asked the operator if this information was posted on the website, the operator said that it was not, and therefore could not guide us to the information.

It is essential that all women who plan to give birth in NYC hospitals understand what is at stake in their decisions about how to give birth and have the information they need to make informed decisions. According to the New York State Department of Health, the c section rate in New York has climbed to 31.7%. In New York City, the 2005 c section rates vary widely across hospitals. North Central Bronx Hospital has the lowest rate in the city- 17.3%. Columbia University Medical Center has a 38.9% c section rate and St. Vincent's Hospital on Staten Island has a staggering 44.6% c section rate! It is important for women to understand that their likelihood of having a cesarean, an episiotomy and other childbirth procedures, and their access to vaginal birth after cesarean is greatly affected by the facility where they give birth.

In 2004 Childbirth Connection conducted a systematic review of best research comparing over 50 outcomes of vaginal and cesarean births and concluded: without a compelling and well-supported reason for cesarean section, vaginal birth is likely to be the safest way for women to give birth and babies to be born.

As the cesarean section rate in the U.S. continues to rise, so does the research showing that mothers and babies frequently pay a high price for this surgery. The short and long-term risks for mothers and babies of cesarean section versus vaginal delivery are numerous. For example, mothers are at higher risk of maternal death, infection, rehospitalization, prolonged and intense pain and serious placental problems, uterine rupture and other adverse effects in future pregnancies. Risks for babies include a higher chance of being accidentally cut during the surgery, and a higher risk for asthma and not being breastfed. The best research continues to support more judicious use of cesarean section, yet rates continue to rise. Childbirth Connection produced this consumer booklet which summarizes the results of a systematic review on cesarean section- What Every Pregnant Woman Needs to Know About Cesarean Section. The booklet is freely available as a downloadable pdf on our website, **www.childbirthconnection.org**

Many factors are playing a role in the rising cesarean rate: pressure on caregivers to practice "defensive medicine", the failure of providers and hospitals to offer women with a prior cesarean the option of VBAC (vaginal birth after cesarean section), and the MYTH that a cesarean birth and especially a planned cesarean is "safe". Cesarean section always carries the risk of major abdominal surgery, and casual use of the surgery may place a mother and her baby in the way of considerable – and – avoidable harm.

Another popular MYTH is that women's requests for initial or primary cesareans without medical reason are driving up the c-section rate. We now have high quality data to refute this MYTH and talk about REALITY.

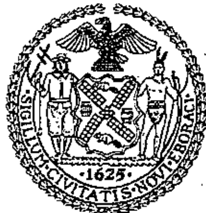
Childbirth Connection's landmark national *Listening to Mothers* survey of U.S. women's childbearing experiences conducted by Harris Interactive among women who gave birth in US hospitals in 2005, found that only one women of more than 1300 surveyed who might have chosen an initial or primary cesarean without medical reason actually did so. In addition, 25% of women who actually had a cesarean reported that they had experienced pressure from a health professional to have one. In addition, 42% of survey mothers felt that the current malpractice environment leads maternity care providers to

perform a cesarean section that is not really needed to avoid being sued. In an environment with increasing professional comfort with birth by major abdominal surgery, we need to provide women with the resources to make wise decisions on behalf of themselves and their babies.

It is also important to note that cesarean sections not only have tremendous physical and emotional costs, but financial costs as well. In 2005, the national average for hospital charges for an uncomplicated vaginal birth was $6, 973. For an uncomplicated cesarean section it was $12, 544, an increase of 80%. Many health care providers also receive higher payments for performing a cesarean. A recent study published in *Obstetrics and Gynecology* verified, once again, that VBACs are safe and should be encouraged. Given the health and financial costs of primary and repeat cesareans, it is important that women know where they can go to find providers who will support their desire to avoid an unnecessary cesarean section or to choose a VBAC.

Once again, we would like to thank Betsy Gotbaum and her staff for working diligently to get New York City hospitals to comply with the Maternity Information Act. We would also like to recognize the New York City Health and Hospitals Corporation for its continued promotion and support of breastfeeding, and its dedication to the creation of baby friendly hospitals in this city. While this piece of legislation is an important first step, we believe that more education and outreach programs- developed by community-based organizations and based upon the best available evidence- are necessary to fully ensure that women are aware of all of their childbearing options. Childbirth Connection will continue to work with the Public Advocate's Office to help ensure that the State and City Health departments and hospitals gather and provide accurate and up-to-date information to the public.

Thank you.



THE CITY OF NEW YORK
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Michael R. Bloomberg
Mayor

Thomas R. Frieden, M.D., M.P.H.
Commissioner

nyc.gov/health

Testimony
of
Deborah Kaplan, P.A., M.P.H.
Assistant Commissioner
Bureau of Maternal, Infant, and Reproductive Health
New York City Department of Health and Mental Hygiene

before the
New York City Council Committee on Health
regarding
General Oversight of Maternal and Newborn Health
and
Int. 575 (Public Advocate)
February 7, 2008

City Hall
Committee Room
New York, NY

Good morning Chairperson Rivera and Chairperson Sears and members of the Health and Women's Issues Committees. My name is Deborah Kaplan and I am the Assistant Commissioner of the Bureau of Maternal, Infant, and Reproductive Health at the Department of Health and Mental Hygiene (DOHMH). On behalf of the Department, I would like to thank you for the opportunity to provide testimony today regarding maternal and newborn health in New York City, as well as on Intro. 575, the proposed amendment to the administrative code to require that DOHMH to post certain maternity information on its website.

There has been progress in improving maternal and infant health in New York City. In 2006, NYC's overall infant mortality rate reached an all time low at 5.9 deaths per 1000 live births. With support from HHC, we made important strides in implementing policies to promote breastfeeding in hospitals and the workplace policies and expanding programs aimed at pregnant women and newborns, such as the Nurse-Family Partnership.

However, many challenges remain. Black infants continue to be twice as likely as white infants to die in the first year of life. And, though maternal deaths are rare, black women are four times more likely to die of a pregnancy related cause than white women. And even as breastfeeding is known to offer many health benefits for mothers and babies, too few women who initiate breastfeeding continue to breastfeed exclusively for the recommended duration. While the teen pregnancy rate in NYC has declined, it remains much higher than the national average. There are approximately 25,000 teen pregnancies in New York City each year, with about 60 percent of these ending in induced abortion. Many NYC teens do not have information about or access to confidential reproductive health services. Continued coordinated efforts on many levels will be needed to successfully address these issues.

The Department is focusing on three key areas: infant and maternal mortality, breastfeeding promotion, and teen pregnancy, prevention targeting communities with highest infant mortality and teen pregnancy rates. I will now describe highlights of this work.

Nurse-Family Partnership (NFP) is a home visiting program that improves the health, well-being, and self-sufficiency of low-income, first-time parents and their children. Paired with Registered Nurses, young mothers are provided with health counseling, education and mentoring through regularly-scheduled home visits that begin during their pregnancy and continue until the child's second birthday. The program has been proven to improve maternal and child health and social outcomes, including reducing childhood injuries and abuse, reducing subsequent pregnancies and increasing intervals between births, increasing maternal employment and improving children's school readiness. The parents are taught how to provide a nurturing and safe home environment and plan a vision for their future.

The Department has expanded NFP three-fold in the past year, and has now served more that 1000 women since it's inception in 2003. HHC is one of our partners in this effort. With the Administration for Children's Services and the Department of Homeless Services, the Department offers NFP to the most challenged populations in New York City, including teens in foster care as well as teens and women in homeless shelters and who are detained at Rikers Island. Five new NFP sites were opened this fiscal year, placing NFP in all 5 boroughs with the

capacity to serve 2600 families. It is the Department's goal to eventually make NFP available to all low-income, first time mothers and families in New York City.

In addition to NFP, the Newborn Home Visiting Program (NHVP) offers a home visit to the families of all newborns in North and Central Brooklyn and in East and Central Harlem, and to all first-time parents in the South Bronx. During these visits, health workers educate mothers on topics such as breastfeeding, safe-sleep practices, smoking cessation, and health insurance access. The health worker also assesses potential health and social problems, as well as potential home environmental hazards, such as peeling paint and lack of window guards. In 2007, the Program made successful visits to almost 5,000 families. Through NHVP and NFP, staff also provides safe-sleep education that incorporates the traditional *Back to Sleep* Campaign messages to help reduce the risk of deaths due to Sudden Infant Death Syndrome (SIDS), and addresses specific risks associated with bed-sharing. Following education, parents who do not have a safe place for their baby to sleep receive a voucher for a portable crib, two sheets, a sleep sack, and netting through the Cribs for Kids program, a national safe-sleep education program for low-income families that aims to prevent injury and sleep-related infant deaths. Since its implementation last May, the Cribs for Kids program has distributed over 500 cribs.

The Infant Mortality Reduction Initiative (IMRI) funded by the NY City Council for the past six years supports community-based organizations. These organizations work with target populations in communities with the poorest health outcomes for infants and mothers. The Department works to increase the efficiency and coordination of these infant mortality reduction activities.

The Department works to address the issues of maternal morbidity and mortality (pregnancy-related illness and death) by reviewing data on all maternal deaths. The Department is also responsible for convening the Maternal Mortality Review Committee, a multidisciplinary team of leading obstetrical care providers, and representatives from New York State Department of Health and the American College of Obstetricians and Gynecologists. This information is used to identify leading causes of maternal mortality and to develop programs and policy interventions that will lead to better pregnancy outcomes and reduced maternal mortality. One result of this effort was the identification of hemorrhage, a complication that is usually preventable, as a leading cause of death. This resulted in issuance of a health alert by the Commissioner, development of improved hospital protocols, and provider education on reducing this risk.

The Department also provides support to new mothers through its Breastfeeding Initiative. While breastfeeding is known to offer many health benefits for mothers and babies, and 84% of NYC mothers initiate breastfeeding, only 61% of women breastfeed for 8 weeks or more after the baby is born, and only 26% exclusively breastfeed- which means breast milk *only* with no supplements- for 8 weeks or more. The goal of the Initiative is to increase initiation, duration, and exclusivity of breastfeeding until the infant is at least six months old, as recommended by the American Academy of Pediatrics. We have partnered with HHC to launch a major Breastmilk Friendly Hospital Initiative at their 11 hospitals, which HHC discussed in their testimony.

Teen mothers are at greater risk for poor pregnancy-related health outcomes, poverty and limited educational attainment. Infants born to teenage mothers are at greater risk of premature birth, low birth weight and child abuse. As such, DOHMH's multi-pronged effort to reduce infant mortality also encompasses teen pregnancy prevention. The Department's teen pregnancy prevention activities are guided by two principles, which are not mutually exclusive: choosing not to have sex is the surest way for teens to avoid getting pregnant or getting a sexually transmitted infection (STI); and teens who have sex should use condoms and another form of birth control to prevent pregnancy and sexually transmitted infections, including HIV. The teen pregnancy reduction objectives are to delay teens' initiation of sexual activity, increase contraceptive use among sexually active teens, reduce multiple partners among sexually active teens, and make reproductive health services more accessible for teens.

DOHMH established the Healthy Teens Initiative to increase the capacity of health care providers to deliver accessible, comprehensive sexual and reproductive health care. In the South Bronx, where teen pregnancy rates are the highest in the city with 153 pregnancies per 1000 teens aged 15-19 in 2005, compared to the NYC average of 94 per 1000 teens, teen pregnancy prevention is a high priority effort. Fifteen partnering organizations have made a commitment to ensure confidential health services for teens, and to remove barriers to teens' use of reproductive health services. The Initiative supplies partners with tools, resources, training and technical assistance on serving adolescents, focusing on the provision of confidential services and elimination of financial barriers.

The Department also increased its pregnancy prevention efforts in schools. In collaboration with the New York State Department of Health, we introduced a reproductive health initiative to provide training and technical assistance to provide reproductive health services at high school School-Based Health Centers. We also recognize that sex education is an integral part of teen pregnancy prevention. That is why the Department has partnered with the Department of Education to pilot sex education at 10 Bronx schools—six high schools and four middle schools—this spring. Results from the pilot will help inform DOE's implementation of sex education at public middle and high schools throughout the City.

Let me now turn my attention to Intro. 575. The legislation would require DOHMH to disseminate and place on its website certain information mandated by the Maternity Information Act of 1989. In addition, the bill would require DOHMH to annually publish a pamphlet that defines maternity-related procedures, and to provide annual data on the number and proportion of these procedures that take place at the City's hospital and birth centers. While the Department supports increasing expectant mothers' accessibility to information and education, including information on maternity-related procedures, a mandate requiring the Department to distribute readily available, duplicative information would require us to use resources that would be better spent supporting and expanding existing evidence-based maternal and infant services that directly impact health outcomes. The Department opposes this bill for several reasons.

First, this is a duplicative service. The New York State Department of Health website currently has a database and website tool that enables the public to view data on maternity-related procedures by hospital and to compare hospitals by maternity-related procedures (http://hospitals.nyhealth.gov/). In addition, New York State Public Health Law Section 2803-j

already requires the State Department of Health and hospitals to design this very pamphlet and individual hospitals to publish this same information.

Second, while the Department believes it is important for pregnant women to have access to information that will allow them to make an informed choice regarding their provider and hospital, this information can be easily misinterpreted. There is often great variability among providers, and hospitals have been designated by the level of care they can provide, from Level 1-4, so that some hospitals treat higher risk pregnant women and infants, and complication rates are directly related to the level of care they provide.

Finally, Intro. 575 states the Commissioner of Health may require that hospitals or birth centers submit to the Department the statistical information compiled by the New York State Health Commissioner pursuant to Public Health Law Section 2803-j. However, pursuant to New York State law, New York City would be preempted from imposing such requirements on most hospitals in New York City.

Despite progress, unacceptable maternal and infant health disparities persist. Reducing and eliminating disparities in maternal and infant health requires a coordinated, multi-faceted effort. If we are successful in scaling up and sustaining evidence-based programs such as the Nurse-Family Partnership and the Healthy Teens Initiative, and other activities described earlier in the testimony, the Department expects to make significant progress in improving maternal and infant health.

Thank you again for inviting me to testify on this very important issue. We look forward to continuing our partnership with the Council in support of maternal and infant health.

I'm happy to answer your questions at this time.

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FOR THE RECORD

Greater New York Hospital Association
555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

February
Six
2008

Mr. Joel Rivera
Chairman
New York City Council Committee on Health
250 Broadway
New York, NY 10007

Dear Chairman Rivera:

I am writing on behalf of the Greater New York Hospital Association (GNYHA), which represents the interests of more than 100 hospitals in New York City and its surrounding communities, regarding Int. No. 575–In relation to requiring the Department of Health and Mental Hygiene (DOHMH) to post on its Web site in a user-friendly format and disseminate certain information mandated by the Maternity Information Act of 1989 (New York State Public Health Law § 2803-j).

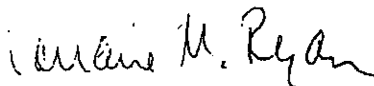
The Maternity Information Act, codified in the Public Health Law of New York State, requires hospitals and birth centers across the State to provide the New York State Department of Health (NYSDOH) with statistical information relating to maternity services. These data are then posted on the NYSDOH's Health Provider Network for consumer access. In addition, hospitals providing maternity services in New York State are required to produce and distribute a Maternity Information Leaflet or pamphlet to all prospective maternity patients. In light of these current requirements, GNYHA believes that it is redundant for DOHMH to post on its Web site the same information that is currently being compiled and made accessible to consumers by NYSDOH. Additionally, GNYHA believes that it is redundant for DOHMH to develop a maternity information pamphlet that will include the same information that is contained in the pamphlet currently being produced by hospitals in New York State for maternity patients and prospective patients, pursuant to State law.

The proposed bill also includes a provision whereby the DOHMH Commissioner may require hospitals to provide the same maternity services-related information that hospitals in New York State currently provide to NYSDOH. In addition to the possible State law preemption issues, GNYHA also believes that this proposed requirement is redundant.

Although we have concerns about this bill, we do believe it is important for the public to have access to this information. GNYHA has recently discussed this issue with NYSDOH representatives and NYSDOH is in the process of making the required information more accessible on the NYSDOH Web site. Posting the required information more prominently on the NYSDOH Web site—where other entities may also be able to link to it—will create a more readily available public resource for patients making decisions on where to receive maternity services.

If you have any questions, please feel free to contact me or my colleague, Lloyd C. Bishop, GNYHA Vice President for Government Affairs and Community Health Initiatives, at (212) 246-7100.

Sincerely,



Lorraine M. Ryan, Esq.
Special Counsel
Regulatory and Professional Affairs

cc: Betsy Gotbaum
Public Advocate for the City of New York

nyc.gov/hhc

NEW YORK CITY COUNCIL COMMITTEE ON HEALTH AND COMMITTEE ON WOMEN'S ISSUES

OVERSIGHT HEARING: MATERNAL AND NEWBORN HEALTH IN NEW YORK CITY

DR. RAMANATHAN RAJU,
EXECUTIVE VICE PRESIDENT &
CHIEF MEDICAL OFFICER

NEW YORK CITY
HEALTH AND HOSPITALS CORPORATION

FEBRUARY 7th, 2008

Good morning Chairpersons Rivera and Sears, Public Advocate Gotbaum, members of the Health and Women's Issues Committees and other distinguished members of the New York City Council. I am Dr. Ramanathan Raju, Executive Vice President, and Chief Medical Officer of the New York City Health and Hospitals Corporation (HHC). Thank you for the opportunity to discuss Maternal and Newborn health services offered by HHC.

Maternity Services at HHC

HHC is proud of the fact that approximately one-fifth, or more than 21,000, of all births in New York City occur at one of our eleven hospitals. Mothers who choose to deliver at an HHC hospital are cared for by experienced obstetrical teams in cheerful, completely modernized birthing centers. Labor and Delivery Suites at several HHC hospitals feature the latest medical technology to protect mother and baby during the birth process. Features include comfortable beds, computers, room for family members to share the occasion and even Jacuzzis at some hospitals to help minimize labor pains. Some of these infants, about 20%, require specialized care in one of our Neonatal Intensive Care Units (NICU).

Regional Perinatal Centers

In 2003, Bellevue Hospital Center and Jacobi Medical Center were designated by the New York State Department of Health (NYSDOH) as Regional Perinatal Centers (RPC). This is the highest designation for a perinatal center granted by NYSDOH. Only seventeen other hospitals in the state have this designation. 10 are located in New York City. As an RPC, these hospitals provide the highest levels of specialized care for the most acutely sick and at-risk pregnant women and newborns. In addition, the RPC's provide quality of care oversight, education and training to affiliate hospitals based on identified needs. Activities include:

- Quarterly site visits to affiliate HHC hospitals (Elmhurst, Harlem, Kings County, Lincoln, Metropolitan, North Central Bronx, Queens, and Woodhull). During site visits, the RPC team discusses maternal and neonatal health outcomes and other issues.
- Share Best Practice Initiatives established to set guidelines for practice.
- Provider education programs – bi-annual full day perinatal conferences.

Level 3 and Level 2 Perinatal Centers

In addition to having two hospitals with RPC designation, HHC has both Level 3 and Level 2 Perinatal Centers. Elmhurst, Harlem, Kings County, Lincoln, Metropolitan, Queens and Woodhull are designated as Level 3 perinatal centers. These facilities provide complex care and operate NICU's to meet the needs of fragile premature infants who require special attention. These hospitals transfer high-risk mothers and newborns that require higher levels of specialized care or procedures to the RPC.

The Level 2 Perinatal Centers - Coney Island Hospital and North Central Bronx Hospital, provide perinatal services to mothers with uncomplicated pregnancies and healthy newborns. Patients are transferred to a Level 3 or RPC for a higher level of care as needed (e.g., NICU).

Midwifery Services

HHC facilities offer perinatal care, labor and delivery services and family planning also by midwives. North Central Bronx Hospital has the largest midwifery program in New York City.

Developmental Care

Developmental Care is a holistic approach that includes reducing environmental stresses and provides care for NICU patients that are tailored to the infant's specific needs at their particular stage of development and clinical state. Premature infants, especially those with very low birth weights, can spend 3 months or more in the NICU depending on birth weight or medical complications. Access to appropriate Developmental Care for these infants is critical.

Current research strongly suggests that this type of care delivery produces significantly improved clinical, neurobehavioral, and parenting outcomes. We have begun to implement Developmental Care in all NICU's. This process to reduce lighting and noise involves careful renovation of the NICU environment to sound proof floors and ceilings, installing shades at windows to reduce light, installing special equipment to support the proper positioning of infants and increasing staff education on the principles of Developmental Care.

Prenatal Care Assistance Program

HHC facilities participate in the State's Prenatal Care Assistance Program (PCAP), which offers comprehensive prenatal care to pregnant women or teens who meet the eligibility criteria (low-income or high risk). Immigration status is not considered when determining eligibility. PCAP services include the following:

- Pregnancy screening;
- Risk assessment at initial visit which includes genetic, nutritional, psychosocial, and historical and emerging obstetrical/fetal and medical-surgical risk factors;
- All appropriate laboratory tests including HIV testing;
- Coordination of care for all services required by a pregnant woman;
- Prenatal or post-partum home visits provided to those women with identified medical or psychosocial indications for such visits;
- Follow up on missed visits;
- Referral to the Women Infant and Children (WIC) program for nutrition services, dental services mental health services, and social services;
- Health education as appropriate for each stage of pregnancy so women know what to expect, when to contact the clinic and when to go to the Emergency Room or to the Labor and Delivery suite; and
- Breastfeeding education is given throughout the prenatal period.

Family Planning Services

Also, post-partum women can receive no cost Family Planning services at any of our Family Planning programs (Harlem, Metropolitan, Jacobi, North Central Bronx Hospital, Gouverneur Healthcare Services, Kings County, Coney Island and Queens) for up to two years after pregnancy, regardless of the pregnancy outcome. Follow-up for newborns, including immunizations, are provided until childhood.

In addition to the comprehensive services that I just described, there are two other areas I would like to bring to your attention.

Nurse Family Partnership

In collaboration with the New York City Department of Health and Mental Hygiene (DOHMH), HHC offers our patients opportunities to participate in the Nurse Family Partnership (NFP) program. The NFP is a national nurse home visiting program for low-income, first-time mothers, their infants and families. Participation in this program affords families the services of a nurse who will make periodic and regular home visits from early pregnancy through the second year of the child's life.

Breastfeeding Promotion Initiative

Last year, as you may recall, HHC began a widespread breastfeeding promotion initiative. The benefits to the mother and baby have been extensively documented, and are generally known to health care professionals and the public. However, we felt that additional information and education was necessary to promote breastfeeding. Initiation of breastfeeding is generally high (up to 85%) in New York City; although exclusive breastfeeding rates and duration of breastfeeding fall short of the national goals stated in the Healthy People 2010 objectives for the nation.

To increase breastfeeding rates, HHC is aggressively promoting this as the preferred choice for infant nutrition. All HHC facilities promote breastfeeding through patient education and counseling, which starts during the prenatal period and continues immediately post-partum and through the period of infancy. HHC clinicians also encourage breastfeeding starting with the introduction of the infant to the breast to initiate breastfeeding within one hour after delivery. We are also encouraging the rooming in of infants with their mothers; breastfeeding on demand; and avoiding the introduction of artificial feeding or pacifiers in the immediate post-partum period unless indicated. Mothers and parents are also provided with access to continuing support upon discharge to the community through peer counseling in established WIC clinics.

HHC is planning to expand this service in all facilities. We also plan to initiate a home visiting program for exclusively breastfeeding mothers. In the home visiting program, within the first two days of discharge from the hospital, nurses will visit mothers and their infants for those who are

exclusively breastfeeding and for those infants born between the 34th-37th weeks of gestation.

As you know, education and training are critical to the success of any program. HHC employees, including both clinical providers and ancillary staff, who work with pregnant patients, mothers, and infants, are receiving education on breastfeeding to enhance their knowledge and skills in counseling mothers/parents on breastfeeding. These educational programs include information on the benefits of breastfeeding, and the risk of not breastfeeding; information on HHC policies and procedures and facility-specific programs to promote breastfeeding; and techniques in counseling and helping mothers to breastfeed.

To prevent undue influence from companies who make baby formula, we have banned the placement of promotional materials in the labor and delivery units in the hospital. In place of free samples or other incentives, HHC provides new mothers with a gift bag that includes information on breastfeeding, a breast milk bottle cooler, disposable nursing pads and other materials to help mothers and their babies have the best breastfeeding experience.

HHC facilities lend breastfeeding mothers, whose babies remain in the hospital, hospital-grade breast pumps to encourage extraction of breast milk to feed their hospitalized babies through a breast pump loaner program. We also provide personal breast pumps, when available and when appropriate, to mothers who may be separated from their infants but wish to continue to extract breast milk to feed their babies.

For mothers whose infants remain hospitalized and who wish to extract breast milk while in the hospital, they are provided a place designed for this activity. These facilities are also available to HHC employees who have returned to work but wish to continue to provide their infants with expressed breast milk.

This concludes my written testimony. I would now be happy to answer any questions you have.

FOR THE RECORD

THE BRONX HEALTH LINK, INC.

STATEMENT OF JOANN CASADO,
EXECUTIVE DIRECTOR,
THE BRONX HEALTH LINK, INC.

Hearings by the New York City Council Health and Women's Issues Committees
On the Maternity Information Legislation
February 7, 2008

The Bronx Health Link, Inc., is a clearinghouse of information for members of the health and human service delivery system of the Bronx. We reach thousands of community members, agencies and others through our electronic mailing list and numerous workgroups, advisory boards, task forces, community based workshops, conferences and forums held throughout the year to inform, educate and organize around issues of importance in the field of health care. Through a contract with the NYC Department of Health and Mental Hygiene under the Infant Mortality Reduction Initiative and a contract with the NYS Department of Health to operate the Perinatal Information Network, we work extensively with the community and health care providers to improve birth outcomes, prenatal care and the reproductive health of Bronx women. Thank you for the opportunity to submit our comments on Intro 575, which we support with some recommendations for additional provisions.

A major focus of our work is seeking to reduce the Bronx's shamefully high rates of infant mortality, maternal mortality, and percentages of prematurity, low birth weight, teen pregnancy, and late or no prenatal care. The rates of all these exceed those of the city and the country. In particular, we seek to reach the African American and Latino mothers and babies who are at greatest risk. We educate women about the importance of prenatal and postpartum medical screening and care, as well as self-care and care of their infants – particularly workshops and information that empower women to make informed choices.

Our educational work is grounded in the principle that pregnant women – and indeed all people – have the fundamental human right to make their own fully informed decisions about whether to undergo or reject medical procedures based on their determination as to what will maximize their own health and well-being. Unfortunately, that is not the predominant ethic within the field of obstetrics today. As Canadian birth

researcher Veronique Bergeron recently wrote in the journal Bioethics[1], describing the standard medical model:

> "... [T]he concept of medicalization has also been applied to normal physical processes such as aging, death and childbirth. The transfer of childbirth from an exclusively female purview to a medical model has brought a change in the conceptualization of pregnancy, making it shift from a normal process that could sometimes go wrong to a potential pathology controlled by a medical specialty.... [W]omen's fear of pain, deformity and unpredictability in uncomplicated childbirth were addressed as so many medical *problems* for which medical *solutions* were offered rather than inherent components of a natural and awesome process for which women are biologically and physiologically ready. The fact that women need to be supported emotionally and physically through labor was mistaken for a need to see the process taken over and taken care of.
>
> "Given the combined play of gender-based oppression in general society and the medical model of childbirth posing the body as a machine and pregnancy as pathology, there never seemed to be any pressing concern to approach childbirth from a woman's perspective with her priorities in mind....
>
> "Because childbirth no longer belongs to birthing women, the latitude of autonomous choice they possess is determined by those who now own the proper conduct of childbirth. Women are thus invited to exercise unlimited autonomy within the limited range of choices presented to them by the medical profession. This uneasy dichotomy calls for critical oversight ensuring that medical options facing birthing women are truly selected in their interest and at their advantage."

We support Intro 575 as a first step toward expanding the information available to pregnant women to help them decide where to obtain obstetrical care. The evidence is overwhelming that the percentages of births nationwide that involve Cesarean sections, epidurals and episiotomies are much higher than those which can be justified by clear medical need, especially given the serious risks that attach to each of these procedures. New York City rates of C-section parallel national percentages. In 2004, 28.6% of all city births were performed by C-section; in the Bronx, for the same period, the percentages varied from 18 to 29, in both cases far above the World Health Organization's guideline that rates should not exceed 15%. Exceeding this recommended WHO goal can result in a higher risk of doing more harm than good to both the mother and the infant. And all evidence suggests that these surgery rates continue to rise each year throughout the U.S.

To again quote researcher Bergeron: "The option of requesting a ceasarean section can exist without being systematically offered as an equal alternative to vaginal delivery. Surgery should remain an exceptional measure to treat exceptional conditions."

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[1] Veronique Bergeron, The Ethics of Cesarean Section on Maternal Request: A Feminist Critique of the American College of Obstetricians and Gynecologists' Position on Patient-Choice Surgery. Bioethics. Vol. 21, No. 9 2007 pp. 478-487.

That is especially important given that the risks of C-sections are substantial: incidence of maternal death two and a half times that of vaginal delivery; increased risk of infection, injury to other organs, and infertility, anesthesia complications; and difficulty with breastfeeding (because recovery can be lengthy and painful). For the baby, there is a risk of accidental surgical cut and short- and long-term breathing problems, and the denial of breastfeeding weakens the bond with the mother. Long-term, the mother runs the risk of a future ectopic pregnancy or placenta previa (placenta growing in the cervix, causing life-threatening vaginal bleeding). Many obstetricians discourage women from having vaginal birth after a Cesarean (VBAC), claiming that there is a high risk of uterine rupture, but recent studies show that women who have had prior Cesareans face no greater risk of uterine rupture than those who have had only vaginal deliveries.[2] Another study just released last week concluded: "Women with prior successful VBAC attempts are at low risk for maternal and neonatal complications during subsequent VBAC attempts."[3]

While providing comparative statistics can shed limited light on a facility's track record, that information only has value to the extent the women affected know it exists. Thus, the information on these medical procedures cannot simply be passively placed on the DOH website and in DOH pamphlets available, as the current bill language states, "upon request" -- it must be proactively distributed to all women. Thus we urge that a provision be added to the bill mandating that all city programs serving women during the preconception period and women who are pregnant – such as Medicaid, prenatal care programs, HHC hospitals and clinics, birth control and STD clinics, and the Nurse-Family Partnership -- automatically include such pamphlets in their standard information packets provided to clients.

But the problem extends beyond women simply not having data showing which facility practices these procedures more often. In order to assist pregnant women in understanding the risks and benefits of C-sections, VBACs, and other medical procedures such as epidurals and episiotomies, it is important that any statistical information on the rates of these procedures be placed in a balanced context. As Public Advocate Betsy Gotbaum reported in December 2006, "In a national survey of women who gave birth in U.S. hospitals in 2005, 25% of those who had a C-section reported having experienced pressure from a health professional to have this procedure."[4] Thus, to empower women to counter such pressure with information, we strongly urge that the current bill be amended to include provisions that parallel those of New York State Assembly bill 07674, by Assemblymember Amy Paulin, which passed the Assembly last year but has not yet passed the Senate. That bill mandates that the State Health Department "conduct

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[2] Kaiser Network, "Vaginal Birth After Multiple C Sections Safe, Study Says," June 30, 2006. Available at www.kaisernetwork.org/daily_reports/rep_women.cfm#38234

[3] Brian M. Mercer, et al. Labor Outcomes With Increasing Number of Prior Vaginal Births After Cesarean Delivery. Obstetrics and Gynecology. Vol. 111, No. 2, Part 1, February 2008, pp. 285-291.

[4] Public Advocate for the City of New York, Giving Birth In The Dark: City Hospitals Still Failing To Provide Legally Mandated Maternity Information, December 2006, p. 2. Available at http://pubadvocate.nyc.gov/policy/reports.html

education and outreach programs for consumers, patients and health care providers" that would include various topics related to pregnancy and childbirth, including "benefits and risks of labor and delivery options such as vaginal delivery and cesarean section delivery; and the appropriate use of drugs during delivery."

In particular, we recommend that city funding be provided to conduct educational and outreach programs (including radio and TV public service announcements and town hall meetings) including evidence-based risk/benefit data. The information must be presented in lay language employing principles of health literacy. The information must also be in the languages of the communities being served, based on a patient empowerment model. We urge that the bill provide that the City Health Department contract with community-based organizations, including the agencies funded by the Infant Mortality Reduction Initiative and others who work closely with consumers in their communities, advocates, as well as those who have done pioneering educational work in this field. The city and state must coordinate these educational efforts; therefore the state-funded Perinatal Information Networks, Community Health Worker programs and others would also be allies in this effort to provide information to women at every opportunity.

Finally, we urge the Health and Women's Issues Committees to begin working on long-term solutions to these problems. Here again, Public Advocate Betsy Gotbaum has made some useful recommendations – which although directed to the State Health Department could also be taken up by the City's Health Department: "The NYS Department of Health should provide leadership in meeting the goal of a Cesarean delivery rate of no more than 15 percent set by the World Health Organization. Action taken should include an initiative that prioritizes reducing the Cesarean rate, emphasizes continued research into the risks associated with the procedure, and establishes 'best practice' procedures for all health care facilities and providers in New York City."[5]

Adopting these policies would mark a first needed step on the path to reversing the unnecessary medicalization of the natural and remarkable experience of childbirth for women in this city. Again, the goal must be empowerment of women to make fully informed decisions that will maximize the health and well-being of themselves and their infants.

Contact Information:

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[5] Public Advocate, Giving Birth in the Dark, p. 4.

FOR THE RECORD

Greater New York Hospital Association
555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

February
Six
2008

Mr. Joel Rivera
Chairman
New York City Council Committee on Health
250 Broadway
New York, NY 10007

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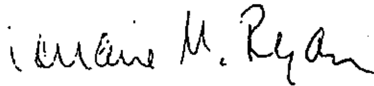

Lorraine M. Ryan, Esq.
Special Counsel
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cc: Betsy Gotbaum
Public Advocate for the City of New York