

COMMITTEE ON WOMEN AND GENDER EQUITY:

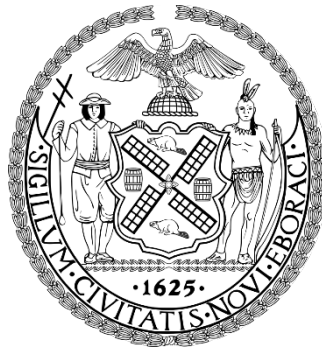
Brenda McKinney, *Counsel*
Chloë Rivera, *Senior Policy Analyst*
Monica Pepple, *Financial Analyst*
Rachael Alexandroff, *Data Analyst*
Julia Fredenburg, *Data Analyst*

COMMITTEE ON HEALTH:

Sara Liss, *Senior Counsel*
Harbani Ahuja, *Counsel*
Emily Balkan, *Senior Policy Analyst*
Lauren Hunt, *Financial Analyst*
Rachael Alexandroff, *Data Analyst*
Brook Frye, *Data Analyst*

COMMITTEE ON HOSPITALS:

Harbani Ahuja, *Counsel*
Emily Balkan, *Senior Policy Analyst*
John Cheng, *Financial Analyst*
Rachael Alexandroff, *Data Analyst*
Brook Frye, *Data Analyst*



THE COUNCIL OF THE CITY OF NEW YORK

COMMITTEE REPORT OF THE HUMAN SERVICES DIVISION

Jeffrey Baker, *Legislative Director*
Andrea Vazquez, *Deputy Director*

COMMITTEE ON WOMEN AND GENDER EQUITY

Hon. Helen K. Rosenthal, Chair

COMMITTEE ON HEALTH

Hon. Mark Levine, Chair

COMMITTEE ON HOSPITALS

Hon. Carlina Rivera, Chair

December 7, 2020

Oversight: Maternal Mortality and Morbidity in New York City

INTRODUCTION NO. 2017 By Council Members Rivera, Kallos, Chin and Brannan

- TITLE:** Local Law to amend the administrative code of the city of New York, in relation to visitation policy guidelines for hospitals during public health emergencies
- ADMINISTRATIVE CODE:** Adds a new chapter 20 to title 17
- INTRODUCTION NO. 2042** By Council Members Gibson, Yeger, Rosenthal, Perkins, Ayala, Chin, Cumbo and Adams
- TITLE:** Local Law to amend the administrative code of the city of New York, in relation to posting information about midwives online
- ADMINISTRATIVE CODE:** Adds a new section 17-199.14 to title 17
- RESOLUTION NO. 1239** By Council Members Rivera, Ampry-Samuel, Louis, Gibson, Chin and Brannan
- TITLE:** Resolution calling on the New York State Legislature to pass, and the Governor to sign, legislation making doulas more accessible to individuals with Medicaid and those without health insurance
- RESOLUTION NO. 1408** By Council Members Rosenthal and Gibson
- TITLE:** Resolution calling on the New York State Legislature to pass, and the Governor to sign, A.10440/S.8307, relating to accreditation, approval, and operation of midwifery birth centers

I. INTRODUCTION

On December 7, 2020, the Committee on Women and Gender Equity, chaired by Council Member Helen K. Rosenthal, the Committee on Health, chaired by Council Member Mark Levine, and the Committee on Hospitals, chaired by Council Member Carlina Rivera, will hold a joint oversight hearing on *Maternal Mortality and Morbidity in New York City* (“NYC” or “City”). The then-Committee on Women¹ and the Committee on Health previously held a hearing on this topic on June 27, 2018, at which time the Committees heard two bills intended to improve health outcomes for pregnant people and pregnant people of color, in particular, including through enhanced reporting on maternal mortality and morbidity. At today’s hearing, the Committees will

¹ In April 2019, the Committee on Women at the City Council amended its name to include the term “gender equity,” which better reflects the Committee’s work and focus.

seek an update on these issues and consider four pieces of legislation, including two bills: Proposed Int. No. 2017, in relation to visitation policy guidelines for hospitals during public health emergencies, and Proposed Int. No. 2042, in relation to posting information about midwives online. The Committees will also hear Resolution No. 1239, which calls on the New York State Legislature to pass, and the Governor to sign, legislation making doulas more accessible to individuals with Medicaid and those without health insurance, and Resolution No. 1408, which calls on the New York State Legislature to pass, and the Governor to sign, A.10440/S.8307, relating to accreditation, approval, and operation of midwifery birth centers. Witnesses invited to testify include representatives from the NYC Department of Health and Mental Hygiene (DOHMH), NYC Health + Hospitals (H+H), the Greater New York Hospital Association (GNYHA), as well as advocacy groups and organizations, hospitals, medical training programs, nurse and midwife groups, doula organizations, and other interested stakeholders.

II. BACKGROUND

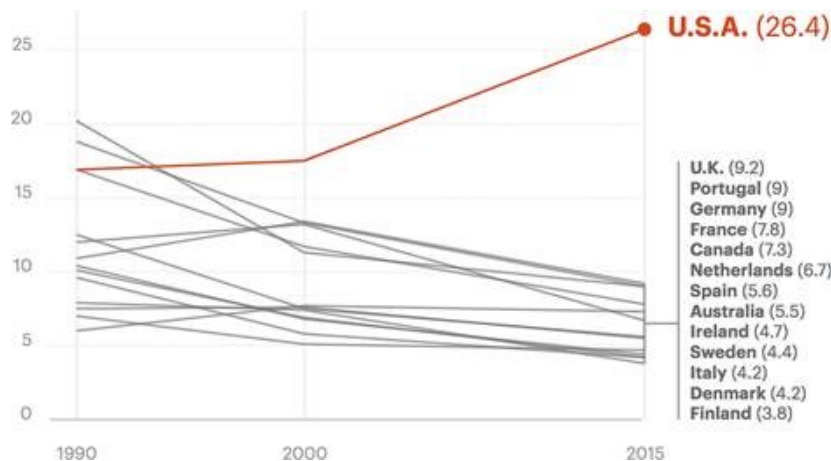
The ability to protect the health of mothers and babies in childbirth is a basic measure of a society's development.² Yet, not only are more women in the United States (U.S.) dying of pregnancy-related complications than in any other developed country, but while the number of reported pregnancy-related deaths has been declining in most of the world,³ only in the U.S. has

² MacDorman MF, Declercq E, Cabral H, Morton C., *Is the United States Maternal Mortality Rate Increasing? Disentangling trends from measurement issues*, *Obstetrics and gynecology* (2016), 447-455, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5001799/pdf/nihms810951.pdf>.

³ World Health Organization, *Trends in Maternal Mortality: 1990 to 2015* (2015), available at https://apps.who.int/iris/bitstream/handle/10665/194254/9789241565141_eng.pdf;jsessionid=A5BCC05853070F3E0AAADCC3FB3CB6EB?sequence=1.

the maternal mortality ratio (MMR), or the number of maternal deaths in a population that occur during a given year per 100,000 live births,⁴ been increasing.⁵

Figure 1: Maternal Deaths Per 100,000 Live Births⁶



According to the Centers for Disease Control and Prevention (CDC), the MMR in the U.S. has more than doubled since 1987, from 7.2 deaths per 100,000 live births in 1987, to a peak of 17.6 in 2014, and dropping slightly to 16.7 deaths per 100,000 live births in 2016.⁷ Data also shows that this trend has worsened in recent years. From 2000 to 2014, the MMR in the U.S. has increased

⁴ See Roosa Tikkanen, Munira Z. Gunja, Molly FitzGerald, and Laurie Zephyrin, *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries* (Nov. 18, 2020), available at <https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries>; World Health Organization, *Maternal mortality ratio (per 100 000 live births)* (last visited Nov. 30, 2020), available at <https://www.who.int/data/gho/indicator-metadata-registry/imr-details/26> (The World Health Organization (WHO) defines maternal death as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes”).

⁵ See “Table 2. Estimates of maternal mortality ratio (maternal mortality ratio, deaths per 100 000 live births), number of maternal deaths, and lifetime risk by United Nations MDG regions, 2008;” see also “Annex 3. Comparison of 1990, 1995, 2000, 2005, and 2008 estimates of maternal mortality ratio (maternal mortality ratio, deaths per 100 000 live births) by country;” World Health Organization, et al., *Trends in maternal mortality: 1990 to 2008* (2010), 18, 28-32, available at http://apps.who.int/iris/bitstream/handle/10665/44423/9789241500265_eng.pdf;jsessionid=E07455C2099CB48EE28744F5BAAA2C34?sequence=1.

⁶ Calpurnia Roberts, *Bronx Infant and Maternal Health Summit*, NEIGHBORHOOD HEALTH ACTION CENTERS (June 21, 2018), citing Kassebaum et. al (2016).

⁷ Centers for Disease Control and Prevention, *Pregnancy Mortality Surveillance System* (last visited Dec. 2, 2020), available at <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm>.

by an estimated 26.6 percent.⁸ Each year, 700-900 American women die and approximately 65,000 suffer potentially mortal complications from pregnancy or childbirth-related causes.⁹ Furthermore, according to a report from nine different maternal mortality review committees, over 60 percent of these pregnancy-related deaths were preventable.¹⁰

Additionally, data shows that health inequities significantly impact pregnancy outcomes. According to the Centers for Disease Control and Prevention (CDC), Black women in the U.S. are three to four times more likely to die from complications related to pregnancy than white women.¹¹ For Black women, the MMR is 42.8 per 100,000 live births, compared with 12.5 for white women and 17.3 for women of all other races.¹² Such disparities also affect birth outcomes. Government data suggest that Black infants are more than twice as likely to die as white infants; 11.3 per 1,000 Black babies, compared with 4.9 per 1,000 white babies, a racial disparity that is actually greater than in 1850, 15 years before slavery was abolished in the U.S.¹³ Research points to race, rather than educational attainment or income level of the patient, as the cause of such discrepancies.¹⁴ In

⁸ M. MacDorman, E. Declercq, H. Cabral, C. Morton, *Is the United States Maternal Mortality Rate Increasing? Disentangling Trends from Measurement Issues*, OBSTETRICS AND GYNECOLOGY 447-455 (2016), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5001799/pdf/nihms810951.pdf>.

⁹ Nina Martin and Renee Montagne, *Focus On Infants During Childbirth Leaves U.S. Moms In Danger*, NATIONAL PUBLIC RADIO and PROPUBLICA (May 12, 2017), available at <https://www.npr.org/2017/05/12/527806002/focus-on-infants-during-childbirth-leaves-u-s-moms-in-danger>.

¹⁰ *Building U.S. Capacity to Review and Prevent Maternal Deaths* (2018), available at http://reviewtoaction.org/Report_from_Nine_MMRCs.

¹¹ Centers for Disease Control and Prevention, *Pregnancy-Related Deaths*, available at <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm>.

¹² Centers for Disease Control and Prevention, *Pregnancy Mortality Surveillance System*, available at <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html>.

¹³ Linda Villarosa, *Why America's Black Mothers Are in a Life-or-Death Crisis*, NEW YORK TIMES (Apr. 11, 2018), available at <https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html>; See also J.D.B. De Bow, *Mortality Statistics of the Seventh Census of the United States 1850* (last visited Nov 25, 2020), available at <https://babel.hathitrust.org/cgi/pt?id=uc2.ark:/13960/t4qj7qt8w;view=1up;seq=40> (showing that the government started to track vital statistics related to mortality, disaggregating info by sex and race, in 1850).

¹⁴ *Id.* (explicitly making this point and explaining, “by the late 1990s, other researchers were trying to chip away at the mystery of the black-white gap in infant mortality. Poverty on its own had been disproved to explain infant mortality, and a study of more than 1,000 women in New York and Chicago, published in *The American Journal of Public Health* in 1997, found that black women were less likely to drink and smoke during pregnancy, and that even when they had access to prenatal care, their babies were often born small Though it seemed radical 25 years ago,

fact, a Black woman with an advanced degree is more likely to lose her baby than a white woman with less than an eighth-grade education.¹⁵

Maternal Mortality in New York City

New York City and State have among the highest rates of maternal deaths in the country.¹⁶ Over the past decade alone, New York state has experienced a 60 percent increase in maternal mortality.¹⁷ In the period from 2001-2003, the number of reported maternal deaths in NYS was 15.4 deaths per 100,000 live births; which over time increased to 19.6 deaths per 100,000 live births in 2014-2016,¹⁸ and a reported 20.9 maternal deaths per 100,000 live births by August of 2018.¹⁹ Although the city's MMR is slightly above the national average, NYC, where half the state's births take place,²⁰ accounts for about 30 of those estimated 700-900 women who die from

few in the field now dispute that the black-white disparity in the deaths of babies is related not to the genetics of race but to the lived experience of race in this country").

¹⁵ Richard V. Reeves and Dayna Bowen Matthew, *Six Charts Showing Race Gaps Within the American Middle Class*, BROOKINGS (Oct. 21, 2016), available at <https://www.brookings.edu/blog/social-mobility-memos/2016/10/21/6-charts-showing-race-gaps-within-the-american-middle-class/>.

¹⁶ Kirsten Gillibrand, *As Maternal Mortality Rates Continue To Rise Across The Country And New York State, Gillibrand Announces New Legislation To Help Prevent Women From Dying Before, During, And After Childbirth* (Aug. 28, 2018), available at <https://www.gillibrand.senate.gov/news/press/release/as-maternal-mortality-rates-continue-to-rise-across-the-country-and-new-york-state-gillibrand-announces-new-legislation-to-help-prevent-women-from-dying-before-during-and-after-childbirth#:~:text=To%20date%2C%20in%20August%202018,deaths%20per%20100%2C000%20live%20births.>

¹⁷ Kirsten Gillibrand, *As Maternal Mortality Rates Continue To Rise Across The Country And New York State, Gillibrand Announces New Legislation To Help Prevent Women From Dying Before, During, And After Childbirth* (Aug. 28, 2018), available at <https://www.gillibrand.senate.gov/news/press/release/as-maternal-mortality-rates-continue-to-rise-across-the-country-and-new-york-state-gillibrand-announces-new-legislation-to-help-prevent-women-from-dying-before-during-and-after-childbirth#:~:text=To%20date%2C%20in%20August%202018,deaths%20per%20100%2C000%20live%20births.>

¹⁸ The New York State Taskforce on Maternal Mortality and Disparate Racial Outcomes, *Recommendations to the Governor to Reduce Maternal Mortality and Racial Disparities*, 1, 4 (March 2019), available at https://health.ny.gov/community/adults/women/task_force_maternal_mortality/docs/maternal_mortality_report.pdf.

¹⁹ Kirsten Gillibrand, *As Maternal Mortality Rates Continue To Rise Across The Country And New York State, Gillibrand Announces New Legislation To Help Prevent Women From Dying Before, During, And After Childbirth* (Aug. 28, 2018), available at <https://www.gillibrand.senate.gov/news/press/release/as-maternal-mortality-rates-continue-to-rise-across-the-country-and-new-york-state-gillibrand-announces-new-legislation-to-help-prevent-women-from-dying-before-during-and-after-childbirth#:~:text=To%20date%2C%20in%20August%202018,deaths%20per%20100%2C000%20live%20births.>

²⁰ Kirsten Gillibrand, *As Maternal Mortality Rates Continue To Rise Across The Country And New York State, Gillibrand Announces New Legislation To Help Prevent Women From Dying Before, During, And After Childbirth* (Aug. 28, 2018), available at <https://www.gillibrand.senate.gov/news/press/release/as-maternal-mortality-rates-continue-to-rise-across-the-country-and-new-york-state-gillibrand-announces-new-legislation-to-help-prevent-women-from-dying-before-during-and-after-childbirth#:~:text=To%20date%2C%20in%20August%202018,deaths%20per%20100%2C000%20live%20births.>

pregnancy or childbirth-related causes each year nationally.²¹ According to the New York State Department of Health (DOH), the MMR in NYC was 31 per 100,000 live births in 2015.²²

Moreover, research has illustrated the impact that racial disparities can have on a person's health outcomes and care in NYC.²³ While about 30 women in NYC die each year of a pregnancy-related cause, statistics indicate that approximately 3,000 women “almost die,” or experience morbidity, during childbirth.²⁴ Black, non-Latina women are the most likely to experience maternal mortality or maternal morbidity,²⁵ which the World Health Organization (WHO) defines as a spectrum ranging from the near death of a woman who has survived a complication occurring during pregnancy or childbirth (or within 42 days of the termination of pregnancy) to non-life-threatening morbidity.²⁶ Additionally, according to a study in the American Journal of Obstetrics and Gynecology, Black women in NYC are more likely to give birth in hospitals that already have a high rate of severe maternal morbidity or complications than white women.²⁷ Only 23 percent of

women-from-dying-before-during-and-after-childbirth#:~:text=To%20date%2C%20in%20August%202018,deaths%20per%20100%2C000%20live%20births.

²¹ The top causes of U.S. pregnancy-related deaths in 2011 were cardiovascular disease, 15.1 percent; non-cardiovascular disease, 14.1 percent; infection or sepsis, 14 percent; and hemorrhage, 11.3 percent. See Robin Fields, *New York City Launches Committee to Review Maternal Deaths*, PROPUBLICA (Nov. 15, 2017), available at <https://www.propublica.org/article/new-york-city-launches-committee-to-review-maternal-deaths>; Linda Villarosa, *Why America's Black Mothers and Babies Are in a Life-or-Death Crisis*, NEW YORK TIMES (Apr. 11, 2018), available at <https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html>.

²² “New York State Maternal Mortality Rate per 100,000 Live Births.” *New York State Department of Health*, Oct. 2017, www.health.ny.gov/statistics/chac/birth/b33_999.htm.

²³ See Nancy Krieger, Maureen Benjamins, Alyash A. Sewell, Presentation: *Prioritizing Equity video series: Research and data for health equity*, AMER. MED. ASSOC. (Nov. 20, 2020), available at <https://www.ama-assn.org/delivering-care/health-equity/prioritizing-equity-video-series-research-and-data-health-equity>; Benjamin Retelus, et. al., *Racial Disparities in COVID-19 Hospitalization and In-hospital Mortality at the Height of the New York City Pandemic* 18(1) 1, 1 (Sep. 18, 2020), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7500250/>.

²⁴ See New York City Department of Health and Mental Hygiene, *Severe Maternal Morbidity in New York City, 2008-2012* (2016), available at <http://www1.nyc.gov/assets/doh/downloads/pdf/data/maternal-morbidity-report-08-12.pdf>.

²⁵ *Id.*

²⁶ See World Health Organization, *Measuring Maternal Health: Focus on Maternal Morbidity* (last visited June 20, 2018), available at <http://www.who.int/bulletin/volumes/91/10/13-117564/en/>.

²⁷ Jamila Taylor, Cristina Novoa, Katie Hamm, and Shilpa Phadke, *Eliminating Racial Disparities in Maternal and Infant Mortality*, CENTER FOR AMERICAN PROGRESS (May 2, 2019), available at <https://www.americanprogress.org/issues/women/reports/2019/05/02/469186/eliminating-racial-disparities-maternal-infant-mortality/>; See March of Dimes, *Nowhere to Go: Maternity Care Deserts Across the U.S.* (2018),

Black patients gave birth in the safest hospitals, compared 63 percent of white patients.²⁸ At the city level, recent data suggests Black mothers in NYC are 12 times more likely to die from pregnancy-related causes than white mothers.²⁹ The Bronx and Brooklyn in particular carry a disproportionate burden of maternal and infant mortality rates.³⁰ From 2006 to 2010, residents of the Bronx had the highest pregnancy-related mortality ratio with 26.0 deaths per 100,000 live births, followed by Brooklyn with 25.7, Queens with 24.6, Staten Island with 17.4 and Manhattan with 13.9.³¹

Several factors appear to have a positive influence on outcomes for persons giving birth in NYC.³² A recent report reveals that women who had doula support were 39 percent less likely to have a caesarean section (C-section), and 15 percent more likely to give birth without needing drugs or labor-inducing techniques.³³ Additionally, a survey regarding doula care in NYC reveals that 72 percent of women reported that their doula helped them communicate their preferences and

available at https://www.marchofdimess.org/materials/Nowhere_to_Go_Final.pdf; National Partnership for Women and Families, *Black Women's Maternal Health: A Multifaceted Approach to Addressing Persistent and Dire Health Disparities* (April 2018), available at <http://www.nationalpartnership.org/research-library/maternal-health/black-womens-maternal-health-issue-brief.pdf>; See also Elizabeth A. Howell, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61(2) Clin Obstet Gynecol. 387, 387 (Jun. 1, 2019), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5915910/>.

²⁸ CNN, *Childbirth is Killing Black Women in the U.S., and Here's Why*, CNN (Nov. 15, 2017), available at <https://www.cnn.com/2017/11/15/health/black-women-maternal-mortality/index.html>; Rates were also high among Puerto Rican and other Latina women compared to White non-Latina women and overall when examining other risk factors. *Pregnancy-Associated Mortality in New York City, 2006-2010* (2015), available at <https://www1.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report.pdf>.

²⁹ ProPublica, *Nothing Protects Black Women From Dying in Pregnancy and Childbirth*, PROPUBLICA (Dec. 7, 2017), available at <https://www.propublica.org/article/nothing-protects-black-women-from-dying-in-pregnancy-and-childbirth>.

³⁰ Calpurnia Roberts, *Bronx Infant and Maternal Health Summit*, NEIGHBORHOOD HEALTH ACTION CENTERS (June 21, 2018), citing Kassebaum et. al (2016).

³¹ Rates were also high among Puerto Rican and other Latina women compared to White non-Latina women and overall when examining other risk factors. *Pregnancy-Associated Mortality in New York City, 2006-2010* (2015), available at <https://www1.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report.pdf> (providing data based on maternal borough of residence).

³² A doula is a trained professional who provides continuous physical, emotional and informational support to a pregnant person and the family before, during and shortly after childbirth.

³³ Bohren MA, Hofmeyr GJ, Sakala C, Fukuzawa RK and Cuthbert A., *Continuous support for women during childbirth*, 7(1) COCHRANE DATABASE OF SYSTEMATIC REVIEWS (2017).

needs, while 80 percent of those surveyed reported that their doula helped them feel more empowered.³⁴ Furthermore, 83 percent of the surveyed women reported that having a doula made their labor and birth experience “much better” than if they had not used a doula, and it made them more relaxed before, during, and after birth.³⁵ However, 88 percent of this cohort reported that cost was an issue when opting to work with a doula.³⁶

III. COVID-19 AND MATERNAL HEALTH, MORTALITY, AND MORBIDITY

Since the COVID-19 outbreak began, healthcare organizations and experts have been addressing its potential effects on maternal health, mortality and morbidity. For example, in June, the Centers for Disease Control and Prevention (CDC) recommended that pregnant women and their families take preventive measures to reduce their risk of contracting COVID-19, as pregnant women were significantly more likely to be hospitalized, admitted to the intensive care unit, and receive mechanical ventilation than non-pregnant women.³⁷ In November, the CDC reported in a Morbidity and Mortality Weekly Report that pregnant women are also at increased risk of death compared to non-pregnant women.³⁸ Black women die at a rate three times higher than white women as a result of childbirth and recent data from the CDC demonstrates that COVID-19 mortality rates are substantially higher among Black, Latinx, and Native American people than

³⁴ “Doula Care in New York City: Advancing the Goals of the Affordable Care Act.” *Choices in Childbirth*, 28 Oct. 2014, <https://choicesinchildbirth.org/wp-content/uploads/2014/10/Doula-Report-10.28.14.pdf>.

³⁵ *Id.*

³⁶ *Id.* The average fee for doula services in NYC is \$1200, which includes one prenatal visit, labor support, and a postpartum follow up visit. However, fees can range from \$150 to \$2800 per birth depending on experience.

³⁷ Sascha Ellington, et al., *Characteristics of Women of Reproductive Age with Laboratory-Confirmed SARS-CoV-2 Infection by Pregnancy Status — United States, January 22–June 7, 2020*, Morbidity and Mortality Weekly Report, Jun. 26, 2020, https://www.cdc.gov/mmwr/volumes/69/wr/mm6925a1.htm?s_cid=mm6925a1_w.

³⁸ Laura D. Zambrano, et al., *Update: Characteristics of Symptomatic Women of Reproductive Age with Laboratory-Confirmed SARS-CoV-2 Infection by Pregnancy Status — United States, January 22–October 3, 2020*, Morbidity and Mortality Weekly Report, Nov. 2, 2020, https://www.cdc.gov/mmwr/volumes/69/wr/mm6944e3.htm?s_cid=mm6944e3_w.

among white or Asian people.³⁹ The CDC study also suggested that pregnant women who are Hispanic or Black might be disproportionately affected by SARS-CoV-2 infection during pregnancy.⁴⁰

According to Ana Langer of Harvard T.H. Chan School of Public Health, even before the pandemic, Black women in the U.S. overall had a maternal mortality rate between 2.4 and 3 times higher than their white counterparts.⁴¹ In New York City, Black women are 8 to 12 times more likely to die.⁴² That disparity is driven by socioeconomic factors, such as where people live and work and access to health care.⁴³ Data has already shown that COVID-19 magnifies existing health disparities, affecting communities of color much more than white communities, so knowing that maternal mortality is higher among Black women suggests that COVID-19 may increase maternal mortality disparities in the U.S.⁴⁴

Significant shifts in access to healthcare during the pandemic also significantly impacted the ability of Black, Indigenous, and other patients of color to receive adequate healthcare.⁴⁵ While on one hand, some patients found that telehealth has been a blessing, allowing them to see doctors without the need to travel or find childcare, many patients stated that telemedicine made it more

³⁹ American Hospital Association, *COVID-19: Maternal and Child Health During COVID-19*, Jul. 2020, https://www.aha.org/system/files/media/file/2020/05/COVID-19-Maternal-Guidelines_rev6.pdf.

⁴⁰ Sascha Ellington, et al., *Characteristics of Women of Reproductive Age with Laboratory-Confirmed SARS-CoV-2 Infection by Pregnancy Status — United States, January 22–June 7, 2020*, Morbidity and Mortality Weekly Report, Jun. 26, 2020, https://www.cdc.gov/mmwr/volumes/69/wr/mm6925a1.htm?s_cid=mm6925a1_w.

⁴¹ Harvard T.H. Chan School of Public Health, *COVID-19 may increase maternal mortality disparities in U.S.*, <https://www.hsph.harvard.edu/news/hsph-in-the-news/covid-19-may-increase-maternal-mortality-disparities-in-u-s/> (last accessed Dec. 2, 2020).

⁴² Emily Bobrow, *She Was Pregnant With Twins During Covid. Why Did Only One Survive?*, New York Times, Aug. 9, 2020, <https://www.nytimes.com/2020/08/06/nyregion/childbirth-Covid-Black-mothers.html>.

⁴³ Harvard T.H. Chan School of Public Health, *COVID-19 may increase maternal mortality disparities in U.S.*, <https://www.hsph.harvard.edu/news/hsph-in-the-news/covid-19-may-increase-maternal-mortality-disparities-in-u-s/> (last accessed Dec. 2, 2020).

⁴⁴ *Id.*

⁴⁵ Anna North, *America is failing Black moms during the pandemic*, Vox, Aug. 10, 2020, <https://www.vox.com/2020/8/10/21336312/covid-19-pregnancy-birth-black-maternal-mortality>.

difficult to convince providers that they needed to be seen in person, even when they had serious conditions.⁴⁶ Furthermore, some patients—especially low-income people and those living in rural areas or on reservations—cannot access telehealth at all because of a lack of internet access or appropriate devices.⁴⁷ The pandemic is also exacerbating other inequities Black birthing people face, including the difficulty of even finding a doctor to treat them, as decades of redlining have left cities and towns segregated across America, with communities of color not receiving the same investment as majority-white, suburban neighborhoods.⁴⁸ There is also a significant lack of prenatal care in certain areas, which is associated with an increased risk of maternal mortality and morbidity.⁴⁹ Moreover, as many pregnancy-related deaths happen in the postpartum period, postpartum follow-up, which was already spotty before the pandemic began, became almost nonexistent.⁵⁰ For example, because of the pandemic, mothers are being discharged so quickly that they do not have proper information about how to care for their wounds, or how to breastfeed properly, and many mothers are showing signs of anxiety and depression as they are experiencing social isolation.⁵¹

The pandemic has also introduced a new risk factor for pregnant patients: isolation.⁵² Several studies have shown that having a doula or other support person during birth can improve outcomes for birthing people and their babies, and doulas are especially important for Black patients and others who experience discrimination during birth.⁵³ At the beginning of the COVID-

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ Emily Bobrow, *She Was Pregnant With Twins During Covid. Why Did Only One Survive?*, New York Times, Aug. 9, 2020, <https://www.nytimes.com/2020/08/06/nyregion/childbirth-Covid-Black-mothers.html>.

⁵² Anna North, *America is failing Black moms during the pandemic*, Vox, Aug. 10, 2020, <https://www.vox.com/2020/8/10/21336312/covid-19-pregnancy-birth-black-maternal-mortality>.

⁵³ *Id.*

19 pandemic in the U.S., however, many hospitals instituted limits on the number of people who could accompany pregnant people into the delivery room, forcing patients to choose between a partner and a doula.⁵⁴ In fact, two major systems in New York City—New York-Presbyterian and Mount Sinai—banned support people from delivery rooms, forcing women to be alone while giving birth.⁵⁵ The limits on visitors were intended to conserve personal protective equipment and slow the spread of COVID-19, but when implementing them, hospitals did not consider the disproportionate impact that they could have on Black patients.⁵⁶ While some of these policies have been reversed, many hospitals still only allow one support person.⁵⁷ In New York, however, Governor Andrew Cuomo convened a task force of multidisciplinary experts to address the effect of COVID-19 on pregnancy and examine the best approaches to provide mothers with safe alternatives to hospitalization, when appropriate.⁵⁸ The COVID-19 Maternity Task Force’s recommendations included testing all pregnant women for the virus and designated doulas as an essential member of the care team, among other suggestions.⁵⁹ On April 29, 2020, Governor Cuomo issued an executive order recognizing doulas as essential members of the delivery team, which allows them to be present to support the mother and her family member during labor and delivery.⁶⁰

⁵⁴ *Id.*

⁵⁵ Katie Van Syckle & Christina Caron, ‘*Women Will Not Be Forced to Be Alone When They Are Giving Birth*’, New York Times, Mar. 28, 2020, <https://www.nytimes.com/2020/03/28/parenting/nyc-coronavirus-hospitals-visitors-labor.html>.

⁵⁶ Anna North, *America is failing Black moms during the pandemic*, Vox, Aug. 10, 2020, <https://www.vox.com/2020/8/10/21336312/covid-19-pregnancy-birth-black-maternal-mortality>.

⁵⁷ *Id.*

⁵⁸ American Hospital Association, *COVID-19: Maternal and Child Health During COVID-19*, Jul. 2020, https://www.aha.org/system/files/media/file/2020/05/COVID-19-Maternal-Guidelines_rev6.pdf.

⁵⁹ *Id.*

⁶⁰ New York State Executive Order No. 202.25: Continuing Temporary Suspension and Modification of Laws Relating to the Disaster Emergency.

Director of Merck for Mothers and physician Mary-Ann Etiebet stated that the hospitals that were most overwhelmed by the pandemic were the same hospitals that Black and brown women in New York City were predominantly giving birth in.⁶¹ However, despite these inequities, the state’s budget bill, signed by Gov. Andrew M. Cuomo in April, includes \$138 million in Medicaid cuts to the city’s public hospitals, which mostly serve Black and Latino residents.⁶²

Tragically, New York City experienced several maternal deaths in hospitals since the onset of the COVID-19 pandemic. Amber Isaac, a 26-year-old Black woman, died on April 21, 2020, shortly after delivering her son, Elias, at Montefiore Medical Center in The Bronx.⁶³ According to reports, Ms. Isaac studied the disproportionate impact of maternal mortality on Black women throughout her pregnancy, and shortly before her death, she tweeted, “Can’t wait to write a tell all about my experience during my last two trimesters dealing with incompetent doctors at Montefiore.”⁶⁴ Shaasia Washington, also a 26-year-old Black woman, died on July 3, 2020, during childbirth at Woodhull hospital, an H+H facility in Brooklyn.⁶⁵ According to some reports, Shaasia died while being given an epidural.⁶⁶ Hendel Lezer, a 33-year-old orthodox Jewish woman, died on November 19, 2020 in Maimonides Hospital in Brooklyn from complications related to Covid 19, one day after delivering her fifth child.⁶⁷ According to reports, Mrs. Lezer’s family and doctor pled with the hospital to treat her with available COVID-19 treatments, but the hospital objected,

⁶¹ Emily Bobrow, *She Was Pregnant With Twins During Covid. Why Did Only One Survive?*, New York Times, Aug. 9, 2020, <https://www.nytimes.com/2020/08/06/nyregion/childbirth-Covid-Black-mothers.html>.

⁶² *Id.*

⁶³ “A Pregnant Woman Tweeted Concerns About a Bronx Hospital. She Died Days Later,” The City, Apr. 27, 2020, available at <https://www.thecity.nyc/health/2020/4/27/21247056/a-pregnant-woman-tweeted-concerns-about-a-bronx-hospital-she-died-days-later>.

⁶⁴ *Id.*

⁶⁵ “A 26-year-old woman died during childbirth in a New York City hospital, another loss in a tragic trend affecting women of color,” Insider, Jul. 8, 2020, available at <https://www.insider.com/black-woman-died-during-childbirth-new-york-hospital-shaasia-washington-2020-7>.

⁶⁶ *Id.*

⁶⁷ “Was the Tragic Death of This Young Mother A Result of Bad Hospital Policy?,” The Yeshiva World, Dec. 1, 2020, available at <https://www.theyeshivaworld.com/news/promotions/1925029/was-the-tragic-death-of-this-young-mother-a-result-of-bad-hospital-policy.html>.

citing protocol that only patients who contracted the virus less than a week ago could receive the treatment.⁶⁸

IV. RESPONSE

A. *New York City and State Response*

There have been a number of government initiatives addressing maternal mortality and morbidity over the past decade. For example, in March 2017, the NYC Council passed the Maternal Mortality Reporting Law, or Local Law 55 of 2017, which requires DOHMH to issue an annual report on maternal mortality, tracking statistics in four areas.⁶⁹ The Council then passed Local Law 188 of 2018, which expanded upon these required reporting criteria.⁷⁰ In December 2017, DOHMH formally launched a city-specific Maternal Mortality and Morbidity Committee (M3-RC, M3RC, or “the Panel”), composed of up to 45 members, including doctors, nurses, the doula community, researchers, first responders, and experts from various facilities and community based organizations.⁷¹ The M3RC meets every two to three months to conduct a multidisciplinary expert review of every maternal death in the City from both a clinical and a social determinants of health perspective.⁷² Additionally, DOHMH and the Fund for Public Health in New York City (FPHNYC) have received two grants from Merck for Mothers to implement severe maternal

⁶⁸ *Id.*

⁶⁹ Local Law 55 of 2017 available at <http://legistar.council.nyc.gov/LegislationDetail.aspx?ID=2709929&GUID=32D3EE5A-6F06-479D-BA51-F64D29EBAF6B&Options=ID|Text|&Search=55>

⁷⁰ Local Law 188 of 2018 available at <https://legistar.council.nyc.gov/LegislationDetail.aspx?ID=3498546&GUID=87504419-6255-4349-B173-F4A9FA5009FE&Options=ID|Text|&Search=188>.

⁷¹ Robin Fields, *New York City Launches Committee to Review Maternal Deaths*, PROPUBLICA, Nov. 15, 2017, available at <https://www.propublica.org/article/new-york-city-launches-committee-to-review-maternal-deaths>; See also Local Law 188 of 2018 available at <https://legistar.council.nyc.gov/LegislationDetail.aspx?ID=3498546&GUID=87504419-6255-4349-B173-F4A9FA5009FE&Options=ID|Text|&Search=188> (codifying the M3RC).

⁷² Sophie Wheelock, et. al., *Complications of Childbirth: Racial & Ethnic Disparities in Severe Maternal Morbidity in New York State*, The New York State Health Foundation, August 2020, available at <https://nyshealthfoundation.org/wp-content/uploads/2020/08/severe-maternal-morbidity.pdf>

morbidity projects, with the first resulting in the implementation of the first citywide severe maternal morbidity surveillance system and the second in the launch of the “Reducing Inequities and Disparities in Preventable Severe Maternal Morbidity in New York City Project.”⁷³ DOHMH has released reports about instances of severe maternal morbidity in New York City, with the latest released in 2016.⁷⁴

In 2018, H+H partnered with DOHMH and the Mayor’s Office to begin implementing a comprehensive maternal care program with the focus of identifying and responding to pregnancy-related morbidity and mortality for women of color, including a maternal medical home and simulation-based programs.⁷⁵ Additionally, implicit bias training has occurred within relevant private and public health care facilities across the City.⁷⁶ In April 2018, DOHMH published the *Summary of Vital Statistics 2016 The City of New York: Infant Mortality*,⁷⁷ part of the maternal associated mortality reports known as Vital Statistics reports,⁷⁸ which have been issued every five years since 2000.⁷⁹ The NYC Council has held hearings about or related to maternal health outcomes, including mortality and morbidity, in June 2018, September 2019, and January 2020.⁸⁰

⁷³ Sophie Wheelock, et. al., *Complications of Childbirth: Racial & Ethnic Disparities in Severe Maternal Morbidity in New York State*, The New York State Health Foundation, August 2020, available at

<https://nyshealthfoundation.org/wp-content/uploads/2020/08/severe-maternal-morbidity.pdf>

⁷⁴ New York City Department of Health and Mental Hygiene, *Severe Maternal Morbidity in New York City, 2008-2012*, 2016, available at <https://www1.nyc.gov/assets/doh/downloads/pdf/data/maternal-morbidity-report-08-12.pdf>

⁷⁵ Testimony from Dr. Mitchell Katz, found at

<https://legistar.council.nyc.gov/LegislationDetail.aspx?ID=4296306&GUID=75241933-0E50-49C2-A17A-A9799F4D64EB&Options=&Search=>

⁷⁶ NYC Health + Hospitals, *De Blasio Administration Launches Comprehensive Plan to Reduce Maternal Deaths and Life-Threatening Complications from Childbirth Among Women of Color*, July 20, 2018, available at

<https://www.nychealthandhospitals.org/pressrelease/comprehensive-plan-takes-maternal-safety-to-the-next-level/>

⁷⁷ Bureau of Vital Statistics, *Summary of Vital Statistics 2016*, available at

<https://www1.nyc.gov/assets/doh/downloads/pdf/vs/2016sum.pdf>

⁷⁸ <https://a816-healthpsi.nyc.gov/epiquery/IMR/index.html>; Section 3.1.3 Infant Mortality of the DOHMH 2016-2018 *Community Health Assessment and Community Health Improvement Plan: Take Care New York 2020* also addresses infant mortality (<https://www1.nyc.gov/assets/doh/downloads/pdf/tny/community-health-assessment-plan.pdf>).

⁷⁹ See, e.g., <https://www1.nyc.gov/assets/doh/downloads/pdf/data/maternal-morbidity-report-08-12.pdf>

⁸⁰ <https://legistar.council.nyc.gov/MeetingDetail.aspx?ID=607470&GUID=4EA45927-1CBC-427A-A16D-2011DF7FA371&Options=info|&Search=>;

<https://legistar.council.nyc.gov/MeetingDetail.aspx?ID=715584&GUID=B80CFE14-2106-4CAA-AD0A->

The Council also has a long history of using discretionary funding to work towards reducing maternal morbidity. In Fiscal 2002, Council launched the Infant Mortality Reduction Initiative, totaling \$2.5 million. The goal of the initiative was to promote women’s health before, during, and after pregnancy and to work in areas in the City with the highest infant mortality rates.⁸¹ Starting in Fiscal 2016, the Council began funding the Healthy Women, Healthy Future program initiative, totaling \$300,000, a program that supports an array of doula services.⁸² Beginning in Fiscal 2017, the two initiatives were grouped together into the Maternal and Child Health Services Initiative. The Council has continued its commitment to these issues and in Fiscal 2021, the Council has designated \$1.9 million to the Maternal and Child Health Services Initiative which supports 19 organizations across all five boroughs.⁸³ In Fiscal 2020, this initiative reached more than 5,408 individuals.⁸⁴

Additionally, beginning in Fiscal 2017 the Council funded the Nurse Family Partnership Initiative for \$2 million, which is an evidence-based maternal and early childhood health program that fosters long-term success for first-time mothers, their babies and society.⁸⁵ The Council has advocated for expansion of funding for the Nurse Family Partnership and in Fiscal 2019, the Council successfully negotiated \$4 million in baseline funding for the program by the

[4C2E2841C798&Options=info&Search=;](https://legistar.council.nyc.gov/LegislationDetail.aspx?ID=4296306&GUID=75241933-0E50-49C2-A17A-A9799F4D64EB&Options=&Search=)
<https://legistar.council.nyc.gov/LegislationDetail.aspx?ID=4296306&GUID=75241933-0E50-49C2-A17A-A9799F4D64EB&Options=&Search=>

⁸¹ <https://council.nyc.gov/budget/wp-content/uploads/sites/54/2015/06/fy2016-skedcf.pdf>

⁸² Ibid.

⁸³ <https://council.nyc.gov/budget/wp-content/uploads/sites/54/2016/05/FY17-Schedule-C.pdf>

⁸⁴ <https://council.nyc.gov/budget/wp-content/uploads/sites/54/2020/06/Fiscal-2021-Schedule-C-Cover-REPORT-Final.pdf>

⁸⁵ <https://council.nyc.gov/budget/wp-content/uploads/sites/54/2016/05/FY17-Schedule-C.pdf>

Administration.⁸⁶ The total budget for Nurse Family Partnership in the Department of Health and Mental Hygiene’s budget is \$14 million.⁸⁷

There have also been a number of initiatives taken at the State level. In January 2018, Governor Cuomo announced a proposal to create a State Maternal Mortality Review Board (“Board”) to review of each maternal death.⁸⁸ The New York State Department of Health (DOH) convenes a Board of diverse experts to conduct a confidential review of each maternal death, determining whether death was preventable, and to identify recommendations.⁸⁹ On April 23, 2018, the Governor announced a series of additional new initiatives focused on maternal mortality and disparate racial outcomes, including another taskforce, a pilot to expand Medicaid to cover doula services, a best practices summit, and a call for enhanced training for medical students.⁹⁰ The Taskforce on Maternal Mortality and Disparate Racial Outcomes (the Taskforce) met three times between June and December 2018, and members of the Taskforce submitted recommendations to the Governor on ways to reduce racial disparities and preventable maternal

⁸⁶ <https://council.nyc.gov/budget/wp-content/uploads/sites/54/2018/06/Fiscal-2019-Schedule-C-Final-Report.pdf>

⁸⁷ New York City Financial Management System

⁸⁸ Note that both the Maternal Mortality Review board and 2010 Maternal Mortality Review initiative are (confusingly) referred to by the acronym “MMR.” <https://www.governor.ny.gov/news/governor-cuomo-announces-efforts-combat-maternal-depression-and-prevent-maternal-mortality> (The governor directed the Department of Financial Services to require that all health insurance policies include coverage for maternal depression screening and that DOH and Office of Mental Health will launch a strategic awareness campaign to address stigma of maternal depression)

⁸⁹ The New York State Taskforce on Maternal Mortality and Disparate Racial Outcomes, *Recommendations to the Governor to Reduce Maternal Mortality and Racial Disparities*, 1, 4 (March 2019), available at https://health.ny.gov/community/adults/women/task_force_maternal_mortality/docs/maternal_mortality_report.pdf.

⁹⁰ *Governor Cuomo Announces Comprehensive Initiative to Target Maternal Mortality and Reduce Racial Disparities in Outcomes*, April 23, 2018, available at <https://www.governor.ny.gov/news/governor-cuomo-announces-comprehensive-initiative-target-maternal-mortality-and-reduce-racial>

mortality and morbidity.⁹¹ The doula pilot faced implementation issues and failed to get off the ground.⁹²

In response to issues arising during the COVID-19 pandemic, the State created a COVID-19 Maternity Task Force.⁹³ On April 29, 2020, the State announced that the Governor accepted the Task Force's recommendations in full, which included measures to diversify birthing site options and support patient choice; extend the period of time a healthy support person can accompany a mother post-delivery; mandate testing of all pregnant New Yorkers; ensure equity in birthing options; create an educational campaign; and review the impact of COVID-19 on pregnancy and newborns with special emphasis on reducing racial disparities in maternal mortality.⁹⁴ Included in the final recommendation was a plan for DOH to host weekly statewide interactive webinars addressing the management of maternity care during the pandemic, as needed, as part of a collaboration with the New York State Perinatal Quality Collaborative in partnership with the American College of Obstetrics and Gynecology District II, including a webinar on obstetrical care and implicit bias within the context of the COVID-19.⁹⁵

B. Medical Community Response and Best Practices

The medical community has done a great deal to respond to the maternal mortality crisis, including creating organizations, conducting studies, holding panel discussions, task forces, and

⁹¹ *New York State Taskforce on Maternal Mortality and Disparate Racial Outcomes Recommendations to the Governor to Reduce Maternal Mortality and Racial Disparities*, March 2019, available at

https://health.ny.gov/community/adults/women/task_force_maternal_mortality/docs/maternal_mortality_report.pdf

⁹² Denis Slattery, *State yet to deliver on Brooklyn doula pilot program expanding Medicaid coverage*, The Daily News, August 12, 2019, available at <https://www.nydailynews.com/news/politics/ny-doula-pilot-program-brooklyn-delayed-medicaid-20190812-nze23w6f6re67n6xepn4c3zdm4-story.html>

⁹³ The New York State Taskforce on Maternal Mortality and Disparate Racial Outcomes, *Recommendations to the Governor to Reduce Maternal Mortality and Racial Disparities*, 1, 4 (March 2019), available at https://health.ny.gov/community/adults/women/task_force_maternal_mortality/docs/maternal_mortality_report.pdf.

⁹⁴ *Secretary to the Governor Melissa DeRosa Issues Report to Governor Cuomo Outlining the COVID-19 Maternity Task Force's Initial Recommendations*, April 29, 2020, available at <https://www.governor.ny.gov/news/secretary-governor-melissa-derosa-issues-report-governor-cuomo-outlining-covid-19-maternity>

⁹⁵ *Id.*

seminars, and coming up with best practices and recommendations to improve maternal outcomes⁹⁶. On a national level, the Surgeon General, via the United States Department of Health and Human Services (HHS), issued a list of recommendations for healthcare providers in January 2020, which include⁹⁷:

- **Collect and evaluate your key maternal safety data** for hypertension, hemorrhage, infections, primary C-section rate and opioid addiction. Every hospital should have a systematic approach to reviewing maternal health complications, acting on the data as appropriate and implementing improvement strategies. It is also important to ensure risk-appropriate care is provided to both high- and low-risk patients to decrease unnecessary interventions and improve screening and detection of complications.
- **Examine care disparities in your maternal population.** Break down your data by place, race, ethnicity and other variables appropriate to your organization and community. Analyze the data over a period of years to help identify disparities and opportunities for improvement in areas, including addressing social determinants of health and maternal health, both prior to and after delivery.
- **Next, engage mothers and their families as advocates for themselves and others.** Empower them to be vocal about their care, and ensure that you have strong referral networks and interventions.

⁹⁶ See Jim Bozen, *How New York City's Public Health Care System Responded to COVID-19* (May 21, 2020), available at <https://knowledge.wharton.upenn.edu/article/new-york-citys-public-health-care-system-responded-covid-19/>; See, e.g., Caribbean Women's Health Association, Inc., Presentation: COVID-19 Response/ Services Available (2020).

⁹⁷ "Achieving Better Health for Mothers and Babies: Taking Action, Saving Lives," Vice Adm. Jerome M. Adams M.D., M.P.H., Surgeon General of the United States and Jay Bhatt, D.O., Senior Vice President and Chief Medical Officer at the American Hospital Association, HHS, Jan. 29, 2020, available at <https://www.hhs.gov/blog/2020/01/29/achieving-better-health-mothers-and-babies.html>.

- **Partner with clinicians and stakeholders in your community.** Engage healthcare providers, community and tactical partners, and other stakeholders in these efforts so that together we can improve maternal health and the well-being of babies and families.

The American Medical Association (AMA) supports and recommends similar data-based solutions to improve maternal outcomes:⁹⁸

- State and county health departments must develop a maternal mortality surveillance system, identify barriers and develop strategies to implement evidence-based practices to reduce poor obstetric outcomes in racial and ethnic minorities;
- Establishment of government-funded maternal mortality review committees (MMRCs);
- Expanding access to health care and social services for postpartum women;
- Improving data collection;
- Expanding existing federal grant programs dedicated to scaling best practices to improve maternity care;
- Authorizing states to expand coverage through longer post-partum coverage under Medicaid, the Children’s Health Insurance Program and the Special Supplemental Nutrition Program for Women, Infants and Children.⁹⁹

On a clinical level, the Society for Maternal Fetal Medicine proposes recommendations to improve clinical care for providers, healthcare systems, and medical systems (see chart below).¹⁰⁰

⁹⁸ “More new moms are dying in U.S. Here’s how to arrest the trend,” AMA, Sep. 24, 2020, available at <https://www.ama-assn.org/delivering-care/population-care/more-new-moms-are-dying-us-here-s-how-arrest-trend>.

⁹⁹ *Id.*

¹⁰⁰ Joses A. Jain, MD, et al., “SMFM Special Report: Putting the “M” back in MFM: Reducing racial and ethnic disparities in maternal morbidity and mortality: A call to action,” Feb. 2018, available at <https://www.ajog.org/action/showPdf?pii=S0002-9378%2817%2932374-8>.

Recommendations	Rationale	Description
For providers		
Use available preventive therapies for high-risk women.	Prevention strategies in high-risk women can lead to an improvement in healthcare costs and care outcomes. ⁶⁷	Prescribe low-dose aspirin to prevent preeclampsia according to US Preventive Services Task Force guidelines.
Assess baseline end-organ damage among high-risk women.	Black women are more likely to have end-organ damage for any given duration of hypertension. ²⁵	Consider an algorithm for high-risk women who may benefit from a maternal echocardiogram, renal function evaluation, and sleep apnea screening either before or early in pregnancy.
Follow existing clinical guidelines.	Specific societies may have recommendations for the management of medical conditions; only 10–40% of women with hypertension or diabetes mellitus will see a primary care provider within 1 year after delivery. ⁶⁸	Follow existing evidence-based guidelines (American Heart Association guidelines for treatment of hypertension; National Institute for Health and Care Excellence guideline key recommendations for a 6- to 8-week postpartum consultation). ^{29,69}
For healthcare systems		
Provide supportive services that facilitate access to care.	Improved access to care is associated with significant increases in usage, preventive care, healthcare quality, and self-reported health, in addition to reductions in emergency department use. ⁷⁰	Incorporate standardized, culturally appropriate patient education materials that illustrate the link between pregnancy complications and future health.
		Provide transportation vouchers and translation services.
		Provide remote visits and home visits when possible. Consider using community-based initiatives to enhance prenatal and postnatal care.
For hospital systems		
Improve the quality of the care provided.	Black women are more likely to deliver at hospitals that serve a predominately black population and have high rates of morbidity. ²⁶	Incorporate recommended care bundles that are related specifically to hypertension, venous thromboembolism prevention, and postpartum hemorrhage.
		Partner with lower resource hospitals to help improve healthcare quality.
Implement maternal morbidity and mortality reviews.	Mortality reviews can help identify areas of substandard care that need improvement. ⁷¹	Undertake a systematic, multidisciplinary review of all cases of death and severe morbidity. ⁷²
		Establish a mechanism to disseminate knowledge gained from those reviews.

Jain. SMFM special report. Am J Obstet Gynecol 2018.

The American College of Obstetricians and Gynecologists have issued recommendations to specifically address racial and ethnic disparities in obstetrics and gynecology¹⁰¹:

- Raise awareness of health disparities among colleagues, practice staff, and administrators through grand rounds presentations, office staff meetings, and resident and student lectures.
- Recommend and support quality improvement projects that identify and develop initiatives to target specific disparities within local health care systems.

¹⁰¹ “Racial and Ethnic Disparities in Obstetrics and Gynecology,” American College of Obstetricians and Gynecologists, Dec. 2015, available at <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2015/12/racial-and-ethnic-disparities-in-obstetrics-and-gynecology>.

- Educate staff and colleagues about community resources for women with limited access to health care.
- Work collaboratively with local public health authorities to address disparities in environmental exposures, health education and literacy, and women’s health services and outcomes (e.g., breast and cervical cancer screening, maternal and infant mortality).
- Encourage health system leadership to advocate for local, state, and national policies to improve women’s health care and reduce disparities.

In New York City, doctors and the medical community have also worked to address maternal health outcomes outside the formal hospital and healthcare setting. For example, Dr. Taraneh Shirazian, an Obstetrician/Gynecologist at NYU Langone founded the non-profit Saving Mothers, which operates around the world and in New York City in underserved areas using low-cost, high-impact programs for women that aim to decrease death in pregnancy and delivery.¹⁰² This year, Saving Mothers created a program in New York City called “mPOWHER,” which teaches community health workers how to identify high-risk patients in the home, how to talk about complications, teach about medical risk in pregnancy, and teach pregnant women how to communicate with their physicians to help ensure their health is prioritized in the health care system.¹⁰³

V. CONCLUSION

The Committees on Women and Gender Equity, Health and Hospitals will seek to follow-up on the June 27, 2018 hearing, specifically issues relating to maternal mortality and morbidity in NYC, with a particular focus on the experience of birthing people of color and their babies. This

¹⁰² See, “This Doctor Is Helping Pregnant NYC Women in the Pandemic With Lessons From Abroad,” May 19, 2020, available at <https://opmed.doximity.com/articles/this-doctor-is-helping-pregnant-nyc-women-in-the-pandemic-with-lessons-from-abroad>; see also, Saving Mothers, available at <https://savingmothers.org/our-vision/>.

¹⁰³ *Id.*

will also include an examination of the City's reports on maternal mortality and access to doulas, which were prepared pursuant to Local Laws 187 and 188 of 2018. Moreover, the Committees are interested in how rates of maternal mortality and morbidity have been impacted by the COVID-19 pandemic as well as how the City is working to mitigate any factors that threaten to further exacerbate racial inequities among birthing people of color. The Committees are also interested in learning what steps the City must take to improve outcomes for birthing people of color and their babies. Lastly, the Committees are interested in hearing testimony on Int. No. 2017 and Int. No. 2042.

VI. ANALYSIS OF INT. NO. 2017

Int. No. 2017 would require DOHMH to develop voluntary guidelines for hospital visitation policies in the event of a public health emergency. Such guidelines would be distributed to hospitals in the City, posted on the DOHMH website, and submitted to the Mayor and Speaker of the Council. This legislation would also require DOHMH to develop voluntary guidelines for hospital visitation policies in response to COVID-19 by July 1, 2020.

This legislation would take effect immediately.

VII. ANALYSIS OF INT. NO. 2042

Int. No. 2042 would require DOHMH to post information about licensed midwives, including the services they offer and how to find them, on the DOHMH website.

This legislation would take effect immediately.

(Page intentionally left blank)

By Council Members Rivera, Kallos, Chin and Brannan

A Local Law to amend the administrative code of the city of New York, in relation to visitation policy guidelines for hospitals during public health emergencies

Be it enacted by the Council as follows:

Section 1. Title 17 of the administrative code of the city of New York is amended by adding a new chapter 20 to read as follows:

CHAPTER 20

PUBLIC HEALTH EMERGENCY RESPONSE

§ 17-2001 Definitions. For the purposes of this chapter, the following terms have the following meanings:

COVID-19. The term “COVID-19” means the 2019 novel coronavirus or 2019-nCoV.

Department. The term “department” means the department of health and mental hygiene.

Public health emergency. The term “public health emergency” means any state of emergency declared by the state or the city in response to an outbreak of an infectious disease.

§ 17-2002 Hospital visitation policy guidelines. a. No later than 14 days after a declaration of a public health emergency, the department shall develop voluntary guidelines for hospital visitation policies. Such guidelines shall take into consideration federal, state and local laws and regulations regarding hospital visitation policies. Such guidelines shall include specific provisions regarding visitors of a patient giving birth.

b. The department shall immediately submit to the mayor and the speaker of the council and shall post conspicuously on the department’s website the voluntary guidelines for hospital visitation policies developed pursuant to subdivision a. The department shall immediately distribute such guidelines to every hospital in the city.

c. No later than July 1, 2020, the department shall submit to the mayor and the speaker of the council and shall post conspicuously on the department's website voluntary guidelines for hospital visitation policies in response to COVID-19, in accordance with subdivisions a of this section. No later than July 1, 2020, the department shall distribute such guidelines to every hospital in the city.

§2. This local law takes effect immediately.

AM
LS #14496
5/22/20

Int. No. 2042

By Council Members Gibson, Yeger, Rosenthal, Perkins, Ayala, Chin, Cumbo and Adams

A Local Law to amend the administrative code of the city of New York, in relation to posting information about midwives online

Be it enacted by the Council as follows:

Section 1. Chapter 1 of title 17 of the administrative code of the city of New York is amended by adding new section 17-199.14 to read as follows:

§ 17-199.14 Information on midwives. a. Definitions. For the purposes of this section, “midwife” means an individual who is licensed or certified to practice midwifery in New York state.

b. The department shall make available information on the services offered by midwives and information on how to find a midwife on the department’s website, in English and in each of the designated citywide languages as defined in section 23-1101.

§ 2. This local law takes effect immediately.

BM
LS #14919
8/19/20 3:00 pm

(Page intentionally left blank)

Res. No. 1239

Resolution calling on the New York State Legislature to pass, and the Governor to sign, legislation making doulas more accessible to individuals with Medicaid and those without health insurance.

By Council Members Rivera, Ampry-Samuel, Louis, Gibson, Chin and Brannan

Whereas, According to DONA International, a doula is a trained professional who provides continuous physical, emotional, and informational support to a pregnant person and the family before, during, and shortly after childbirth; and

Whereas, Doulas have proven to be beneficial to pregnant people and their health; and

Whereas, According to the New York City Department of Health and Mental Hygiene's (DOHMH's) report *The State of Doula Care in NYC 2019* ("doula report"), doula care has been associated with lower rates of Cesarean birth, preterm birth, low birthweight, and postpartum depression, as well as with increased rates of breastfeeding, and greater patient satisfaction with maternity care; and

Whereas, A recent report published by Cochrane reveals that people who had doula support were 39 percent less likely to have a caesarean section and 15 percent more likely to give birth without needing drugs or labor-inducing techniques; and

Whereas, According to Choices in Childbirth, a survey regarding doula care in New York City reveals that 72 percent of people reported that their doula helped them communicate their preferences and needs, while 80 percent of those surveyed reported that their doula helped them feel more empowered; and

Whereas, 83 percent of survey respondents reported having a doula made their labor and birth experience “much better” than if they had not used a doula, and it made them more relaxed before, during, and after birth; and

Whereas, 88 percent of this cohort reported that cost was an issue when opting to work with a doula; and

Whereas, According to DOHMH’s doula report, the average cost of birth-doula services was \$1,550 per client among doulas surveyed for the report, with a range of \$225 to \$5,000; and

Whereas, Doula services are generally not covered by Medicaid or private insurance; and

Whereas, Doula care should be more accessible, especially given the maternal mortality and morbidity rates in New York City as well as the inequitable health outcomes for women of color and infants of color, specifically those who are Black; and

Whereas, Of the 15 pregnancy-related deaths in New York City in 2016, six were of people who were Black and six were of people who were Latina, accounting for nearly every pregnancy-related death; and

Whereas, In New York City in 2016, the rate of severe maternal morbidity was highest among Black people (428.6 per 10,000 births), followed by people of other, multiple, or not reported races (354.5), people who are Latina (288.3), Asian/Pacific Islander (207.9), and, last, people who are White (160.8); and

Whereas, By expanding access to doulas, New York City could better tackle these insidious inequities; and

Whereas, Doulas face barriers providing care to all those who need it; and

Whereas, According to DOHMH's doula report, among doulas surveyed, 9 of every 10 have turned clients away, for reasons including clients' living outside their coverage area (47 percent), being already booked with other families (43 percent), and clients' being unable to afford their fee (37 percent); and

Whereas, Currently New York State is considering legislation to include doula services in Medicaid coverage, and, in April 2018, New York State announced the launch of a Medicaid pilot program to cover doula services; and

Whereas, This legislation and pilot are extremely controversial in the doula community for numerous reasons; and

Whereas, As of DOHMH's doula report, the Medicaid pilot program has yet to launch in Brooklyn because of lack of doula participation; and

Whereas, There are many flaws with the pilot program, including a reimbursement rate that would likely be lower than minimum wage; and

Whereas, DOHMH's doula report on doula care provides numerous recommendations for stakeholders to improve access to doulas; and

Whereas, Recommendations fall within four key components, including increasing access for underserved communities, making hospital environments more welcoming of doulas, amplifying community voices to help expand access to doula services, and improving data collection; and

Whereas, The New York State Legislature should consider these recommendations, and should develop legislation, in collaboration with doulas and people with lived experience, in order to best understand the most effective and significant ways to expand access to doula services; now, therefore, be it,

Resolved, The Council of the City of New York calls on the New York State Legislature to pass, and the Governor to sign, legislation making doulas more accessible to individuals with Medicaid and those without health insurance

EB
LS 13225
01/23/2020

Res. No. 1408

Resolution calling on the New York State Legislature to pass, and the Governor to sign, A. 10440/S. 8307, relating to accreditation, approval, and operation of midwifery birth centers.

By Council Members Rosenthal and Gibson

Whereas, A novel coronavirus, called SARS-CoV-2, first emerged in late 2019 and spread rapidly around the world; and

Whereas, The virus has greatly impacted New York City, which was the epicenter of the pandemic for months; and

Whereas, As of July 28, 2020, 220,907 residents of New York City had tested positive for the disease caused by SARS-CoV-2, called COVID-19, with over 56,000 hospitalized for treatment; and

Whereas, COVID-19 has disproportionately impacted New Yorkers who are Black, Latinx, and lower income; and

Whereas, New York City's hospital systems were stretched dangerously thin during the crisis, with hospitals concerned about access to equipment and resources; and

Whereas, Pregnant people and people giving birth during the pandemic are facing additional stress and barriers to care, along with the typical stress associated with childbirth; and

Whereas, According to the New York Times, people who gave birth during the peak of cases in the city in spring 2020 reported issues with being able to have their partners with them for the duration of their recovery, with being separated from their newborns if they test positive for COVID-19, and with other issues; and

Whereas, According to the American Association of Birth Centers, a birth center is a freestanding health care facility for childbirth where care is provided in the midwifery and wellness model, and is not a hospital; and

Whereas, In 2016, Public Health Law Article 28 was amended to promote midwifery birth centers (MBCs), and, almost four years later, there is not a single MBC licensed under Article 28; and

Whereas, According to the New York Times, as of 2018, New York State had only three free-standing birthing centers, whereas Texas had more than 70 centers and California had about 40; and

Whereas, To better address the needs of pregnant people and newborns during the pandemic, the State developed a COVID-19 Maternity Task Force; and

Whereas; The Task Force recommended the New York State Department of Health (NYSDOH) move to expedite the finalization of the licensure process for the establishment of midwifery led birthing centers in New York State; and

Whereas, By expediting the final licensure process, NYSDOH will help to ensure there are sufficient birthing facilities available to meet community need during emergency situations; and

Whereas, Governor Andrew Cuomo, in response to the recommendations, announced that NYSDOH approved two new temporary birthing centers and is also now accepting Certificate of Need applications for MBCs pursuant to Public Health Law Article 28; and

Whereas, A. 10440/S. 8307, sponsored by Assembly Member Richard Gottfried and Senator Gustavo Rivera, relates to the accreditation, approval, and operation of MBCs; and

Whereas, This legislation would provide that if a proposed MBC meets the standards of a national accrediting organization that specializes in accrediting MBCs and is recognized by

NYSDOH, then the proposed MBC shall be deemed to meet New York's requirements for issues covered by those standards; and

Whereas, A. 10440/S. 8307 would make it easier for MBCs to be established in New York, which will provide more birthing options for pregnant people; and

Whereas, COVID-19 and maternal mortality and morbidity disproportionately impact those who are Black and Latinx, therefore, the state should act to ensure individuals have as many safe birthing options as possible and work to further address racial health disparities; now, therefore, be it

Resolved, The Council of the City of New York calls on the New York State Legislature to pass, and the Governor to sign, A. 10440/S. 8307, relating to accreditation, approval, and operation of midwifery birth centers

EB
LS 15190
07/28/2020